ANCILLARY CARE SERVICES

PROVIDER MANUAL

HealthSmart®

www.healthsmart.com

HS-AC-0722

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Welcome

Welcome to Ancillary Care Services!

Ancillary Care Services (ACS) is delighted to welcome you as a Participating Provider in the ACS national networks. As a wholly owned provider network of HealthSmart, ACS enables providers to further their mission by simplifying contracting and revenue cycle management for the mid-market payor segment.

ACS is committed to a long-term, mutually beneficial relationship with you and will work closely with your team to ensure a positive experience.

Quick Reference Guide

Joining Our Network	**Join our Network form** Join Our Network *For more details go to the **ACS Provider Network Management***
Eligibility & Prior Authorization	**Refer to the member ID card** on eligibility instructions as details vary by client For more details go to ***Eligibility***
Submitting Claims	**Refer to the member ID card** for claim submission instructions as details vary by client For more details go to ***Claims***
Claim Status & Appeals	Please allow 30 days for the appeal to be submitted to the applicable payor and reprocessed before contacting ACS for status of an appeal. Call 844-516-3335 to check the status of a claim or appeal *For more details go to the **Claims***
Payments, Remittance Advice & Explanation of Benefits	Providers enroll with ECHO Health online using a payer specific URL to receive ACH payments. Enrollments by payer are done separately. To enroll in payer direct ACH for ACS, complete the enrollment process at: https://enrollments.echohealthinc.com/EFTERADirect/HealthSmart **Call:** 800-937-0896 **Email:** EDI@ECHOHealthInc.com for EFT/ERA/835 For more details go to ***Billing & Payments***
Submitting Demographic & Provider Changes	Submit changes using our online forms For more details go to ***Submission of Provider Updates*** for instructions
Provider Search	ACS Provider Search is available to everyone at https://providerlookup.healthsmart.com/searchproviders.aspx
Provider Relations & Credentialing	**Email:** VIPproviders@anci-care.com **Phone:** 844.516.3335 **Fax:** 214.574.1121 For more details go to the ***Credentialing***
Customer & Provider Services	**Email:** customerservice@anci-care.com **Phone:** 844.516.3335 **Fax:** 806.473.3228
Client List	**Request client list** at https://healthsmart.com/Contact-Us
Payor List	**Request payor list** at https://healthsmart.com/Contact-Us
ACS Corporate	HealthSmart Preferred Care II, LP d/b/a Ancillary Care Services (ACS) 222 W. Las Colinas Blvd., Suite 500N Irving, TX 75039 **Phone:** 972.388.3115 (844.516.3335 Toll Free) **Fax:** 806.473.3228

III Ancillary Care Services (a HealthSmart Company)

Vision and Mission

Our Vision. To be the innovative leader committed to value creation within the ancillary provider healthcare systems. To be the knowledgeable, trusted, and responsive partner to our stakeholders, we will always conduct ourselves with integrity and professionalism.

Our Mission. Our mission is to improve the health of our members while treating them with dignity and respect, and to reduce healthcare costs for our clients and members with innovative solutions and a flexible approach.

Definition of Our Business. ACS offers national ancillary provider networks comprised of over 50,000 provider locations. The ACS network provides a complete outsourced solution for a wide variety of healthcare payors and plan sponsors including self-insured employers, indemnity insurers, PPOs, and third-party administrators.

For additional information, please visit www.healthsmart.com/ACS

The lines of business supported by ACS extend your reach to markets and product segments otherwise difficult to penetrate and manage.

Primary network: The ACS primary group health network includes access to national & regional PPO networks as well as over 170 TPA payors and employer groups across the nation. ACS providers are given in-network status and paid in accordance with their ACS Provider Agreements.

Secondary/Complimentary network: Providers are advantaged by holding a contract with ACS, especially when they are considered out-of-network by the payor. It provides predictability in revenue and improves revenue cycle outcomes. ACS Providers will be paid directly from the payor and there is absolutely no Silent PPO activity!

Worker's Compensation: ACS has a national network of providers with unparalleled specialty depth. ACS continues to expand our national network to better serve our client needs. The ACS worker's compensation clients use prospective, concurrent & retrospective delivery models.

Auto liability network: ACS connects its clients and their members with providers treating trauma-related injuries and post-trauma medical needs with maximum cost efficiency. ACS Providers will be paid directly from the payor for these patients.

Participation in any and all of these network products provides you:

+ **Services at no cost -** ACS provides value add administrative services at no cost.
+ **Administrative Support -** ACS employs professionals who aggressively pursue payment for your claims. We initiate claims appeals and triage claim disputes.
+ **Higher productivity -** Because ACS consolidates and simplifies the administrative work associated with regional carriers, third party administrators and PPO contract relationships, your staff will spend less time on costly and time-consuming administrative tasks.
+ **Shorter reimbursement cycles -** ACS is different from other networks because we are paid only if our Participating Providers are paid. This means ACS will work much harder to ensure your claims are paid promptly.
+ **Electronic payment and remittance advice** functionality through ECHO Health.

IV ACS Provider Network Management

Join Our Network

Providers can join the Network as an:

+ **Individual Provider**
+ **Group of Providers**
+ **Ancillary / Facility / Clinic**

Complete the online Join Our Network form. Upon completion of the form, the HealthSmart Provider Relations team will start the Credentialing process.

Provider Nominations

Members can nominate a provider by completing the online Nominate a Provider form.

Upon completion of the form, the HealthSmart Provider Relations team will review the nomination to ensure the provider satisfies our business needs and requirements, including, but not limited to the HealthSmart credentialing and contracting requirements.

Credentialing

ACS is committed to build and maintain the highest quality provider network(s). This commitment involves the rigorous credentialing and re-credentialing of certain provider types before accepting them into our networks. Providers are required to participate in and pass our Credentialing process. The HealthSmart/ACS Medical Advisory has the responsibility to establish and adopt necessary criteria for participation, termination, and direction of the credentialing procedures, including participation, denial, and termination. ACS conducts a Medical Advisory Committee meeting each month. The Credentialing process begins once the provider has completed and executed a Participating Provider Agreement. Failure of an applicant to adequately respond to a request for missing or expired information may result in termination of the application process and denial for participation in the network(s). Upon receipt and verification of all required documentation and information, providers will be submitted to the HealthSmart/ACS Medical Advisory Committee to review for approval or denial of the providers' network participation.

The following information and supporting documentation on the next page may be required to complete ACS's credentialing process:

Individual Practitioners & Groups:

- Active State License
- Highest level of Education including residency (including a recent CV)
- Board Certifications (if applicable)
- Education/Training required (if provider is not board certified)
- Current malpractice insurance policy face sheet which includes insured dates and the amounts of coverage
- Current Drug Enforcement Administration (DEA) registration certificate (if applicable)
- Complete and signed W-9 form
- Documentation on any and all state sanctions, restrictions on Licensure and or limitation on scope of practice
- Listing of malpractice claims and license agency actions
- Documentation of hospital privileges in good standing or alternate admitting arrangements (where applicable)
- Documentation of Federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General)

Facility, Ancillary Providers:

- State License
- Accreditation
- Medicare and/or Medicaid Certification
- Medicare/Medicaid (Office of Inspector General (OIG)
- Site Visit (if non accredited)

Recredentialing

ACS initiates a re-credentialing process every 36 months from the date of the providers previous credentialing approval decision. The purpose of this process is to identify any changes in the provider's licensure, sanctions, certification, competence, or health status which may affect the provider's ability to perform services under the contract. This process includes all providers, facilities, and ancillary providers previously credentialed and currently participating in the network. In between credentialing cycles, ACS conducts provider performance monitoring activities on all Participating Providers. Additionally, ACS can review reports released by the Office of Inspector General to identify any Participating Providers who have been newly sanctioned or excluded from participation in Medicare or Medicaid. A Participating Provider's agreement may be terminated if at any time it is determined by the HealthSmart/ACS Medical Advisory Committee that credentialing requirements or standards are no longer being met.

Delegated Credentialing

ACS offers delegated credentialing for provider groups and entities that meet ACS's guidelines for initial and re-credentialing of its providers. A pre-delegation audit will be performed prior to granting delegated status. ACS will review the group's policy and procedures for compliance with NCQA standards and may review random sample of the group's credentialing files.

Delegated groups must sign a Delegated Credentialing Agreement upon approval by the ACS Medical Advisory Committee which outlines the standards and obligations to be maintained throughout the term of the delegation arrangement.

Delegated Monthly Reporting Requirements

On a regular basis, no less than monthly, the Delegated group shall submit a report and roster capturing any actions taken related to providers changes including:

- Licensing Status
- Hospital privilege changes
- Additions to the group
- Demographic changes
- Termination from the group
- Any other changes to the provider roster

Delegated Program Change Notification

The delegated group is required to provide 15 days advance notice to ACS of any material changes to the organization or to its performance of any of the delegated functions.

Please submit changes using our online forms

For submission of complete roster see Data file specifications below. Submit rosters to VIPproviders@anci-care.com.

Provider Data File Specifications

Field Name	Field Description	Required?	Max-Length	Comments
Change, Add, Terminate (CAT) Indicator (if no change leave blank)	Change, Add, Terminate indicator	Yes	1	C= change to any information in an established record. A = any new added record. An effective date is required to be populated on network contracts for all additions. T = a terminated record. A termination date is always required on a terminated record.
CAT EffectiveDate	Facility open date or acquisition date	Yes	10	MM/DD/YYYY
Term Date	Termination date of facility	Yes	10	MM/DD/YYYY
Term Reason	Termination Reason	Yes		Examples: Closed, Out of Business, Moved, Insurance, License, Credentialing, Provider Requested
ProviderID#	Provider Identification	Condition	10	Required if available
TaxId	Tax ID	Yes	9	Example : 205498481 (Must have Nine Characters - No Dashes Please)
NPI	NPI #	Yes	10	National Plan Identifier - Required if available
Facility/Provider Name	Facility/Provider Name	Yes	60	Facility Name (Exactly match legal name or where provided the DBA on W9)
FacilityAddress	Facility Address	Yes	35	
FacilityCity	Facility City	Yes	35	
FacilityState	Facility State	Yes	2	
FacilityZip	Facility Zip	Yes	10	Minimum 5 Characters, maximum 10 including (-) e.g.12345-1234
Contact Name	Facility Contact	Yes	30	Put "General" as default if not populated.
FacilityPhone	Facility Phone	Yes	12	Example 972-308-6888
FacilityFax	Facility Fax	Optional	12	Example 972-308-6888
FacilityEmail				Primary Contact email address
FacilityWeb		Optional		Facility website address (www. .com/. net/.org)
Medicare ID	Medicare ID	Optional	50	
Medicaid ID	Medicaid ID	Optional	50	
DEA	DEA Number	Optional	50	
LicenseNo	License Number	Optional	50	
JCAHO	JCAHO Number	Optional	50	
BillingName	Billing Provider Name			Match Facility Name (Exactly match legal name or where provided the DBA on W9)

Provider Data File Specifications

Field Name	Field Description	Required?	Max-Length	Comments
BillingAddress	Billing Address 1	Yes	35	If not populated, copy address from Parent
BillingCity	Billing City	Yes	35	If not populated, copy City from Parent
BillingState	Billing State	Yes	2	If not populated, copy State from Parent
BillingZip	Billing Zip	Yes	10	Minimum 5 Characters, maximum 10 including (-) e.g.12345-1234
Billing Contact Name	Billing Contact	Yes	30	Put "General" as default if not populated.
BillingPhone	Billing Phone	Yes	12	Example 972-308-6888
BillingFax	Billing Fax	Optional	12	Example 972-308-6888
BillingEmail				Primary Billing Contact email address
BillingWeb				www.example.com/.net/.org
CorporateAddress	Corporate Address	Yes	35	If not populated, copy address from Parent
CorporateCity	Corporate City	Yes	35	If not populated, copy City from Parent
CorporateState	Corporate State	Yes	2	If not populated, copy State from Parent
CorporateZip	Corporate Zip	Yes	10	Minimum 5 Characters, maximum 10 including (-) e.g.12345-1234
Corporate Contact Name	Corporate Contact	Yes	30	Put "General" as default if not populated.
CorporatePhone	Corporate Phone	Yes	12	Example 972-308-6888
CorporateFax	Corporate Fax	Optional	12	Example 972-308-6888
CorporateEmail	Corporate Contact email address			Corporate Contact email address
CorporateWeb				Corporate website address (www. .com/.net/.org)

Audit

ACS reserves the right to continually monitor, and audit delegated entities performance of credentialing and re-credentialing by examining their policies and procedures and credentialing/re-credentialing files. Audits can be conducted electronically, or onsite with advance written notice in accordance with our Policy and Procedure or the Delegated Provider Agreement.

Delegated groups will receive a written notice of their annual audit results within 45 business days of the Medical Advisory Committee approval.

Corrective Action

If a deficiency in service or delegation responsibility are identified by ACS, the delegated group will provide a written response within 15 days that either:

+ Disputes the deficiency and provides supporting evidence or;
+ Submits a corrective action plan, including procedures and timelines.

If the parties fail to reach an agreement on the existence of a deficiency, or the appropriate corrective action and timeframe, ACS reserves the right to terminate the Delegated Credentialing agreement with a 15-day notice.

Monthly Reporting Requirements

On a monthly basis, the delegated group is required to submit a monthly report and updated roster that captures any actions taken related to providers changes including:

+ Licensing Status
+ Additions
+ Demographic changes
+ Terminations
+ Any other changes significant to individuals credentialing or recredentialing

Please submit changes using our online forms

For submission of complete roster see Data file specifications above. Submit rosters to VIPproviders@anci-care.com.

Submission of Provider Updates

For ACS to maintain accurate provider profiles, provider directories, and for reimbursement purposes, Participating Providers are contractually obligated to notify ACS of any relevant changes to credentialing information within 10 days of the effective date of the change.

Changes that require notice to ACS may include, but are not limited to, the following:

Provider demographic changes:

- Must include provider name, TIN, NPI for identification purposes
- Include old information, new information and effective date of change
- Medicare numbers
- Hospital privileges
- National Provider Indicator (NPI) change
- Address change
- Office hours change
- Phone number change
- Practice name change

Provider joining existing practice/group:

- New provider must first be credentialed before rendering treatment to any plan member
- Information must include provider name, Specialty, Practice Location, Practice Phone, Practice Email, TIN, CAQH for credentialing

Provider deletions / terminations (provider no longer participating with the practice/group):

- Must include provider name, Specialty, Practice Location, Remit Address, Practice Phone, TIN, NPI for identification purposes (if available). Include effective date of termination

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Billing Changes

- Updates pertaining to billing information such as Tax Identification number and billing address must be submitted with an updated W-9

Tax identification number change

- Changes in practice name, legal entity or tax ID numbers may require an amendment, assignment or new agreement, depending on the reason for the change

ACS requires that changes such as those outlined above be submitted at least 30 days prior to the effective date of the change to facilitate accurate directory information and claims payment.

Please submit changes using our online forms

For submission of complete roster see Data file specifications above. Submit rosters to VIPproviders@anci-care.com.

Provider Termination

Obligations of Participating Provider following Termination:

Participating Providers are responsible for all contractual obligations for all services and transactions that occurred prior to the termination date.

After termination, Participating Providers remain responsible for maintaining confidentiality of and access to medical records, proprietary information, continuation of services, and indemnification, and any other provisions explicitly stated in the Provider Agreement that survive the termination.

Coordination of Care Following Termination of ACS Participation

If the network participation ends, ACS eligible persons must be transitioned timely and for appropriate care. If an eligible person is receiving ongoing care, continued services may be required for a reasonable time at the in-network contracted rate. Customer Service is available to assist you and our members with this transition.

Provider Lookup Tool

Participating Providers will be added to the ACS Provider Lookup.

Members can access the **ACS Provider Lookup**

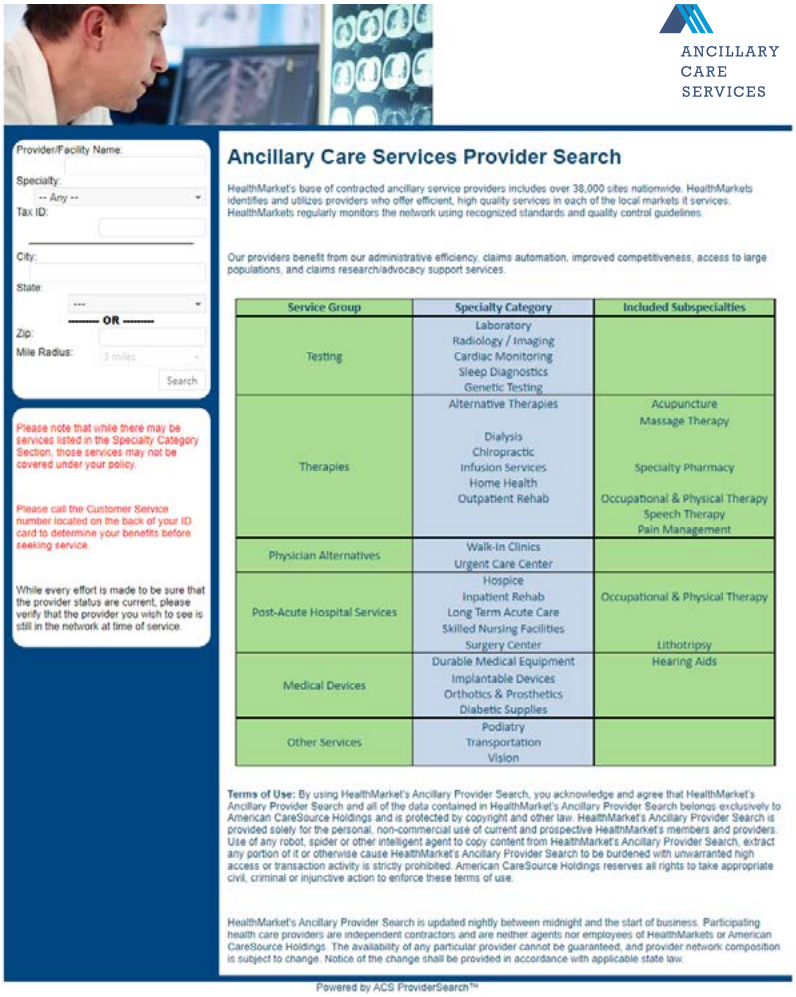
The ACS Provider Lookup allows members to search by:

+ Specialty Type, TIN Facility Type and/or Provider Name

Provider Lookup search results will provide a listing of all Participating Providers that meet the search criteria. From the search results, members can click on any provider name to see details.

The Provider Lookup also has the following features:

+ Print results
+ Google Map of location
+ Driving directions



V Provider Requirements

Provider Rights & Responsibilities

Provider Rights:

- To be treated by ACS, its Eligible persons and Payor clients with dignity and respect.
- To have ACS Eligible person furnish their ID cards and requested medical information as requested.
- To expect other ACS Participating Providers to act as partners in Eligible persons' treatment plans.
- To expect Eligible person to follow their health care instructions and directions.
- To make a complaint or file an appeal against ACS, Payor and/or an Eligible person.
- To file a grievance on behalf of a member, with the Eligible person's consent.
- To contact ACS Provider Services and or Customer Service with any questions, comments, or problems.
- To collaborate with other health care professionals who are involved in the care of Eligible person.
- To collect member copays, coinsurance, and deductibles at the time of service.

Provider Responsibilities:

- Participating Provider shall provide health care services to patients within the scope of its licensure or accreditation.
- Participating Provider acknowledges and agrees to participate in the products and plans for which they are contracted and render covered services to eligible person(s).
- Participating Provider acknowledges and agrees to delegate the asset of each claim to ACS.
- Participating Provider shall make available and provide medically necessary covered services within the scope of Participating Provider's license in accordance with generally accepted medical practices and standards prevailing in the medical community.
- Participating Provider shall comply with all applicable laws, including but not limited to, the Americans with Disabilities Act.
- Participating Provider shall provide covered services to eligible person(s) in the same time and manner as customarily and regularly provided by Participating Provider to other patients who are not eligible person(s) and shall not discriminate against, any eligible person on basis of race, color age, religion, sex, national origin, ancestry, marital status, source of payment, disability, health status, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status, or any other unlawful basis including, without limitation, the filing of a complaint, grievance or legal action against Participating Provider.
- Participating Provider shall verify the eligibility of eligible person(s) to receive covered services and obtain preauthorization from payor prior to rendering covered services, as may be required and in accordance with payor's policies and procedures and/or the plan.
- Participating Provider shall cooperate with, participate in, and observe the protocols of the Utilization Management Program Guidelines, Quality Management Programs, and Provider Manual, and shall provide Covered Services to Eligible person in accordance with the applicable Utilization Management Program, as well as any other policies, procedures, standards, rules or guidelines adopted by Payor.
- Participating Providers that are a hospital, clinic, outpatient center, laboratory, or other health care facility, are accredited, and have and maintain all licenses, permits and certifications required by law for operation of its facility, parts thereof and/or equipment.
- Participating Providers that are a physician, doctor of osteopathy, or allied health professional, are duly licensed to practice medicine, osteopathy, or its applicable specialty and to provide covered services under the terms of this Agreement and shall maintain such licensure at all times it provides services to Eligible person.
- Participating Provider is in compliance with all applicable local, state, and federal laws relating to the provision of services, and renders services in accordance with all applicable licensing requirements as well as all area standards of professional ethics and practice.
- Participating Provider abides and will abide by recognized standards of coding and not engage in any unbundling, upcoding or other similar activities.

- Participating Provider currently complies with and shall continue to meet and remain in compliance with, the ACS participation and credentialing criteria.
- Participating Provider shall submit provider rosters, demographic, and tax identification changes to ACS on a monthly basis, or thirty (30) days prior to the effective date of such change, as applicable.
- Participating Provider agrees that, when medically appropriate, Participating Provider shall refer eligible persons to ACS Network Participating Providers for covered services which are not available from Participating Provider.
- Participating Provider will not bill balance bill eligible person(s) for any amounts over and above the contractual or imposed reimbursement amounts.
- Participating Provider shall bill or collect from Eligible person(s)) deductibles, coinsurance or copayments required by the plan; and/or fees or charges for services that are not covered services; fees which exceed a specific benefit limitation.
- Participating Provider shall submit clean claims electronically or on paper on a UB-04, CMS-1500 or successor form(s) with an itemized bill when applicable or requested in accordance with applicable law and within the time constraints outlined in their provider agreement.
- Participating Provider shall maintain medical records in accordance with good professional standards, to the extent necessary for continuity of care, for all other necessary purposes, and in compliance with all applicable laws.
- Participating Provider shall provide any accounting, administrative, and medical records maintained and pertaining to eligible person and/or to Participating Provider's performance to the Center for Medicare and Medicaid Services (CMS), any Peer Review Organization (PRO) with which ACS and/or Payor contracts as required by CMS, the US Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, "Governmental Officials") as required by law and as may be necessary for compliance by ACS and/or Payor with the provisions of all state and federal laws.
- Participating Provider will transfer the medical records of the eligible person(s) to such other Participating Provider acquiring applicable disclosure and following confidentiality laws.
- Participating Provider shall cooperate with accreditation and credentialing surveys, and compliance monitoring.
- Participating Provider will maintain policies of comprehensive general and professional liability insurance in amounts reasonably satisfactory to ACS and in accordance with standard industry practice.
- Participating Provider shall give prompt written notice to ACS whenever they become aware of any claims, suits or disciplinary actions have been taken against them.

Non-discrimination

ACS requires Participating Providers to provide covered health care services to all eligible person(s) in the same time and manner as customarily and regularly provided without regard to race, ethnicity, age, religion, sex, national origin, ancestry, marital status, source of payment, disability, health status, utilization of medical or mental health services or supplies, sexual preference or orientation, veteran's status or any other unlawful basis deemed unlawful under federal, state or local law.

Facility Management

When providing services to ACS eligible persons:

+ Verify the eligible person's eligibility and benefits before rendering services which can be done by contacting the number on the eligible person's ID card.
+ Prior authorize services when required. Contact the number on the eligible person's ID card.
+ Failure to verify eligibility and obtain prior authorization may result in claim denial or reduction of benefits.

Office Hours

Participating Providers are expected to provide the same office hours of operation to ACS eligible persons as those offered to PPO and commercial eligible persons. There are a range of primary, specialty, facility, and ancillary services available and accessible to ACS eligible persons in their service area.

After Hours Care

Life-threatening situations require the immediate services of an emergency department. Urgent care can provide quick after-hours treatment and is appropriate for infections, fever, and symptoms of cold or flu. Participating Providers that cannot provide services after hours should refer eligible persons to an urgent care center when appropriate. Physicians or an appropriately licensed professional must be available for after-hours calls.

Wait Times for Eligible persons

The following expected wait times for ACS eligible persons to schedule an appointment with a ACS Participating Provider should not exceed the following:

+ Twenty-four (24) to forty-eight (48) hours for urgent appointments
+ Four (4) weeks for specialty care appointments
+ Six (6) weeks for routine appointments

Timeliness Standards for Notifying Eligible person of Test Results

After receiving results, notify eligible persons within:

+ **Urgent:** 24 hours
+ **Non-urgent:** 10 business days

Data Management

Medical Records

Participating Providers shall maintain complete and professionally adequate medical records for all patients, in accordance with good professional standards, to the extent necessary for continuity of care, for all other necessary purposes, and in compliance with all applicable laws.

ACS may request and has the right to inspect any accounting, administrative, and medical records maintained by Participating Provider pertaining to eligible persons and/or to Participating Provider's performance.

Participating Provider shall provide such information to the Center for Medicare and Medicaid Services (CMS), any Peer Review Organization (PRO) with which ACS and/or Payor contracts as required by CMS, the US Comptroller General, their designees and any other governmental officials entitled to such access by law (collectively, **"Governmental Officials"**) as required by law and for compliance by ACS and/or Payor with the provisions of all state and federal laws.

ACS, Payor, and Government Officials shall have access to, and copies of, the medical records, books, charts, and papers relating to Participating Provider's provision of health care services to eligible persons, and payment received by Participating Provider from eligible persons (or from others on their behalf).

These records are required to be maintained for least six (6) years after the end of each contract year, or longer period if required by law. Participating Provider shall make readily available to ACS, Payor and/or governmental agencies with regulatory authority, all medical and related administrative and financial records of eligible person(s) who receive Covered Services. Payor (or its designee) may request, and Participating Provider shall not unreasonably withhold or delay, additional records as may be requested in order to verify that Participating Provider's charges are reasonable and in line with prevailing community standards, to the extent not prohibited by applicable law.

Participating Provider shall, upon request of eligible person(s) or other Participating Provider, and subject to applicable disclosure and confidentiality laws, transfer the medical records of the eligible person(s) to such other Participating Provider at no charge to the eligible person(s). This obligation shall survive any termination or expiration of Participating Provider's agreement with ACS.

Confidentiality –HIPAA/ PHI

ACS Participating Providers agree that all Protected Health Information, including that related to patient conditions, medical utilization, and pharmacy utilization, available by any means, will be used exclusively for patient care, medical records, claims submissions, and all other related purposes as permitted by the HIPAA Privacy Rule.

Confidential or Proprietary Information

Participating Provider may, from time to time, receive confidential or proprietary information from ACS, including business plans, customers, customer lists, operations, programs, relationships, targets, compensation terms and arrangements described within the ACS Provider Agreement. Participating Provider agrees that such information shall be kept confidential and, unless otherwise required by law (in which case Participating Provider will provide prompt written notice to ACS prior to such required disclosure) shall not be disclosed to any person except as authorized in writing by ACS.

Regulatory Requirements

Incorporation of Other Legal Requirements

Any provisions now or hereafter required to be included in this manual by applicable federal and/or state laws and regulations or by CMS shall be binding upon and enforceable against Participating Providers and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this manual or elsewhere in Participating Provider's agreement.

Administrative, Medical and Reimbursement Policy Changes

From time to time, ACS may amend its policies to comply with applicable federal, state, or local laws and regulations. ACS will communicate changes to the Provider Manual as technology, procedures, policies, and programs change.

These may be communicated through a variety of methods including but not limited to:

+ Periodic Provider Manual updates
+ Letter
+ Facsimile
+ Email
+ Website updates

Providers are responsible for periodically checking ACS's website for policy updates in the Provider Manual and complying with these changes upon receipt of these notices or otherwise becoming aware or informed of such changes.

Eligible Persons Rights & Responsibilities

Participating Providers must comply with the rights of Eligible person as set forth below. Eligible persons have the right:

1. To receive accurate information about ACS services, ACS Participating Providers, the rights of eligible persons and Participating Providers, and how to contact ACS with any questions or concerns.
2. To be treated with respect and dignity.
3. To privacy of their personal health information, consistent with state and federal laws, and ACS policies.
4. To communicate with their providers about the medically necessary care and treatments for their condition, regardless of cost or benefit coverage. Eligible persons have a right to know about and understand any costs they will need to pay.
5. To register complaints about ACS services or the care provided by a ACS Participating Provider. This includes the right to have their complaints addressed in a timely and appropriate manner.
6. To choose the healthcare provider in the ACS network consistent with the terms of their benefit plan and applicable state and federal law.
7. To adequate access to qualified medical practitioners and treatment or services regardless of age, race, creed, sex, sexual orientation, national origin, or religion. Sex discrimination includes, but is not limited to, discrimination on the basis of pregnancy, gender identity and sex stereotyping.
8. To access medically necessary urgent and emergency services 24 hours a day and seven days a week.

Eligible person Responsibilities

1. To read and understand, to the best of their ability, all materials concerning their health benefits or to ask for assistance if they need it.
2. To treat all health care professionals and staff with courtesy and respect.
3. To give accurate and complete information about present conditions, past illnesses, hospitalizations, medications, and other matters about their health.

Eligible persons should make it known whether they clearly understand their care and what is expected of them. The member needs to ask questions of their provider, so they understand the care they are receiving.

4. To show their I.D. card and keep scheduled appointments with their provider and call the provider's office during office hours whenever possible if the member has a delay or cancellation.
5. To follow all health benefit plan guidelines, provisions, policies, and procedures.
6. To give all information about any other medical coverage they have at the time service.
7. To pay all deductible amounts, copayment amounts, or cost-sharing percentages at the time of service.

VI Eligibility

ACS does not determine Covered Person(s) eligibility or perform prior authorization. Always contact the Payor located on the member's ID card to obtain eligibility and benefit information before rendering services. Health Plan design may vary, and restrictions may apply. At the time of service, obtain an estimate of patient's coinsurance, deductible, plan design and copay information to determine Covered Person's payment responsibility.

Certifying treatment does not guarantee payment for services rendered to any Covered Person. When a determination is made not to approve or certify a health care service, written notification is sent to the attending Physician, Hospital, Covered Person and Payor and an appeal may be initiated by the Provider and/or the Covered Person.

Covered Persons are sometimes covered by more than one insurance policy. Always obtain complete benefit information from each Payor when verifying an Covered Person's health plan benefit and precertification requirements.

VII Claims

Claims Submission

When a Payor receive claims from an ACS Provider, they automatically forward the claim to ACS for re-pricing. ACS processes the claims in accordance with your Provider Agreement and your re-priced claims are returned to the Client and or Payor. ACS is unique in that as a Participating Provider you have delegated the asset of each claim to ACS so that we can relieve you of some administrative responsibilities like initial billing and collection of the claim's payment. We perform that work on your behalf and finalize your claims immediately upon receipt of EOP and or payment from our Payors.

All claims should be submitted in accordance with the instructions found on the patient's identification card.

Repricing and Coding Guidelines

Anesthesia Payment Guidelines: All anesthesia services shall be repriced using ASA Guidelines, units, and modifiers inclusive of A, P and Q modifiers. In the event an appropriate ASA code is not available, Participating Provider shall use appropriate CPT-4 coding and/or modifiers.

AWP: All drugs and biological (HCPCS) codes shall have rates set utilizing MediSpan AWP pricing. This pricing shall be maintained with updates no more than quarterly (Jan., April, July, and Oct) or as per effective dates indicated by the state of Texas for state supplied vaccines as appropriate.

Coding Guidelines: ACS shall recognize standard DRG, APC, ADA, NCCI, CPT-4, ASA, ICD-9, ICD-10 Medicare guidelines to re-price claims.

CPT Modifiers: ACS shall recognize standard insurance HCPCS, CPT-4, ADA, and ASA modifiers in accordance with Medicare standards.

Coding Methodologies: ACS shall recognize the following coding methodologies in accordance with published coding manuals and guidelines described in the Participating Provider's Agreement. ACS recognizes these publications will change from time to time. Therefore, ACS shall utilize current year at the time of service as a guide for re-pricing claims. Additional information on such coding methodology may be found at the following website locations:

- CPT-4 www.ama-assn.org/go/cpt
- ASA www.asahq.org
- HCPCS www.cms.hhs.gov/medicare/hcpcs
- ICD-9 www.cms.hhs.gov/medlearn/icd9code.asp
- ICD-10 www.cms.gov/Medicare/Coding/ICD10
- DRG www.cms.hhs.gov
- Revenue Codes www.cms.hhs.gov

Down Coding and Rebundling: ACS does not currently apply down coding or rebundling methodologies in its re-pricing of claims. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply covered benefits. For payor claims processing procedures and covered benefit information please contact the payor directly.

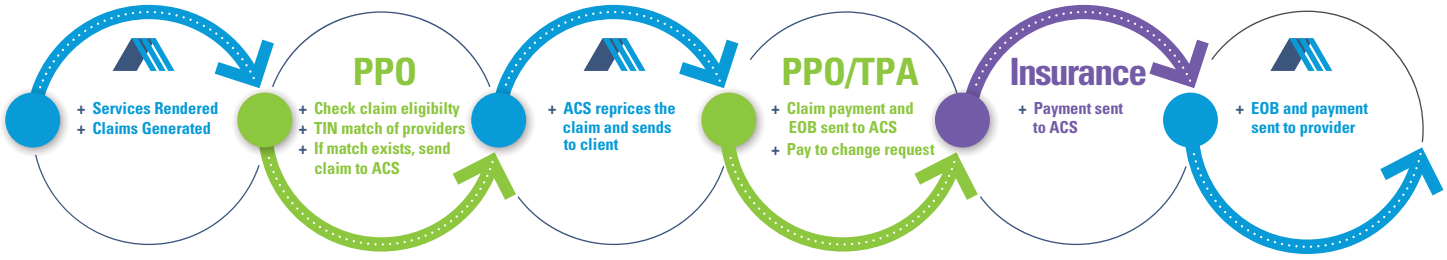
Multiple Surgeries: If more than one surgical procedure is performed during a single surgical episode, the claim will be priced in accordance with the Provider Agreement and claims logic applied by the payor.

Repricing Guidelines: The above represented claims re-pricing procedures reflect those of ACS only and are subject to change from time to time. Such procedures shall remain consistent with and in accordance with the Agreement, and applicable State and Federal law. These guidelines are in no way intended to represent subsequent payor claims processing procedures, guarantee of payment or imply Covered Services. For payor claims processing procedures and Covered Benefit information please contact the payor directly. For a complete list of ACS Payors, contact us.

The average turnaround time for re-pricing claims is less than 24 hours from the time the claim is received. Over 85% of all claims are re-priced and sent back to the payor within minutes. ACS begins calling on the claim two weeks from the time it is billed. The average time it takes for the provider to be paid from the date it submitted its claim to our clients is 30 days.

ACS's CLAIMS FLOW PROCESS (TPA's)

ACS's CLAIMS FLOW PROCESS (PPO's)



The ACS Customer Service and Operations team manages all aspects of the claim flow process, including claim status look-up, dispute resolution and appeals management.

VIII Billing & Payments

Reimbursement

Ancillary Care Services is committed to prompt and accurate claims payment. In order to achieve this result, we rely on providers to submit accurate claims. Participating Providers must submit original claims to the claims address listed on the back of the patient's insurance card according to your normal process (paper or electronic). ACS requires that claims be billed using usual and customary charges.

We cannot price claims that are submitted with charges matching the contracted amount. Upon receipt of those claims from ACS providers the ACS Clients and their Payors immediately forward them to ACS electronically for processing.

At this time, the ACS TIN and address are added to the claims as the "Pay To" entity, as a billing service would be, and the discounted re-priced amount is calculated for the claim. Most claims are re-priced and sent back to the Payor within minutes of ACS receiving them. Claims that require review by our Quality Assurance Department are turned around on average within 24 hours of receiving them. After ACS has completed this process, your claims are returned to the Payor for adjudication.

ACS begins the collections process immediately upon submission of your claim to our client. We have specialists that follow-up on claim status and drive quick processing times. These staff members are familiar with the requirements for each Payor, and they act on your behalf and treat every claim as if it were their own. Remember – since there is no fee to participate in the network, ACS does NOT get paid unless we get your claims paid. If additional information is required in order to receive payment, they will contact your office via phone and/or mail (EOP).

Electronic Fund Transfer (EFT)

Electronic payment and remittance options helps save time and simplify reconciliation. Details and options for setup with Echo below.

1. Virtual Card Services

A Virtual Credit Card payment (VCP) is a form of EFT payment where the provider is given a virtual credit card number to process the payment. There is a fee associated with each transaction based on the contract between the provider and their merchant acquirer. Cards not processed within 30 days of issuance will automatically be resent by ECHO and those not processed after 60 days will be issued as the next available payment method for the provider.

You can manage any issued virtual card payments and/or select a different payment method at https://echovcards.com.

2. EFT Payments

Payer Direct ACH: Providers enroll with ECHO Health online using a payer specific URL to receive ACH payments. Enrollments by payer are done separately. To enroll in payer direct ACH for ACS, complete the enrollment process at https://enrollments.echohealthinc.com/EFTERADirect/HealthSmart

All Payer ACH: Providers contract with ECHO Health to receive ACH payments from all payers. Enrollment occurs online at https://enrollments.echohealthinc.com/EFTERAInvitation.aspx, or by paper submission, and is only required once. The provider is automatically enrolled with existing and future payers for EFT and ERA delivery. This option ensures the quality of the 835 is balanced and formatted in the way the provider has instructed.

Elavon is a processor of credit card transactions, (a.k.a. Merchant Acquirer) which offers a payment solution program (Transend Pay) that pushes through a payment delivery system to deliver funds to the providers' bank account. Unlike a virtual card, the provider (merchant) does not need to key in the credit card number. Providers contract directly with Elavon for this service.

3. Medical Payments Exchange (MPX)

Medical Payments Exchange (MPX) is an online paper check replacement option that allows providers who receive paper checks the option to print and deposit the check, convert the payment to Virtual Card on demand, or enroll in ACH for future payments.

If you are not enrolled with us to receive payments via electronic funds transfer (EFT) and have enrolled for MPX you will receive your payments in your MPX portal account. Otherwise, you may receive a MPX payment by Choice Card notification or Paper Check notification, with information on how you can enroll for free printable paper checks delivered with your Explanation of Payment (EOP) 7-10 days faster than normal paper checks. The notification includes instructions for selecting your preferred payment option via our website https://echochecks.com.

Instructions to get setup:

If you are currently enrolled with ECHO in their All Payer ACH program, there is no additional action required. If you are not enrolled and wish to receive payments via ACH, please complete the steps below.

To sign-up to receive EFT for HealthSmart only, visit https://enrollments.echohealthinc.com/EFTERADirect/HealthSmart No Fees apply.

To sign-up to receive EFT from all payers processing payments on the ECHO platform, visit https://enrollments.echohealthinc.com/EFTERAInvitation.aspx. A fee for this service may be required.

From the landing page review the instructions, then select the ***"Click Here"*** button to begin the enrollment process. When presented with the sign in screen, select ***"Enroll using TIN"*** to begin.

You will be asked to provide your Tax Identification Number (TIN), an ECHO payment draft number and amount as part of the enrollment authentication process. You can enter any valid ECHO draft number and amount from a payment issued to you from ECHO in the last six months, regardless of the payer.

If you do not have a valid ECHO draft number, you will not be able to complete the authentication process. When you receive your first payment from ECHO, you can use the draft number and amount to complete the authentication and EFT/ERA enrollment process.

Provider Payments Portal

The Provider Payment Portal is dedicated to expanding the benefits of the ECHO system to your providers. The portal offers many benefits to providers, including but not limited to the ability to:

+ Centralized location for viewing documents from all payers under the ECHO umbrella
+ View PDF images of EPP documents (non-payments and payments)
+ View or download 835 files produced by ECHO for their Tax ID
+ View settlement status of payments issued to their Tax ID; for paper checks, this will show the front and back of the cleared check image
+ View PDF image of 1099 form, and manage their account, including edit notification settings and complete ACH deposit ping testing.

Echo Contract Information

URL: www.providerpayments.com
Call: 800.937.0896
Email: EDI@ECHOHealthInc.com

Explanation of Payment

All payments and EOBs for your claims are sent to ACS first. These payments and denials are posted to our claim record and go through a variety of edits to determine if it was paid accurately and according to the terms of its contract with the payor. ACS will send you an Explanation of Payment (EOP) that details each payment or denial, reflecting all patient responsibility and non-covered services EXACTLY as determined by the Payor.

If any claims are improperly paid or require appeal, ACS will begin the appeals process on behalf of the Provider. For appeal instruction go to Disputes, Appeals & Grievances

Ancillary Care Services, Inc. 1
222 Las Colinas Blvd W, Ste 500N
Irving TX 75039-5421

ANCILLARY CARE SERVICES

NORTEX URGENT CARE CENTER
2112 W CENTER RD
JUSTIN TX 75902

Your name, NORTEX URGENT CARE CENTER, and Tax ID have been verified by the IRS.

Please call customer service number listed below with questions or visit myHealth.HealthSmart.com

Tax ID: *27678568* ***EPC Draft #:*** *25894629* ***Payment Week:*** 21 ***Payment Date:*** *05/26/2022* Page 1 of 2

Dates of Service	Procedures (Modifiers)	Total Charge	Provider Discount	Other Plan Payment (COB)	Other Adjustment	Contract Rate	Patient Responsibility				Payment Amount	Explanation Codes
							Co -Ins	Co -Pay	Deductible	Not Covered		
Client: HS Accel					**Patient Acct # :** 486410				**Reference Number:** 0000059459			
Payor: 8 WEST INC.					**Enrollee ID:** XXX-XX-0099				**Customer Service #:** 844-516-3335			
Patient Name: LEE PEARSON					**Claim Number:** BV8RD2C3P0							
04/14/22	99204	325.00	162.50	0.00	0.00	162.50	2.79	0.00	150.00	0.00	9.71	
Total:		325.00	162.50	0.00	0.00	162.50	2.79	0.00	150.00	0.00	9.71	

Statement Summary Administered By	Total Charge	Provider Discount	Other Plan Payment (COB)	Other Adjustment	Patient Responsibility	Contract Rate	Net Payment Amount
Ancillary Care Services	325.00	162.50	0.00	0.00	152.79	162.50	9.71

Important Information

This Explanation of Payment reflects payments and benefit determinations received by ACS as a result of your membership in the Ancillary Care Services Network. All patient responsibility and other benefit determinations have been made by the members' plan administrator and are reflected here exactly as they are on the member's original EOB. Payment is based on your contract fee schedule with ACS, less non-covered services, coordination of benefits and

EOP Information Key

1. Check information: A Check number and total amount will show if the EOP Is accompanying a check. B. Check number and total amount will show a 0.00 if the EOP results in 0.00 payments.

2. Important Information: Due to the unique workflow of our business model, it is often confusing to the business office personnel as to why our EOP may be different from the original EOB sent to the member by the payor. This section gives an explanation and should help with understanding how to post any differences, should they occur.

3. Patient Name and Account number, as it appears on your claim.

4. Insured Name and ID, as it appears on your claim.

5. Client: The payor, TPA, or PPO network that we work with to process your claims.

6. Payor: The actual payor/adjudicator of the claims.

7. Billed Amount: "Charges" from your original claim (box 24F).

8. ACS Contract Rate: For each procedure line, this will reflect the fee schedule rate or calculated rate based on your contract with ACS. *This is not the amount allowed by the payor, as it is based solely on your contract terms.

9. Non-covered: The amount of charges that the payor determines are non-covered services or are disallowed, and you are not allowed to pass these charges on to the patient.

10. Explanation Code: The HIPAA standard code assigned to the reason for the non-covered determination. *Detailed description can be found in #15.

11. Patient Responsibility: Breakdown of the payors adjudication and determination of charges that can be billed to the patient, including Deductible, Co-Pay, Coinsurance, and Non-Covered services.

12. COB—Coordination of Benefits: The amount that you received from a primary insurance carrier. *This amount is subtracted from your ACS contract rate to calculate your payment.

13. Payment: The calculated amount for each line item that you are receiving from ACS (contract rate less patient responsibilities, non-covered charges, and COB).

IX Disputes, Appeals & Grievances

Credentialing Disputes

HealthSmart may deny participation or terminate participation during the credentialing or re-credentialing process for the following:

- Failure to meet the standards and criteria set forth in ACS's Credentialing Policies and Procedures.
- Failure of an applicant to adequately respond to a request for missing or expired information.
- Providers accepted or treated a patient prior to being fully credentialed.
- Failure to meet credentialing standards conducted every 36 months.
- Failure to meet annual audit process standards (Delegated groups).
- Failure to meet monthly reporting standards (Delegated groups).
- Failure to provide notice to HealthSmart of any material changes to their organization.
- Failure to provide demographics or roster changes.

Corrective Action Notifications indicate a deficiency in a providers credentialing documentation, application or delegated responsibilities. Notified providers are required to submit a written response within 15 days of receipt of a Corrective Action Notice, outlining:

- A disposition and response to the deficiencies stated in the Notification.
- Dispute of the deficiency with valid supporting evidence.
- A corrective action plan to address the deficiencies, including procedures and timelines.

If the parties fail to reach an agreement on the existence or resolution of a deficiency, ACS reserves the right to terminate the credentialing process, the Participating Providers status, or the Agreement in question with Notice.

For questions regarding a provider credentialing status, termination or correction action notification please contact the issuing party on the Notice or our Provider Relations Team.

Clinical Or Medical Necessity Appeals

An appeal is a request to the health insurer or Participating Provider to review an adverse benefit determination.

The appeal process is available to any provider that wishes to initiate the process. The appeals process may vary by the client or payor's Utilization Management program and/or as mandated by state or federal law. If you or an eligible person do not agree with a determination to not approve or certify a health care service made under the Utilization Management program, you or the eligible person have the right to appeal the determination in accordance with Utilization Management program's appeal process. Please contact the appropriate Utilization Management vendor on the member's ID card. Failure to observe the protocols of the Utilization Management program may result in a reduction of benefits to the Eligible person.

Providers may access an appeal process if they disagree with the payment of services and/or explanation of benefits received. An appeal is warranted when there is a dispute between the health care provider and ACS for reason(s) including, but not limited to: contractual issues, timely filing, authorization, and notification of payment issues. Providers will not be penalized for filing an appeal, and there is no action required by the member in order to initiate an appeal. ACS will initiate the appeals process before you receive your payment if we note a discrepancy.

The provider may file an appeal up to 180 days after the paid date of the Explanation of Payment (EOP) by submitting a written request for review with a copy of the claim, the EOP, and any appropriate supporting documentation.

The request will be reviewed to determine the appropriate action. If necessary, ACS will appeal the claim with the payor on behalf of the provider. If ACS or the payor need additional information, a letter will be sent to the provider within 15 days of receipt of the original appeal.

A determination letter will be sent to the provider upon receipt of complete appeal information. ACS must abide by the payor guidelines. Therefore, all benefit information will be furnished by the payor, and ACS will provide this information to the provider. The response will include the following information:

+ Provider's name and Tax ID#
+ Patient name and ID#
+ Dates of service
+ Written description of concern
+ Determination

Each member's plan may have other voluntary alternative dispute resolution options. If a provider is dissatisfied with the appeal resolution (as furnished by payor), additional appeals may be filed as are allowed by the member's group. This should be a written appeal and should be submitted within 30 days of receipt of the first level determination letter.

If a provider is dissatisfied with an appeal resolution that deals strictly with ACS contractual obligations, a Second Level administrative appeal can be filed. This should be a written appeal and should be submitted within 30 days of receipt of the first level determination letter. The request will be reviewed jointly by the Operations and Provider Development areas and a determination letter will be mailed within 30 days.

Disputes, Appeals & Grievances of any nature can be mailed to:
HealthSmart Preferred Care II, LP d/b/a Ancillary Care Services (ACS)

Attn: Appeals
222 W. Las Colinas Blvd., Suite 500N
Irving, Texas 75039
FAX: 806.473.3228

Please provide the following information when submitting an appeal/complaint:
+ Contact information (name, phone number, fax number and email address of the submitter)
+ Description of the issue and appeal/complaint with relevant and supporting documentation
+ An EOB and/or a copy of the claim(s) in question

X Clients

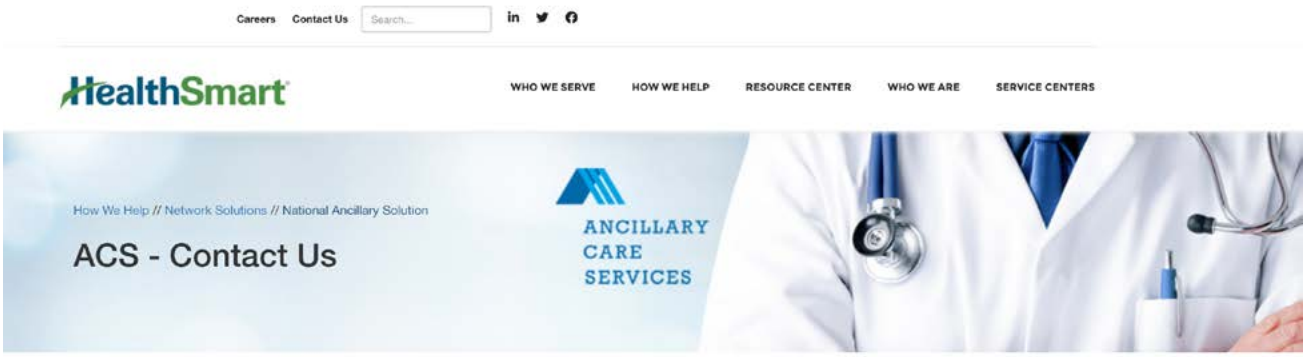
ACS Network Solutions has many and variety of customer types. We work directly with our clients to customize a plan that meets their needs and the needs of their customers. Our goal is to be as flexible and affordable as possible while providing a high-quality product. ACS expects its clients to consider and observe the terms and conditions of our Participating Provider Agreements.

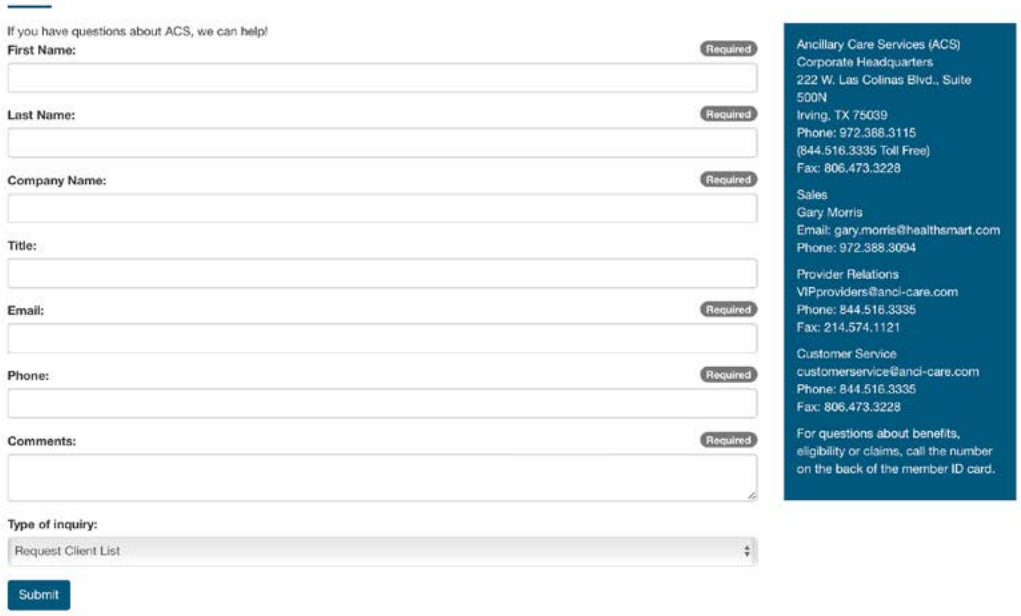
The customers who access our network products include but are not limited to:

- Third Party Administrators (TPA)
- Health Plans
- Network Aggregators
- Self-funded Unions
- Bill Review Vendors

Client/Payor List

To obtain a current client list, Contact Us. List" in the ***"Type of Inquiry"*** drop down box.





XI Glossary

- **Access to the ACS Provider Network** means the relationship of ACS with a Client wherein ACS agrees and allows such Client to have access to the ACS Provider Networks and to benefit from the ACS Negotiated Rates with Participating Providers. Such access to Participating Providers may be customized for Client and/or Payor to include or exclude certain Participating Providers.
- **ACS Client Fee Schedule** means a fee schedule for Ancillary Services arranged and/or negotiated, directly, or indirectly, by ACS with each Client and/or Payor and which establishes and sets the maximum payments that shall be made for Ancillary Services by Client and/or Payor to ACS, for Ancillary Services that are delivered to Client and/or Payor's Covered Persons.
- **ACS Provider Network** is the network(s) of Participating Providers under contract with ACS to provide Ancillary Services.
- **Ancillary Service** means any health care services not generally provided in a medical doctor's office or acute inpatient facility. Ancillary Service shall include, without limitation, those services provided in a post-acute inpatient facility, such as acute inpatient rehabilitation, long-term care hospital facility, or skilled nursing facility.
- **Claim or Complete Claim** means a request for payment for Ancillary Services submitted by a Participating Provider which is accurate, complete and legible and includes all information as defined by law on forms UB-04 (or successor forms) or CMS-Form 1500 (or successor forms) or for electronic claims using the ASC XI2N 837 format and in compliance with all applicable federal laws relating to electronic health care claims.
- **Client(s)** means those Plans and/or Payors contracting with ACS for Access to the ACS Provider Network.
- **Client Agreement** means an agreement between ACS and a Client setting forth the terms and conditions for access to ACS's Participating Providers.
- **Coinsurance** means a fixed percentage of the cost, if any, of Ancillary Services required to be paid by a Covered Person under the Plan.
- **Copayment** means a payment that a Covered Person is required to make for Ancillary Services under a Plan which is calculated as a fixed dollar payment.
- **Covered Person** means any person covered to receive Ancillary Services or benefits under a Plan.
- **Covered Person Expenses** means any amounts that are the Covered Person's responsibility to pay Provider in accordance with the Covered Person's Plan, including but not limited to Copayments, Coinsurance and Deductibles.
- **Deductible** means that portion of the cost, if any, of Ancillary Services required to be paid by a Covered Person prior to the commencement of payment for such Ancillary Services by the Plan.
- **Medical Necessity** means those health care services or supplies which are determined to be: (i) appropriate and necessary for the symptoms, diagnosis or treatment of the injury, illness or disease; (ii) provided for the diagnosis or direct care and treatment of the injury, illness or disease; (iii) preventive services as provided in a Plan; (iv) within standards of good medical practice within the medical community; (v) not primarily for the convenience of the Covered Person or of any Participating Provider providing Ancillary Services to the Covered Person; and (vi) an appropriate supply or level of service needed to provide safe and adequate care; PROVIDED, HOWEVER, that a Plan may provide a different definition of Medical Necessity and the Plan's definition shall prevail.
- **Negotiated Rates** means the contractually agreed upon rates between ACS and Provider that are to be paid for Ancillary Services provided to ACS Clients' Covered Persons and that are reflected in the rate exhibits which are attached to and made a part of this Provider Agreement.

- **Normal Billed Charges** means the Provider's usual charges for health care services and supplies before any discounts or reductions are applied as set forth on Provider's charge master.
- **Participating Provider** means any Provider specializing in the administration or delivery of Ancillary Services and that has met the credentialing standards established by ACS and has entered into a contractual arrangement with ACS.
- **Payor** means an insurance company, third party administrator, an employer, union, governmental agency, association, trust, entity or other party with the responsibility for payment of Ancillary Services provided to Covered Persons.
- **Plan** means a health benefits plan, group accident and/or workers compensation coverage sponsored or issued by a Payor which contains the terms and conditions of coverage and includes incentives for a Covered Person to receive Ancillary Services from Participating Providers.
- **Provider Agreement** means this agreement between ACS and Provider.
- **Provider's Payment** means the Negotiated Rate which is reflected in the rate exhibits which are attached to and made a part of this Provider Agreement.
- **Regulatory Addenda** are the exhibits attached hereto that set forth contract language requirements under applicable state and federal laws.
- **State** means the state in which the Provider is located.
- **Utilization Management** means a system for prospective or concurrent review of the Medical Necessity and appropriateness of Ancillary Services provided to a Covered Person.

XII Appendix