Anthem Health Plans of New Hampshire, Inc., Doing Business As Anthem Blue Cross and Blue Shield and Matthew Thornton Health Plan, Inc.

AND

City of Portsmouth, NH

STANDARD GROUND AMBULANCE STANDARD PROVIDER AGREEMENT

This Standard Ground Ambulance Standard Provider Agreement (hereinafter "Agreement") is made and entered into by and between Anthem Health Plans of New Hampshire, Inc., doing business as Anthem Blue Cross and Blue Shield and Matthew Thornton Health Plan, Inc., (hereinafter "Carrier") and City of Portsmouth, NH (hereinafter "Provider") and shall be effective on the date it is fully executed by both the Carrier and the Provider (hereinafter "the Parties"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the Parties, the Parties agree as follows:

1.0 DEFINITIONS

1.1 "Affiliate" means any entity that is owned or controlled, either directly or through a parent or subsidiary entity, by Carrier, or is under common control with Carrier and may include a health maintenance organization, health insurance company or third party administrator. Unless otherwise set forth in this Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

1.2 "Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Carrier.

1.3 "Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by Carrier to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers and instructions, Carrier medical policies and clinical Utilization Management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include

medical record review for quality and risk adjustment initiatives, or activities conducted by Carrier's Special Investigation Unit ("SIU").

1.4 "Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Carrier submitted by a provider for payment by Carrier for Health Services rendered to a Member.

1.5 "Claims Payment Policies and Procedures" are protocols established by the Carrier for the review and adjudication of claims for health care services as set forth in the Provider Manual and other Carrier Policies and Procedures.

1.6 "CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

1.7 "Commercial Business" means Health Benefit Plans that exclude coverage provided under Government Programs and that include coverage for individual and employer groups that is either a Fully Insured Plan insured by Carrier or a Self-Funded Plan administered by Carrier and under which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers.

1.8 "Clean claim" means a claim for payment of Covered Services that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.

1.9 "Cost Sharing" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be consist of coinsurance, copayment, deductible, or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

1.10 "Covered Services" means Medically Necessary Health Services, as determined by Carrier and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

1.11 "Facility" means any health care facility including but not limited to an acute care hospital, community mental health facility,

freestanding ambulatory surgery center, transitional care unit, behavioral health facility, extended care facility, rehabilitation facility, or skilled nursing facility.

1.12 “Fully Insured Plan” or “Fully Insured Members” means health coverage or persons with such coverage pursuant to which the Carrier provides or arranges for Covered Services and other related administrative services for Members and with respect to which the Carrier assumes the financial risk for Covered Services received by Members.

1.13 "Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Carrier maintains a contract to furnish health coverage services.

1.14 “Ground Ambulance Provider” means a public or private organization licensed by the New Hampshire Department of safety under RSA 153-A:10 to provide ground ambulance services.

1.15 “Ground Ambulance Services" means:

(a) The rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10; and

(b) Ground ambulance transport between health care facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10.

1.16 "Health Benefit Plan" or “Plan” means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

1.17 “Health Carrier” means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance Carrier, a health maintenance organization, a health service corporation, or any other entity providing or administering a plan of health insurance, health benefits, or health services.

1.18 "Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

1.19 "Medically Necessary" or "Medical Necessity" means health care services or products provided to Members for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1.19.1 Consistent with generally accepted standards of medical practice;

1.19.2 Clinically appropriate in terms of type, frequency, extent, site, and duration;

1.19.3 Demonstrated through scientific evidence to be effective in improving health outcomes;

1.19.4 Representative of "best practices" in the medical profession; and

1.19.5 Not primarily for the convenience of the member or physician or other health care provider.

1.20 "Member" means any individual who is eligible, as determined by Carrier, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all appendices, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Participant, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

1.21 "Network" means a group of Health Service providers that support, through a direct or indirect contractual relationship, one or more Health Benefit Plans, product(s) and/or program(s) in which Members are enrolled.

1.22 "Participating Provider" means a person or entity, or an employee or subcontractor of such person or entity, that is directly or indirectly party to an agreement to provide Covered Services to Members that has met all applicable Carrier credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Carrier to participate in one or more Network(s).

1.23 "Payor" is the person or entity obligated to a Member to provide reimbursement for Covered Services under the Member's Health Benefit Plan and that may be the Carrier or an Affiliate, or the plan sponsor that has entered into a Self-Funded Plan with the Carrier acting as administrator, or the person or entity which Carrier has agreed may directly or indirectly access services under this Agreement pursuant to a network rental product. Carrier is the Payor only for Covered Services under an insurance policy or HMO contract issued by Carrier or an affiliate and not for Self-Funded Plans or medical rental products.

1.24 "Policies and Procedures" means those policies and procedures applied by the Carrier in a standard manner across similarly situated providers in its network. Such policies and procedures are written in various documents including but not limited to the Provider Manual, the Carrier Quality Management program, Utilization Management program, claims processing manuals, benefits administration policies, credentialing and recredentialing program, payment and billing guidelines, and policies on confidentiality of information.

1.25 "Provider Manual" or "Manual" is the document setting forth Carrier Policies and Procedures and other requirements applicable to Participating Providers and the products insured or administered by the Carrier. The Manual is made available on the Carrier's public website, with paper copies available upon request.

1.26 "Quality Management" means the program described in the Policies and Procedures relating to assuring the quality of Covered Services

provided to Members.

1.27 "Regulatory Requirements" means all applicable common law and any and all state, federal or local statutes, ordinances, codes, rules, regulations, restrictions, orders, procedures, standards, directives, guidelines, instructions, bulletins, policies or requirements enacted, adopted, promulgated, applied, followed or imposed by any governmental authority, as amended, modified, revised or replaced, interpreted or enforced by any governmental authority, as applicable to each respective party to this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

1.28 "Self-Funded Plan" or "Self-Insured Members" means an arrangement between the Carrier and a third party pursuant to which: (1) the Carrier provides or arranges for Covered Services and other related administrative services for eligible participants and their dependents ("Self-Insured Members"); and (2) such third party assumes financial risk for Covered Services received by Self-Insured members. The types of third parties in a Self-Funded Plan include, but are not limited to, employers, union trusts, insurers, multiple employer welfare arrangements, U.S. military governmental agencies, or pooled risk management programs operating pursuant to Regulatory Requirements.

1.29 "Standard Ground Ambulance Provider Contract" means this Agreement the template for which is in compliance with the requirements of RSA 420-J:23 and which Health Carriers are required, under RSA 420-J:23, to offer to any Ground Ambulance Provider that is qualified and willing to meet its terms.

1.30 "Standard Ground Ambulance Rate Schedule" means the rate schedule referenced in RSA 420-J:21 for compensating Participating Ground Ambulance Providers for Covered Services that is incorporated in the Standard Ground Ambulance Provider Contract.

1.31 "Utilization Management" means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Carrier's Policies and Procedures.

2.0 RESPONSIBILITIES OF THE PARTIES

2.1 Member Identification. Carrier shall ensure that it provides a means of identifying Members either by issuing a paper, plastic, electronic, or other identification document to Members or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Carrier to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member. Carrier makes no representations or guarantees concerning the number of Members that will be referred to Provider as a result of this Agreement

2.2 Benefit Information. Carrier will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Member is entitled as specified in the Policies and Procedures.

2.3 Provision of Services. Provider agrees to provide to members Covered Services which it customarily provides to its patients in an economic and efficient manner. Such Covered Services shall be provided in accordance with the provisions concerning services standards as contained in the Provider Manual and other Carrier Policies and Procedures. All Covered Services provided by Provider to members shall be under the terms of this Agreement.

2.4 Provider Standards and Qualifications. Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider warrants that it is duly licensed under the laws of the state where service is provided, and that all services under this Agreement will be delivered by individuals who (i) are duly licensed under the Regulatory Requirements of the state where service is provided, (ii) are eligible to provide services to Members, and (iii) are Board Certified or Board Eligible in the specialty in which they are delivering services, as applicable. Provider will ensure that each employer individuals

rendering services under this Agreement maintains such status.

2.5 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type or kind of Health Service to Members that he/she/it does not customarily provide to others.

2.6 Provider Cooperation with the Credentialing Process. Provider shall provide the Carrier with appropriate credentialing information if it is not already a Participating Provider. Provider agrees to comply with the Carrier's credentialing and recredentialing policies and procedures, including but not limited to such policies as are set forth in the Provider Manual. Neither the Provider nor any of the Provider employed individuals shall provide Covered Services to any Member under this Agreement until Provider's participation is approved by the Carrier. Provider agrees that each Provider-Affiliate providing Covered Services pursuant to this Agreement must be credentialed by the Carrier pursuant to the Carrier's credentialing policy in order to provide Covered Services and be paid therefore.

2.7 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Carrier of:

2.7.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Carrier, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement;

2.7.2 Any change in Provider accreditation, affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community; or

2.7.3 Any disciplinary action concerning the Provider or any individual employed by or under contract with the Provider taken by any state or federal agency responsible for Provider licensing, certification, or the payment for health care services.

2.8 Carrier Discretion with Respect to Credentialing. The Carrier represents that it complies with all Regulatory Requirements related to provider credentialing. The Carrier has full discretion to grant or deny credentialing approval or take any disciplinary action relative to the credentialing approval of the Provider based on clinical quality issues or any other matters deemed relevant by the Carrier. Without limitation to any of the foregoing, the Carrier shall have the right to terminate immediately the Provider's credentials and participation under this Agreement in the Carrier's networks, or to take such other disciplinary action as it deems appropriate, for the following reasons:

2.8.1 suspension, termination or non-renewal of a license of the Provider,

2.8.2 acts or omissions which threaten the life, health or safety of a patient or patients,

2.8.3 failure to meet standard of care as required for Carrier Providers and determined by the Carrier,

2.8.4 repeated failure to comply with accepted ethical and professional standards of behavior;

2.8.5 provider inactivity as described in Subsection 2.16.3;

2.8.6 dissolution or sale of substantially all assets;

2.8.7 institution of proceeding in bankruptcy, insolvency, assignment for benefit of creditors or other action generally to secure rights of creditors; or

2.8.8 failure to provide credentialing or recredentialing information to the Carrier upon request.

Any decision by the Carrier to deny, non-renew, or withdraw the

credentials of Provider, or to terminate the credentials of Provider, shall be in writing, shall state the reasons for such termination, and, shall include notice of a Provider's right to an appeal.

2.9 Compliance with Carrier Policies and Procedures. Provider agrees to abide by and cooperate with Carrier's Provider Manual, and all other Policies and Procedures established and implemented by Carrier, including, without limitation, Policies and Procedures relating to credentialing, Utilization Management, Quality Management and improvement, the delivery of preventive health services, claims submission, cost sharing collections, confidentiality of Provider, patient and Carrier information, duplicate coverage, and subrogation recoveries. In the event of any conflict between Carrier Policies and Procedures and this Agreement, the terms of this Agreement will prevail. The Carrier may, at its discretion and at any time, amend the Provider Manual, its Policies and Procedures, and any other programs or administrative policies and procedures, such changes to be binding upon Provider; provided further, that Provider shall be notified in writing of modifications in Covered Services or modifications in the Carrier's procedures, documents or requirements including those associated with Utilization management, Quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Carrier and Provider.

2.10 Publication and Use of Provider Information. Provider agrees that Carrier or its designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, compensation rates, and information related to Provider for transparency initiatives.

2.11 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the Parties agree that they may identify Provider as a participant in the Network(s) in which Provider participates.

2.12 Cooperation Regarding Member Complaints and Grievance Procedures. Provider agrees to cooperate with Carrier in the review and resolution of Member complaints or grievances that may arise relating to the provision of Covered Services to Members including but not limited to providing any information or records needed to render a decision on a complaint or grievance. Provider agrees to provide such information and records with sufficient promptness to allow the Carrier to meet state and federal regulatory requirements for timely processing of Member complaints and grievances. It is understood that certain complaints and grievances must be processed by the Carrier on an expedited basis. The Carrier and Provider agree that complaints received by the Carrier or the Provider with respect to the provision of Covered Services shall ultimately be resolved in accordance with the Carrier's grievance procedures or upon external review under RSA 420-J:5-a through 420-J:5-e. The Carrier will forward to Provider copies of any such complaints or grievances, upon Provider's request and to the extent necessary for Provider to comply with this Section. Provider agrees, to the extent permitted by Regulatory Requirements, to fully advise the Carrier of any Member complaint, grievance or claim known to Provider relating to services provided under this Agreement.

2.13 General Cooperation Requirement. Provider shall also cooperate with Carrier and Carrier Affiliates in implementing those policies and programs as may be reasonably requested by Carrier or a Carrier Affiliate for purposes of Carrier's or the Carrier Affiliate's business operations or required by Carrier or a Carrier Affiliate to comply with Regulatory Requirements or accreditation requirements.

2.14 Records. Provider shall maintain medical records and documents relating to Members as may be required by Regulatory Requirements and for the period of time required by law. Medical records of Members and any other records containing individually identifiable information relating to Members will be regarded as confidential, and Provider and Carrier shall comply with applicable federal and state law regarding such records. Provider will obtain Members' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Carrier with a copy of Members' medical records and other records maintained by Provider relating to Members. These records shall be provided to Carrier at no charge and within the timeframes requested by Carrier and will also be made available during normal

business hours for inspection by Carrier, Carrier's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement.

2.15 Participation in Networks Supporting Commercial Business. Provider will render Commercial Business Covered Services to Commercial Business Members in accordance with the terms and conditions of this Agreement. Provider agrees to participate in all of Carrier's Commercial Business networks.

2.16 Provider Directory Updates, Name Use, Inactivity, and Provider Directory Suppression.

2.16.1 Provider Directory Updates. Provider shall cooperate with Carrier's efforts to maintain accurate provider directories by complying with Regulatory Requirements and the Carrier's Policies and Procedures, including those set forth in the Provider Manual, for verification of provider directory information related to Provider and advance notification requirements for any changes to Provider and/or Provider's Provider contact and demographic information, including without limitation, digital contact information, with specification as to each location in which each Provider regularly provides services to patients, specialty, any medical group and/or Facility affiliations, Facility accreditation status, any languages spoken other than English, and board certification(s).

2.16.2 Name Use. Provider agrees that the Carrier may use Provider's demographic information including without limitation, Provider's name(s), address(es), telephone number(s), website/URL(s), digital contact information, a description of Facilities, a description of care and specialty services provided, as may be appropriate and necessary in advertising of the Carrier, provided that such advertising shall be done in accordance with Regulatory Restrictions. The Carrier agrees that, with the prior written consent of the Carrier, Provider may use the Carrier's name in statements or announcements that Provider accepts the coverage of Carrier

Members.

2.16.3 Provider Inactivity. In accordance with applicable Carrier Policies and Procedures, the Carrier may terminate a Provider that has not, (i) verified their provider directory information or provided other information required by the Carrier or Regulatory Requirements or (ii) provided services to patients or submitted a claim for services for a period of two years. Under such circumstances, Provider may reapply to become a participating provider through the Carrier's standard credentialing and enrollment processes set forth in Carrier Policies and Procedures.

2.16.4 Provider Directory Suppression. The Carrier may suppress provider directory information (i) that cannot be verified by the Carrier as described in the Provider Manual, (ii) to the extent required by Regulatory Requirements, (iii) where Carrier deems a Provider terminated from the network if such Provider has not verified such information as required under the Provider Manual and has no activity in the Carrier's system for more than two years, or (iv) as otherwise required by Carrier to ensure accurate claims processing and benefit administration.

2.17 Referral Incentives/Kickbacks Prohibited. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Carrier.

2.18 Member Incentives Prohibited. Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Member incentive. Participant Incentive means any arrangement by Provider to:

2.18.1 reduce or satisfy a Participant's Cost-Sharing obligations;

2.18.2 pay on behalf of or reimburse a Member for any portion of the Member's costs for coverage under a policy or plan insured or administered by Carrier or a Carrier Affiliate; or

2.18.3 to provide a Member with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from Provider or its affiliates.

In the event of non-compliance with this provision: Carrier may terminate this Agreement, such non-compliance being a "material breach" of this Agreement; Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Member in connection with a Member incentive; and Carrier may take such other action appropriate to enforce this provision.

2.19 Provider Service or Organizational Changes. Provider shall notify the Carrier in writing in accordance with the Notice section of this Agreement at least 90 days prior to any significant service or organizational change that occurs after the Effective Date of this Agreement, whether or not such change is occurring as a result of a merger, acquisition, affiliation or any other formal or informal business combination, including without limitation: (i) any action to sell, transfer or convey its business or any substantial portion of its business assets to another entity, or when Provider is the subject of a sale, transfer or conveyance of its business by another entity, (ii) when Provider enters into a management contract with another entity to deliver any new type of Covered Service not previously provided by Provider, (iii) when Provider contracts to deliver of any Covered Services provided by Provider in additional facilities or practice locations, and/or (iv) when there is significant growth or other changes impacting the size of the Provider, including through merger, acquisition, or changes to any of Provider's affiliations. Such service or organizational changes are not automatically included under the terms of this Agreement and any inclusion thereof shall require mutual written agreement by the Parties. If Provider fails to timely notify Carrier of a service or organizational change falling under this paragraph, then Carrier may include or exclude the new service or organizational composition under this agreement by serving notice on Provider under the Notice section of this Agreement. However, Carrier will accept any new service or organizational composition of Provider as coming under this Agreement if Provider remains qualified and willing to accept the terms of the Standard Ground Ambulance Provider Contract.

3.0 COMPENSATION

3.1 Submission and Adjudication of Claims. Provider shall submit, and Carrier shall adjudicate, claims in accordance with the Carrier's Claims Payment Policies and Procedures as detailed in the Provider Manual and other Carrier Policies and Procedures as may be issued by the Carrier from time to time. Claims for payment for Covered Services to Members shall not be payable under this Agreement if not submitted to the Carrier in accordance with such Policies and Procedures.

3.2 Non-Medically Necessary Services. Provider shall not charge a Member for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Member in writing that the particular service will not be covered by Carrier and the Member acknowledges in writing that he or she will be responsible for payment for such service.

3.3 The Standard Ground Ambulance Rate Schedule. The Standard Ground Ambulance Rate Schedule shall apply as provided in Appendix A to Provider compensation for Covered Services to Members with respect to products and Health Benefit Plans offered or maintained by Carrier in its Commercial Business.

3.4 Applicability of the Rates. The rates in this Agreement apply to all services provided by Provider to Members in the products and Health Benefit Plan types covered by this Agreement, including services covered under a Member's in or out-of-network benefits (e.g. PPO or POS plans), and whether the Payor or Member is financially responsible for payment.

3.5 Cost Sharing. Provider shall be solely responsible for the collection of all applicable Cost Sharing from Members, subject to the Carrier Policies and Procedures. Provider agrees to make reasonable efforts to verify Cost Sharing amounts prior to billing for such amounts. The Carrier shall have no responsibility for payment or collection of such Cost Sharing and any such amounts payable by Members for Covered Services will be debited against amounts owed to Provider under this Agreement.

3.6 Effect of Member Coverage as of the Date of Service. The Payor will be responsible for payment for Covered Services if the patient is an active Member and eligible for such service on the date of service.

The Carrier, on behalf of itself and the Payor, reserves the right to deny or recover payment if, after receipt of a claim, it is determined that the patient was not a Member on the date of service unless the patient was entitled to an extension of benefits by operation of law. Provider may bill such patient or his or her third party insurance carrier directly for those non-reimbursed services furnished to such patient.

3.7 Payment in Full and Hold Harmless.

3.7.1 Provider will look solely to the Payor for payment of Covered Services provided to Members. Except when the Carrier is also the Payor, the Parties hereto acknowledge that the Carrier shall act solely as the Payor's payment agent hereunder. Carrier is not the insurer, guarantor or underwriter of the liability of such Payor for benefits provided to or under Self-Insured Plans, provided, however, that the Carrier is not relieved of its responsibility under its contracts with such Payors to administer payment to Provider for Covered Services rendered to Self-Insured Plan Members. Provider agrees to accept as payment in full, in all circumstances, the amount that is required under this Agreement whether such payment is in the form of a Cost Sharing, a payment by Carrier, or a payment by another source, such as through coordination of benefits or subrogation. In no event shall Carrier be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the amount that is required under this Agreement less Cost Sharing payments or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the amount that is required under this Agreement as payment in full even if the Member has not yet satisfied his/her deductible.

3.7.2 Provider agrees that in no event, including but not limited to nonpayment by the Carrier or intermediary, insolvency of the Carrier or intermediary, or breach of this Agreement, shall the Provider (or its assignees or subcontractors) have the right to seek any type of payment from, bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a Member or a person acting on behalf of the Member (other than the Carrier or intermediary) for Covered Services provided pursuant to this Agreement, except for the collection

of Cost Sharing for services covered by the Health Benefit Plan, whether or not compensation has actually been received by the Provider for such Services or whether or not this Agreement remains in effect. This agreement does not prohibit the Provider from collecting fees for uncovered services delivered on a fee-for-service basis to Members. Nor does this Agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the Member, as long as the Provider has clearly informed the Member that the Carrier may not cover or continue to cover a specific service or services. Covered Services which the Provider is prohibited from billing Members for shall include services denied by the Carrier pursuant to its utilization management Policies and Procedures for failure to meet the Carrier's Medically Necessary criteria and/or administrative denials issued by the Carrier pursuant to Carrier Policies and Procedures. Provider's sole redress shall be against the assets of the Payor. The requirements of this provision shall survive any termination of this Agreement for services rendered prior to the termination, regardless of the cause of such termination. The Carrier's Members, any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement hereafter entered into between Provider and the Member or any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder. Except as provided in this Agreement, this agreement does not prohibit the provider from pursuing any available legal remedy.

3.8 Payment Time Frames. For Claims subject to New Hampshire law, Carrier or its designee and Provider shall comply with the requirements of the New Hampshire prompt pay legislation (RSA 420-J:8-a), as may be applicable, for payment of Clean Claims for Covered Services.

3.9 Audits and Carrier Access to Provider Records. The Carrier shall have the right to conduct audits to verify the accuracy of Member bills and compliance with the Carrier's billing guidelines, as set forth in the Provider Manual or in other Carrier Policies and Procedures. The Provider shall cooperate with the Carrier and its auditor in accordance with the procedures set forth in the Provider Manual or

in other Carrier Policies and Procedures. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the Provider Manual and/or other Carrier Policies and Procedures, shall permit Carrier or its designees to have, with appropriate working space and without charge, on-site access to and the right to examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Carrier in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the Provider Manual, and compliance with this Agreement. In lieu of on-site access, at Carrier's request, Provider or its designees shall submit records to Carrier, or its designees via photocopy or electronic transmittal, within 30 days, at no charge to Carrier from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Provider acknowledges that failure to submit records to Carrier in accordance with this provision and/or the Provider Manual, and/or other Carrier Policies and Procedures may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.10 Reimbursement of Amounts Collected In Error From a Member. If Provider collects payment from a Member when not permitted to collect under either this Agreement or the Policies and Procedures, Provider must repay the amount within 2 weeks of a request from Carrier or the Member or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Carrier may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments to Provider.

3.11 Carrier Offset Rights. Carrier shall be entitled to recoup, offset and adjust an amount equal to any erroneous payments (including, but not limited to, any improper payment, duplicate payment, or

overpayment) made by Carrier to Provider against any payments due and payable by Carrier to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all erroneous payments regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Carrier that any erroneous payment is due from Provider, Provider must refund the amount to Carrier within 30 days of when Carrier notifies Provider. If such reimbursement is not received by Carrier within the 30 days following the date of such notice, Carrier shall be entitled to offset such erroneous payment against any payments due and payable by Carrier to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider disagree with any determination by Carrier that Provider has received an erroneous payment, Provider shall have the right to appeal such determination under Carrier's procedures set forth in the Provider Manual, and such appeal shall not suspend Carrier's right to recoup the erroneous payment amount during the appeal process, unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Carrier reserves the right to employ a third-party collection agency in the event of non-payment.

3.12 Underpayments. If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Carrier or its designee within the timeframe and in accordance with the process as set forth in the Carrier’s Provider Manual and other Policies and Procedures. The request may be further pursued as set forth in Sections 5.11 and 5.12 below. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill the Carrier, the Payor or the Member for those services.

3.13 Coordination of Benefits. Certain claims for Covered Services are claims for which another Payor may be primarily responsible under Coordination of Benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Carrier’s Policies and Procedures.

3.13.1 Carrier's Payment as Secondary Payor (Non-Medicare). Carrier's payment, when added to the amount payable from other sources under the applicable COB rules, will be no

greater than the payment for Covered Services under this Agreement, and is subject to the terms and conditions of the Member's Health Benefit Plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Carrier that, when added to the amount payable from other sources, is less than 100 percent of the payment for Covered Services under this Agreement.

3.13.2 When Medicare is the Primary Payor. When the Carrier is the secondary payor to Medicare, Provider and Carrier are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Carrier's financial responsibility as the secondary payor to be limited to the Member's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Member liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.0 TERM AND TERMINATION

4.1 Term of This Agreement. This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth below.

4.2 How This Agreement Can Be Terminated. Provider can terminate this Agreement at any time by providing at least 90 days advance written notice. Carrier can terminate this Agreement immediately for good cause (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement or Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Carrier from obligations under this Agreement prior to the effective date of termination and from all other provisions of this Agreement that, by their own terms, survive

the termination of this Agreement.

4.3 Continuing Coverage. As required under Regulatory Requirements, NCQA accreditation standards, and the applicable Health Benefit Plan, the Carrier and the Provider shall permit a Member enrolled in Commercial Business coverage to continue to receive Covered Services from Provider, and Provider shall continue to provide such Covered Services for a certain period of time following termination of such Provider's participation under this Agreement, as follows:

4.3.1 Member Continued Access Rights Post Termination. As provided in RSA 420-J:8 XI and RSA 420-J:7-d, Members with Fully Insured coverage will have continued covered access to Provider's services in the event of the termination of this Agreement. The continued access shall be made available by Provider for 60 days from the date of termination of this Agreement (and for an additional 60 days thereafter if so ordered by the New Hampshire Insurance Commissioner) and shall be provided and paid for in accordance with the terms and conditions of the Member's Health Benefit Plan and this Agreement. Within 5 business days of the termination of this Agreement, Carrier shall provide written notice to affected Members explaining their continued access rights.

4.3.2 Continuity of Care. Carrier and Provider shall permit a Member who is in an active course of treatment, pregnant, or terminally ill ("Continuing Care Patient") to receive Continuity of Care in connection with the active treatment, pregnancy, or terminal illness. The Continuity of Care for active course of treatment continues until the earliest of the following: (i) for up to 90 days following the date the Member received notice of the terminated Provider; (ii) the date the Member is no longer undergoing an active course of treatment with the terminated Provider as a Continuing Care Patient; (iii) the date that care is successfully transitioned to another Provider; (iv) the date benefit limitations under the Member's Health Benefit Plan are met or exceeded; or (v) the date the Carrier determines the care is no longer Medically Necessary. The Continuity of Care for Members who are terminally ill continues until the Member's death. The Continuity of Care for Members who are pregnant continues through the post-partum period as defined by NCQA accreditation standards. Continuity of Care begins on (i) the effective date of the

termination of Provider's participation under this Agreement or (ii) the date of the Member notice of such termination, whichever is later. The Provider agrees to cooperate with the Carrier in promptly determining, as necessary, which Members may be informed of their eligibility to receive Continuity of Care. Provider providing Covered Services pursuant to this Section must accept payment at the reimbursement and other financial terms as provided in this Agreement and in the Member's Health Benefit Plan as payment in full and must not seek any payment from the Member for such Covered Services, except for any applicable Cost Sharing. Provider must adhere to all other terms and conditions of this Agreement including, but not limited to, compliance with quality standards, the Carrier's procedures regarding Referral and obtaining prior Authorizations, and compliance with other Carrier Policies and Procedures. The Carrier's Continuity of Care obligations set forth in this section shall not apply in instances where a Provider's termination from participation under this Agreement is based upon quality related issues or fraud.

5.0 GENERAL PROVISIONS

5.1 Confidentiality. As a result of this Agreement, Provider may have access to certain of Carrier's confidential and proprietary information. Provider shall hold such information in confidence and will not use or disclose such information to any person without the prior written consent of Carrier except as may be required by law. This provision shall not be construed to prohibit Carrier from disclosing information to Carrier Affiliates or the agents or subcontractors of Carrier or Carrier Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Members or other customers of Carrier or Carrier Affiliates or their representatives. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

5.2 Independent Parties. In entering into this Agreement and in the performance of the duties described herein, Provider and its employees are acting as independent contractors of the Carrier. Carrier and Provider do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration, population health management, pay for performance, Quality Management, Utilization Management, and other similar programs, nor any coverage determination made by Carrier or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Carrier or any other party to intervene in or influence Provider's medical decision-making regarding any Member.

5.3 Indemnification. As Carrier and Provider are independent contractors, and not employees, agents or representatives of each other, Carrier and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Carrier nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Carrier from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's provision of care to Members. Carrier agrees to indemnify and hold harmless Provider from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Carrier's administration of Plans. This provision will survive the termination of this Agreement

5.4 Subcontractor Compliance. All subcontracts or written agreements for the provision of Covered Services to Members entered into by Provider with other providers must set forth requirements for compliance with all regulatory and NCQA requirements set forth herein and Carrier's Policies and Procedures. Such subcontracts or other written agreements, or a form of such subcontracts or other written agreements, including the reimbursement methodology shall be provided to the Carrier upon request. Provider may not use any method of reimbursement in its subcontracting arrangements

which acts as an incentive to withhold medically necessary services to Members. Provider shall provide at least 90 days prior notice to the Carrier of Provider's intent to execute, amend or terminate any such subcontracts entered into for the purpose of providing Covered Services to Members.

5.5 Liability Insurance. Provider shall procure and maintain professional, including medical malpractice, and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are, at a minimum, commensurate with prevailing industry standards or licensing or accreditation standards and which are no less than the following amounts: $1,000,000 per occurrence/ $3,000,000 in the aggregate. The Carrier shall procure and maintain professional and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are commensurate with prevailing industry standard or licensing or accreditation standards. All insurance coverage obligations under this Section shall cover any claim arising during the term of this Agreement, even if not made or communicated until after the term of this Agreement. The Parties agree to provide, upon request, certificates of such insurance to each other. The Parties shall immediately report to the other any lapse or modification in any such coverage.

5.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of New Hampshire and applicable federal law.

5.7 Notices. Notices required under this Agreement shall be in writing and shall be deemed to have been duly given (i) on the third day after deposit in the United States mail, postage prepaid, and properly addressed as specified below; or, (ii) on the date of delivery if sent via overnight delivery to the party to whom notice is to be given and properly addressed as specified below; or (iii) on the date of service if served personally on the party to whom notice is to be given. Having provided notice as described above, the Parties may also notify each other by sending an electronic notice with automatic receipt verification to the other Party's e-mail address listed below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

The proper address for notices under this Agreement is as follows:

If to Carrier:
Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield and Matthew Thornton Health Plan, Inc.
2015 Staples Mill Rd
Richmond, VA 23230

Attention: Lanette Cotton, Director Network Management

Email Address: Lanette.Cotton@elevancehealth.com

If to Provider:
City of Portsmouth, NH
Address:
City, State, Zip

Attention:

Email Address:

5.8 Compliance With Regulatory Requirements. The Carrier shall comply with all Regulatory Requirements, and Provider agrees to assist the Carrier in complying therewith and to take no action that would put the Carrier in violation of Regulatory Requirements. During the Term of this Agreement, Provider shall comply with any Regulatory Requirements governing its operations, contracts, all reporting requirements and deadlines, and any obligations related to fraud, waste, and abuse. Provider shall further ensure that all Provider's individual service providers are licensed as required by Regulatory Requirements.

5.9 Assignment and Delegation. Except as specifically provided in this Agreement, neither Carrier nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Carrier includes any successor in interest and Carrier may assign its duties, rights and interests under this Agreement in whole or in part to an Affiliate of Carrier or may delegate any and all of its duties to a third party in the ordinary course of business.

5.10 Non-Exclusivity. This Agreement is non-exclusive. The Carrier may contract with other ground ambulance providers and Provider may contract with other insurers and third-party payers.

5.11 Dispute Resolution. Any dispute that might arise between the Parties regarding the performance or interpretation of the Agreement or that is related in any way to this agreement shall be resolved using the dispute resolution and arbitration procedures set forth below. A dispute must first be addressed through the applicable internal dispute resolution process outlined in the Provider Manual and other Carrier Policies and Procedures. In the event the dispute is not resolved through the internal dispute resolution process, either party can request in writing that the Parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the Parties who have authority to settle the dispute. If the matter is not resolved within 120 days of such a request, or such shorter timeframe as may be mutually agreed upon, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Carrier's internal dispute resolution process unless applicable law specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, Carrier’s final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Carrier, the Payor or the Member for any payment denied because of the failure to timely submit a request for arbitration.

5.12 Arbitration. Any dispute or claim arising out of or relating to the Agreement, including breach, termination, or validity of the Agreement, that is not resolved through internal dispute resolution will be settled by confidential, binding arbitration. The arbitration shall be conducted in accordance with the Rules of the American Arbitration Association then in effect, and which, to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. A Party’s liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party’s actual damages, and the arbitrator may award only actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whether arising in contract, tort, or otherwise

arising out of this Agreement. The Parties recognize that in the event of a breach by either party of any obligations under this Agreement or other violations of the other party's rights in connection with this Agreement, the damage caused, if any, is not irreparable or sufficient to entitle the other party to injunctive relief. The Parties, on behalf of themselves and those that they may now or hereafter represent, each agree to waive their right to seek injunctive relief and further agree that the arbitrator(s) are not authorized to issue injunctive relief. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The Parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other Parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. This section shall survive the termination of this Agreement.

5.13 Communications with Members. The Parties acknowledge and agree that no term or condition of this Agreement shall be construed to prohibit Provider from freely and in good faith communicating with a Member regarding the provisions, terms or requirements of the Member's Health Benefit Plan as they relate to the Member's needs, any and all available treatment options, including medication treatment options, related to the health care needs of such Member, regardless of the Carrier's benefit coverage exclusions or limitations or any terms or conditions relating thereto. The Carrier agrees that it shall not refuse to contract with or compensate Provider if otherwise eligible, solely because Provider (a) communicated with or advocated on behalf of one or more prospective, current or former Member(s) regarding the provisions terms or requirements of the Member's Health Benefit Plan as they relate to the needs of such Member(s); or (b) communicated with one or more prospective, current or former Member(s) with respect to a member's internal grievance procedure or external review.

5.14 Referrals. As provided in RSA 420-J:8 XIV, if Provider is employed by a hospital or any hospital affiliate, Provider shall not be required or in any way obligated under this Agreement to refer patients to providers also employed or under contract with the hospital or any

affiliate.

5.15 Force Majeure. In the event that performance by either Carrier or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife and commotion, labor unrest, sentinel event, epidemic, or acts of God, then performance of such covenant, duty or obligation by such party shall be excused during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

5.16 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement/Counterparts/Electronic Signatures. If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This Agreement, including any Appendices to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the Parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement. This Agreement may be executed in 2 or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Signature Page

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

AGREED AND ACCEPTED BY

Provider

City of Portsmouth, NH

_____
Provider Name

_____
Signature

_____
Printed Name

_____
Title

_____
Date Signed

_____
Federal Tax ID

_____
National Provider Identifier

Carrier

Anthem Health Plans of New Hampshire, Inc., d/b/a Anthem Blue Cross and Blue Shield and Matthew Thornton Health Plan, Inc.

_____
Business Entity Name

_____
Signature

_____
Printed Name

_____
Title

_____
Date Signed

APPENDIX A

REIMBURSEMENT FOR SERVICES PROVIDED: CARRIER'S COMMERCIAL BUSINESS

This Appendix A sets forth compensation to Provider for Covered Services provided to all Members enrolled in the Carrier's Commercial business.

In consideration for Provider's provision of Covered Services to Members, Carrier shall pay Provider and Provider shall accept as payment in full, reimbursement in accordance with the Standard Ground Ambulance Rate Schedule as follows. As provided under RSA 420-J:21 I:

a. For the period beginning January 1, 2026, and continuing through December 31, 2027, except as provided in paragraph b below, the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule equal to 3.25 times the Medicare rate as defined in 42 CFR Part 414 Subpart H and any subregulatory guidance issued by the Centers for Medicare & Medicaid Services.

b. For the period beginning January 1, 2026, and continuing through December 31 2027, if it is determined by the New Hampshire Insurance Commissioner that the Provider has failed, after due notice and opportunity to cure, to cooperate with the New Hampshire ground ambulance cost study as provided in RSA 420-J:26 IV by failing to substantially comply with cost data submission requirements or requirements to facilitate data validation or cost report auditing requirements, then the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule which shall be at the carrier's nonparticipating rate or at the Medicare rate that is current as of the date of service, whichever is higher. This rate schedule shall continue until it is determined by the Commissioner that Provider is in substantial compliance with the requirements of the cost study or until December 31, 2027, whichever is earlier.

c. Beginning January 1, 2028, and continuing thereafter, Carrier shall reimburse Provider for covered ground ambulance services according to the cost-based rate schedule established and published by the New Hampshire Insurance Commissioner under RSA 420-J:21 I (b) and as revised annually under RSA 420-J:21 I (c).

The Standard Ground Ambulance Rate Schedule shall apply to all Networks, products, and Health Benefit Plans offered or maintained by Carrier in its Commercial Business.

Any payment made by the Carrier will be subject to the Carrier's Policies and Procedures, less any Cost Sharing amounts, which shall be the sole responsibility of the Member.

APPENDIX B

BCBSA REQUIREMENTS

1. Blue Cross Blue Shield Association (BCBSA). Provider hereby expressly acknowledges his/her/its understanding that this Agreement constitutes a contract between Provider and Carrier, that Carrier is an independent corporation operating under a license from the Blue Cross and Blue Shield Association ("BCBSA"), an association of independent Blue Cross and/or Blue Shield Plans, permitting Carrier to use the Blue Cross and/or Blue Shield service marks in the state where Carrier is located, and that Carrier is not contracting as the agent of the BCBSA. Provider further acknowledges and agrees that he/she/it has not entered into this Agreement based upon representations by any person other than Carrier, and that no person, entity or organization other than Carrier shall be held accountable or liable to Provider for any of Carrier's obligations to Provider created under this Agreement. Provider has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Provider to use the Brands. Any references to the Brands made by Provider in his/her/its own materials are subject to review and approval by Carrier. This section shall not create any additional obligations whatsoever on the part of Carrier other than those obligations created under other provisions of this Agreement.

2. Blue Cross Blue Shield Out of Area Program. Provider agrees to provide Covered Services to any person who is covered under another BCBSA out of area or reciprocal program, and to submit Claims for payment in accordance with current BCBSA Claims filing guidelines. Provider agrees to accept payment by Carrier at the Carrier Rate as payment in full except Provider may bill, collect and accept compensation for Cost Sharing. The provisions of this Agreement shall apply to charges for Covered Services under the out of area or reciprocal programs. Provider further agrees to comply with other similar programs of the BCBSA. For Members who are enrolled under BCBSA out of area or reciprocal programs, Provider shall comply with the applicable Carrier's Utilization Management policies.

CIGNA HEALTH AND LIFE INSURANCE COMPANY

AND

CITY OF PORTSMOUTH, NH

STANDARD GROUND AMBULANCE STANDARD PROVIDER AGREEMENT

This Standard Ground Ambulance Standard Provider Agreement (hereinafter "Agreement") is made and entered into by and between Cigna Health and Life Insurance Company (hereinafter "Carrier") and City of Portsmouth, NH (hereinafter "Provider") and shall be effective on the date it is fully executed by both the Carrier and the Provider (hereinafter "the Parties"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the Parties, the Parties agree as follows:

1.0 DEFINITIONS

1.1 "Affiliate" means any entity that is owned or controlled, either directly or through a parent or subsidiary entity, by Carrier, or is under common control with Carrier and may include a health maintenance organization, health insurance company or third party administrator. Unless otherwise set forth in this Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

1.2 "Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Carrier.

1.3 "Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by Carrier to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers and instructions, Carrier medical policies and clinical Utilization Management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives, or activities conducted by Carrier's Special Investigation Unit ("SIU").

1.4 "Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Carrier submitted by a provider for payment by Carrier for Health Services rendered to a Member.

1.5 "Claims Payment Policies and Procedures" are protocols established by the Carrier for the review and adjudication of claims for health care services as set forth in the Provider Manual and other Carrier Policies and Procedures.

1.6 "CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

1.7 "Commercial Business" means Health Benefit Plans that exclude coverage provided under Government Programs and that include coverage for individual and employer groups that is either a Fully Insured Plan insured by Carrier or a Self-Funded Plan administered by Carrier and under which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers.

1.8 "Clean claim" means a claim for payment of Covered Services that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.

1.9 "Cost Sharing" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be consist of coinsurance, copayment, deductible, or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

1.10 "Covered Services" means Medically Necessary Health Services, as determined by Carrier and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

1.11 "Facility" means any health care facility including but not limited to an acute care hospital, community mental health facility, freestanding ambulatory surgery center, transitional care unit, behavioral health facility, extended care facility, rehabilitation

facility, or skilled nursing facility.

1.12 “Fully Insured Plan” or “Fully Insured Members” means health coverage or persons with such coverage pursuant to which the Carrier provides or arranges for Covered Services and other related administrative services for Members and with respect to which the Carrier assumes the financial risk for Covered Services received by Members.

1.13 "Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Carrier maintains a contract to furnish health coverage services.

1.14 “Ground Ambulance Provider” means a public or private organization licensed by the New Hampshire Department of safety under RSA 153-A:10 to provide ground ambulance services.

1.15 “Ground Ambulance Services" means:

(a) The rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10; and

(b) Ground ambulance transport between health care facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10.

1.16 "Health Benefit Plan" or “Plan” means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

1.17 “Health Carrier” means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance Carrier, a

health maintenance organization, a health service corporation, or any other entity providing or administering a plan of health insurance, health benefits, or health services.

1.18 "Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

1.19 "Medically Necessary" or "Medical Necessity" means health care services or products provided to Members for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1.19.1 Consistent with generally accepted standards of medical practice;

1.19.2 Clinically appropriate in terms of type, frequency, extent, site, and duration;

1.19.3 Demonstrated through scientific evidence to be effective in improving health outcomes;

1.19.4 Representative of "best practices" in the medical profession; and

1.19.5 Not primarily for the convenience of the member or physician or other health care provider.

1.20 "Member" means any individual who is eligible, as determined by Carrier, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all appendices, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Participant, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

1.21 "Network" means a group of Health Service providers that support, through a direct or indirect contractual relationship, one or more Health Benefit Plans, product(s) and/or program(s) in which

Members are enrolled.

1.22 "Participating Provider" means a person or entity, or an employee or subcontractor of such person or entity, that is directly or indirectly party to an agreement to provide Covered Services to Members that has met all applicable Carrier credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Carrier to participate in one or more Network(s).

1.23 "Payor" is the person or entity obligated to a Member to provide reimbursement for Covered Services under the Member's Health Benefit Plan and that may be the Carrier or an Affiliate, or the plan sponsor that has entered into a Self-Funded Plan with the Carrier acting as administrator, or the person or entity which Carrier has agreed may directly or indirectly access services under this Agreement pursuant to a network rental product. Carrier is the Payor only for Covered Services under an insurance policy or HMO contract issued by Carrier or an affiliate and not for Self-Funded Plans or medical rental products.

1.24 "Policies and Procedures" means those policies and procedures applied by the Carrier in a standard manner across similarly situated providers in its network. Such policies and procedures are written in various documents including but not limited to the Provider Manual, the Carrier Quality Management program, Utilization Management program, claims processing manuals, benefits administration policies, credentialing and recredentialing program, payment and billing guidelines, and policies on confidentiality of information.

1.25 "Provider Manual" or "Manual" is the document setting forth Carrier Policies and Procedures and other requirements applicable to Participating Providers and the products insured or administered by the Carrier. The Manual is made available on the Carrier's public website, with paper copies available upon request.

1.26 "Quality Management" means the program described in the Policies and Procedures relating to assuring the quality of Covered Services provided to Members.

1.27 "Regulatory Requirements" means all applicable common law and any and all state, federal or local statutes, ordinances, codes, rules,

regulations, restrictions, orders, procedures, standards, directives, guidelines, instructions, bulletins, policies or requirements enacted, adopted, promulgated, applied, followed or imposed by any governmental authority, as amended, modified, revised or replaced, interpreted or enforced by any governmental authority, as applicable to each respective party to this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

1.28 "Self-Funded Plan" or "Self-Insured Members" means an arrangement between the Carrier and a third party pursuant to which: (1) the Carrier provides or arranges for Covered Services and other related administrative services for eligible participants and their dependents ("Self-Insured Members"); and (2) such third party assumes financial risk for Covered Services received by Self-Insured members. The types of third parties in a Self-Funded Plan include, but are not limited to, employers, union trusts, insurers, multiple employer welfare arrangements, U.S. military governmental agencies, or pooled risk management programs operating pursuant to Regulatory Requirements.

1.29 "Standard Ground Ambulance Provider Contract" means this Agreement the template for which is in compliance with the requirements of RSA 420-J:23 and which Health Carriers are required, under RSA 420-J:23, to offer to any Ground Ambulance Provider that is qualified and willing to meet its terms.

1.30 "Standard Ground Ambulance Rate Schedule" means the rate schedule referenced in RSA 420-J:21 for compensating Participating Ground Ambulance Providers for Covered Services that is incorporated in the Standard Ground Ambulance Provider Contract.

1.31 "Utilization Management" means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Carrier's Policies and Procedures.

2.0 RESPONSIBILITIES OF THE PARTIES

2.1 Member Identification. Carrier shall ensure that it provides a means of identifying Members either by issuing a paper, plastic, electronic,

or other identification document to Members or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Carrier to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member. Carrier makes no representations or guarantees concerning the number of Members that will be referred to Provider as a result of this Agreement

2.2 Benefit Information. Carrier will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Member is entitled as specified in the Policies and Procedures.

2.3 Provision of Services. Provider agrees to provide to members Covered Services which it customarily provides to its patients in an economic and efficient manner. Such Covered Services shall be provided in accordance with the provisions concerning services standards as contained in the Provider Manual and other Carrier Policies and Procedures. All Covered Services provided by Provider to members shall be under the terms of this Agreement.

2.4 Provider Standards and Qualifications. Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider warrants that it is duly licensed under the laws of the state where service is provided, and that all services under this Agreement will be delivered by individuals who (i) are duly licensed under the Regulatory Requirements of the state where service is provided, (ii) are eligible to provide services to Members, and (iii) are Board Certified or Board Eligible in the specialty in which they are delivering services, as applicable. Provider will ensure that each employer individuals rendering services under this Agreement maintains such status.

2.5 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time

availability in which Provider provides Health Services to any other individual. Provider will not differentiate or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type or kind of Health Service to Members that he/she/it does not customarily provide to others.

2.6 Provider Cooperation with the Credentialing Process. Provider shall provide the Carrier with appropriate credentialing information if it is not already a Participating Provider. Provider agrees to comply with the Carrier's credentialing and recredentialing policies and procedures, including but not limited to such policies as are set forth in the Provider Manual. Neither the Provider nor any of the Provider employed individuals shall provide Covered Services to any Member under this Agreement until Provider's participation is approved by the Carrier. Provider agrees that each Provider-Affiliate providing Covered Services pursuant to this Agreement must be credentialed by the Carrier pursuant to the Carrier's credentialing policy in order to provide Covered Services and be paid therefore.

2.7 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Carrier of:

2.7.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Carrier, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement;

2.7.2 Any change in Provider accreditation, affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community; or

2.7.3 Any disciplinary action concerning the Provider or any individual employed by or under contract with the Provider taken by any state or federal agency responsible for Provider licensing, certification, or the payment for health care

services.

2.8 Carrier Discretion with Respect to Credentialing. The Carrier represents that it complies with all Regulatory Requirements related to provider credentialing. The Carrier has full discretion to grant or deny credentialing approval or take any disciplinary action relative to the credentialing approval of the Provider based on clinical quality issues or any other matters deemed relevant by the Carrier. Without limitation to any of the foregoing, the Carrier shall have the right to terminate immediately the Provider's credentials and participation under this Agreement in the Carrier's networks, or to take such other disciplinary action as it deems appropriate, for the following reasons:

2.8.1 suspension, termination or non-renewal of a license of the Provider,

2.8.2 acts or omissions which threaten the life, health or safety of a patient or patients,

2.8.3 failure to meet standard of care as required for Carrier Providers and determined by the Carrier,

2.8.4 repeated failure to comply with accepted ethical and professional standards of behavior;

2.8.5 provider inactivity as described in Subsection 2.16.3;

2.8.6 dissolution or sale of substantially all assets;

2.8.7 institution of proceeding in bankruptcy, insolvency, assignment for benefit of creditors or other action generally to secure rights of creditors; or

2.8.8 failure to provide credentialing or recredentialing information to the Carrier upon request.

Any decision by the Carrier to deny, non-renew, or withdraw the credentials of Provider, or to terminate the credentials of Provider, shall be in writing, shall state the reasons for such termination, and, shall include notice of a Provider's right to an appeal.

2.9 Compliance with Carrier Policies and Procedures. Provider agrees to abide by and cooperate with Carrier's Provider Manual, and all other Policies and Procedures established and implemented by Carrier, including, without limitation, Policies and Procedures relating to credentialing, Utilization Management, Quality Management and improvement, the delivery of preventive health services, claims submission, cost sharing collections, confidentiality of Provider, patient and Carrier information, duplicate coverage, and subrogation recoveries. In the event of any conflict between Carrier Policies and Procedures and this Agreement, the terms of this Agreement will prevail. The Carrier may, at its discretion and at any time, amend the Provider Manual, its Policies and Procedures, and any other programs or administrative policies and procedures, such changes to be binding upon Provider; provided further, that Provider shall be notified in writing of modifications in Covered Services or modifications in the Carrier's procedures, documents or requirements including those associated with Utilization management, Quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Carrier and Provider.

2.10 Publication and Use of Provider Information. Provider agrees that Carrier or its designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, compensation rates, and information related to Provider for transparency initiatives.

2.11 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the Parties agree that they may identify Provider as a participant in the Network(s) in which Provider participates.

2.12 Cooperation Regarding Member Complaints and Grievance Procedures. Provider agrees to cooperate with Carrier in the review and resolution of Member complaints or grievances that may arise relating to the provision of Covered Services to Members including

but not limited to providing any information or records needed to render a decision on a complaint or grievance. Provider agrees to provide such information and records with sufficient promptness to allow the Carrier to meet state and federal regulatory requirements for timely processing of Member complaints and grievances. It is understood that certain complaints and grievances must be processed by the Carrier on an expedited basis. The Carrier and Provider agree that complaints received by the Carrier or the Provider with respect to the provision of Covered Services shall ultimately be resolved in accordance with the Carrier's grievance procedures or upon external review under RSA 420-J:5-a through 420-J:5-e. The Carrier will forward to Provider copies of any such complaints or grievances, upon Provider's request and to the extent necessary for Provider to comply with this Section. Provider agrees, to the extent permitted by Regulatory Requirements, to fully advise the Carrier of any Member complaint, grievance or claim known to Provider relating to services provided under this Agreement.

2.13 General Cooperation Requirement. Provider shall also cooperate with Carrier and Carrier Affiliates in implementing those policies and programs as may be reasonably requested by Carrier or a Carrier Affiliate for purposes of Carrier's or the Carrier Affiliate's business operations or required by Carrier or a Carrier Affiliate to comply with Regulatory Requirements or accreditation requirements.

2.14 Records. Provider shall maintain medical records and documents relating to Members as may be required by Regulatory Requirements and for the period of time required by law. Medical records of Members and any other records containing individually identifiable information relating to Members will be regarded as confidential, and Provider and Carrier shall comply with applicable federal and state law regarding such records. Provider will obtain Members' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Carrier with a copy of Members' medical records and other records maintained by Provider relating to Members. These records shall be provided to Carrier at no charge and within the timeframes requested by Carrier and will also be made available during normal business hours for inspection by Carrier, Carrier's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the

termination of this Agreement.

2.15 Participation in Networks Supporting Commercial Business.

Provider will render Commercial Business Covered Services to Commercial Business Members in accordance with the terms and conditions of this Agreement. Provider agrees to participate in all of Carrier's Commercial Business networks.

2.16 Provider Directory Updates, Name Use, Inactivity, and Provider Directory Suppression.

2.16.1 Provider Directory Updates. Provider shall cooperate with Carrier's efforts to maintain accurate provider directories by complying with Regulatory Requirements and the Carrier's Policies and Procedures, including those set forth in the Provider Manual, for verification of provider directory information related to Provider and advance notification requirements for any changes to Provider and/or Provider's Provider contact and demographic information, including without limitation, digital contact information, with specification as to each location in which each Provider regularly provides services to patients, specialty, any medical group and/or Facility affiliations, Facility accreditation status, any languages spoken other than English, and board certification(s).

2.16.2 Name Use. Provider agrees that the Carrier may use Provider's demographic information including without limitation, Provider's name(s), address(es), telephone number(s), website/URL(s), digital contact information, a description of Facilities, a description of care and specialty services provided, as may be appropriate and necessary in advertising of the Carrier, provided that such advertising shall be done in accordance with Regulatory Restrictions. The Carrier agrees that, with the prior written consent of the Carrier, Provider may use the Carrier's name in statements or announcements that Provider accepts the coverage of Carrier Members.

2.16.3 Provider Inactivity. In accordance with applicable Carrier Policies and Procedures, the Carrier may terminate a Provider

that has not, (i) verified their provider directory information or provided other information required by the Carrier or Regulatory Requirements or (ii) provided services to patients or submitted a claim for services for a period of two years. Under such circumstances, Provider may reapply to become a participating provider through the Carrier's standard credentialing and enrollment processes set forth in Carrier Policies and Procedures.

2.16.4 Provider Directory Suppression. The Carrier may suppress provider directory information (i) that cannot be verified by the Carrier as described in the Provider Manual, (ii) to the extent required by Regulatory Requirements, (iii) where Carrier deems a Provider terminated from the network if such Provider has not verified such information as required under the Provider Manual and has no activity in the Carrier's system for more than two years, or (iv) as otherwise required by Carrier to ensure accurate claims processing and benefit administration.

2.17 Referral Incentives/Kickbacks Prohibited. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Carrier.

2.18 Member Incentives Prohibited. Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Member incentive. Participant Incentive means any arrangement by Provider to:

2.18.1 reduce or satisfy a Participant's Cost-Sharing obligations;

2.18.2 pay on behalf of or reimburse a Member for any portion of the Member's costs for coverage under a policy or plan insured or administered by Carrier or a Carrier Affiliate; or

2.18.3 to provide a Member with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from Provider or its affiliates.

In the event of non-compliance with this provision: Carrier may terminate this Agreement, such non-compliance being a "material breach" of this Agreement; Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Member in connection with a Member incentive; and Carrier may take such other action appropriate to enforce this provision.

2.19 Provider Service or Organizational Changes. Provider shall notify the Carrier in writing in accordance with the Notice section of this Agreement at least 90 days prior to any significant service or organizational change that occurs after the Effective Date of this Agreement, whether or not such change is occurring as a result of a merger, acquisition, affiliation or any other formal or informal business combination, including without limitation: (i) any action to sell, transfer or convey its business or any substantial portion of its business assets to another entity, or when Provider is the subject of a sale, transfer or conveyance of its business by another entity, (ii) when Provider enters into a management contract with another entity to deliver any new type of Covered Service not previously provided by Provider, (iii) when Provider contracts to deliver of any Covered Services provided by Provider in additional facilities or practice locations, and/or (iv) when there is significant growth or other changes impacting the size of the Provider, including through merger, acquisition, or changes to any of Provider's affiliations. Such service or organizational changes are not automatically included under the terms of this Agreement and any inclusion thereof shall require mutual written agreement by the Parties. If Provider fails to timely notify Carrier of a service or organizational change falling under this paragraph, then Carrier may include or exclude the new service or organizational composition under this agreement by serving notice on Provider under the Notice section of this Agreement. However, Carrier will accept any new service or organizational composition of Provider as coming under this Agreement if Provider remains qualified and willing to accept the terms of the Standard Ground Ambulance Provider Contract.

3.0 COMPENSATION

3.1 Submission and Adjudication of Claims. Provider shall submit, and Carrier shall adjudicate, claims in accordance with the Carrier's

Claims Payment Policies and Procedures as detailed in the Provider Manual and other Carrier Policies and Procedures as may be issued by the Carrier from time to time. Claims for payment for Covered Services to Members shall not be payable under this Agreement if not submitted to the Carrier in accordance with such Policies and Procedures.

3.2 Non-Medically Necessary Services. Provider shall not charge a Member for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Member in writing that the particular service will not be covered by Carrier and the Member acknowledges in writing that he or she will be responsible for payment for such service.

3.3 The Standard Ground Ambulance Rate Schedule. The Standard Ground Ambulance Rate Schedule shall apply as provided in Appendix A to Provider compensation for Covered Services to Members with respect to products and Health Benefit Plans offered or maintained by Carrier in its Commercial Business.

3.4 Applicability of the Rates. The rates in this Agreement apply to all services provided by Provider to Members in the products and Health Benefit Plan types covered by this Agreement, including services covered under a Member's in or out-of-network benefits (e.g. PPO or POS plans), and whether the Payor or Member is financially responsible for payment.

3.5 Cost Sharing. Provider shall be solely responsible for the collection of all applicable Cost Sharing from Members, subject to the Carrier Policies and Procedures. Provider agrees to make reasonable efforts to verify Cost Sharing amounts prior to billing for such amounts. The Carrier shall have no responsibility for payment or collection of such Cost Sharing and any such amounts payable by Members for Covered Services will be debited against amounts owed to Provider under this Agreement.

3.6 Effect of Member Coverage as of the Date of Service. The Payor will be responsible for payment for Covered Services if the patient is an active Member and eligible for such service on the date of service. The Carrier, on behalf of itself and the Payor, reserves the right to deny or recover payment if, after receipt of a claim, it is determined that the patient was not a Member on the date of service unless the patient was entitled to an extension of benefits by operation of law.

Provider may bill such patient or his or her third party insurance carrier directly for those non-reimbursed services furnished to such patient.

3.7 Payment in Full and Hold Harmless.

3.7.1 Provider will look solely to the Payor for payment of Covered Services provided to Members. Except when the Carrier is also the Payor, the Parties hereto acknowledge that the Carrier shall act solely as the Payor's payment agent hereunder. Carrier is not the insurer, guarantor or underwriter of the liability of such Payor for benefits provided to or under Self-Insured Plans, provided, however, that the Carrier is not relieved of its responsibility under its contracts with such Payors to administer payment to Provider for Covered Services rendered to Self-Insured Plan Members. Provider agrees to accept as payment in full, in all circumstances, the amount that is required under this Agreement whether such payment is in the form of a Cost Sharing, a payment by Carrier, or a payment by another source, such as through coordination of benefits or subrogation. In no event shall Carrier be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the amount that is required under this Agreement less Cost Sharing payments or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the amount that is required under this Agreement as payment in full even if the Member has not yet satisfied his/her deductible.

3.7.2 Provider agrees that in no event, including but not limited to nonpayment by the Carrier or intermediary, insolvency of the Carrier or intermediary, or breach of this Agreement, shall the Provider (or its assignees or subcontractors) have the right to seek any type of payment from, bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a Member or a person acting on behalf of the Member (other than the Carrier or intermediary) for Covered Services provided pursuant to this Agreement, except for the collection of Cost Sharing for services covered by the Health Benefit Plan, whether or not compensation has actually been received by the Provider for such Services or whether or not this Agreement remains in effect. This agreement does not prohibit the

Provider from collecting fees for uncovered services delivered on a fee-for-service basis to Members. Nor does this Agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the Member, as long as the Provider has clearly informed the Member that the Carrier may not cover or continue to cover a specific service or services. Covered Services which the Provider is prohibited from billing Members for shall include services denied by the Carrier pursuant to its utilization management Policies and Procedures for failure to meet the Carrier's Medically Necessary criteria and/or administrative denials issued by the Carrier pursuant to Carrier Policies and Procedures. Provider's sole redress shall be against the assets of the Payor. The requirements of this provision shall survive any termination of this Agreement for services rendered prior to the termination, regardless of the cause of such termination. The Carrier's Members, any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement hereafter entered into between Provider and the Member or any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder. Except as provided in this Agreement, this agreement does not prohibit the provider from pursuing any available legal remedy.

3.8 Payment Time Frames. For Claims subject to New Hampshire law, Carrier or its designee and Provider shall comply with the requirements of the New Hampshire prompt pay legislation (RSA 420-J:8-a), as may be applicable, for payment of Clean Claims for Covered Services.

3.9 Audits and Carrier Access to Provider Records. The Carrier shall have the right to conduct audits to verify the accuracy of Member bills and compliance with the Carrier's billing guidelines, as set forth in the Provider Manual or in other Carrier Policies and Procedures. The Provider shall cooperate with the Carrier and its auditor in accordance with the procedures set forth in the Provider Manual or in other Carrier Policies and Procedures. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the Provider Manual and/or other Carrier Policies and Procedures, shall permit Carrier or

its designees to have, with appropriate working space and without charge, on-site access to and the right to examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Carrier in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the Provider Manual, and compliance with this Agreement. In lieu of on-site access, at Carrier's request, Provider or its designees shall submit records to Carrier, or its designees via photocopy or electronic transmittal, within 30 days, at no charge to Carrier from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Provider acknowledges that failure to submit records to Carrier in accordance with this provision and/or the Provider Manual, and/or other Carrier Policies and Procedures may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.10 Reimbursement of Amounts Collected In Error From a Member. If Provider collects payment from a Member when not permitted to collect under either this Agreement or the Policies and Procedures, Provider must repay the amount within 2 weeks of a request from Carrier or the Member or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Carrier may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments to Provider.

3.11 Carrier Offset Rights. Carrier shall be entitled to recoup, offset and adjust an amount equal to any erroneous payments (including, but not limited to, any improper payment, duplicate payment, or overpayment) made by Carrier to Provider against any payments due and payable by Carrier to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all erroneous payments regardless of the cause, including, but not

limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Carrier that any erroneous payment is due from Provider, Provider must refund the amount to Carrier within 30 days of when Carrier notifies Provider. If such reimbursement is not received by Carrier within the 30 days following the date of such notice, Carrier shall be entitled to offset such erroneous payment against any payments due and payable by Carrier to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider disagree with any determination by Carrier that Provider has received an erroneous payment, Provider shall have the right to appeal such determination under Carrier's procedures set forth in the Provider Manual, and such appeal shall not suspend Carrier's right to recoup the erroneous payment amount during the appeal process, unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Carrier reserves the right to employ a third-party collection agency in the event of non-payment.

3.12 Underpayments. If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Carrier or its designee within the timeframe and in accordance with the process as set forth in the Carrier’s Provider Manual and other Policies and Procedures. The request may be further pursued as set forth in Sections 5.11 and 5.12 below. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill the Carrier, the Payor or the Member for those services.

3.13 Coordination of Benefits. Certain claims for Covered Services are claims for which another Payor may be primarily responsible under Coordination of Benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Carrier’s Policies and Procedures.

3.13.1 Carrier's Payment as Secondary Payor (Non-Medicare). Carrier's payment, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under this Agreement, and is subject to the terms and conditions of the Member's Health Benefit Plan and applicable state and federal law. Use of applicable COB provisions may result in a payment

from Carrier that, when added to the amount payable from other sources, is less than 100 percent of the payment for Covered Services under this Agreement.

3.13.2 When Medicare is the Primary Payor. When the Carrier is the secondary payor to Medicare, Provider and Carrier are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Carrier's financial responsibility as the secondary payor to be limited to the Member's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Member liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.0 TERM AND TERMINATION

4.1 Term of This Agreement. This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth below.

4.2 How This Agreement Can Be Terminated. Provider can terminate this Agreement at any time by providing at least 90 days advance written notice. Carrier can terminate this Agreement immediately for good cause (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement or Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Carrier from obligations under this Agreement prior to the effective date of termination and from all other provisions of this Agreement that, by their own terms, survive the termination of this Agreement.

4.3 Continuing Coverage. As required under Regulatory Requirements, NCQA accreditation standards, and the applicable Health Benefit Plan, the Carrier and the Provider shall permit a Member enrolled in

Commercial Business coverage to continue to receive Covered Services from Provider, and Provider shall continue to provide such Covered Services for a certain period of time following termination of such Provider's participation under this Agreement, as follows:

4.3.1 Member Continued Access Rights Post Termination. As provided in RSA 420-J:8 XI and RSA 420-J:7-d, Members with Fully Insured coverage will have continued covered access to Provider's services in the event of the termination of this Agreement. The continued access shall be made available by Provider for 60 days from the date of termination of this Agreement (and for an additional 60 days thereafter if so ordered by the New Hampshire Insurance Commissioner) and shall be provided and paid for in accordance with the terms and conditions of the Member's Health Benefit Plan and this Agreement. Within 5 business days of the termination of this Agreement, Carrier shall provide written notice to affected Members explaining their continued access rights.

4.3.2 Continuity of Care. Carrier and Provider shall permit a Member who is in an active course of treatment, pregnant, or terminally ill ("Continuing Care Patient") to receive Continuity of Care in connection with the active treatment, pregnancy, or terminal illness. The Continuity of Care for active course of treatment continues until the earliest of the following: (i) for up to 90 days following the date the Member received notice of the terminated Provider; (ii) the date the Member is no longer undergoing an active course of treatment with the terminated Provider as a Continuing Care Patient; (iii) the date that care is successfully transitioned to another Provider; (iv) the date benefit limitations under the Member's Health Benefit Plan are met or exceeded; or (v) the date the Carrier determines the care is no longer Medically Necessary. The Continuity of Care for Members who are terminally ill continues until the Member's death. The Continuity of Care for Members who are pregnant continues through the post-partum period as defined by NCQA accreditation standards. Continuity of Care begins on (i) the effective date of the termination of Provider's participation under this Agreement or (ii) the date of the Member notice of such termination, whichever is later. The Provider agrees to cooperate with the Carrier in promptly determining, as necessary, which Members may be informed of their eligibility to receive

Continuity of Care. Provider providing Covered Services pursuant to this Section must accept payment at the reimbursement and other financial terms as provided in this Agreement and in the Member's Health Benefit Plan as payment in full and must not seek any payment from the Member for such Covered Services, except for any applicable Cost Sharing. Provider must adhere to all other terms and conditions of this Agreement including, but not limited to, compliance with quality standards, the Carrier's procedures regarding Referral and obtaining prior Authorizations, and compliance with other Carrier Policies and Procedures. The Carrier's Continuity of Care obligations set forth in this section shall not apply in instances where a Provider's termination from participation under this Agreement is based upon quality related issues or fraud.

5.0 GENERAL PROVISIONS

5.1 Confidentiality. As a result of this Agreement, Provider may have access to certain of Carrier's confidential and proprietary information. Provider shall hold such information in confidence and will not use or disclose such information to any person without the prior written consent of Carrier except as may be required by law. This provision shall not be construed to prohibit Carrier from disclosing information to Carrier Affiliates or the agents or subcontractors of Carrier or Carrier Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Members or other customers of Carrier or Carrier Affiliates or their representatives. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

5.2 Independent Parties. In entering into this Agreement and in the performance of the duties described herein, Provider and its employees are acting as independent contractors of the Carrier. Carrier and Provider do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration,

population health management, pay for performance, Quality Management, Utilization Management, and other similar programs, nor any coverage determination made by Carrier or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Carrier or any other party to intervene in or influence Provider's medical decision-making regarding any Member.

5.3 Indemnification. As Carrier and Provider are independent contractors, and not employees, agents or representatives of each other, Carrier and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Carrier nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Carrier from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's provision of care to Members. Carrier agrees to indemnify and hold harmless Provider from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Carrier's administration of Plans. This provision will survive the termination of this Agreement

5.4 Subcontractor Compliance. All subcontracts or written agreements for the provision of Covered Services to Members entered into by Provider with other providers must set forth requirements for compliance with all regulatory and NCQA requirements set forth herein and Carrier's Policies and Procedures. Such subcontracts or other written agreements, or a form of such subcontracts or other written agreements, including the reimbursement methodology shall be provided to the Carrier upon request. Provider may not use any method of reimbursement in its subcontracting arrangements which acts as an incentive to withhold medically necessary services to Members. Provider shall provide at least 90 days prior notice to the Carrier of Provider's intent to execute, amend or terminate any such subcontracts entered into for the purpose of providing Covered Services to Members.

5.5 Liability Insurance. Provider shall procure and maintain professional, including medical malpractice, and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are, at a minimum, commensurate with prevailing industry standards or licensing or accreditation standards and which are no less than the following amounts: $1,000,000 per occurrence/ $3,000,000 in the aggregate. The Carrier shall procure and maintain professional and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are commensurate with prevailing industry standard or licensing or accreditation standards. All insurance coverage obligations under this Section shall cover any claim arising during the term of this Agreement, even if not made or communicated until after the term of this Agreement. The Parties agree to provide, upon request, certificates of such insurance to each other. The Parties shall immediately report to the other any lapse or modification in any such coverage.

5.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of New Hampshire and applicable federal law.

5.7 Notices. Notices required under this Agreement shall be in writing and shall be deemed to have been duly given (i) on the third day after deposit in the United States mail, postage prepaid, and properly addressed as specified below; or, (ii) on the date of delivery if sent via overnight delivery to the party to whom notice is to be given and properly addressed as specified below; or (iii) on the date of service if served personally on the party to whom notice is to be given. Having provided notice as described above, the Parties may also notify each other by sending an electronic notice with automatic receipt verification to the other Party's e-mail address listed below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

The proper address for notices under this Agreement is as follows:

Cigna Health and Life Insurance Company
1750 Elm Street, Suite 800
Manchester, New Hampshire 03104

Attention: VP of Provider Contracting

Email Address: nhprovidercontracting@cignahealthcare.com

If to Provider:
City of Portsmouth, NH
1 Junkins Ave., Portsmouth, New Hampshire 03801

Attention: Jason Gionet

Email Address: jmgionet@portsmouthnh.gov

5.8 Compliance With Regulatory Requirements. The Carrier shall comply with all Regulatory Requirements, and Provider agrees to assist the Carrier in complying therewith and to take no action that would put the Carrier in violation of Regulatory Requirements. During the Term of this Agreement, Provider shall comply with any Regulatory Requirements governing its operations, contracts, all reporting requirements and deadlines, and any obligations related to fraud, waste, and abuse. Provider shall further ensure that all Provider's individual service providers are licensed as required by Regulatory Requirements.

5.9 Assignment and Delegation. Except as specifically provided in this Agreement, neither Carrier nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Carrier includes any successor in interest and Carrier may assign its duties, rights and interests under this Agreement in whole or in part to an Affiliate of Carrier or may delegate any and all of its duties to a third party in the ordinary course of business.

5.10 Non-Exclusivity. This Agreement is non-exclusive. The Carrier may contract with other ground ambulance providers and Provider may contract with other insurers and third-party payers.

5.11 Dispute Resolution. Any dispute that might arise between the Parties regarding the performance or interpretation of the Agreement or that is related in any way to this agreement shall be resolved using the dispute resolution and arbitration procedures set forth below. A dispute must first be addressed through the applicable internal dispute resolution process outlined in the Provider Manual and other Carrier Policies and Procedures. In the event the dispute is not resolved through the internal dispute resolution process, either party can request in writing that the

Parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the Parties who have authority to settle the dispute. If the matter is not resolved within 120 days of such a request, or such shorter timeframe as may be mutually agreed upon, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Carrier's internal dispute resolution process unless applicable law specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, Carrier's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Carrier, the Payor or the Member for any payment denied because of the failure to timely submit a request for arbitration.

5.12 Arbitration. Any dispute or claim arising out of or relating to the Agreement, including breach, termination, or validity of the Agreement, that is not resolved through internal dispute resolution will be settled by confidential, binding arbitration. The arbitration shall be conducted in accordance with the Rules of the American Arbitration Association then in effect, and which, to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages, and the arbitrator may award only actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whether arising in contract, tort, or otherwise arising out of this Agreement. The Parties recognize that in the event of a breach by either party of any obligations under this Agreement or other violations of the other party's rights in connection with this Agreement, the damage caused, if any, is not irreparable or sufficient to entitle the other party to injunctive relief. The Parties, on behalf of themselves and those that they may now or hereafter represent, each agree to waive their right to seek injunctive relief and further agree that the arbitrator(s) are not authorized to issue injunctive relief. Each party shall assume its

own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The Parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other Parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. This section shall survive the termination of this Agreement.

5.13 Communications with Members. The Parties acknowledge and agree that no term or condition of this Agreement shall be construed to prohibit Provider from freely and in good faith communicating with a Member regarding the provisions, terms or requirements of the Member's Health Benefit Plan as they relate to the Member's needs, any and all available treatment options, including medication treatment options, related to the health care needs of such Member, regardless of the Carrier's benefit coverage exclusions or limitations or any terms or conditions relating thereto. The Carrier agrees that it shall not refuse to contract with or compensate Provider if otherwise eligible, solely because Provider (a) communicated with or advocated on behalf of one or more prospective, current or former Member(s) regarding the provisions terms or requirements of the Member's Health Benefit Plan as they relate to the needs of such Member(s); or (b) communicated with one or more prospective, current or former Member(s) with respect to a member's internal grievance procedure or external review.

5.14 Referrals. As provided in RSA 420-J:8 XIV, if Provider is employed by a hospital or any hospital affiliate, Provider shall not be required or in any way obligated under this Agreement to refer patients to providers also employed or under contract with the hospital or any affiliate.

5.15 Force Majeure. In the event that performance by either Carrier or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife and commotion, labor unrest, sentinel event, epidemic, or acts of God, then performance of such covenant, duty or obligation by such party shall be excused

during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

5.16 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement/Counterparts/Electronic Signatures. If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This Agreement, including any Appendices to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the Parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement. This Agreement may be executed in 2 or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Signature Page

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

AGREED AND ACCEPTED BY:

Provider	**Carrier**
City of Portsmouth, NH	**Cigna Health and Life Insurance Company**
Provider Name	Business Entity Name
Signature	Signature
Printed Name	**Anthony Cali** Printed Name
Title	**VP, Network Management – New England Market** Title
Date Signed	Date Signed
02-6000714 Federal Tax ID	
1457339152 National Provider Identifier	

APPENDIX A

REIMBURSEMENT FOR SERVICES PROVIDED: CARRIER'S COMMERCIAL BUSINESS

This Appendix A sets forth compensation to Provider for Covered Services provided to all Members enrolled in the Carrier's Commercial business.

In consideration for Provider's provision of Covered Services to Members, Carrier shall pay Provider and Provider shall accept as payment in full, reimbursement in accordance with the Standard Ground Ambulance Rate Schedule as follows. As provided under RSA 420-J:21 I:

a. For the period beginning May 20, 2026, and continuing through December 31, 2027, except as provided in paragraph b below, the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule equal to 3.25 times the Medicare rate as defined in 42 CFR Part 414 Subpart H and any subregulatory guidance issued by the Centers for Medicare & Medicaid Services.

b. For the period beginning May 20, 2026, and continuing through December 31 2027, if it is determined by the New Hampshire Insurance Commissioner that the Provider has failed, after due notice and opportunity to cure, to cooperate with the New Hampshire ground ambulance cost study as provided in RSA 420-J:26 IV by failing to substantially comply with cost data submission requirements or requirements to facilitate data validation or cost report auditing requirements, then the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule which shall be at the carrier's nonparticipating rate or at the Medicare rate that is current as of the date of service, whichever is higher. This rate schedule shall continue until it is determined by the Commissioner that Provider is in substantial compliance with the requirements of the cost study or until December 31, 2027, whichever is earlier.

c. Beginning January 1, 2028, and continuing thereafter, Carrier shall reimburse Provider for covered ground ambulance services according to the cost-based rate schedule established and published by the New Hampshire Insurance Commissioner under RSA 420-J:21 I (b) and as revised annually under RSA 420-J:21 I (c).

The Standard Ground Ambulance Rate Schedule shall apply to all Networks, products, and Health Benefit Plans offered or maintained by Carrier in its Commercial Business.

Any payment made by the Carrier will be subject to the Carrier's Policies and Procedures, less any Cost Sharing amounts, which shall be the sole responsibility of the Member.

APPENDIX B

NETWORK RENTAL PRODUCTS ADDENDUM

1. Network Rental Products. "Network Rental Products" are defined as those plans, products and/or programs, designated by Carrier in writing, from time to time, in which Carrier provides access to its health care provider network(s) and repricing services, network credentialing services, specialty program agreements, and/or other network administration functions to entities that either: (i) are responsible for underwriting, funding or paying Provider for rendering Covered Services; or (ii) are not responsible for funding Covered Services but which contract, directly or indirectly, with persons or entities that are financially responsible for funding Covered Services (each a "Payor"). The term "Network Rental Product" does not include plans, products or programs that are underwritten by Carrier and/or for which Carrier serves as the third-party administrator.

2. Designation of Network Rental Products. Carrier designates the following as Network Rental Products as of the Effective Date of this agreement:

   Strategic Alliances, Shared Administration and Payer Solutions through Cigna's OAP, Open Access Plus, Local Plus networks
   *Please refer to the Cigna Healthcare Reference Guide for more information

3. Payment. In consideration of Provider's agreement to provide Covered Services to Members of Network Rental Products in accordance with this Network Rental Products Addendum ("Addendum") and the Agreement, Provider shall be paid according to the terms of the Standard Ground Ambulance Rate Schedule referenced in this Agreement. Provider understands and agrees that the utilization management/claims management, appeal and/or other policies of the applicable Payor (which may differ from Carrier's policies) shall apply. Provider understands and agrees that the applicable Payor (subject to applicable Member copayments, coinsurance and deductibles) and not Carrier is responsible for paying Provider claims and fees for Covered Services related to the Medical Rental Products and that, in no event, shall Carrier be responsible for funding claims or paying provider, in whole or in part. Provider agrees

that it shall not file suit against Carrier as a result of any Payor's or Member's nonpayment or underpayment.

4. Other Provisions. Notwithstanding anything to the contrary in this Agreement, Carrier may, in its discretion, sell, lease, transfer, rent or grant access to Payors the benefits of the Agreement and may eliminate and/or designate new Network Rental Products under this Addendum.

5. Agreement Terms and Conditions/Conflict. All terms and conditions of the Agreement, not in conflict with the terms and conditions set forth in this Addendum (to the extent reasonably applicable to Network Rental Products) shall apply to this Addendum. In the event of a conflict between the terms of the Agreement and this Addendum, the terms of this Addendum shall apply. All terms not capitalized herein shall have the meanings ascribed to them in the Agreement.

Granite State Health Plan, Inc.

AND

City of Portsmouth Fire Department

STANDARD GROUND AMBULANCE STANDARD PROVIDER AGREEMENT

This Standard Ground Ambulance Standard Provider Agreement (hereinafter "Agreement") is made and entered into by and between Granite State Health Plan, Inc. (hereinafter "Carrier") and City of Portsmouth Fire Department (hereinafter "Provider") and shall be effective on the date it is fully executed by both the Carrier and the Provider (hereinafter "the Parties"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the Parties, the Parties agree as follows:

1.0 DEFINITIONS

1.1 "Affiliate" means any entity that is owned or controlled, either directly or through a parent or subsidiary entity, by Carrier, or is under common control with Carrier and may include a health maintenance organization, health insurance company or third party administrator. Unless otherwise set forth in this Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

1.2 "Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Carrier.

1.3 "Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by Carrier to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers and instructions, Carrier medical policies and clinical Utilization Management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives, or activities conducted by Carrier's Special Investigation Unit ("SIU").

1.4 "Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Carrier submitted by a provider for payment by Carrier for Health Services rendered to a Member.

1.5 "Claims Payment Policies and Procedures" are protocols established by the Carrier for the review and adjudication of claims for health care services as set forth in the Provider Manual and other Carrier Policies and Procedures.

1.6 "CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

1.7 "Commercial Business" means Health Benefit Plans that exclude coverage provided under Government Programs and that include coverage for individual and employer groups that is either a Fully Insured Plan insured by Carrier or a Self-Funded Plan administered by Carrier and under which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers.

1.8 "Clean claim" means a claim for payment of Covered Services that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.

1.9 "Cost Sharing" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be consist of coinsurance, copayment, deductible, or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

1.10 "Covered Services" means Medically Necessary Health Services, as determined by Carrier and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

1.11 "Facility" means any health care facility including but not limited to an acute care hospital, community mental health facility, freestanding ambulatory surgery center, transitional care unit, behavioral health facility, extended care facility, rehabilitation

facility, or skilled nursing facility.

1.12 “Fully Insured Plan” or “Fully Insured Members” means health coverage or persons with such coverage pursuant to which the Carrier provides or arranges for Covered Services and other related administrative services for Members and with respect to which the Carrier assumes the financial risk for Covered Services received by Members.

1.13 "Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Carrier maintains a contract to furnish health coverage services.

1.14 “Ground Ambulance Provider” means a public or private organization licensed by the New Hampshire Department of safety under RSA 153-A:10 to provide ground ambulance services.

1.15 “Ground Ambulance Services" means:

(a) The rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10; and

(b) Ground ambulance transport between health care facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10.

1.16 "Health Benefit Plan" or “Plan” means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

1.17 “Health Carrier” means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance Carrier, a

health maintenance organization, a health service corporation, or any other entity providing or administering a plan of health insurance, health benefits, or health services.

1.18 "Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

1.19 "Medically Necessary" or "Medical Necessity" means health care services or products provided to Members for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1.19.1 Consistent with generally accepted standards of medical practice;

1.19.2 Clinically appropriate in terms of type, frequency, extent, site, and duration;

1.19.3 Demonstrated through scientific evidence to be effective in improving health outcomes;

1.19.4 Representative of "best practices" in the medical profession; and

1.19.5 Not primarily for the convenience of the member or physician or other health care provider.

1.20 "Member" means any individual who is eligible, as determined by Carrier, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all appendices, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Participant, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

1.21 "Network" means a group of Health Service providers that support, through a direct or indirect contractual relationship, one or more Health Benefit Plans, product(s) and/or program(s) in which

Members are enrolled.

1.22 "Participating Provider" means a person or entity, or an employee or subcontractor of such person or entity, that is directly or indirectly party to an agreement to provide Covered Services to Members that has met all applicable Carrier credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Carrier to participate in one or more Network(s).

1.23 "Payor" is the person or entity obligated to a Member to provide reimbursement for Covered Services under the Member's Health Benefit Plan and that may be the Carrier or an Affiliate, or the plan sponsor that has entered into a Self-Funded Plan with the Carrier acting as administrator, or the person or entity which Carrier has agreed may directly or indirectly access services under this Agreement pursuant to a network rental product. Carrier is the Payor only for Covered Services under an insurance policy or HMO contract issued by Carrier or an affiliate and not for Self-Funded Plans or medical rental products.

1.24 "Policies and Procedures" means those policies and procedures applied by the Carrier in a standard manner across similarly situated providers in its network. Such policies and procedures are written in various documents including but not limited to the Provider Manual, the Carrier Quality Management program, Utilization Management program, claims processing manuals, benefits administration policies, credentialing and recredentialing program, payment and billing guidelines, and policies on confidentiality of information.

1.25 "Provider Manual" or "Manual" is the document setting forth Carrier Policies and Procedures and other requirements applicable to Participating Providers and the products insured or administered by the Carrier. The Manual is made available on the Carrier's public website, with paper copies available upon request.

1.26 "Quality Management" means the program described in the Policies and Procedures relating to assuring the quality of Covered Services provided to Members.

1.27 "Regulatory Requirements" means all applicable common law and any and all state, federal or local statutes, ordinances, codes, rules,

regulations, restrictions, orders, procedures, standards, directives, guidelines, instructions, bulletins, policies or requirements enacted, adopted, promulgated, applied, followed or imposed by any governmental authority, as amended, modified, revised or replaced, interpreted or enforced by any governmental authority, as applicable to each respective party to this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

1.28 "Self-Funded Plan" or "Self-Insured Members" means an arrangement between the Carrier and a third party pursuant to which: (1) the Carrier provides or arranges for Covered Services and other related administrative services for eligible participants and their dependents ("Self-Insured Members"); and (2) such third party assumes financial risk for Covered Services received by Self-Insured members. The types of third parties in a Self-Funded Plan include, but are not limited to, employers, union trusts, insurers, multiple employer welfare arrangements, U.S. military governmental agencies, or pooled risk management programs operating pursuant to Regulatory Requirements.

1.29 "Standard Ground Ambulance Provider Contract" means this Agreement the template for which is in compliance with the requirements of RSA 420-J:23 and which Health Carriers are required, under RSA 420-J:23, to offer to any Ground Ambulance Provider that is qualified and willing to meet its terms.

1.30 "Standard Ground Ambulance Rate Schedule" means the rate schedule referenced in RSA 420-J:21 for compensating Participating Ground Ambulance Providers for Covered Services that is incorporated in the Standard Ground Ambulance Provider Contract.

1.31 "Utilization Management" means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Carrier's Policies and Procedures.

2.0 RESPONSIBILITIES OF THE PARTIES

2.1 Member Identification. Carrier shall ensure that it provides a means of identifying Members either by issuing a paper, plastic, electronic,

or other identification document to Members or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Carrier to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member. Carrier makes no representations or guarantees concerning the number of Members that will be referred to Provider as a result of this Agreement

2.2 Benefit Information. Carrier will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Member is entitled as specified in the Policies and Procedures.

2.3 Provision of Services. Provider agrees to provide to members Covered Services which it customarily provides to its patients in an economic and efficient manner. Such Covered Services shall be provided in accordance with the provisions concerning services standards as contained in the Provider Manual and other Carrier Policies and Procedures. All Covered Services provided by Provider to members shall be under the terms of this Agreement.

2.4 Provider Standards and Qualifications. Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider warrants that it is duly licensed under the laws of the state where service is provided, and that all services under this Agreement will be delivered by individuals who (i) are duly licensed under the Regulatory Requirements of the state where service is provided, (ii) are eligible to provide services to Members, and (iii) are Board Certified or Board Eligible in the specialty in which they are delivering services, as applicable. Provider will ensure that each employer individuals rendering services under this Agreement maintains such status.

2.5 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time

availability in which Provider provides Health Services to any other individual. Provider will not differentiate or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type or kind of Health Service to Members that he/she/it does not customarily provide to others.

2.6 Provider Cooperation with the Credentialing Process. Provider shall provide the Carrier with appropriate credentialing information if it is not already a Participating Provider. Provider agrees to comply with the Carrier's credentialing and recredentialing policies and procedures, including but not limited to such policies as are set forth in the Provider Manual. Neither the Provider nor any of the Provider employed individuals shall provide Covered Services to any Member under this Agreement until Provider's participation is approved by the Carrier. Provider agrees that each Provider-Affiliate providing Covered Services pursuant to this Agreement must be credentialed by the Carrier pursuant to the Carrier's credentialing policy in order to provide Covered Services and be paid therefore.

2.7 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Carrier of:

2.7.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Carrier, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement;

2.7.2 Any change in Provider accreditation, affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community; or

2.7.3 Any disciplinary action concerning the Provider or any individual employed by or under contract with the Provider taken by any state or federal agency responsible for Provider licensing, certification, or the payment for health care

services.

2.8 Carrier Discretion with Respect to Credentialing. The Carrier represents that it complies with all Regulatory Requirements related to provider credentialing. The Carrier has full discretion to grant or deny credentialing approval or take any disciplinary action relative to the credentialing approval of the Provider based on clinical quality issues or any other matters deemed relevant by the Carrier. Without limitation to any of the foregoing, the Carrier shall have the right to terminate immediately the Provider's credentials and participation under this Agreement in the Carrier's networks, or to take such other disciplinary action as it deems appropriate, for the following reasons:

2.8.1 suspension, termination or non-renewal of a license of the Provider,

2.8.2 acts or omissions which threaten the life, health or safety of a patient or patients,

2.8.3 failure to meet standard of care as required for Carrier Providers and determined by the Carrier,

2.8.4 repeated failure to comply with accepted ethical and professional standards of behavior;

2.8.5 provider inactivity as described in Subsection 2.16.3;

2.8.6 dissolution or sale of substantially all assets;

2.8.7 institution of proceeding in bankruptcy, insolvency, assignment for benefit of creditors or other action generally to secure rights of creditors; or

2.8.8 failure to provide credentialing or recredentialing information to the Carrier upon request.

Any decision by the Carrier to deny, non-renew, or withdraw the credentials of Provider, or to terminate the credentials of Provider, shall be in writing, shall state the reasons for such termination, and, shall include notice of a Provider's right to an appeal.

2.9 Compliance with Carrier Policies and Procedures. Provider agrees to abide by and cooperate with Carrier's Provider Manual, and all other Policies and Procedures established and implemented by Carrier, including, without limitation, Policies and Procedures relating to credentialing, Utilization Management, Quality Management and improvement, the delivery of preventive health services, claims submission, cost sharing collections, confidentiality of Provider, patient and Carrier information, duplicate coverage, and subrogation recoveries. In the event of any conflict between Carrier Policies and Procedures and this Agreement, the terms of this Agreement will prevail. The Carrier may, at its discretion and at any time, amend the Provider Manual, its Policies and Procedures, and any other programs or administrative policies and procedures, such changes to be binding upon Provider; provided further, that Provider shall be notified in writing of modifications in Covered Services or modifications in the Carrier's procedures, documents or requirements including those associated with Utilization management, Quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Carrier and Provider.

2.10 Publication and Use of Provider Information. Provider agrees that Carrier or its designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, compensation rates, and information related to Provider for transparency initiatives.

2.11 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the Parties agree that they may identify Provider as a participant in the Network(s) in which Provider participates.

2.12 Cooperation Regarding Member Complaints and Grievance Procedures. Provider agrees to cooperate with Carrier in the review and resolution of Member complaints or grievances that may arise relating to the provision of Covered Services to Members including

but not limited to providing any information or records needed to render a decision on a complaint or grievance. Provider agrees to provide such information and records with sufficient promptness to allow the Carrier to meet state and federal regulatory requirements for timely processing of Member complaints and grievances. It is understood that certain complaints and grievances must be processed by the Carrier on an expedited basis. The Carrier and Provider agree that complaints received by the Carrier or the Provider with respect to the provision of Covered Services shall ultimately be resolved in accordance with the Carrier's grievance procedures or upon external review under RSA 420-J:5-a through 420-J:5-e. The Carrier will forward to Provider copies of any such complaints or grievances, upon Provider's request and to the extent necessary for Provider to comply with this Section. Provider agrees, to the extent permitted by Regulatory Requirements, to fully advise the Carrier of any Member complaint, grievance or claim known to Provider relating to services provided under this Agreement.

2.13 General Cooperation Requirement. Provider shall also cooperate with Carrier and Carrier Affiliates in implementing those policies and programs as may be reasonably requested by Carrier or a Carrier Affiliate for purposes of Carrier's or the Carrier Affiliate's business operations or required by Carrier or a Carrier Affiliate to comply with Regulatory Requirements or accreditation requirements.

2.14 Records. Provider shall maintain medical records and documents relating to Members as may be required by Regulatory Requirements and for the period of time required by law. Medical records of Members and any other records containing individually identifiable information relating to Members will be regarded as confidential, and Provider and Carrier shall comply with applicable federal and state law regarding such records. Provider will obtain Members' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Carrier with a copy of Members' medical records and other records maintained by Provider relating to Members. These records shall be provided to Carrier at no charge and within the timeframes requested by Carrier and will also be made available during normal business hours for inspection by Carrier, Carrier's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the

termination of this Agreement.

2.15 Participation in Networks Supporting Commercial Business.

Provider will render Covered Services to Fully Insured Members in accordance with the terms and conditions of this Agreement. Provider agrees to participate in all of Carrier's Fully Insured Plan networks.

2.16 Provider Directory Updates, Name Use, Inactivity, and Provider Directory Suppression.

2.16.1 Provider Directory Updates. Provider shall cooperate with Carrier's efforts to maintain accurate provider directories by complying with Regulatory Requirements and the Carrier's Policies and Procedures, including those set forth in the Provider Manual, for verification of provider directory information related to Provider and advance notification requirements for any changes to Provider and/or Provider's Provider contact and demographic information, including without limitation, digital contact information, with specification as to each location in which each Provider regularly provides services to patients, specialty, any medical group and/or Facility affiliations, Facility accreditation status, any languages spoken other than English, and board certification(s).

2.16.2 Name Use. Provider agrees that the Carrier may use Provider's demographic information including without limitation, Provider's name(s), address(es), telephone number(s), website/URL(s), digital contact information, a description of Facilities, a description of care and specialty services provided, as may be appropriate and necessary in advertising of the Carrier, provided that such advertising shall be done in accordance with Regulatory Restrictions. The Carrier agrees that, with the prior written consent of the Carrier, Provider may use the Carrier's name in statements or announcements that Provider accepts the coverage of Carrier Members.

2.16.3 Provider Inactivity. In accordance with applicable Carrier Policies and Procedures, the Carrier may terminate a Provider

that has not, (i) verified their provider directory information or provided other information required by the Carrier or Regulatory Requirements or (ii) provided services to patients or submitted a claim for services for a period of two years. Under such circumstances, Provider may reapply to become a participating provider through the Carrier's standard credentialing and enrollment processes set forth in Carrier Policies and Procedures.

2.16.4 Provider Directory Suppression. The Carrier may suppress provider directory information (i) that cannot be verified by the Carrier as described in the Provider Manual, (ii) to the extent required by Regulatory Requirements, (iii) where Carrier deems a Provider terminated from the network if such Provider has not verified such information as required under the Provider Manual and has no activity in the Carrier's system for more than two years, or (iv) as otherwise required by Carrier to ensure accurate claims processing and benefit administration.

2.17 Referral Incentives/Kickbacks Prohibited. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Carrier.

2.18 Member Incentives Prohibited. Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Member incentive. Participant Incentive means any arrangement by Provider to:

2.18.1 reduce or satisfy a Participant's Cost-Sharing obligations;

2.18.2 pay on behalf of or reimburse a Member for any portion of the Member's costs for coverage under a policy or plan insured or administered by Carrier or a Carrier Affiliate; or

2.18.3 to provide a Member with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from Provider or its affiliates.

In the event of non-compliance with this provision: Carrier may terminate this Agreement, such non-compliance being a "material breach" of this Agreement; Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Member in connection with a Member incentive; and Carrier may take such other action appropriate to enforce this provision.

2.19 Provider Service or Organizational Changes. Provider shall notify the Carrier in writing in accordance with the Notice section of this Agreement at least 90 days prior to any significant service or organizational change that occurs after the Effective Date of this Agreement, whether or not such change is occurring as a result of a merger, acquisition, affiliation or any other formal or informal business combination, including without limitation: (i) any action to sell, transfer or convey its business or any substantial portion of its business assets to another entity, or when Provider is the subject of a sale, transfer or conveyance of its business by another entity, (ii) when Provider enters into a management contract with another entity to deliver any new type of Covered Service not previously provided by Provider, (iii) when Provider contracts to deliver of any Covered Services provided by Provider in additional facilities or practice locations, and/or (iv) when there is significant growth or other changes impacting the size of the Provider, including through merger, acquisition, or changes to any of Provider's affiliations. Such service or organizational changes are not automatically included under the terms of this Agreement and any inclusion thereof shall require mutual written agreement by the Parties. If Provider fails to timely notify Carrier of a service or organizational change falling under this paragraph, then Carrier may include or exclude the new service or organizational composition under this agreement by serving notice on Provider under the Notice section of this Agreement. However, Carrier will accept any new service or organizational composition of Provider as coming under this Agreement if Provider remains qualified and willing to accept the terms of the Standard Ground Ambulance Provider Contract.

3.0 COMPENSATION

3.1 Submission and Adjudication of Claims. Provider shall submit, and Carrier shall adjudicate, claims in accordance with the Carrier's

Claims Payment Policies and Procedures as detailed in the Provider Manual and other Carrier Policies and Procedures as may be issued by the Carrier from time to time. Claims for payment for Covered Services to Members shall not be payable under this Agreement if not submitted to the Carrier in accordance with such Policies and Procedures.

3.2 Non-Medically Necessary Services. Provider shall not charge a Member for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Member in writing that the particular service will not be covered by Carrier and the Member acknowledges in writing that he or she will be responsible for payment for such service.

3.3 The Standard Ground Ambulance Rate Schedule. The Standard Ground Ambulance Rate Schedule shall apply as provided in Appendix A to Provider compensation for Covered Services to Members with respect to products and Health Benefit Plans offered or maintained by Carrier in its Commercial Business.

3.4 Applicability of the Rates. The rates in this Agreement apply to all services provided by Provider to Members in the products and Health Benefit Plan types covered by this Agreement, including services covered under a Member's in or out-of-network benefits (e.g. PPO or POS plans), and whether the Payor or Member is financially responsible for payment.

3.5 Cost Sharing. Provider shall be solely responsible for the collection of all applicable Cost Sharing from Members, subject to the Carrier Policies and Procedures. Provider agrees to make reasonable efforts to verify Cost Sharing amounts prior to billing for such amounts. The Carrier shall have no responsibility for payment or collection of such Cost Sharing and any such amounts payable by Members for Covered Services will be debited against amounts owed to Provider under this Agreement.

3.6 Effect of Member Coverage as of the Date of Service. The Payor will be responsible for payment for Covered Services if the patient is an active Member and eligible for such service on the date of service. The Carrier, on behalf of itself and the Payor, reserves the right to deny or recover payment if, after receipt of a claim, it is determined that the patient was not a Member on the date of service unless the patient was entitled to an extension of benefits by operation of law.

Provider may bill such patient or his or her third party insurance carrier directly for those non-reimbursed services furnished to such patient.

3.7 Payment in Full and Hold Harmless.

3.7.1 Provider will look solely to the Payor for payment of Covered Services provided to Members. Except when the Carrier is also the Payor, the Parties hereto acknowledge that the Carrier shall act solely as the Payor's payment agent hereunder. Carrier is not the insurer, guarantor or underwriter of the liability of such Payor for benefits provided to or under Self-Insured Plans, provided, however, that the Carrier is not relieved of its responsibility under its contracts with such Payors to administer payment to Provider for Covered Services rendered to Self-Insured Plan Members. Provider agrees to accept as payment in full, in all circumstances, the amount that is required under this Agreement whether such payment is in the form of a Cost Sharing, a payment by Carrier, or a payment by another source, such as through coordination of benefits or subrogation. In no event shall Carrier be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the amount that is required under this Agreement less Cost Sharing payments or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the amount that is required under this Agreement as payment in full even if the Member has not yet satisfied his/her deductible.

3.7.2 Provider agrees that in no event, including but not limited to nonpayment by the Carrier or intermediary, insolvency of the Carrier or intermediary, or breach of this Agreement, shall the Provider (or its assignees or subcontractors) have the right to seek any type of payment from, bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a Member or a person acting on behalf of the Member (other than the Carrier or intermediary) for Covered Services provided pursuant to this Agreement, except for the collection of Cost Sharing for services covered by the Health Benefit Plan, whether or not compensation has actually been received by the Provider for such Services or whether or not this Agreement remains in effect. This agreement does not prohibit the

Provider from collecting fees for uncovered services delivered on a fee-for-service basis to Members. Nor does this Agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the Member, as long as the Provider has clearly informed the Member that the Carrier may not cover or continue to cover a specific service or services. Covered Services which the Provider is prohibited from billing Members for shall include services denied by the Carrier pursuant to its utilization management Policies and Procedures for failure to meet the Carrier's Medically Necessary criteria and/or administrative denials issued by the Carrier pursuant to Carrier Policies and Procedures. Provider's sole redress shall be against the assets of the Payor. The requirements of this provision shall survive any termination of this Agreement for services rendered prior to the termination, regardless of the cause of such termination. The Carrier's Members, any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement hereafter entered into between Provider and the Member or any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder. Except as provided in this Agreement, this agreement does not prohibit the provider from pursuing any available legal remedy.

3.8 Payment Time Frames. For Claims subject to New Hampshire law, Carrier or its designee and Provider shall comply with the requirements of the New Hampshire prompt pay legislation (RSA 420-J:8-a), as may be applicable, for payment of Clean Claims for Covered Services.

3.9 Audits and Carrier Access to Provider Records. The Carrier shall have the right to conduct audits to verify the accuracy of Member bills and compliance with the Carrier's billing guidelines, as set forth in the Provider Manual or in other Carrier Policies and Procedures. The Provider shall cooperate with the Carrier and its auditor in accordance with the procedures set forth in the Provider Manual or in other Carrier Policies and Procedures. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the Provider Manual and/or other Carrier Policies and Procedures, shall permit Carrier or

its designees to have, with appropriate working space and without charge, on-site access to and the right to examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Carrier in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the Provider Manual, and compliance with this Agreement. In lieu of on-site access, at Carrier's request, Provider or its designees shall submit records to Carrier, or its designees via photocopy or electronic transmittal, within 30 days, at no charge to Carrier from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Provider acknowledges that failure to submit records to Carrier in accordance with this provision and/or the Provider Manual, and/or other Carrier Policies and Procedures may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.10 Reimbursement of Amounts Collected In Error From a Member. If Provider collects payment from a Member when not permitted to collect under either this Agreement or the Policies and Procedures, Provider must repay the amount within 2 weeks of a request from Carrier or the Member or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Carrier may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments to Provider.

3.11 Carrier Offset Rights. Carrier shall be entitled to recoup, offset and adjust an amount equal to any erroneous payments (including, but not limited to, any improper payment, duplicate payment, or overpayment) made by Carrier to Provider against any payments due and payable by Carrier to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all erroneous payments regardless of the cause, including, but not

limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Carrier that any erroneous payment is due from Provider, Provider must refund the amount to Carrier within 30 days of when Carrier notifies Provider. If such reimbursement is not received by Carrier within the 30 days following the date of such notice, Carrier shall be entitled to offset such erroneous payment against any payments due and payable by Carrier to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider disagree with any determination by Carrier that Provider has received an erroneous payment, Provider shall have the right to appeal such determination under Carrier's procedures set forth in the Provider Manual, and such appeal shall not suspend Carrier's right to recoup the erroneous payment amount during the appeal process, unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Carrier reserves the right to employ a third-party collection agency in the event of non-payment.

3.12 Underpayments. If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Carrier or its designee within the timeframe and in accordance with the process as set forth in the Carrier’s Provider Manual and other Policies and Procedures. The request may be further pursued as set forth in Sections 5.11 and 5.12 below. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill the Carrier, the Payor or the Member for those services.

3.13 Coordination of Benefits. Certain claims for Covered Services are claims for which another Payor may be primarily responsible under Coordination of Benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Carrier’s Policies and Procedures.

3.13.1 Carrier's Payment as Secondary Payor (Non-Medicare). Carrier's payment, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under this Agreement, and is subject to the terms and conditions of the Member's Health Benefit Plan and applicable state and federal law. Use of applicable COB provisions may result in a payment

from Carrier that, when added to the amount payable from other sources, is less than 100 percent of the payment for Covered Services under this Agreement.

3.13.2 When Medicare is the Primary Payor. When the Carrier is the secondary payor to Medicare, Provider and Carrier are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Carrier's financial responsibility as the secondary payor to be limited to the Member's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Member liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.0 TERM AND TERMINATION

4.1 Term of This Agreement. This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth below.

4.2 How This Agreement Can Be Terminated. Provider can terminate this Agreement at any time by providing at least 90 days advance written notice. Carrier can terminate this Agreement immediately for good cause (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement or Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Carrier from obligations under this Agreement prior to the effective date of termination and from all other provisions of this Agreement that, by their own terms, survive the termination of this Agreement.

4.3 Continuing Coverage. As required under Regulatory Requirements, NCQA accreditation standards, and the applicable Health Benefit Plan, the Carrier and the Provider shall permit a Member enrolled in

Commercial Business coverage to continue to receive Covered Services from Provider, and Provider shall continue to provide such Covered Services for a certain period of time following termination of such Provider's participation under this Agreement, as follows:

4.3.1 Member Continued Access Rights Post Termination. As provided in RSA 420-J:8 XI and RSA 420-J:7-d, Members with Fully Insured coverage will have continued covered access to Provider's services in the event of the termination of this Agreement. The continued access shall be made available by Provider for 60 days from the date of termination of this Agreement (and for an additional 60 days thereafter if so ordered by the New Hampshire Insurance Commissioner) and shall be provided and paid for in accordance with the terms and conditions of the Member's Health Benefit Plan and this Agreement. Within 5 business days of the termination of this Agreement, Carrier shall provide written notice to affected Members explaining their continued access rights.

4.3.2 Continuity of Care. Carrier and Provider shall permit a Member who is in an active course of treatment, pregnant, or terminally ill ("Continuing Care Patient") to receive Continuity of Care in connection with the active treatment, pregnancy, or terminal illness. The Continuity of Care for active course of treatment continues until the earliest of the following: (i) for up to 90 days following the date the Member received notice of the terminated Provider; (ii) the date the Member is no longer undergoing an active course of treatment with the terminated Provider as a Continuing Care Patient; (iii) the date that care is successfully transitioned to another Provider; (iv) the date benefit limitations under the Member's Health Benefit Plan are met or exceeded; or (v) the date the Carrier determines the care is no longer Medically Necessary. The Continuity of Care for Members who are terminally ill continues until the Member's death. The Continuity of Care for Members who are pregnant continues through the post-partum period as defined by NCQA accreditation standards. Continuity of Care begins on (i) the effective date of the termination of Provider's participation under this Agreement or (ii) the date of the Member notice of such termination, whichever is later. The Provider agrees to cooperate with the Carrier in promptly determining, as necessary, which Members may be informed of their eligibility to receive

Continuity of Care. Provider providing Covered Services pursuant to this Section must accept payment at the reimbursement and other financial terms as provided in this Agreement and in the Member's Health Benefit Plan as payment in full and must not seek any payment from the Member for such Covered Services, except for any applicable Cost Sharing. Provider must adhere to all other terms and conditions of this Agreement including, but not limited to, compliance with quality standards, the Carrier's procedures regarding Referral and obtaining prior Authorizations, and compliance with other Carrier Policies and Procedures. The Carrier's Continuity of Care obligations set forth in this section shall not apply in instances where a Provider's termination from participation under this Agreement is based upon quality related issues or fraud.

5.0 GENERAL PROVISIONS

5.1 Confidentiality. As a result of this Agreement, Provider may have access to certain of Carrier's confidential and proprietary information. Provider shall hold such information in confidence and will not use or disclose such information to any person without the prior written consent of Carrier except as may be required by law. This provision shall not be construed to prohibit Carrier from disclosing information to Carrier Affiliates or the agents or subcontractors of Carrier or Carrier Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Members or other customers of Carrier or Carrier Affiliates or their representatives. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

5.2 Independent Parties. In entering into this Agreement and in the performance of the duties described herein, Provider and its employees are acting as independent contractors of the Carrier. Carrier and Provider do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration,

population health management, pay for performance, Quality Management, Utilization Management, and other similar programs, nor any coverage determination made by Carrier or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Carrier or any other party to intervene in or influence Provider's medical decision-making regarding any Member.

5.3 Indemnification. As Carrier and Provider are independent contractors, and not employees, agents or representatives of each other, Carrier and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Carrier nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Carrier from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's provision of care to Members. Carrier agrees to indemnify and hold harmless Provider from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Carrier's administration of Plans. This provision will survive the termination of this Agreement

5.4 Subcontractor Compliance. All subcontracts or written agreements for the provision of Covered Services to Members entered into by Provider with other providers must set forth requirements for compliance with all regulatory and NCQA requirements set forth herein and Carrier's Policies and Procedures. Such subcontracts or other written agreements, or a form of such subcontracts or other written agreements, including the reimbursement methodology shall be provided to the Carrier upon request. Provider may not use any method of reimbursement in its subcontracting arrangements which acts as an incentive to withhold medically necessary services to Members. Provider shall provide at least 90 days prior notice to the Carrier of Provider's intent to execute, amend or terminate any such subcontracts entered into for the purpose of providing Covered Services to Members.

5.5 Liability Insurance. Provider shall procure and maintain professional, including medical malpractice, and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are, at a minimum, commensurate with prevailing industry standards or licensing or accreditation standards and which are no less than the following amounts: $1,000,000 per occurrence/ $3,000,000 in the aggregate. The Carrier shall procure and maintain professional and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are commensurate with prevailing industry standard or licensing or accreditation standards. All insurance coverage obligations under this Section shall cover any claim arising during the term of this Agreement, even if not made or communicated until after the term of this Agreement. The Parties agree to provide, upon request, certificates of such insurance to each other. The Parties shall immediately report to the other any lapse or modification in any such coverage.

5.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of New Hampshire and applicable federal law.

5.7 Notices. Notices required under this Agreement shall be in writing and shall be deemed to have been duly given (i) on the third day after deposit in the United States mail, postage prepaid, and properly addressed as specified below; or, (ii) on the date of delivery if sent via overnight delivery to the party to whom notice is to be given and properly addressed as specified below; or (iii) on the date of service if served personally on the party to whom notice is to be given. Having provided notice as described above, the Parties may also notify each other by sending an electronic notice with automatic receipt verification to the other Party's e-mail address listed below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

The proper address for notices under this Agreement is as follows:

If to Carrier:
Attn: President
Granite State Health Plan, Inc.
2 Executive Park Drive
Suite 223
Bedford, NH 03110

If to Provider:
City of Portsmouth Fire Department
1 Junkins Ave.
Portsmouth, NH 03801

Attention: Jason Gionet
Email Address: jmgionet@portsmouthnh.gov

5.8 Compliance With Regulatory Requirements. The Carrier shall comply with all Regulatory Requirements, and Provider agrees to assist the Carrier in complying therewith and to take no action that would put the Carrier in violation of Regulatory Requirements. During the Term of this Agreement, Provider shall comply with any Regulatory Requirements governing its operations, contracts, all reporting requirements and deadlines, and any obligations related to fraud, waste, and abuse. Provider shall further ensure that all Provider's individual service providers are licensed as required by Regulatory Requirements.

5.9 Assignment and Delegation. Except as specifically provided in this Agreement, neither Carrier nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Carrier includes any successor in interest and Carrier may assign its duties, rights and interests under this Agreement in whole or in part to an Affiliate of Carrier or may delegate any and all of its duties to a third party in the ordinary course of business.

5.10 Non-Exclusivity. This Agreement is non-exclusive. The Carrier may contract with other ground ambulance providers and Provider may contract with other insurers and third-party payers.

5.11 Dispute Resolution. Any dispute that might arise between the Parties regarding the performance or interpretation of the Agreement or that is related in any way to this agreement shall be resolved using the dispute resolution and arbitration procedures set forth below. A dispute must first be addressed through the applicable internal dispute resolution process outlined in the Provider Manual and other Carrier Policies and Procedures. In the event the dispute is not resolved through the internal dispute resolution process, either party can request in writing that the

Parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the Parties who have authority to settle the dispute. If the matter is not resolved within 120 days of such a request, or such shorter timeframe as may be mutually agreed upon, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Carrier's internal dispute resolution process unless applicable law specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, Carrier's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Carrier, the Payor or the Member for any payment denied because of the failure to timely submit a request for arbitration.

5.12 Arbitration. Any dispute or claim arising out of or relating to the Agreement, including breach, termination, or validity of the Agreement, that is not resolved through internal dispute resolution will be settled by confidential, binding arbitration. The arbitration shall be conducted in accordance with the Rules of the American Arbitration Association then in effect, and which, to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages, and the arbitrator may award only actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whether arising in contract, tort, or otherwise arising out of this Agreement. The Parties recognize that in the event of a breach by either party of any obligations under this Agreement or other violations of the other party's rights in connection with this Agreement, the damage caused, if any, is not irreparable or sufficient to entitle the other party to injunctive relief. The Parties, on behalf of themselves and those that they may now or hereafter represent, each agree to waive their right to seek injunctive relief and further agree that the arbitrator(s) are not authorized to issue injunctive relief. Each party shall assume its

own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The Parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving other Parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. This section shall survive the termination of this Agreement.

5.13 Communications with Members. The Parties acknowledge and agree that no term or condition of this Agreement shall be construed to prohibit Provider from freely and in good faith communicating with a Member regarding the provisions, terms or requirements of the Member's Health Benefit Plan as they relate to the Member's needs, any and all available treatment options, including medication treatment options, related to the health care needs of such Member, regardless of the Carrier's benefit coverage exclusions or limitations or any terms or conditions relating thereto. The Carrier agrees that it shall not refuse to contract with or compensate Provider if otherwise eligible, solely because Provider (a) communicated with or advocated on behalf of one or more prospective, current or former Member(s) regarding the provisions terms or requirements of the Member's Health Benefit Plan as they relate to the needs of such Member(s); or (b) communicated with one or more prospective, current or former Member(s) with respect to a member's internal grievance procedure or external review.

5.14 Referrals. As provided in RSA 420-J:8 XIV, if Provider is employed by a hospital or any hospital affiliate, Provider shall not be required or in any way obligated under this Agreement to refer patients to providers also employed or under contract with the hospital or any affiliate.

5.15 Force Majeure. In the event that performance by either Carrier or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife and commotion, labor unrest, sentinel event, epidemic, or acts of God, then performance of such covenant, duty or obligation by such party shall be excused

during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

5.16 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement/Counterparts/Electronic Signatures. If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This Agreement, including any Appendices to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the Parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement. This Agreement may be executed in 2 or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Signature Page

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

AGREED AND ACCEPTED BY:

Provider

City of Portsmouth Fire Department

Provider Name

Signature

Printed Name

Title

Date Signed

02-6000714

Federal Tax ID

1457339152

National Provider Identifier

Carrier

Granite State Health Plan, Inc.

Business Entity Name

Signature

Geraldine M. Vaughan

Printed Name

Plan President and CEO

Title

Date Signed

APPENDIX A

REIMBURSEMENT FOR SERVICES PROVIDED: CARRIER'S FULLY INSURED BUSINESS

This Appendix A sets forth compensation to Provider for Covered Services provided to all Members enrolled in the Carrier's Fully Insured Plans.

In consideration for Provider's provision of Covered Services to Members, Carrier shall pay Provider and Provider shall accept as payment in full, reimbursement in accordance with the Standard Ground Ambulance Rate Schedule as follows. As provided under RSA 420-J:21 I:

a. For the period beginning May 20, 2026, and continuing through December 31, 2027, except as provided in paragraph b below, the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule equal to 3.25 times the Medicare rate as defined in 42 CFR Part 414 Subpart H and any subregulatory guidance issued by the Centers for Medicare & Medicaid Services.

b. For the period beginning May 20, 2026, and continuing through December 31 2027, if it is determined by the New Hampshire Insurance Commissioner that the Provider has failed, after due notice and opportunity to cure, to cooperate with the New Hampshire ground ambulance cost study as provided in RSA 420-J:26 IV by failing to substantially comply with cost data submission requirements or requirements to facilitate data validation or cost report auditing requirements, then the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule which shall be at the carrier's nonparticipating rate or at the Medicare rate that is current as of the date of service, whichever is higher. This rate schedule shall continue until it is determined by the Commissioner that Provider is in substantial compliance with the requirements of the cost study or until December 31, 2027, whichever is earlier.

c. Beginning January 1, 2028 and continuing thereafter, Carrier shall reimburse Provider for covered ground ambulance services according to the cost-based rate schedule established and published by the New Hampshire Insurance Commissioner under RSA 420-J:21 I (b) and as revised from year to year under RSA 420-J:21 I (c).

The Standard Ground Ambulance Rate Schedule shall apply to all Networks, products, and Health Benefit Plans offered or maintained by Carrier in its Fully Insured Business.

Any payment made by the Carrier will be subject to the Carrier's Policies and Procedures, less any Cost Sharing amounts, which shall be the sole responsibility of the Member.

Boston Medical Center Health Plan, Inc.

d/b/a WELLSENSE HEALTH PLAN

AND

CITY OF PORTSMOUTH NEW HAMPSHIRE

STANDARD GROUND AMBULANCE STANDARD PROVIDER AGREEMENT

This Standard Ground Ambulance Standard Provider Agreement (hereinafter "Agreement") is made and entered into by and between Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan ("Plan" or "WellSense") (hereinafter "Carrier") and City of Portsmouth NHS (hereinafter "Provider") and shall be effective on the date it is fully executed by both the Carrier and the Provider (hereinafter "the Parties"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the Parties, the Parties agree as follows:

1.0 DEFINITIONS

1.1 "Affiliate" means any entity that is owned or controlled, either directly or through a parent or subsidiary entity, by Carrier, or is under common control with Carrier and may include a health maintenance organization, health insurance company or third-party administrator. Unless otherwise set forth in this Agreement, an Affiliate may access the rates, terms and conditions of this Agreement.

1.2 "Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Carrier.

1.3 "Audit" means a post-payment review of the Claim(s) and supporting clinical information reviewed by Carrier to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of submission and payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers and instructions, Carrier medical policies and clinical Utilization Management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives, or

activities conducted by Carrier's Special Investigation Unit ("SIU").

1.4 "Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Carrier submitted by a provider for payment by Carrier for Health Services rendered to a Member.

1.5 "Claims Payment Policies and Procedures" are protocols established by the Carrier for the review and adjudication of claims for health care services as set forth in the Provider Manual and other Carrier Policies and Procedures.

1.6 "CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

1.7 "Commercial Business" means Health Benefit Plans that exclude coverage provided under Government Programs and that include coverage for individual and employer groups that is either a Fully Insured Plan insured by Carrier or a Self-Funded Plan administered by Carrier and under which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers.

1.8 "Clean claim" means a claim for payment of Covered Services that is submitted to a health carrier on the carrier's standard claim form using the most current published procedural codes, with all the required fields completed with correct and complete information in accordance with the carrier's published filing requirements.

1.9 "Cost Sharing" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may consist of coinsurance, copayment, deductible, or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

1.10 "Covered Services" means Medically Necessary Health Services, as determined by Carrier and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

1.11 "Facility" means any health care facility including but not limited to an acute care hospital, community mental health facility,

freestanding ambulatory surgery center, transitional care unit, behavioral health facility, extended care facility, rehabilitation facility, or skilled nursing facility.

1.12 “Fully Insured Plan” or “Fully Insured Members” means health coverage or persons with such coverage pursuant to which the Carrier provides or arranges for Covered Services and other related administrative services for Members and with respect to which the Carrier assumes the financial risk for Covered Services received by Members.

1.13 "Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Carrier maintains a contract to furnish health coverage services.

1.14 “Ground Ambulance Provider” means a public or private organization licensed by the New Hampshire Department of safety under RSA 153-A:10 to provide ground ambulance services.

1.15 “Ground Ambulance Services" means:

(a) The rendering of medical treatment and care at the scene of a medical emergency or while transporting a patient from the scene to an appropriate health care facility or behavioral health emergency services provider when the services are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10; and

(b) Ground ambulance transport between health care facilities when the services are medically necessary and are provided by one or more ground ambulance vehicles designed for this purpose and licensed by the New Hampshire Department of Safety under RSA 153-A:10.

1.16 "Health Benefit Plan" or “Plan” means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

1.17 “Health Carrier” means an entity that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurance Carrier, a health maintenance organization, a health service corporation, or any other entity providing or administering a plan of health insurance, health benefits, or health services.

1.18 "Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

1.19 "Medically Necessary" or "Medical Necessity" means health care services or products provided to Members for the purpose of preventing, stabilizing, diagnosing, or treating an illness, injury, or disease or the symptoms of an illness, injury, or disease in a manner that is:

1.19.1 Consistent with generally accepted standards of medical practice;

1.19.2 Clinically appropriate in terms of type, frequency, extent, site, and duration;

1.19.3 Demonstrated through scientific evidence to be effective in improving health outcomes;

1.19.4 Representative of "best practices" in the medical profession; and

1.19.5 Not primarily for the convenience of the member or physician or other health care provider.

1.20 "Member" means any individual who is eligible, as determined by Carrier, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all appendices, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Participant, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and

the meaning of each is synonymous with any such other.

1.21 "Network" means a group of Health Service providers that support, through a direct or indirect contractual relationship, one or more Health Benefit Plans, product(s) and/or program(s) in which Members are enrolled.

1.22 "Participating Provider" means a person or entity, or an employee or subcontractor of such person or entity, that is directly or indirectly party to an agreement to provide Covered Services to Members that has met all applicable Carrier credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Carrier to participate in one or more Network(s).

1.23 "Payor" is the person or entity obligated to a Member to provide reimbursement for Covered Services under the Member's Health Benefit Plan and that may be the Carrier or an Affiliate, or the plan sponsor that has entered into a Self-Funded Plan with the Carrier acting as administrator, or the person or entity which Carrier has agreed may directly or indirectly access services under this Agreement pursuant to a network rental product. Carrier is the Payor only for Covered Services under an insurance policy or HMO contract issued by Carrier or an affiliate and not for Self-Funded Plans or medical rental products.

1.24 "Policies and Procedures" means those policies and procedures applied by the Carrier in a standard manner across similarly situated providers in its network. Such policies and procedures are written in various documents including but not limited to the Provider Manual, the Carrier Quality Management program, Utilization Management program, claims processing manuals, benefits administration policies, credentialing and recredentialing program, payment and billing guidelines, and policies on confidentiality of information.

1.25 "Provider Manual" or "Manual" is the document setting forth Carrier Policies and Procedures and other requirements applicable to Participating Providers and the products insured or administered by the Carrier. The Manual is made available on the Carrier's public website, with paper copies available upon request.

1.26 “Quality Management” means the program described in the Policies and Procedures relating to assuring the quality of Covered Services provided to Members.

1.27 "Regulatory Requirements" means all applicable common law and any and all state, federal or local statutes, ordinances, codes, rules, regulations, restrictions, orders, procedures, standards, directives, guidelines, instructions, bulletins, policies or requirements enacted, adopted, promulgated, applied, followed or imposed by any governmental authority, as amended, modified, revised or replaced, interpreted or enforced by any governmental authority, as applicable to each respective party to this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

1.28 “Self-Funded Plan” or “Self-Insured Members” means an arrangement between the Carrier and a third party pursuant to which: (1) the Carrier provides or arranges for Covered Services and other related administrative services for eligible participants and their dependents ("Self-Insured Members"); and (2) such third party assumes financial risk for Covered Services received by Self-Insured members. The types of third parties in a Self-Funded Plan include, but are not limited to, employers, union trusts, insurers, multiple employer welfare arrangements, U.S. military governmental agencies, or pooled risk management programs operating pursuant to Regulatory Requirements.

1.29 “Standard Ground Ambulance Provider Contract” means this Agreement the template for which is in compliance with the requirements of RSA 420-J:23 and which Health Carriers are required, under RSA 420-J:23, to offer to any Ground Ambulance Provider that is qualified and willing to meet its terms.

1.30 “Standard Ground Ambulance Rate Schedule” means the rate schedule referenced in RSA 420-J:21 for compensating Participating Ground Ambulance Providers for Covered Services that is incorporated in the Standard Ground Ambulance Provider Contract.

1.31 “Utilization Management” means a process to review and determine whether certain health care services provided or to be provided are

Medically Necessary and in accordance with the Carrier's Policies and Procedures.

2.0 RESPONSIBILITIES OF THE PARTIES

2.1 Member Identification. Carrier shall ensure that it provides a means of identifying Members either by issuing a paper, plastic, electronic, or other identification document to Members or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Carrier to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member. Carrier makes no representations or guarantees concerning the number of Members that will be referred to Provider as a result of this Agreement

2.2 Benefit Information. Carrier will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Member is entitled as specified in the Policies and Procedures.

2.3 Provision of Services. Provider agrees to provide to members Covered Services which it customarily provides to its patients in an economic and efficient manner. Such Covered Services shall be provided in accordance with the provisions concerning services standards as contained in the Provider Manual and other Carrier Policies and Procedures. All Covered Services provided by Provider to members shall be under the terms of this Agreement.

2.4 Provider Standards and Qualifications. Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Provider warrants that it is duly licensed under the laws of the state where service is provided, and that all services under this Agreement will be delivered by individuals who (i) are duly licensed under the Regulatory

Requirements of the state where service is provided, (ii) are eligible to provide services to Members, and (iii) are Board Certified or Board Eligible in the specialty in which they are delivering services, as applicable. Provider will ensure that each employer individuals rendering services under this Agreement maintains such status.

2.5 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall not be required to provide any type or kind of Health Service to Members that he/she/it does not customarily provide to others.

2.6 Provider Cooperation with the Credentialing Process. Provider shall provide the Carrier with appropriate credentialing information if it is not already a Participating Provider. Provider agrees to comply with the Carrier's credentialing and recredentialing policies and procedures, including but not limited to such policies as are set forth in the Provider Manual. Neither the Provider nor any of the Provider employed individuals shall provide Covered Services to any Member under this Agreement until Provider's participation is approved by the Carrier. Provider agrees that each Provider-Affiliate providing Covered Services pursuant to this Agreement must be credentialed by the Carrier pursuant to the Carrier's credentialing policy in order to provide Covered Services and be paid therefore.

2.7 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Carrier of:

2.7.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Carrier, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement;

2.7.2 Any change in Provider accreditation, affiliation, insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community; or

2.7.3 Any disciplinary action concerning the Provider or any individual employed by or under contract with the Provider taken by any state or federal agency responsible for Provider licensing, certification, or the payment for health care services.

2.8 Carrier Discretion with Respect to Credentialing. The Carrier represents that it complies with all Regulatory Requirements related to provider credentialing. The Carrier has full discretion to grant or deny credentialing approval or take any disciplinary action relative to the credentialing approval of the Provider based on clinical quality issues or any other matters deemed relevant by the Carrier. Without limitation to any of the foregoing, the Carrier shall have the right to terminate immediately the Provider's credentials and participation under this Agreement in the Carrier's networks, or to take such other disciplinary action as it deems appropriate, for the following reasons:

2.8.1 suspension, termination or non-renewal of a license of the Provider,

2.8.2 acts or omissions which threaten the life, health or safety of a patient or patients,

2.8.3 failure to meet standard of care as required for Carrier Providers and determined by the Carrier,

2.8.4 repeated failure to comply with accepted ethical and professional standards of behavior;

2.8.5 provider inactivity as described in Subsection 2.16.3;

2.8.6 dissolution or sale of substantially all assets;

2.8.7 institution of proceeding in bankruptcy, insolvency, assignment for benefit of creditors or other action generally to

secure rights of creditors; or

2.8.8 failure to provide credentialing or recredentialing information to the Carrier upon request.

Any decision by the Carrier to deny, non-renew, or withdraw the credentials of Provider, or to terminate the credentials of Provider, shall be in writing, shall state the reasons for such termination, and, shall include notice of a Provider's right to an appeal.

2.9 Compliance with Carrier Policies and Procedures. Provider agrees to abide by and cooperate with Carrier's Provider Manual, and all other Policies and Procedures established and implemented by Carrier, including, without limitation, Policies and Procedures relating to credentialing, Utilization Management, Quality Management and improvement, the delivery of preventive health services, claims submission, cost sharing collections, confidentiality of Provider, patient and Carrier information, duplicate coverage, and subrogation recoveries. In the event of any conflict between Carrier Policies and Procedures and this Agreement, the terms of this Agreement will prevail. The Carrier may, at its discretion and at any time, amend the Provider Manual, its Policies and Procedures, and any other programs or administrative policies and procedures, such changes to be binding upon Provider; provided further, that Provider shall be notified in writing of modifications in Covered Services or modifications in the Carrier's procedures, documents or requirements including those associated with Utilization management, Quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided 60 days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Carrier and Provider.

2.10 Publication and Use of Provider Information. Provider agrees that Carrier or its designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, compensation rates, and information related to Provider for transparency initiatives.

2.11 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the Parties agree that they may identify Provider as a participant in the Network(s) in which Provider participates.

2.12 Cooperation Regarding Member Complaints and Grievance Procedures. Provider agrees to cooperate with Carrier in the review and resolution of Member complaints or grievances that may arise relating to the provision of Covered Services to Members including but not limited to providing any information or records needed to render a decision on a complaint or grievance. Provider agrees to provide such information and records with sufficient promptness to allow the Carrier to meet state and federal regulatory requirements for timely processing of Member complaints and grievances. It is understood that certain complaints and grievances must be processed by the Carrier on an expedited basis. The Carrier and Provider agree that complaints received by the Carrier or the Provider with respect to the provision of Covered Services shall ultimately be resolved in accordance with the Carrier's grievance procedures or upon external review under RSA 420-J:5-a through 420-J:5-e. The Carrier will forward to Provider copies of any such complaints or grievances, upon Provider's request and to the extent necessary for Provider to comply with this Section. Provider agrees, to the extent permitted by Regulatory Requirements, to fully advise the Carrier of any Member complaint, grievance or claim known to Provider relating to services provided under this Agreement.

2.13 General Cooperation Requirement. Provider shall also cooperate with Carrier and Carrier Affiliates in implementing those policies and programs as may be reasonably requested by Carrier or a Carrier Affiliate for purposes of Carrier's or the Carrier Affiliate's business operations or required by Carrier or a Carrier Affiliate to comply with Regulatory Requirements or accreditation requirements.

2.14 Records. Provider shall maintain medical records and documents relating to Members as may be required by Regulatory Requirements and for the period of time required by law. Medical records of Members and any other records containing individually identifiable information relating to Members will be regarded as confidential, and Provider and Carrier shall comply with applicable

federal and state law regarding such records. Provider will obtain Members' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Carrier with a copy of Members' medical records and other records maintained by Provider relating to Members. These records shall be provided to Carrier at no charge and within the timeframes requested by Carrier and will also be made available during normal business hours for inspection by Carrier, Carrier's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement.

2.15 Participation in Networks Supporting Commercial Business. Provider will render Commercial Business Covered Services to Commercial Business Members in accordance with the terms and conditions of this Agreement. Provider agrees to participate in all of Carrier's Commercial Business networks.

2.16 Provider Directory Updates, Name Use, Inactivity, and Provider Directory Suppression.

2.16.1 Provider Directory Updates. Provider shall cooperate with Carrier's efforts to maintain accurate provider directories by complying with Regulatory Requirements and the Carrier's Policies and Procedures, including those set forth in the Provider Manual, for verification of provider directory information related to Provider and advance notification requirements for any changes to Provider and/or Provider's Provider contact and demographic information, including without limitation, digital contact information, with specification as to each location in which each Provider regularly provides services to patients, specialty, any medical group and/or Facility affiliations, Facility accreditation status, any languages spoken other than English, and board certification(s).

2.16.2 Name Use. Provider agrees that the Carrier may use Provider's demographic information including without limitation, Provider's name(s), address(es), telephone number(s), website/URL(s), digital contact information, a description of Facilities, a description of care and specialty

services provided, as may be appropriate and necessary in advertising of the Carrier, provided that such advertising shall be done in accordance with Regulatory Restrictions. The Carrier agrees that, with the prior written consent of the Carrier, Provider may use the Carrier's name in statements or announcements that Provider accepts the coverage of Carrier Members.

2.16.3 Provider Inactivity. In accordance with applicable Carrier Policies and Procedures, the Carrier may terminate a Provider that has not, (i) verified their provider directory information or provided other information required by the Carrier or Regulatory Requirements or (ii) provided services to patients or submitted a claim for services for a period of two years. Under such circumstances, Provider may reapply to become a participating provider through the Carrier's standard credentialing and enrollment processes set forth in Carrier Policies and Procedures.

2.16.4 Provider Directory Suppression. The Carrier may suppress provider directory information (i) that cannot be verified by the Carrier as described in the Provider Manual, (ii) to the extent required by Regulatory Requirements, (iii) where Carrier deems a Provider terminated from the network if such Provider has not verified such information as required under the Provider Manual and has no activity in the Carrier's system for more than two years, or (iv) as otherwise required by Carrier to ensure accurate claims processing and benefit administration.

2.17 Referral Incentives/Kickbacks Prohibited. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Carrier.

2.18 Member Incentives Prohibited. Provider shall not directly or indirectly establish, arrange, encourage, participate in or offer any Member incentive. Participant Incentive means any arrangement by

Provider to:

2.18.1 reduce or satisfy a Participant's Cost-Sharing obligations;

2.18.2 pay on behalf of or reimburse a Member for any portion of the Member's costs for coverage under a policy or plan insured or administered by Carrier or a Carrier Affiliate; or

2.18.3 to provide a Member with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from Provider or its affiliates.

In the event of non-compliance with this provision: Carrier may terminate this Agreement, such non-compliance being a "material breach" of this Agreement; Provider shall not be entitled to reimbursement under this Agreement with respect to Covered Services provided to a Member in connection with a Member incentive; and Carrier may take such other action appropriate to enforce this provision.

2.19 Provider Service or Organizational Changes. Provider shall notify the Carrier in writing in accordance with the Notice section of this Agreement at least 90 days prior to any significant service or organizational change that occurs after the Effective Date of this Agreement, whether or not such change is occurring as a result of a merger, acquisition, affiliation or any other formal or informal business combination, including without limitation: (i) any action to sell, transfer or convey its business or any substantial portion of its business assets to another entity, or when Provider is the subject of a sale, transfer or conveyance of its business by another entity, (ii) when Provider enters into a management contract with another entity to deliver any new type of Covered Service not previously provided by Provider, (iii) when Provider contracts to deliver of any Covered Services provided by Provider in additional facilities or practice locations, and/or (iv) when there is significant growth or other changes impacting the size of the Provider, including through merger, acquisition, or changes to any of Provider’s affiliations. Such service or organizational changes are not automatically included under the terms of this Agreement and any inclusion thereof shall require mutual written agreement by the Parties. If Provider fails to timely notify Carrier of a service or organizational

change falling under this paragraph, then Carrier may include or exclude the new service or organizational composition under this agreement by serving notice on Provider under the Notice section of this Agreement. However, Carrier will accept any new service or organizational composition of Provider as coming under this Agreement if Provider remains qualified and willing to accept the terms of the Standard Ground Ambulance Provider Contract.

3.0 COMPENSATION

3.1 Submission and Adjudication of Claims. Provider shall submit, and Carrier shall adjudicate, claims in accordance with the Carrier's Claims Payment Policies and Procedures as detailed in the Provider Manual and other Carrier Policies and Procedures as may be issued by the Carrier from time to time. Claims for payment for Covered Services to Members shall not be payable under this Agreement if not submitted to the Carrier in accordance with such Policies and Procedures.

3.2 Non-Medically Necessary Services. Provider shall not charge a Member for a service that is not Medically Necessary unless, in advance of providing the service, Provider has notified the Member in writing that the particular service will not be covered by Carrier and the Member acknowledges in writing that he or she will be responsible for payment for such service.

3.3 The Standard Ground Ambulance Rate Schedule. The Standard Ground Ambulance Rate Schedule shall apply as provided in Appendix A to Provider compensation for Covered Services to Members with respect to products and Health Benefit Plans offered or maintained by Carrier in its Commercial Business.

3.4 Applicability of the Rates. The rates in this Agreement apply to all services provided by Provider to Members in the products and Health Benefit Plan types covered by this Agreement, including services covered under a Member's in or out-of-network benefits (e.g. PPO or POS plans), and whether the Payor or Member is financially responsible for payment.

3.5 Cost Sharing. Provider shall be solely responsible for the collection of all applicable Cost Sharing from Members, subject to the Carrier

Policies and Procedures. Provider agrees to make reasonable efforts to verify Cost Sharing amounts prior to billing for such amounts. The Carrier shall have no responsibility for payment or collection of such Cost Sharing and any such amounts payable by Members for Covered Services will be debited against amounts owed to Provider under this Agreement.

3.6 Effect of Member Coverage as of the Date of Service. The Payor will be responsible for payment for Covered Services if the patient is an active Member and eligible for such service on the date of service. The Carrier, on behalf of itself and the Payor, reserves the right to deny or recover payment if, after receipt of a claim, it is determined that the patient was not a Member on the date of service unless the patient was entitled to an extension of benefits by operation of law. Provider may bill such patient or his or her third party insurance carrier directly for those non-reimbursed services furnished to such patient.

3.7 Payment in Full and Hold Harmless.

3.7.1 Provider will look solely to the Payor for payment of Covered Services provided to Members. Except when the Carrier is also the Payor, the Parties hereto acknowledge that the Carrier shall act solely as the Payor's payment agent hereunder. Carrier is not the insurer, guarantor or underwriter of the liability of such Payor for benefits provided to or under Self-Insured Plans, provided, however, that the Carrier is not relieved of its responsibility under its contracts with such Payors to administer payment to Provider for Covered Services rendered to Self-Insured Plan Members. Provider agrees to accept as payment in full, in all circumstances, the amount that is required under this Agreement whether such payment is in the form of a Cost Sharing, a payment by Carrier, or a payment by another source, such as through coordination of benefits or subrogation. In no event shall Carrier be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the amount that is required under this Agreement less Cost Sharing payments or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the amount that is required under this Agreement as payment in full even if the Member has not yet satisfied his/her

deductible.

3.7.2 Provider agrees that in no event, including but not limited to nonpayment by the Carrier or intermediary, insolvency of the Carrier or intermediary, or breach of this Agreement, shall the Provider (or its assignees or subcontractors) have the right to seek any type of payment from, bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a Member or a person acting on behalf of the Member (other than the Carrier or intermediary) for Covered Services provided pursuant to this Agreement, except for the collection of Cost Sharing for services covered by the Health Benefit Plan, whether or not compensation has actually been received by the Provider for such Services or whether or not this Agreement remains in effect. This agreement does not prohibit the Provider from collecting fees for uncovered services delivered on a fee-for-service basis to Members. Nor does this Agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the Member, as long as the Provider has clearly informed the Member that the Carrier may not cover or continue to cover a specific service or services. Covered Services which the Provider is prohibited from billing Members for shall include services denied by the Carrier pursuant to its utilization management Policies and Procedures for failure to meet the Carrier's Medically Necessary criteria and/or administrative denials issued by the Carrier pursuant to Carrier Policies and Procedures. Provider's sole redress shall be against the assets of the Payor. The requirements of this provision shall survive any termination of this Agreement for services rendered prior to the termination, regardless of the cause of such termination. The Carrier's Members, any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement hereafter entered into between Provider and the Member or any persons acting on the Member's behalf, other than the Carrier, and the employer or group health maintenance contract holder. Except as provided in this Agreement, this agreement does not prohibit the provider from pursuing any available legal remedy.

3.8 Payment Time Frames. For Claims subject to New Hampshire law, Carrier or its designee and Provider shall comply with the requirements of the New Hampshire prompt pay legislation (RSA 420-J:8-a), as may be applicable, for payment of Clean Claims for Covered Services.

3.9 Audits and Carrier Access to Provider Records. The Carrier shall have the right to conduct audits to verify the accuracy of Member bills and compliance with the Carrier's billing guidelines, as set forth in the Provider Manual or in other Carrier Policies and Procedures. The Provider shall cooperate with the Carrier and its auditor in accordance with the procedures set forth in the Provider Manual or in other Carrier Policies and Procedures. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the Provider Manual and/or other Carrier Policies and Procedures, shall permit Carrier or its designees to have, with appropriate working space and without charge, on-site access to and the right to examine, copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Carrier in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of Claims coding and payment, risk adjustment assessment as described in the Provider Manual, and compliance with this Agreement. In lieu of on-site access, at Carrier's request, Provider or its designees shall submit records to Carrier, or its designees via photocopy or electronic transmittal, within 30 days, at no charge to Carrier from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Provider acknowledges that failure to submit records to Carrier in accordance with this provision and/or the Provider Manual, and/or other Carrier Policies and Procedures may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.10 Reimbursement of Amounts Collected In Error From a Member. If Provider collects payment from a Member when not permitted to collect under either this Agreement or the Policies and Procedures, Provider must repay the amount within 2 weeks of a request from Carrier or the Member or of the date Provider has knowledge of the error. If Provider fails to make the repayments, then Carrier may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments to Provider.

3.11 Carrier Offset Rights. Carrier shall be entitled to recoup, offset and adjust an amount equal to any erroneous payments (including, but not limited to, any improper payment, duplicate payment, or overpayment) made by Carrier to Provider against any payments due and payable by Carrier to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all erroneous payments regardless of the cause, including, but not limited to, payments for claims where the claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Carrier that any erroneous payment is due from Provider, Provider must refund the amount to Carrier within 30 days of when Carrier notifies Provider. If such reimbursement is not received by Carrier within the 30 days following the date of such notice, Carrier shall be entitled to offset such erroneous payment against any payments due and payable by Carrier to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. Should Provider disagree with any determination by Carrier that Provider has received an erroneous payment, Provider shall have the right to appeal such determination under Carrier's procedures set forth in the Provider Manual, and such appeal shall not suspend Carrier's right to recoup the erroneous payment amount during the appeal process, unless suspension of the right to recoup is otherwise required by Regulatory Requirements. Carrier reserves the right to employ a third-party collection agency in the event of non-payment.

3.12 Underpayments. If Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Carrier or its designee within the timeframe and in accordance with the process as set forth in the Carrier’s Provider Manual and other Policies and Procedures. The request may be

further pursued as set forth in Sections 5.11 and 5.12 below. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill the Carrier, the Payor or the Member for those services.

3.13 Coordination of Benefits. Certain claims for Covered Services are claims for which another Payor may be primarily responsible under Coordination of Benefit (COB) rules. Provider may pursue those claims in accordance with the process set out in the Carrier's Policies and Procedures.

3.13.1 Carrier's Payment as Secondary Payor (Non-Medicare). Carrier's payment, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under this Agreement, and is subject to the terms and conditions of the Member's Health Benefit Plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Carrier that, when added to the amount payable from other sources, is less than 100 percent of the payment for Covered Services under this Agreement.

3.13.2 When Medicare is the Primary Payor. When the Carrier is the secondary payor to Medicare, Provider and Carrier are required to follow Medicare billing rules. Payment will be made in accordance with all applicable Medicare requirements, including but not limited to Medicare COB rules. The Medicare COB rules require Carrier's financial responsibility as the secondary payor to be limited to the Member's financial liability (i.e., the applicable Medicare copayment, coinsurance, and/or deductible) after application of the Medicare-approved amount. The Medicare payment plus the Member liability (applicable Medicare copayment, coinsurance, and/or deductible) amounts constitute payment in full, and Provider is prohibited from collecting any monies in excess of this amount.

4.0 TERM AND TERMINATION

4.1 Term of This Agreement. This Agreement begins on the Effective Date and continues from year to year unless terminated as set forth

below.

4.2 How This Agreement Can Be Terminated. Provider can terminate this Agreement at any time by providing at least 90 days advance written notice. Carrier can terminate this Agreement immediately for good cause (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform its duties under this Agreement or Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Provider or Carrier from obligations under this Agreement prior to the effective date of termination and from all other provisions of this Agreement that, by their own terms, survive the termination of this Agreement.

4.3 Continuing Coverage. As required under Regulatory Requirements, NCQA accreditation standards, and the applicable Health Benefit Plan, the Carrier and the Provider shall permit a Member enrolled in Commercial Business coverage to continue to receive Covered Services from Provider, and Provider shall continue to provide such Covered Services for a certain period of time following termination of such Provider's participation under this Agreement, as follows:

4.3.1 Member Continued Access Rights Post Termination. As provided in RSA 420-J:8 XI and RSA 420-J:7-d, Members with Fully Insured coverage will have continued covered access to Provider's services in the event of the termination of this Agreement. The continued access shall be made available by Provider for 60 days from the date of termination of this Agreement (and for an additional 60 days thereafter if so ordered by the New Hampshire Insurance Commissioner) and shall be provided and paid for in accordance with the terms and conditions of the Member's Health Benefit Plan and this Agreement. Within 5 business days of the termination of this Agreement, Carrier shall provide written notice to affected Members explaining their continued access rights.

4.3.2 Continuity of Care. Carrier and Provider shall permit a Member who is in an active course of treatment, pregnant, or terminally ill ("Continuing Care Patient") to receive Continuity

of Care in connection with the active treatment, pregnancy, or terminal illness. The Continuity of Care for active course of treatment continues until the earliest of the following: (i) for up to 90 days following the date the Member received notice of the terminated Provider; (ii) the date the Member is no longer undergoing an active course of treatment with the terminated Provider as a Continuing Care Patient; (iii) the date that care is successfully transitioned to another Provider; (iv) the date benefit limitations under the Member's Health Benefit Plan are met or exceeded; or (v) the date the Carrier determines the care is no longer Medically Necessary. The Continuity of Care for Members who are terminally ill continues until the Member's death. The Continuity of Care for Members who are pregnant continues through the post-partum period as defined by NCQA accreditation standards. Continuity of Care begins on (i) the effective date of the termination of Provider's participation under this Agreement or (ii) the date of the Member notice of such termination, whichever is later. The Provider agrees to cooperate with the Carrier in promptly determining, as necessary, which Members may be informed of their eligibility to receive Continuity of Care. Provider providing Covered Services pursuant to this Section must accept payment at the reimbursement and other financial terms as provided in this Agreement and in the Member's Health Benefit Plan as payment in full and must not seek any payment from the Member for such Covered Services, except for any applicable Cost Sharing. Provider must adhere to all other terms and conditions of this Agreement including, but not limited to, compliance with quality standards, the Carrier's procedures regarding Referral and obtaining prior Authorizations, and compliance with other Carrier Policies and Procedures. The Carrier's Continuity of Care obligations set forth in this section shall not apply in instances where a Provider's termination from participation under this Agreement is based upon quality related issues or fraud.

5.0 GENERAL PROVISIONS

5.1 Confidentiality. As a result of this Agreement, Provider may have access to certain of Carrier's confidential and proprietary

information. Provider shall hold such information in confidence and will not use or disclose such information to any person without the prior written consent of Carrier except as may be required by law. This provision shall not be construed to prohibit Carrier from disclosing information to Carrier Affiliates or the agents or subcontractors of Carrier or Carrier Affiliates or from disclosing the terms and conditions of this Agreement, including reimbursement rates, to existing or potential Payors, Members or other customers of Carrier or Carrier Affiliates or their representatives. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

5.2 Independent Parties. In entering into this Agreement and in the performance of the duties described herein, Provider and its employees are acting as independent contractors of the Carrier. Carrier and Provider do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Provider's participation in care collaboration, population health management, pay for performance, Quality Management, Utilization Management, and other similar programs, nor any coverage determination made by Carrier or a Payor, is intended to interfere with or affect Provider's independent judgment in providing health care services to its patients. Nothing in the Agreement is intended to create any right for Carrier or any other party to intervene in or influence Provider's medical decision-making regarding any Member.

5.3 Indemnification. As Carrier and Provider are independent contractors, and not employees, agents or representatives of each other, Carrier and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Carrier nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Carrier from any and all third party claims, liabilities and causes of action (including, but not limited to,

reasonable attorneys' fees) arising out of Provider's provision of care to Members. Carrier agrees to indemnify and hold harmless Provider from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Carrier's administration of Plans. This provision will survive the termination of this Agreement

5.4 Subcontractor Compliance. All subcontracts or written agreements for the provision of Covered Services to Members entered into by Provider with other providers must set forth requirements for compliance with all regulatory and NCQA requirements set forth herein and Carrier's Policies and Procedures. Such subcontracts or other written agreements, or a form of such subcontracts or other written agreements, including the reimbursement methodology shall be provided to the Carrier upon request. Provider may not use any method of reimbursement in its subcontracting arrangements which acts as an incentive to withhold medically necessary services to Members. Provider shall provide at least 90 days prior notice to the Carrier of Provider's intent to execute, amend or terminate any such subcontracts entered into for the purpose of providing Covered Services to Members.

5.5 Liability Insurance. Provider shall procure and maintain professional, including medical malpractice, and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are, at a minimum, commensurate with prevailing industry standards or licensing or accreditation standards and which are no less than the following amounts: $1,000,000 per occurrence/ $3,000,000 in the aggregate. The Carrier shall procure and maintain professional and comprehensive general liability insurance (or equivalent self-insurance) in amounts that are commensurate with prevailing industry standard or licensing or accreditation standards. All insurance coverage obligations under this Section shall cover any claim arising during the term of this Agreement, even if not made or communicated until after the term of this Agreement. The Parties agree to provide, upon request, certificates of such insurance to each other. The Parties shall immediately report to the other any lapse or modification in any such coverage.

5.6 Governing Law. This Agreement shall be construed in accordance with the laws of the State of New Hampshire and applicable federal

law.

5.7 Notices. Notices required under this Agreement shall be in writing and shall be deemed to have been duly given (i) on the third day after deposit in the United States mail, postage prepaid, and properly addressed as specified below; or, (ii) on the date of delivery if sent via overnight delivery to the party to whom notice is to be given and properly addressed as specified below; or (iii) on the date of service if served personally on the party to whom notice is to be given. Having provided notice as described above, the Parties may also notify each other by sending an electronic notice with automatic receipt verification to the other Party's e-mail address listed below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

The proper address for notices under this Agreement is as follows:

If to Carrier:
Boston Medical Center Health Plan, Inc.
100 City Square, Suite 200
Charlestown, MA 02129
Attention: Chief Financial Officer

with a copy to:

Boston Medical Center Health Plan, Inc.
100 City Square, Suite 200
Charlestown, MA 02129
Attention: Chief Legal Officer

Email Address: LegalDL@wellsense.org

If to Provider:
City of Portsmouth New Hampshire
1 Junkins Ave
Portsmouth, NH 03801
Attention: Jason Gionet

Email Address: jmgionet@portsmouthnh.gov

5.8 Compliance With Regulatory Requirements. The Carrier shall comply with all Regulatory Requirements, and Provider agrees to assist the Carrier in complying therewith and to take no action that would put the Carrier in violation of Regulatory Requirements. During the Term of this Agreement, Provider shall comply with any Regulatory Requirements governing its operations, contracts, all reporting requirements and deadlines, and any obligations related to fraud, waste, and abuse. Provider shall further ensure that all Provider's individual service providers are licensed as required by Regulatory Requirements.

5.9 Assignment and Delegation. Except as specifically provided in this Agreement, neither Carrier nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Carrier includes any successor in interest and Carrier may assign its duties, rights and interests under this Agreement in whole or in part to an Affiliate of Carrier or may delegate any and all of its duties to a third party in the ordinary course of business.

5.10 Non-Exclusivity. This Agreement is non-exclusive. The Carrier may contract with other ground ambulance providers and Provider may contract with other insurers and third-party payers.

5.11 Dispute Resolution. Any dispute that might arise between the Parties regarding the performance or interpretation of the Agreement or that is related in any way to this agreement shall be resolved using the dispute resolution and arbitration procedures set forth below. A dispute must first be addressed through the applicable internal dispute resolution process outlined in the Provider Manual and other Carrier Policies and Procedures. In the event the dispute is not resolved through the internal dispute resolution process, either party can request in writing that the Parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the Parties who have authority to settle the dispute. If the matter is not resolved within 120 days of such a request, or such shorter timeframe as may be mutually agreed upon, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute (excluding termination with notice), Provider must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under Carrier's

internal dispute resolution process unless applicable law specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, Carrier's final decision under its internal dispute resolution process will be binding on Provider, and Provider shall not bill Carrier, the Payor or the Member for any payment denied because of the failure to timely submit a request for arbitration.

5.12 Arbitration. Any dispute or claim arising out of or relating to the Agreement, including breach, termination, or validity of the Agreement, that is not resolved through internal dispute resolution will be settled by confidential, binding arbitration. The arbitration shall be conducted in accordance with the Rules of the American Arbitration Association then in effect, and which, to the extent of the subject matter of the arbitration, shall be binding not only on all Parties to the agreement, but on any other entity controlled by, in control of or under common control with the party to the extent that such affiliate joins in the arbitration, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages, and the arbitrator may award only actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whether arising in contract, tort, or otherwise arising out of this Agreement. The Parties recognize that in the event of a breach by either party of any obligations under this Agreement or other violations of the other party's rights in connection with this Agreement, the damage caused, if any, is not irreparable or sufficient to entitle the other party to injunctive relief. The Parties, on behalf of themselves and those that they may now or hereafter represent, each agree to waive their right to seek injunctive relief and further agree that the arbitrator(s) are not authorized to issue injunctive relief. Each party shall assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs shall be borne equally by the Parties. The decision of the arbitrator shall be final, conclusive and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator. The Parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision shall not be consolidated with an arbitration involving

other Parties, and that the arbitrator shall be without power to conduct an arbitration on a class basis. This section shall survive the termination of this Agreement.

5.13 Communications with Members. The Parties acknowledge and agree that no term or condition of this Agreement shall be construed to prohibit Provider from freely and in good faith communicating with a Member regarding the provisions, terms or requirements of the Member's Health Benefit Plan as they relate to the Member's needs, any and all available treatment options, including medication treatment options, related to the health care needs of such Member, regardless of the Carrier's benefit coverage exclusions or limitations or any terms or conditions relating thereto. The Carrier agrees that it shall not refuse to contract with or compensate Provider if otherwise eligible, solely because Provider (a) communicated with or advocated on behalf of one or more prospective, current or former Member(s) regarding the provisions terms or requirements of the Member's Health Benefit Plan as they relate to the needs of such Member(s); or (b) communicated with one or more prospective, current or former Member(s) with respect to a member's internal grievance procedure or external review.

5.14 Referrals. As provided in RSA 420-J:8 XIV, if Provider is employed by a hospital or any hospital affiliate, Provider shall not be required or in any way obligated under this Agreement to refer patients to providers also employed or under contract with the hospital or any affiliate.

5.15 Force Majeure. In the event that performance by either Carrier or Provider of any covenant, duty or obligation imposed under this Agreement becomes impossible or impracticable because of the occurrence of an event of force majeure, including, without limitation, acts of war, insurrection, civil strife and commotion, labor unrest, sentinel event, epidemic, or acts of God, then performance of such covenant, duty or obligation by such party shall be excused during the continuance of such event of force majeure; provided, however, that such performance by such party shall be accomplished as soon as reasonably practicable after such event of force majeure has ceased.

5.16 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement/Counterparts/Electronic Signatures. If any party waives

a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This Agreement, including any Appendices to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the Parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement. This Agreement may be executed in 2 or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement. Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Signature Page

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

AGREED AND ACCEPTED BY:

CITY OF PORTSMOUTH NEW HAMPSHIRE	**BOSTON MEDICAL CENTER HEALTH PLAN, INC., D/B/A WELLSENSE HEALTH PLAN**
_____	_____
Signature	Signature
_____	DARREN J. BENNETT
Printed Name	Printed Name
_____	CHIEF FINANCIAL OFFICER
Title	Title
_____	_____
Date Signed	Date Signed

02-0310679
Federal Tax ID

1457339152
National Provider Identifier

APPENDIX A

REIMBURSEMENT FOR SERVICES PROVIDED: CARRIER'S COMMERCIAL BUSINESS

This Appendix A sets forth compensation to Provider for Covered Services provided to all Members enrolled in the Carrier's Commercial business.

In consideration for Provider's provision of Covered Services to Members, Carrier shall pay Provider and Provider shall accept as payment in full, reimbursement in accordance with the Standard Ground Ambulance Rate Schedule as follows. As provided under RSA 420-J:21 I:

a. For the period beginning January 1, 2026, and continuing through December 31, 2027, except as provided in paragraph b below, the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule equal to 3.25 times the Medicare rate as defined in 42 CFR Part 414 Subpart H and any subregulatory guidance issued by the Centers for Medicare & Medicaid Services.

b. For the period beginning January 1, 2026, and continuing through December 31, 2027, if it is determined by the New Hampshire Insurance Commissioner that the Provider has failed, after due notice and opportunity to cure, to cooperate with the New Hampshire ground ambulance cost study as provided in RSA 420-J:26 IV by failing to substantially comply with cost data submission requirements or requirements to facilitate data validation or cost report auditing requirements, then the Provider shall be reimbursed for ground ambulance services at a temporary rate schedule which shall be at the carrier's nonparticipating rate or at the Medicare rate that is current as of the date of service, whichever is higher. This rate schedule shall continue until it is determined by the Commissioner that Provider is in substantial compliance with the requirements of the cost study or until December 31, 2027, whichever is earlier.

c. Beginning January 1, 2028, and continuing thereafter, Carrier shall reimburse Provider for covered ground ambulance services according to the cost-based rate schedule established and published by the New Hampshire Insurance Commissioner under RSA 420-J:21 I (b) and as revised annually under RSA 420-J:21 I (c).

The Standard Ground Ambulance Rate Schedule shall apply to all Networks, products, and Health Benefit Plans offered or maintained by Carrier in its Commercial Business.

Any payment made by the Carrier will be subject to the Carrier's Policies and Procedures, less any Cost Sharing amounts, which shall be the sole responsibility of the Member.