

## HORIZON HEALTH EAP SERVICES, INC. PRACTITIONER SERVICES AGREEMENT

THIS AGREEMENT is made and entered into as of the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_ by and between **Horizon Health EAP Services, Inc.** (hereinafter "HH"), and \_\_\_\_\_ (hereinafter "Practitioner") a behavioral health provider licensed or certified under the laws of the State in which Practitioner practices.

Execution of this Agreement expressly supersedes and replaces any and all agreements, contracts or other payment or reimbursement understandings, whether written or oral, currently in force between Practitioner and HH, and any other purchasers of health care services that have entered into Agreements with HH insofar as those agreements, contracts or understandings may pertain to provision of mental health and chemical dependency services.

### RECITALS:

WHEREAS, HH enters into agreements with self-insured employers, health maintenance organizations, health insurance companies, and other third-party payor's to manage the delivery of mental health care and substance abuse treatment services; and

WHEREAS, HH desires to contract with behavioral health practitioners, group practices and organizational providers to provide behavioral health services, and to ensure the appropriate level of care to individuals entitled to care from third party Payors; and

WHEREAS, Practitioner is a licensed or certified health care professional trained and experienced in psychiatry and/or psychotherapy who is capable of providing behavioral health services and is willing to contract with HH on the terms and conditions set forth in this Agreement; and

WHEREAS, HH and Practitioner mutually desire to arrange for the provision of behavioral health services at a reasonable cost, subject to the terms and conditions set forth more fully below, while preserving and enhancing the dignity of individuals entitled to such services;

NOW, THEREFORE, in consideration of the mutual covenants contained herein, the parties hereby agree as follows:

### ARTICLE I Definitions

1.1 Applicable Law. All federal, state and local statutes, rules, regulations, and ordinances applicable to the subject matter of this Agreement or the Parties' performance of their duties and obligations hereunder; and all standards, rules and regulations of all regulatory and accreditation bodies which have jurisdiction over the subject matter of this Agreement or the Parties performance of their duties hereunder.

1.2 Clinical Appeals Committee. An internal committee within the HH managed care division that reviews all clinical denials on a routine basis. Except in the instance that a Payor has contracted with HH to the contrary, the Clinical Appeals Committee will adjudicate appeals.

1.3 Complaint Procedures. The applicable HH and/or Payor's written procedures outlining the method in which complaints or disputes with a Covered Person or Network Provider are to be resolved.

1.4 Coinsurance. A percentage that the member pays for Covered Services after the deductible is met. Coinsurance may vary depending on the type of plan or service provided.

1.5 Coordination of Benefits. The determination of which of two or more health plans will be responsible, either as primary or secondary coverage, for providing, arranging or paying for services to a Member. Coordination of Benefits is intended to prevent a Member from receiving from the responsible payor or plan, a total of more than one hundred percent (100%) of covered charges from all Payor or Plan coverages.

1.6 Copayment. The payment to be collected directly by Practitioner from the Covered Person for Covered

Services in the amount specified in the applicable Mental Health Benefits Plan.

1.7 Coverage Certificate. A document provided by a Payor to a Member which sets forth the terms and conditions for the provision of Covered Services.

1.8 Covered Person. Any subscriber or dependent who is entitled to Covered Services under a Mental Health Benefits Plan.

1.9 Covered Services. Those medically necessary emergency, acute inpatient, outpatient and partial hospitalization behavioral health services ordinarily provided by Practitioner which are benefits available to a Member pursuant to the terms of the Member's Coverage Certificate. These services must be appropriate and necessary, as determined by HH in accordance with acceptable standards of mental health practice, to preserve a Member's mental health and must be performed in the most efficient type of setting appropriate for the condition.

1.10 Deductibles. The amount a Member must pay each benefit year before the insurance plan pays for covered services.

1.11 Emergency Services. The sudden and unexpected onset of a symptom or illness, which, in the judgment of HH's Medical Director, or other designated, qualified peer review physician, requires immediate diagnosis and/or treatment to reduce symptoms of mental illness on an emergency basis. The condition so treated must require treatment of such immediate nature that the patient's life, health, mental health, or the safety of others would be jeopardized if the patient were not treated immediately.

1.12 Medically Necessary Services. Those covered services, which are appropriate and necessary, as determined by HH in accordance with acceptable standards of mental health practice, to preserve a Member's health. Medically Necessary Services must be performed in the most cost-effective manner appropriate for the condition.

1.13 Mental Health Benefits Plan. The Payor's written plan that provides mental health and/or substance abuse benefits for Covered Persons.

1.14 Network Provider. A licensed physician, clinical social worker, psychologist or other licensed and/or credentialed behavioral health care professional or health care provider who has entered into an agreement with HH to provide behavioral health care services to Covered Persons. This definition is to be used simultaneously with Practitioner and/or HH Practitioner.

1.15 Payor. An insurance carrier, health service corporation, health care plan, health maintenance organization, self-insured employer, employee welfare benefit plan, multiple employer welfare arrangement, state or federal governmental agency, third party administrator or any other individual or entity which has entered into an agreement with HH in which HH is to manage and/or provide mental health and/or substance abuse treatment for Covered Persons utilizing HH Network Providers.

1.16 Payor's Agent. The party, whether it be HH, a third-party administrator or other corporation or entity, designated by the Payor to pay claims submitted by health care providers.

1.17 Practitioner Manual. A manual prepared by HH to acquaint Network Practitioners with the philosophy, policies, and procedures of HH. The Practitioner Manual is incorporated by reference within the Agreement.

1.18 Quality Improvement/Utilization Management Program. The systems established by HH to provide for a quality improvement and utilization management program, including, but not limited to, HH's Utilization Management Program description, utilization review criteria and Quality Improvement Plan. Such systems include, but are not limited to, monitoring the delivery of Covered Services to Covered Persons with respect to their quality, costs, effectiveness, and utilization, and implementing corrective actions determined to be necessary and appropriate by HH.

**ARTICLE II**  
**Obligations of Practitioner**

2.1 Licensure; Accreditation; Capability. Practitioner warrants that s/he is currently licensed or certified by the state in which Practitioner practices and that s/he will maintain said license or certification during the term of this Agreement. Practitioner also warrants that s/he will maintain, at Practitioner's own cost and expense, an appropriate license or certification to practice psychotherapy in the state in which Practitioner practices, and in that regard, shall pay all fees and attend any and all professional education that may be required in order to maintain such license or certification and do all other things incident to the maintenance of said license. Practitioner shall provide to HH a copy of each renewed license or certification no later than thirty (30) days after the effective date of renewal.

2.2 Credentialing. Practitioner hereby agrees to comply with all applicable provisions of the HH Provider Manual as amended from time to time and consents to the completion of a Practitioner Application and to the verification of credentialing and recredentialing information as may be necessary to satisfy HH policies. Practitioner agrees to furnish authorizations for the release of information regarding Practitioner as requested by HH to either HH or a third party contracting with HH. Practitioner acknowledges that credentialing and recredentialing may include, but is not limited to, receipt of information by HH from the State Board of Licensure of Certification and/or the National Practitioner Data Bank regarding sanctions or limitations on licensure from the appropriate state agency, State Board of Medical Examiners, Federation of State Medical Boards, and regional Medicare and Medicaid offices.

2.3 Required Notification to HH. Practitioner shall notify HH immediately after the occurrence of one of the following:

- a) Practitioner's license or certification to practice in the state in which Practitioner practices is suspended, revoked, voluntarily relinquished, or subjected to terms of probation or other restriction;
- b) Practitioner's clinical privileges at any health facility are denied, revoked, suspended (temporarily or permanently), restricted or voluntarily relinquished;
- c) A threat by a Covered Person to report Practitioner's conduct to a disciplinary board or Practitioner becomes subject to any formal disciplinary proceeding or action before the state in which Practitioner practices. Or to any disciplinary board or similar agency in another state;
- d) Practitioner becomes subject to any federal governmental action, including investigations, asset freezes or forfeitures, criminal arrest, indictment, fine or penalty, civil sanctions, including civil monetary penalties, Medicare exclusion or Medicaid disbarment;
- e) A threat of civil action or initiation of civil action is brought against Practitioner as a result of Covered Services to a Covered Person or a civil action is settled or judgment made against Practitioner that relates to or arises out of Practitioner's professional practice;
- f) Criminal charges are filed against Practitioner or Practitioner is arrested for any reason that relates in any way to Practitioner's treatment of a Covered Person;
- g) There is a loss of or inability to secure professional liability insurance as required by this Agreement; or
- h) An allegation of impropriety alleged by a Covered Person or representative of a Covered Person involving allegations of impropriety on the part of Practitioner, which involve allegations of immoral or unethical conduct.

Practitioner acknowledges that HH reserves the right to suspend referrals of Covered Members to Practitioners upon notice of any of the foregoing items, a through h, if HH determines that such suspension is necessary to ensure maintenance of the highest quality or to protect the health and safety of the Covered Member. Practitioner agrees to assist HH with the investigation of any of the above referenced actions. Practitioner agrees to assist HH with the investigation of any complaints made to HH, a Payor, the Division of Insurance, any grievance panel or licensing authority concerning Practitioner. Practitioner agrees to return all telephone calls from HH regarding the above within two (2) days of notification regarding any complaint or allegation. Practitioner understands that failure to comply with this Section may result in automatic termination of this Agreement.

2.4 Provision of Covered Services. Practitioner within the scope of his/her professional licensure and capabilities, shall provide Covered Services to Covered Persons in a manner consistent with sound clinical judgment and nothing in this section is intended to require Practitioner to take any action inconsistent with his/her professional judgment. Practitioner shall be solely and exclusively responsible for the provision of Covered Services except as provided in Sections regarding psychiatric emergencies, Practitioner shall provide services to Covered Persons only upon receipt of A) authorization prior to the provision of services or b) such other pre-authorization process as HH may designate.

Practitioner is aware that HH shall at times enter into Agreement's with various Payor groups. Practitioner agrees to comply with the terms, covenants and conditions for Practitioners and/or subcontractors as stated in these Agreements. Practitioner acknowledges and agrees that Payors contracting with HH for the provision of behavioral health services shall have the opportunity to grant prior approval or to disapprove the participation status of Practitioner for the provision of service to their Covered Person(s). Practitioner is aware that HH may charge an annual network participation fee for Practitioner's participation in the HH network.

Practitioner agrees that Covered Services shall be delivered to Covered Persons in an appropriate, timely, and cost effective manner. Further, Practitioner represents and warrants that s/he will furnish Covered Services according to generally accepted medical, mental health, and chemical dependency practices, as well as community standards within the state in which Practitioner practices, and shall be in compliance with all Applicable Laws and state and federal regulations. Practitioner agrees to obtain ongoing training and clinical supervision according to generally accepted medical, mental health, and chemical dependency practices. Practitioner agrees to provide a summary of such training upon request of HH.

Practitioner agrees that in the event that HH refers Medicare enrollee and/or Medicaid Enrollee to the Practitioner and the Practitioner elects to receive such referral, Practitioner shall abide by all of the provisions of the Medicare and/or Medicaid Addendum, which shall be included as part of this Agreement. Practitioner agrees that if s/he is a Medicare and/or Medicaid provider, s/he will follow all applicable Medicare and/or Medicaid rules and regulations for the provision of services to Medicare and/or Medicaid Covered Persons, which may be amended from time to time by HH, Medicare, and/or Medicaid.

2.5 Continuity and Coordination of Care. Practitioner ensures that the behavioral health services provided to Covered Persons are coordinated and integrated with general medical care and will collaborate with HH to increase appropriate use and reduce inappropriate use of psychopharmacological medications and reduce the incidence of adverse drug reactions. In providing continuity of care, Practitioner agrees to seek the consent of the Covered Person to inform the Covered Person's primary care physician of the Covered Person's diagnosis, medications and treatments in a timely manner. Practitioner agrees to then notify the Covered Person's primary care physician of the above within a timely manner.

2.6 Covering Arrangements. In the event Practitioner has arranged for coverage of HH Covered Persons with a behavioral health practitioner who is not a Network Provider, Practitioner shall ascertain that such practitioner is a qualified professional with any and all licenses required by law and will cooperate with all of the provisions of this Agreement, and accept the findings of HH regarding medical necessity and appropriateness of care, and will seek authorization from HH prior to all hospitalization and referrals of Covered Persons. For services rendered by any covering practitioner on behalf of Practitioner, regardless of whether the practitioner is or is not a Network Provider, it shall be Practitioner's sole responsibility to make suitable arrangements with the covering practitioner regarding the manner in which said practitioner will be reimbursed or otherwise compensated, provided that Practitioner shall ensure that the covering practitioner will not under any circumstances bill the Covered Person for Covered Services. This provision does not prohibit practitioner from collecting deductibles, co-insurance, or co-payments as specifically provided in the Covered Persons health care plan or fees or supplemental charges for uncovered services delivered. Practitioner further agrees that this Section shall survive the termination of this Agreement regardless of the reason for such termination, including insolvency of HH or Payor(s) and shall be construed to be for the benefit of the Covered Person.

2.7 Covered Person Rights and Responsibilities. Practitioner will, to the best of his/her ability, adhere to the HH standards regarding the rights and responsibilities of Covered Persons as set forth in the Provider Manual. It remains the ultimate responsibility of Practitioner to ensure that a preauthorization by HH was obtained prior to rendering any service to the Covered Person. Failure to obtain preauthorization may result in Practitioner's liability for payment of claims associated with the referral. Practitioner shall not bill Covered Person for any cancelled or missed sessions.

2.8 Discrimination. Practitioner shall not discriminate in the treatment of Covered Persons or delivery of services to Covered Persons, either in the quality, quantity or type of services rendered or in any other manner, on the basis of race, color, sex, disability, handicap, sexual orientation, age, religion, national origin, ancestry, Vietnam-era veteran's status, place of residence, health status, need for health services, source of payment for services rendered, or a Covered Person's participation in a publicly financed program. Practitioner will observe, protect, and promote the rights of Covered Persons as clients. Practitioner acknowledges that Covered Persons have a right to be treated with respect and recognition of their dignity and need for privacy; Covered Persons have a right to participate with Practitioner in decision-making regarding their treatment planning; Covered Persons have a right to voice complaints or appeals about Practitioner or the care provided. Practitioner shall provide Covered Services to Covered Persons in the same manner as provided to any other patient.

2.9 Verification of Eligibility. Prior to providing non-emergent services to Covered Persons, Practitioner shall contact HH to verify eligibility of Covered Persons for Covered Services or to establish a procedure for verifying such eligibility.

2.10 Preauthorization Requirements. Practitioner shall admit a Covered Person and provide Covered Services only when services are preauthorized by HH. Practitioner understands that non-preauthorized services may be subject to benefit denial. In the event that services were provided to a Covered Person without preauthorization by HH, Practitioner understands that Practitioner may not seek compensation from the Covered Person (or representative of the Covered Person), HH or any primary Payor. Practitioner understands that the sole responsibility for obtaining any preauthorizations rests with the Practitioner who recommends or orders such services, treatments, or procedures (including, but not limited to, psychological testing, ECT, EKG, dietary consult for eating disorders, MRI, neurodiagnostic testing, neuropsychological testing, ambulance transport) and not with the Covered Person. If laboratory tests are necessary, Practitioner shall contact the primary care physician or his/her office administrator for a determination of which laboratory location in which to refer a Covered Person, in an effort to minimize expense to the Covered Person.

Regarding all other referrals for testing, treatments or procedures, HH has many Payors with differing preauthorization requirements. It is the responsibility of Practitioner to contact HH for a determination of what type of preauthorization is required by that Covered Person's Payor or to obtain a preauthorization for such services from HH. Failure to preauthorize may result in Practitioner's liability for the expense of such referral. In no event shall Practitioner seek compensation, copayments or deductibles from the Covered Person (or representative of the Covered Person), HH or any Payor for any non-preauthorized service.

In emergency situations, preauthorizations are not required but Practitioner shall notify HH within one (1) hour that an emergency existed, and preauthorization was not able to be obtained, and then describe the course of action taken by the Practitioner regarding the care and treatment of the Covered Person. Unless otherwise specified, except in cases of medication management or case rate payments, all outpatient authorizations for service shall expire three (3) months from the date the service was initially authorized by HH. Inpatient authorizations are reviewed on a daily basis.

2.11 Utilization Review. Practitioner shall comply with all relevant utilization review policies while providing treatment for the Covered Person. In the event that the number of treatment sessions provided to a Covered Person exceeds the number authorized under HH utilization management policies as Medically Necessary, HH shall not be required to pay nor shall Practitioner be entitled to bill, charge, collect a deposit from, or have any recourse against any Covered Person (or person acting on behalf of such Covered Person) for Covered Services provided pursuant to this Agreement. This provision does not prohibit Practitioner from collecting deductibles, co-insurance, or co-payments as specifically provided in the Covered Person's health care plan. Practitioner agrees that (a) this Section shall survive the termination of this Agreement regardless of the reason for such termination, including insolvency of HH or Payor(s) and shall be construed to be for the benefit of the Covered Person and the laws of the state in which Practitioner practices and shall apply to all authorized Covered Services rendered prior to the termination of the Agreement and that (b) this Section supersedes any oral or written contrary agreement now existing or hereafter entered into between Practitioner and a Covered Person (or person acting on behalf of such Covered Person) insofar as such contrary agreement relates to liability for payment for or continuation of services provided pursuant to agreements entered into by HH with Payors or this Agreement.

2.12 Accessibility. Practitioner shall satisfy such accessibility requirements as may be reasonably requested by HH in its Provider Manual. In no event shall a Covered Person wait for a scheduled appointment for more than fifteen (15) minutes after the time of the appointment.

2.13 Facilities; Equipment. Practitioner shall maintain sufficient and appropriate professional office space and facilities for the provision of Covered Services to Covered Persons. Practitioner shall further maintain such personnel and office equipment, including, without limitation, a twenty-four (24) hour answering service, telephone and pager, as shall be necessary to perform Practitioner's obligations hereunder.

2.14 Review of Adverse Determinations, Appeals and Denials. Practitioner, on the behalf of the Covered Person, may appeal any clinical adverse determination. Practitioner must comply with HH policy and procedure guidelines for all review decisions, requests for reconsideration and appeals of adverse determinations. All appeals must be submitted within thirty (30) days of the date of the denial, and accompanied by a signature of agreement by the Covered Person. Unless preempted by contract and/or state and federal regulations, any appeal received by HH after thirty (30) days of the denial will be deemed untimely and shall not be heard by the Clinical Appeals Committee. HH policies and procedures regarding the appellate process shall be made available upon request.

2.15 Reports. At Practitioner's own cost and expense, Practitioner shall provide in a timely manner, as requested by HH, information, either verbal or written, regarding each Covered Person admitted to Practitioner, including admission date, age, admitting diagnosis, treatment plan, treatment progress and disposition expectations.

2.16 Records; Confidentiality. Practitioner agrees to maintain standard medical records and business records relating to the provision of Covered Services to Covered Persons during the term of this Agreement and for a period of ten (10) years thereafter. Practitioner further agrees that all medical records of Covered Persons shall be treated as confidential so as to comply with all applicable state and federal laws, including 42 CFR Part 2, if applicable. Notwithstanding the foregoing, HH, upon its request, shall have access to, and shall have the right to inspect and copy, upon reasonable notice to Practitioner and without any cost or charge to HH: (a) all medical records maintained by Practitioner relating to the provision of Covered Services to Covered Persons, and (b) all business records relating to any payments received by Practitioner in connection with the provision of Covered Services to Covered Persons. At the initial appointment Practitioner shall obtain from each Covered Person treated by Practitioner written authorization for HH to have access to such Covered Person's records, unless the Covered Person has previously given a valid written consent to the applicable Payor or to HH. The provisions of this Section shall survive the termination of this Agreement.

2.17 Medical Care Decisions. Practitioner shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of HH, Payor, or any entity representing or working with HH or Payor. HH, Payor, or any entity representing or working with HH or Payor shall not be prohibited from protesting or expressing disagreement with a decision, policy, or practice of Practitioner. HH or Payor shall not terminate any Agreement with Practitioner because Practitioner a) expresses disagreement with HH or Payor's decision to deny or limit benefits to Covered Persons; or b) because Practitioner assists the Covered Person in seeking reconsideration of a HH or Payor decision; or c) because Practitioner discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by HH or Payor or not, policy provisions of a plan, or Practitioner's recommendations regarding selection of a health plan based on Practitioner's knowledge of the health needs of the patient.

2.18 Referral to other Entities. Unless otherwise authorized by HH, Practitioner shall provide only the services preauthorized by HH. In the event that a referral is necessary, Practitioner shall refer the Covered Person back to HH. Failure to preauthorize any referral with HH may result in Practitioner's liability for charges incurred. In no event shall Practitioner seek compensation from the Covered Person (or representative of the Covered Person), HH or any Payor for Practitioner's failure to obtain preauthorization of services.

2.19 Provision of Additional Services to Covered Persons. Notwithstanding any other provision of this Agreement, if a Covered Person requires or desires services which are not Covered Services, Practitioner shall be entitled to enter into an agreement with such Covered Person to provide such services upon the condition that Practitioner has explained in advance of the performance of such service that the required or requested service is not a Covered Service, verifies the expense to the Covered Person, and obtains in writing the preauthorization of the Covered Person to pursue such non-covered service. HH shall have no obligation to compensate Practitioner for such services. Practitioner shall be entitled to set the fee for such services without HH authorization but agrees to set the fee for service based on community standards.

2.20 Recourse against Covered Persons. If a Covered Person is entitled to Covered Services pursuant to a health maintenance organization plan, the Practitioner hereby agrees that in no event, including, but not limited to, non-payment by HH or the health maintenance organization plan, the insolvency of HH or the health maintenance organization plan or breach

of this Agreement, shall the Practitioner bill, charge, collect a deposit from, or have any recourse against any Covered Person (or person acting on behalf of such Covered Person) for Covered Services provided pursuant to this Agreement. This provision does not prohibit Practitioner from collecting deductibles, co-insurance, or co-payments as specifically provided in the Covered Person's health care plan, or fees and/or supplemental charges for uncovered services delivered.

Practitioner further agrees that (a) this Section shall survive the termination of this Agreement regardless of the reason for such termination, including insolvency of HH or Payors, and shall be construed to be for the benefit of the Covered Person and the state in which Practitioner practices and shall apply to all authorized Covered Services rendered prior to the termination of the Agreement and that (b) this Section supersedes any oral or written contrary agreement now existing or hereafter entered into between the Practitioner and a Covered Person (or person acting on behalf of such Covered Person) insofar as such contrary agreement relates to liability for payment for or continuation of services provided pursuant to agreements entered into by HH with Payors or this Practitioner Services Agreement.

2.21 Compliance with Quality Improvement and Utilization Management Activities. Practitioner agrees to participate in, cooperate with, and comply with HH's Quality Improvement (QI) activities and standards. Practitioner shall allow HH to have access to the treatment records of HH Covered Persons as permitted by state and federal confidentiality laws. Practitioner understands that sanctions for noncompliance with HH's requirements may involve termination of this Agreement. Practitioner understands that HH will actively monitor, evaluate and oversee quality improvement measures to ensure that measures meet NCQA standards.

2.22 Compliance with Outcome Measurement Activities. Practitioner agrees to participate in Outcome Measurement activities as requested by HH. Practitioner understands that this Agreement may terminate if results of Outcomes data fall below acceptable performance standards.

2.23 HH Audit. On at least ten (10) days notice by HH, Practitioner shall participate in an audit which may include on-site inspection of office site conducted by a representative of HH to ensure that Practitioner is complying with HH's standards. Practitioner shall furnish such administrative policies and procedures, data and/or documentation as the auditing entity may reasonably request. Practitioner further agrees to participate in a medical records audit by HH from time to time to ensure that Practitioner maintains adequate and proper records of Covered Person visits, histories, diagnoses, treatments and other pertinent information. In the event that deficits are found, Practitioner shall comply with the corrective action plan as detailed in the Provider Manual. Failure to comply with the plan and remedy deficits may result in the termination of this Agreement. HH reserves the right to re-audit Practitioner's office site to ensure remedial efforts for improvement have been implemented.

### **ARTICLE III** **Obligations of HH**

3.1 Administrative Services. HH shall perform or arrange for the performance of all administrative services, including marketing, claims processing, management and credentialing services, necessary to the performance of this Agreement and its Agreement with Payors. HH or one of its subsidiaries shall contract on behalf of the Practitioner with Payors according to the reimbursement schedule of HH in place at the time services were rendered. HH shall further maintain adequate personnel to provide prompt telephone and written response to inquiries by Practitioner regarding eligibility, Covered Services, utilization management procedures and other information related to this Agreement.

3.2 Utilization Management Policies and Procedures. HH shall establish and implement utilization management policies and procedures in general and specific to individual Payors, including procedures for prospective, concurrent and retrospective review of the appropriateness and level of care, and utilization of the Covered Services provided to Covered Persons. The provision of Covered Services by Practitioner shall at all times be subject to the utilization management procedures established by HH and/or Payors.

3.3 Quality Management. HH shall maintain a system for the assessment of the quality of the services rendered by Practitioner consistent with NCQA standards.

**ARTICLE IV**  
**Compensation**

4.1 **Claims Submission.** Practitioner shall comply with the applicable provisions of the Provider Manual regarding claims, which shall be amended from time to time. In the event of an overpayment of a claim by Payor or Payor's Agent, Payor or Payor's Agent may offset any future claims from Practitioner by the amount of such overpayment. HH shall maintain adequate personnel to provide prompt telephone and written response to inquiries by Practitioner regarding capitated contracts, fee for service and fee retainer agreements.

4.2 **Coordination of Benefits.** Practitioner shall cooperate with HH or Payor in identifying third party liability, including other insurance coverage, workers' compensation, subrogation or no-fault coverage. HH shall compensate Practitioner according to the reimbursement schedule of HH in place on the date services were rendered to the Covered Person. Practitioner shall not withhold or refuse to render Covered Services to Covered Persons nor require Covered Persons to pay for Covered Services pending a decision regarding the order of payment pursuant to applicable coordination of benefits rules. Practitioner agrees to adhere to the guidelines regarding Coordination of benefits as set forth in the HH policies and the Provider Manual.

**ARTICLE V**  
**Insurance and Liability**

5.1 **Liability.** Each party shall be solely liable for any and all claims, costs and expenses arising from or out of any act or omission in the performance of its obligations hereunder.

5.2 **Practitioner Insurance.** Practitioner, at his/her sole cost and expense, shall maintain professional liability insurance in the minimum amount of \$1,000,000 per person per occurrence and \$3,000,000 in the aggregate. Practitioner, at his/her sole expense, shall cause a certificate of insurance or verifications of required coverage to be issued to HH for the coverage listed herein and for subsequent renewals of such coverage. In the event that Practitioner maintains professional liability insurance on a "Claims Made" basis, Practitioner shall maintain such policy in effect, or maintain appropriate "tail coverage", for a period of three (3) years following any termination of this Agreement, regardless of the circumstances giving rise to such termination. Practitioner acknowledges that HH is under no obligation to provide professional liability insurance, Worker's compensation or general liability coverage for Practitioner or any of Practitioner's employees.

5.3 **HH Insurance.** HH, at its sole cost and expense, shall procure and maintain such policies of general liability and other insurance as shall be necessary to insure HH and its employees or agents against any claim or claims for damages arising by reason of an act or omission in the performance of its obligations hereunder.

5.4 **Worker's Compensation and Employer's Liability Insurance.** Practitioner shall obtain and maintain worker's compensation and employer's liability insurance to cover Practitioner's statutory and legal obligations for employee job related injuries with minimum policy limits of five hundred thousand dollars (\$500,000.00) for each incident. Policy shall provide for statutory benefits. Practitioner, at his/her own expense, shall furnish copies of same to HH.

5.5 **Indemnification.** Practitioner shall indemnify and hold HH harmless from any and all liability, loss, damage, claims, and all costs or expenses related thereto (including reasonable attorneys' fees), that may arise out of and/or be incurred in connection with any act or failure to act by Practitioner in connection with its obligations under this Agreement. The provisions of this Section 5.5 shall survive the termination of this Agreement.

5.6 **Survival of Provisions.** The provisions of this Article shall survive any termination of this Agreement and shall not be affected by the insolvency of HH or Practitioner.

**ARTICLE VI**  
**Term and Termination**

6.1 **Term.** This Agreement shall be automatically extended for one (1) year on each successive January 1, terminated as set forth below.

6.2 **Termination.** This Agreement may be terminated prior to the release date upon the following:

a) By either Party upon thirty (30) days advance written notice of specific breach of this Agreement and the failure of the breaching party to cure said breach within the thirty-day period. This Agreement shall terminate upon the expiration of the thirty-day period.

b) Administrative Terminations: HH, upon ninety (90) days advance written notice, may terminate this Agreement with Practitioner for business reasons, including, but not limited to, excessive number of Practitioners for geographical region, violation of HH policies and Procedures, or the inability of HH and Practitioner to work cooperatively regarding disputes and disagreements. It is understood by Practitioner that HH has the right to terminate this Agreement if HH finds that Practitioner or an agent of Practitioner is making statements, either written or oral, which are false or maliciously critical and which are intended to injure HH's reputation and relationship with Members. It is further understood by Practitioner that HH has the right to terminate this agreement with Practitioner if HH finds that an agent or representative of Practitioner is making material misrepresentations regarding the terms, provisions, or requirements of HH's Covered Services. Administrative terminations are not reported to the National Practitioner Data Bank.

If this Agreement is terminated by HH, Practitioner shall continue to provide Covered Services to Covered Persons for a maximum of ninety (90) days following the date of termination. If coverage for a Covered Person under a health care plan is terminated for any reason other than non-payment of premium, fraud, or abuse, Practitioner shall continue to provide Covered Services to Covered Persons being treated at inpatient facilities until the Covered Person is discharged.

c) Clinical Terminations: HH, immediately upon written notice, may terminate this Agreement with Practitioner in cases in which a) HH determines in good faith that the health, safety or welfare of Covered Persons is jeopardized by continuation of this Agreement; b) Practitioner has furnished incomplete or inaccurate information on his/her credentialing application, c) Practitioner suffers voluntary relinquishment, revocation, termination, suspension or other limitation of his/her license or certification, medical staff privileges or d) loss of the ability of Practitioner to perform the services required hereunder. Termination shall occur immediately upon notification to HH of the above. HH shall send written notice of the termination to Practitioner in a timely manner. Terminations based on Quality of Care are reportable to the National Practitioner Data Bank.

Within five (5) working days following the date HH gives or receives a notice of written termination of its Agreement with Practitioner or any other agreement with a Payor, Practitioner shall provide HH and/or Payor a list of Practitioner's patients who are covered under a health care plan of HH or Payor.

6.3 Service Obligations upon Termination. Practitioner agrees that in the event of termination of this Agreement for any reason, including but not limited to, insolvency or other cessation of operations of HH or Payors contracting with HH, Practitioner shall continue to provide benefits to Covered Persons in accordance with HH's policies and procedures. In the event that a Covered Person requests transfer of professional records to any new practitioner, Practitioner shall cooperate in such transfer of records. Practitioner hereby agrees that under no circumstances, including, but not limited to, non-payment by HH or Payors, the insolvency of HH or Payors, or breach of agreements between Payors and HH or this Agreement, shall the Practitioner bill, charge, seek compensation, remuneration or reimbursement from, or have any recourse against any Covered Person, or persons acting on Covered Person's behalf, for such services provided pursuant to this Agreement or any such agreement HH has entered into with insurers or managed care organizations.

Practitioner agrees that (a) this Section shall survive the termination of this Agreement or agreements made between HH and insurers or managed care organizations, regardless of the reason for such termination, including insolvency of HH or Payors, and shall be construed to be for the benefit of the Covered Person, and (b) this Section supersedes any oral or written contrary agreement now existing or hereafter entered into between the Practitioner and a Covered Person (or person acting on behalf of such Covered Person) insofar as such contrary agreement relates to liability for payment for or continuation of services provided pursuant to agreements entered into by HH with insurers or managed care companies or this Practitioner Services Agreement. No changes, modifications, additions or deletions shall be made to the provisions of this section without prior written consent of the Secretary of the United States Department of Health and Human Services and such changes, modifications, additions, or deletions shall become effective on a date no earlier than thirty (30) days after the Commissioner of Insurance has received written notice of such proposed changes, modifications, additions or deletions.

## **ARTICLE VII**

### **General Provisions**

7.1 Relationship of the Parties. HH and Practitioner are independent contractors and shall not be construed to be the joint venture, partner or employee of the other Party.

7.2 Non-exclusive Agreement. This Agreement in no manner precludes or prohibits Practitioner from negotiating or entering into similar and/or separate agreements with other individuals or entities for the provision of behavioral health care services. HH recognizes that Practitioner is employed or under contract from time to time with other clinics, hospitals and medical offices, and agrees to make no claim to enjoin Practitioner from providing services to any other clinic or facility at any time.

7.3 Use of Name and Trademarks. HH and Payors may use the name, address, telephone number and a factual description of the facilities and services of Practitioner in promotional materials and directories provided to Covered Persons. With HH's prior written consent, which shall not be unreasonably withheld, Practitioner may use the name, address, telephone number and factual description of services of HH in promotional materials of Practitioner.

7.4 Pre-Arbitration and Arbitration Proceedings. Both HH and Practitioner agree to meet and confer in good faith to resolve any disputes arising during the term of this Agreement through informal discussions between the Parties. If the Parties are unable to resolve the dispute through such discussions, either Party may submit a written complaint to the other Party describing and proposing a manner of resolving that dispute. The Party receiving the complaint shall respond by accepting, rejecting or modifying the proposal, in writing, within thirty (30) days of the date that it receives the complaint.

In the event the Parties are still unable to resolve the dispute, either Party may submit the dispute to final and binding arbitration in accordance with the Commercial Arbitration Rules of the American Arbitration Association, to the extent that such rules are not inconsistent with this Agreement. Any award rendered by the arbitrator shall be final and binding upon the Parties hereto, and judgement upon any such award may be entered in any court having jurisdiction thereof. The fees and expenses of the arbitrators shall be borne equally by the Parties. Each Party shall pay its own fees and costs relating to any arbitrated proceedings, including attorney's fees. In no event shall either Party disclose or discuss, directly or indirectly, any such dispute, disagreement or grievance with Covered Persons or any other entity. Nothing in this section prohibits communications with legal counsel.

7.5 Interference with Contractual Relations. Throughout the term of this Agreement, Practitioner shall not, directly or indirectly, advise entities currently under contract with HH to cancel or modify contracts with HH. Practitioner shall not interfere or in any way impede negotiations HH is pursuing regarding the provision of health care services nor shall Practitioner utilize a HH Covered membership list to solicit, directly or indirectly, individuals or groups for the purpose of competing with HH. In the event of a breach of this section by Practitioner, HH shall be entitled to specific performance and/or injunctive relief and any other such remedies in law or equity.

7.6 Governing Law and Venue. This Agreement shall be governed by the state in which Practitioner practices. To the extent required by applicable laws and regulations, Practitioner and HH shall make this Agreement and relevant records available to the Secretary of the Department of Health and Human Services or any duly authorized representative. Venue of any judicial or other proceeding brought to enforce this Agreement shall be in the state in which Practitioner practices.

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

7.8 Waiver. A waiver of any of the terms and conditions hereof shall not be construed as a waiver of any other terms and conditions hereof.

7.9 Headings. The headings of the various Articles and Sections of this Agreement are inserted merely for convenience of reference. The headings do not expressly or by implication limit, define, or extend the specific terms of the Articles and Sections so designated.

7.10 Confidentiality. Practitioner acknowledges and agrees that this Agreement and all documents and materials, whether or not incorporated by reference, including, but not limited to, policies and procedures and information related to reimbursement rates, constitute confidential and proprietary information, the unauthorized use or disclosure of which could result in irreparable harm to HH. Practitioner shall maintain in confidence and not disclose such materials except as may be requested by law or permitted in writing by HH. Practitioner shall take reasonable precautions to prevent and protect such information from unauthorized disclosure by his/her agents and employees; and further, during and after termination of this Agreement, shall not use or allow his/her agents or employees to use any such information to the competitive disadvantage of

HH or in any way which is detrimental to HH. HH has the right to provide a copy of this Agreement to Payors upon receipt of an agreement from them to hold such information confidential.

7.11 Ownership of and Access to Data. It is agreed and understood that the medical records created and maintained by Practitioner shall be owned by Practitioner. Notwithstanding the foregoing, any records derived from such medical records or information provided to HH shall be owned by HH. Subject to applicable law, HH and its subsidiaries and affiliates shall be permitted to access electronically or otherwise and use data obtained from Practitioner provided such access and use preserves patient confidences. Subject to Applicable Law, HH may access and aggregate data maintained by Practitioner with other data into a reporting and research data warehouse, for any and all purposes. This provision shall survive the termination of this Agreement regardless of the reason for termination.

7.12 Government Programs. To the extent that this Agreement relates to Medicare risk arrangements, Medicaid risk arrangements, or any governmental sponsored health care program involving HH, the terms and provisions under those arrangements and programs shall supersede any conflicting provisions contained herein. In addition, this Agreement shall be self-amending to accommodate the terms and provisions of those arrangements and programs.

7.13 Notices. All notices, requests, demands and other communications required or permitted under this Agreement shall be in writing and shall be deemed to have been duly given, made and received only when personally delivered as documented by a courier's receipt or upon actual receipt of registered or certified mail, postage prepaid, return receipt requested; or by facsimile upon actual receipt, addressed as set forth below (or at such other addresses as may be stated in notices similarly given):

If to Practitioner:  
Practitioner's Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Office Telephone Number \_\_\_\_\_  
Facsimile Number \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_

If to HH  
HORIZON HEALTH EAP SERVICES, INC.  
Attn: Network Manager  
PO BOX 293508  
Lewisville, Texas 75029-3508

7.14 Assignment. Practitioner shall not assign or transfer his/her rights, duties or obligations under this Agreement without the prior written consent of HH. HH may, without the consent of Practitioner, assign, delegate, or otherwise transfer any or all of its rights, duties, and obligations under this Agreement to a subsidiary, affiliate, parent or successor corporation.

7.15 Force Majeure. Neither party shall be liable for an inability to meet its obligations under this Agreement by "force majeure." "Force Majeure" means any cause beyond the control of a party including, but not limited to, an act of God, act or omission of civil or military authorities of a state or nation, fire, strike, flood, riot, war, delay of transportation, or inability due to any of these causes to obtain necessary labor, materials or facilities; provided, however, that the lack of financial resources or the failure to maintain Policies of insurance shall never be excused.

7.16 Duplicate Originals. This Agreement may be executed in several counterparts, each of which shall be deemed an original; however, all shall constitute one and the same Agreement.

IN WITNESS WHEREOF, the undersigned have duly executed this Agreement effective as of the date and year first above written. Practitioner has had adequate opportunity for review by counsel of Practitioner's choice and fully understands the terms of this Agreement.

Signature Page to Follow

"HH"  
**Horizon Health EAP Services, Inc.**

"PRACTITIONER"  
**Practitioner Name**

By: \_\_\_\_\_  
Alan Berry,  
Vice President of Administrative Operations

\_\_\_\_\_  
Practitioner Name (print)

Mailing Address:  
Provider Services Department  
P.O. Box 293508  
Lewisville, TX 75029-3508

\_\_\_\_\_  
Practitioner Signature

Federal Tax ID# \_\_\_\_\_

Effective Date: \_\_\_\_\_

Mailing Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Billing Address:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Office Location(s):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_