SUMMARY

Prime Therapeutics LLC
Medical Provider Participation Agreement

Note that this summary is based on, and specific to the draft Medical Provider Participation Agreement provided by Prime Therapeutics LLC and prospective participants. All agreements for participation in the Prime network may not be identical. In addition, the content below represents an objective summary of key terms in the Prime agreement, but in no way represents an opinion as to any specific term or our views on whether to accept or decline a proposal from Prime. Each practice should consult with its advisors and make its own, independent assessment and decision on whether to join the Prime network. Each practice should also avoid sharing its decision on whether to join the Prime network with CSRO or other practices. Note that if independent practices discuss the terms of the draft Prime agreement, particularly the reimbursement rates, with each other or coordinate their responses to Prime, such activities could raise antitrust concerns.

1. General. The Medical Provider Participation Agreement ("Agreement") between a practice (referred to in the Agreement as "Provider") and Prime Therapeutics LLC ("Prime") is for the Provider's participation in the benefit plans administered through Prime. By joining the Prime network, a Provider will be reimbursed for Specialty Drugs and other products and services provided to "Covered Persons" according to the rates identified on page 36 (copied below).

   In calculating the reimbursement, a Provider will paid its "Provider Taxes" PLUS, the lesser of: (A) Usual and Customary Charge, or (B) Provider's submitted cost plus the applicable dispensing fee, or (C) the sum of the reimbursement identified below less any Transaction Fee.

IntegratedRx - Medical Network Rates for Covered Specialty Drug Services for All Participating Providers	
Specialty Drugs	ASP + 10%
Non-ASP Priced Biosimilars	AWP – 30%
Non-ASP Priced Drugs	AWP – 15%

Drug Specific Reimbursement for Covered Services: Participating Provider accepts the following reimbursement for these specific Covered Services instead of the Rates outlined above		
HCPCS	**Drug**	**Reimbursement**
Q5103	INFLECTRA	$40 per 10mg unit

2. Usual and Customary Charges. Oregon law, specifically ORS 743B.405(1)(b), states: "A medical services contract may not require the provider, as an element of the contract or as a condition of compensation for services, to agree: to charge the other party to the medical services contract a rate for services rendered pursuant to the medical services contract that is no greater than the lowest rate that the provider charges for the same service to any other person." As such, the Agreement should remove caps on reimbursement that tie back to "Usual and Customary" charges.

3. Term and Termination. The Agreement's term begins when Prime accepts and countersigns the Agreement and continues until terminated by either party without cause upon at least 90 days' prior notice. There are also

"for cause" reasons for termination, including the failure by either party to cure a breach within 10 days. There are a host of other, customary termination events (for example, bankruptcy of a party or if Provider ceases to maintain licensure).

Note that under Section 6.3.9, if Prime proposes to amend the Agreement, and the Provider objects to the amendment under Section 9.3.2, Prime may terminate the Agreement on 30 days' notice to Provider, and there is no timeframe within which Prime must exercise this option. For example, if 2 years pass after Provider objects to a proposed amendment, Prime could terminate the Agreement on this basis with 30 days' notice.

4. Provider Manual. Many of the rules associated with the arrangement are set forth in Prime's Provider Manual. The Policy Manual may be amended unilaterally by Prime (see Section 1.29), and its terms are made part of the Agreement. Essentially, while amending the Agreement would entitle a Provider to advance notice, changes to the Provider Manual may be made without notice or prospective application. Section 2.3 specifically states that a change to the Provider Manual does not constitute an amendment to the Agreement (so no notice is required as would be for an amendment).

5. Assignment. Section 7.1 would bar a Provider from assigning the Agreement, including an assignment to any "successor" (for example, another practice with which it might combine or sell to). Section 7.2 notes that a change of ownership could occur if a Provider's ownership changes. Given that a practice may add or remove a provider as an owner routinely, consider that Prime would be entitled to notice and the right to terminate in those events.

6. Amendments. Under Section 9.3, Prime may amend the Agreement by providing 90 days' notice to a Provider. Unless the Provider objects and terminates the Agreement within 30 days, the amendment will take effect. If the Provider objects, Prime may terminate the Agreement with 30 days' notice (see comment above).

7. Indemnification. Section 8.1 includes mutual indemnities (rather than solely for Prime's benefit) that apply to claims arising from the other party's breach or violation of law (but not from negligence).

8. Payment of Claims. Section 3.2 states that claims will be paid within an average of 30 days. Oregon law requires all claims to be paid within 30 days of submission of a clean claim. However, the section is not clear as to how defects in claims may be remedied by Providers. From time to time, payor contracts will have provisions entitling a practice to notice of a defect, and the opportunity to fix it and resubmit, which this Agreement lacks.

9. Records Requests. If Prime requests records under Section 2.17.2, a Provider would have to furnish the records at Prime's expense, during normal business hours. However, the Agreement would allow Prime to inspect records "without notice."

10. Audits. Under Section 2.17.3, during the term and for two (2) years following termination, Prime may audit a Provider's performance or (b) investigate Provider's activities related to this Agreement. This section also requires a Provider to cooperate with the audit/investigation and bear its own costs and expenses associated with any audit or investigation. This would be the case even if there is no reason provided by Prime behind the audit or when cooperation could be contrary to the Provider's best interests (for example, in the event that sharing information may result in a waiver of applicable privileges).

11. Payment Recoupment. Section 3.5 allows Prime to withhold funds from a Provider based upon outstanding amounts owed by a Provider, which Prime may do in its discretion. A Provider's recourse would be to resolve via the dispute resolution process outlined below.

12. Dispute Resolution. Section 9.10 states that disputes will be resolved in accordance with a dispute resolution process, but the details of this process (for example, mediation or arbitration) are not specified. Furthermore, before invoking the "good faith" efforts to resolve any dispute, a Provider must first exhaust all relevant appeals process, which could make it challenging from an administrative and timing perspective for a Provider to seek legitimate recourse. Also, a Provider would waive its right to pursue any action based on a breach of contract if not made within 1 year of the breach. If, before pursuing litigation to resolve a breach, Provider had to first (a) exhaust all appeals processes, and (b) attempt to resolve the dispute in good faith as required under 9.10.1, the 1-year period may have expired.

13. Drafting Notes.
    - There is a definition of "Subscriber" which is only used once in the Agreement and which seems redundant with the term for "Covered Person." Is a Subscriber different than a Covered Person? If so, how?

    - Section 2.1 states services are to be provided in a "culturally competent manner." This is a subjective, unknowable standard that could result in inconsistent treatment of providers. Consider defaulting to the prevailing industry standards or commercially reasonable manner.

    - The last sentence Section 2.2 references an Exhibit C for Medicare programs, but there is no Exhibit C.

    - Note that Sections 2.23 and 2.24 include reporting and performance guarantees by the Provider, which are to be outlined in Exhibit F. Exhibit F includes no relevant terms.

    - Section 2.8.4 references a "Provider Disclosure Statement" that a Provider must complete. No copy was included.