

PROVIDER AGREEMENT

AETNA HEALTH INC. D/B/A AETNA BETTER HEALTH OF OHIO, on behalf of itself and its Affiliates (“Company”), and **[INSERT PROVIDER NAME]**, on behalf of itself and any and all of its Group Providers and locations (“Provider”), are entering into this Provider Agreement (the “Agreement”) as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** and **Definitions** that follow, and the **Medicaid Product Addendum**. It also includes and incorporates one or more of the following parts: **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, other **Product Addendum(a)**, or other attachments or addenda.

PRODUCT CATEGORIES:

As of the Effective Date, Provider agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in the Agreement.

✓ **Medicaid Products (as defined in the Agreement)**

EFFECTIVE DATE: [DATE] (or later date that credentialing is complete) (the “Effective Date”)

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days’ advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider has read and understood this Agreement, has had the opportunity to review it with an attorney of Provider’s choice, and is authorized to bind Provider, including all Group Providers and Provider locations, to the terms of the Agreement.

PROVIDER

By: _____

Printed Name: _____

Title: _____

FEDERAL TAX I.D. NUMBER: _____

NPI NUMBER: _____

COMPANY

By: _____

Printed Name: _____

Title: _____

As required by Section 8.6 (“Notices”) of this Agreement, notices shall be sent to the following addresses:

Provider:

Company:

Aetna Health Inc. d/b/a Aetna Better Health of Ohio
7400 W Campus Rd., New Albany OH 43054
ATTN: Plan Chief Executive Officer

GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 **General Obligations.** Provider agrees that it and all Group Providers will:

- (a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;
- (b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;
- (c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);
- (d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;
- (e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;
- (f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;
- (g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;
- (h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;
- (i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;
- (j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);
- (k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;
- (l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

- (m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (ii) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (iii) change in the ownership or management of Provider; and (iv) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.
- (n) The provider will report to Aetna immediately, but no later than one business day after discovering any critical incidents defined in paragraphs (E)(1) through (E)(5) of rule 5160-44-05 of the Administrative Code, as well as all deaths for a youth enrolled on the OhioRISE program. Additionally, upon discovering the incident, the provider will take immediate action to ensure the health and welfare of the individual.

1.2 **Provider and Group Provider Contact and Service Information.** Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers and Provider locations, that is complete and accurate as of the Effective Date. Provider will notify Company within ten (10) business days of all changes to the list of Group Providers, the services it/they provide and all contact and billing information for Provider and Group Providers. Provider understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's additional requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.3 **Compliance with Company Policies.** Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment.** Subject to Applicable Law, Provider agrees:

- (a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));
- (b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;
- (c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within three hundred sixty five days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;
- (d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

- (e) to notify Company of any underpayment or payment/claim denial dispute within no later than 12 months from the date of service or 60 calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later and to follow Company's dispute and appeal Policies for resolution;
- (f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;
- (g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;
- (h) in the event that Provider acquires or takes operational responsibility for another Participating Provider, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Provider with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.
- (i) Company and the Ohio Department of Medicaid (ODM) have the right to audit or review its paid claim, and recover any identified overpayments as allowed under ODM's Ohio Resilience Through Integrated and Excellence (OhioRISE) Plan Provider Agreement with the company and Ohio Revised Code (ORC) 5164.57.

1.5 **Member Billing.** Provider agrees that Members will not be billed or charged any amount for Covered Services. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations.** Company agrees that:

- (a) unless an exception is stated in the applicable **Product Addendum**, Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;
- (b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;
- (c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;
- (d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment.** Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and Company agrees:

- (a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and

(b) when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services,

within twenty-one (21) days of receipt of a clean, complete, undisputed ~~electronic~~ claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Provider acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Provider, as appropriate, in collecting payments from Payers.

The Company will notify providers who have submitted claims of claim status (paid, denied, and suspended/ held) within 30 calendar days of receipt.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Provider, to:

- (a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and
- (b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category.

Company will notify Provider of the rates that will apply for any addition and will, as necessary, send Provider a new or revised **Product Addendum** and **Service and Rate Schedule**.

Provider can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate, include, or continue to include Provider, any specific Group Provider(s) or any specific Provider location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation), product, specialty program or geographic area. Company may operate networks in which Provider is not included, whether for specific Payers/customers or otherwise. In certain situations, Provider may treat a Member of a Plan or Product Category in which Provider does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Provider has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required by Applicable Law, Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss

Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

- 5.1 **Termination of Individual Group Providers.** Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.
- 5.2 **Termination for Breach.** This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.
- 5.3 **Immediate Termination or Suspension.** Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.
- 5.4 **Obligations Following Termination.** Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.
- 5.5 **Obligations During Dispute Resolution Procedures.** In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

- 6.1 **Independent Contractor Status/Indemnification.** Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Company 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 Company 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 and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

- 6.2 **Use of Name.** Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent.
- 6.3 **Interference with Contractual Relations.** Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

- 7.1 **Dispute Resolution.** Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.
- 7.2 **Arbitration.** Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars (\$10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars (\$10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of \$250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any

court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

- 8.1 **Entire Agreement.** This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.
- 8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings.** The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.
- 8.3 **Limitation of Liability.** 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. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.
- 8.4 **Assignment.** Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.
- 8.5 **Amendments.** This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Additionally, Company may amend this Agreement, upon at least ninety (90) days prior written notice to Provider. If Provider is not willing to accept an Amendment that is not required by Applicable Law, it may terminate the Agreement, with at least sixty (60) days written notice to Company in advance of the effective date of the Amendment.
- 8.6 **Notices.** Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable

Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

- 8.7 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider: (a) employed by Provider; or (b) who, through a contract or arrangement with Provider, provides services to Members for which Provider is reimbursed under this Agreement or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this “Addendum”), the capitalized terms “Plan(s)” and “Product Category(ies)” shall each include “Medicaid Products”, as defined in the **Service and Rate Schedule (Medicaid Products)**.

1. **Definitions.**
 - a. **Government Sponsor(s).** A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.
 - b. **State Contract(s).** Company’s contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.
2. **Payment for Covered Services.** The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate’s duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.
3. **Overpayments to Provider.** If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company’s other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.
4. **Medicaid Product/State Contract Requirements.** Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Product)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.
5. **The Federal 21st Century Cures Act (“Cures Act”).** Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.
6. **Government Approvals.** One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the “Government Approvals”). Provider acknowledges and agrees that all Company

obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products.

7. **Immediate Termination or Suspension Due to Termination of State Contract.** This Agreement and/or Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.
8. **Termination of Medicaid Products.** Company may exercise its for cause and immediate termination rights in the Agreement as to, and may terminate without cause with ninety (90) days prior written notice, one or more specific Medicaid Products, in which case the Agreement between Company and Provider with respect to all other Medicaid Products shall remain in full force and effect. Company may exercise its termination rights under the Agreement with respect to this Addendum. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following (all together, the “Medicaid Product(s)”):

- A. The Medicaid and/or CHIP Plans and/or any other publicly funded or subsidized managed care programs for low-income, uninsured, underinsured or otherwise qualified individuals offered by Company within the State, including specifically the program for complex behavioral health and multi-system needs known as “OhioRISE (Resilience through Integrated Systems and Excellence)” or its successor(s).
- B. The fully integrated Medicare-Medicaid Plans (a/k/a MMPs) offered by Company within the State.
- C. Any other Medicaid Products included in the **State Compliance Addendum (Medicaid Products)** incorporated into this Agreement.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider’s actual billed charges, whichever is less:

Medicaid and/or CHIP Plans:	Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans:	Aetna Medicare-Medicaid Plan Market Fee Schedule

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

- A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.
- B. Aetna Medicare-Medicaid Plan Market Fee Schedule (AMMPMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable Medicare Allowable Payment (Inpatient Services), Medicare Allowable Payment (Outpatient Services), Dialysis Services Payment, Home Health Care Services Payment, or Medicare Physician Fee Schedule (as applicable).
- C. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Operating Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and adjustments due to Company payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.
- D. Medicare Allowable Payment (Outpatient Services) is defined as the current payment that Provider will receive from Company for outpatient services or procedures, pursuant to the Outpatient Prospective Payment System (OPPS), where applicable payment for these services is geographically adjusted using the provider-specific wage index. The Medicare Allowable Payment (Outpatient Services) is subject to Company’s payment and processing guidelines and is final and will not be impacted by cost settlements, reconciliations, or any other retroactive adjustments performed by a Medicare Administrative Contractor (MAC) for both overpayments and underpayments. Pursuant to CMS rules, specific revenue codes are packaged when billed without HCPCS codes. Payment for these dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary independent service reported

with an applicable HCPCS codes. Therefore, separate payment will not be made for claims reported with these packaged revenue codes when billed without HCPCS codes. Consistent with this, Company will not make separate payment(s) for packaged revenue codes. Company will follow the OPSS payment updates as published annually by CMS in the OPSS final rule.

- E. Dialysis Services Payment is defined as the current payment that Provider will receive from Company for dialysis services based on CMS's ESRD Prospective Payment System (PPS).
- F. Home Health Care Services Payment is defined as the current payment that Provider will receive from Company for home health care services based on the CMS Home Health prospective payment system (PPS).
- G. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPSS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPSS cap payments, or the CMS conversion factors. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.
- H. Medicare-Medicaid Plans. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Company shall compensate Provider at the AMMPMFS rate. For Covered Services that are *only* covered under Medicaid when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.
- I. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (e.g., Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).
- J. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

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