Health Plans

INDIANA UNIVERSITY HEALTH PLAN
PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement ("Agreement") is effective as of this **1** day of **November**, **2020**, by and between **Indiana University Health Plan Services, LLC,** an Indiana limited liability company ("Health Plan") and **Centrality Behavioral Support Training LLC dba Centrality LLC, a Centria Company**, who is fully licensed and legally authorized to practice medicine or provide healthcare or related services in the State of Indiana ("Provider"). Health Plan and Provider are collectively hereinafter referred to as "parties".

WHEREAS, Provider desires to enter into a services agreement with Health Plan to provide health care services to Covered Persons.

WHEREAS, Health Plan desires to enter into an agreement with Provider whereby Health Care Provider will, in accordance with the terms of this Agreement and the applicable Coverage Plans (as defined herein) provide high quality health care services to Covered Persons.

In consideration of the mutual promises and covenants set forth in this Agreement, the sufficiency of which is acknowledged by both parties, the parties agree as follows:

1. DEFINITIONS

1.1 **Affiliate.** To a party, any entity that controls, is controlled by, or that is under common control with such party now or in the future. For purposes of this provision the term "control" (as used in the terms "control(s)," "controlled" and "under common control with") means either (i) holding fifty percent (50%) or more of the outstanding voting securities of an entity; (ii) having the power to designate a majority of the directors of a corporation or, in the case of unincorporated entities, of individuals exercising similar functions; or, (iii) in the case of an entity without outstanding voting securities, having the right to fifty-one percent (51%) or more of the profits of the entity or the right in the event of dissolution to fifty percent (50%) or more of the assets of the entity or to designate a majority of the directors of the entity.

1.2 **Agreement.** This Agreement between Health Plan and Provider, including all incorporated exhibits, attachments, and amendments hereto, including the Provider Manual, which is incorporated herein by this reference.

1.3 **Applicable Law.** Federal or State laws, rules, regulations, and administrative agency directives, instructions, policy letters, or guidelines from a regulatory agency, and any operational policy letters that govern or regulate the actions of Health Plan or Provider.

1.4 **Billed Charges.** The regular, uniform rate or price Provider determines and submits to Health Plan as charges for Health Services provided to Members. Such Provider Charges shall be no greater than the billed rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or health care benefit payor to accept a different rate or price as payment in full for such services.

1.5 **Claim.** Either the uniform bill claim form or electronic claim form in the format prescribed by Health Plan submitted by a provider for payment for Health Services rendered to a Member.

1.6 **Clean Claim.** Unless another definition is required by Applicable Law, a complete and accurate claim for payment of Covered Services, free of outstanding subrogation, coordination of benefits, required substantiating documentation, or other secondary payer issues, filed in a correct format

electronically or on the appropriate Health Plan designated claim form, and containing all pertinent information as may be required in accordance with applicable statutory and regulatory guidelines.

A clean claim from an institutional provider shall consist of: (a) the UB-04 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Billing Committee ("NUBC"); (b) entries stated as mandatory by the NUBC; and, (c) any State-designated data requirements determined and approved by the Indiana State Uniform Billing Committee and included in the UB-04 billing manual effective at the time of service.

A clean claim for dentists shall consist of the form and data set approved by the American Dental Association.

A clean claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or electronic format as adopted by the National Uniform Claims Committee.

A clean claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs.

1.8 **Coordination of Benefits.** The determination of benefits when a Covered Person is eligible for health care benefits under more than one source of coverage.

1.9 **Coded Service Identifier(s).** A listing of descriptive terms and identifying codes, updated from time to time by the Centers for Medicare and Medicaid Services ("CMS") or other industry source, for reporting Health Services on the CMS 1500 or UB-04 claim forms or their successors. The codes include, but are not limited to, American Medical Association Current Procedural Terminology (CPT®-4), CMS Healthcare Common Procedure Coding System (HCPCS), International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), National Drug Code (NDC), and ADA Current Dental Terminology (CDT), or their successors.

1.10 **Cost Sharing Amount.** Any amount which a Covered Person is responsible for paying to Participating Health Care Provider under the applicable Coverage Plan in connection with the delivery of Covered Services including, but not limited to, any copayment, coinsurance and/or permitted deductible amounts.

1.11 **Coverage Plan.** A program of health care coverage, or network portion thereof, that is offered, administered or developed by Health Plan pursuant to a group, labor and/or association contract, individual contract, government contract (including, but not limited to, government employee and Medicare and Medicaid prepaid product lines and children's health care programs), administrative services only contract and/or an agreement with another health care plan or association of health care plans, and which is set forth in Attachment A as amended.

1.12 **Covered Person.** Any individual who is enrolled in a Coverage Plan and entitled to receive Covered Services.

1.13 **Covered Service(s).** Those medical, hospital and other health care services to which Covered Persons are entitled under the terms of the applicable Coverage Plan or which are required by state or federal law, regulations or mandates, as determined by Health Plan.

1.14 **Effective Date.** The date first set forth above.

1.15 **Emergency Condition.** A medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain that, in the absence of immediate medical attention, could reasonably be expected by a prudent layperson who possesses an average

knowledge of health and medicine to result in any of the following: (i) placing a person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to a person's bodily functions or, (iii) serious dysfunction of a bodily organ or part of a person.

1.16 **Health Benefit Plan.** The document(s) issued by Health Plan or another Payor describing the health benefits covered under a fully-insured, self-funded, or governmental health benefit program.

1.17 **Health Care Provider.** A health professional or any other entity or institutional health care provider who or which is duly licensed in the jurisdiction in which he/she/it practices.

1.18 **Health Plan.** Indiana University Health Plan Services, LLC, the wholly owned subsidiary of Indiana University Health, Inc., or an entity as designated by Health Plan, or another Payor. For purposes of this Agreement, when the term "Health Plan" is used to apply to an entity other than Indiana University Health Plan Services, LLC, then "Health Plan" shall be construed to only mean such other entity.

1.19 **Health Plan Certificate.** The document(s) issued by the Health Plan describing the partially or wholly insured, underwritten, and/or administered, marketed health care benefits, or services program between the Health Plan and an employer, governmental entity, or other entity or individual.

1.20 **Health Plan Rate.** The total reimbursement amount that Provider and Health Plan have agreed upon as set forth in the Payment Exhibit. The Health Plan Rate shall represent payment in full to Provider for Covered Services.

1.21 **Health Services.** Those services or supplies that a health care provider is licensed, equipped, and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

1.22 **HEDIS.** HEDIS, or "Healthcare Effectiveness Data and Information Set" is a health plan performance tool administered by the National Committee on Quality Assurance (NCQA) that measures a health plan's performance against national standards for a member's access to care, the quality of care delivered, and the member satisfaction with the health plan and health plan providers. The collection and evaluation of the performance measures are carried out by the health plan and provider through claims administration, data collection, and reported performance.

1.23 **Investigational/Experimental/Off-label.** Any service or supply that is judged to be Investigational, Experimental, or Off-label at Health Plan's sole discretion. Any supply or drug used must have received final approval to market by the U.S. Food and Drug Administration ("FDA") for the particular indication or application in question. In addition, the amount of any drug or medication used, except those drugs used in the treatment of cancer pain and prescribed in compliance with established statutes pertaining to patients with intractable cancer pain, must be within recommended maximum daily dose or duration established by the FDA or any of the standard reference compendia defined by Health Plan.

1.24 **Medically Necessary or Medical Necessity.** The health care services that a Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing, or treating a condition, disease, illness, injury, or its symptoms, and that are: (i) in accordance with recognized standards of medical practice for the Member's condition, disease, illness, or injury; (ii) clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the patient's condition, disease, illness, injury; and, (iii) not primarily for the convenience of the patient, physician, or other health care provider, and the most appropriate supply or level of service which can, with reasonable safety, be provided to a Member and not more

costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results and, in the context of inpatient services, the Member's medical symptoms or condition requires that the diagnosis, treatment, or service cannot, with reasonable safety, be provided as an outpatient. The foregoing definition of Medically Necessary/Medical Necessity shall be inapplicable to the extent that a different definition is required by government contract, or where any Applicable Law requires a different definition.

1.25 **Member.** Any individual who is eligible, as determined by Health Plan, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, manual(s), notices, and communications related to this Agreement, the term "Member" maybe be used interchangeably with the terms insured, Member, Covered Person, subscriber, dependent spouse/domestic partner, child, or contract holder, and the meaning of each is synonymous with the other.

1.26 **Member Cost Share.** All amounts that a Member is required to pay to a Participating Healthcare Provider under the terms of the applicable Health Benefit Plan in connection with the delivery of a Covered Service. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty, or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

1.27 **NCQA.** The National Committee for Quality Assurance, an accreditation organization for health plan operations.

1.28 **Network.** A health care professional or facility, including hospital, designated by Health Plan to participate in one or more Networks.

1.29 **Panel Status (Open and Closed).** "Panel Status" is the Provider's current status of accepting new Members and patients. A Provider who accepts new Members or patients will have an Open Panel Status, and a Provider who does not accept new Members or patients will have a Closed Panel Status.

1.30 **Participating Provider/Provider.** "Participating Provider" or "Provider" means a Participating Provider, Participating Physician, Participating Physician Group, or any other person, institution, or entity that (i) is duly licensed; or certified to provide the health care services such person or entity is providing under the laws of the State of Indiana; (ii) either directly or indirectly, has entered into a participation agreement with Health Plan to provide Covered Services to Members or is an employee of or under contract with a Participating Provider; and, (iii) is duly credentialed in accordance with the then-current credentialing requirements for the services the Participating Provider provides.

1.31 **Payment Exhibit.** The document(s) attached to or made a part of this Agreement which sets forth the Health Plan Rate(s) and compensation-related terms in which provider participates. The Payment Exhibit may include additional provider obligations and specific Health Plan compensation-related terms and requirements.

1.32 **Payors.** The persons or entities utilizing the Networks pursuant to an agreement with Health Plan and responsible for payment of Covered Services rendered to Members, including but not limited to, self-funded plans, Health Plan enrollees, fully insured plans, third party administrators, and governmental plans including Medicare and Medicaid managed care plans.

1.33 **Preventable Adverse Events.** Any medical occurrence, condition, or injury, unrelated to the underlying condition, resulting from the medical management of the member by Provider.

1.34 **Provider Manual.** A working document, developed and maintained by Health Plan, including associated bulletins and provider notices, which defines certain terms of this Agreement and provides specific guidelines and direction for carrying out the responsibilities of Participating Providers. Any such document may be updated from time to time, and may be provided by Health Plan in an electronic format and made available upon request or posted on Health Plan's website.

1.35 **Program Requirements.** Those policies, protocols and procedures which are established and updated by Health Plan from time to time to assist in the administration of one or more Coverage Plans, including, but not limited to, Covered Person eligibility verification, claims submission criteria, Quality Assurance and Quality Management, Utilization Management, the Health Plan drug formulary, credentialing, re-credentialing and Covered Person grievance procedures.

1.36 **Self-Insurer.** An employee benefit plan or similar entity, including, but not limited to, employee welfare benefit plans, multiple employer welfare arrangements and Taft-Hartley Trusts, which has entered into an agreement with Health Plan and underwritten or sponsored a Coverage Plan pursuant to which the entity is financially responsible for the Covered Services rendered to Covered Persons.

1.37 **URAC.** An accreditation organization for health plan operations.

2. PROVIDER OBLIGATIONS

2.1 **Qualifications/Standards of Care.** Provider shall maintain all licenses, certifications, and accreditations required by Applicable Law; certification under Titles XVIII and XIX of the Social Security Act; and, all applicable requirements of Health Plan concerning participating provider status. Provider shall provide proof of applicable licenses, certifications, and accreditations upon request by Health Plan and shall promptly notify Health Plan of any loss, revocation, or suspension of any such licenses, certifications, or accreditations. Provider shall individually submit all proposed treatment sites for approval and credentialing by Health Plan. Provider shall ensure that Members are treated only at sites approved by Health Plan for credentialed sites under this Agreement. Provider shall render all Covered Services in a manner consistent with professionally or generally recognized standards of health care. Provider shall ensure that each provider employed by or under contract with Provider is duly licensed, certified, or registered as required, and performs his or her duties in accordance with all Applicable Laws and regulations and applicable standards of professional ethics and practice. Provider shall notify Health Plan within three (3) business days following Provider's receipt of any notice regarding any adverse action related to any restrictions upon, or any suspension, loss or surrender of: (i) any professional license, certification or registration; (ii) medical staff privileges; (iii) Drug Enforcement Administration ("DEA") provider number; (iv) Medicare or Medicaid participation status, or, (v) any other action that impacts Provider's ability to render Covered Services. Provider shall submit to Health Plan evidence of Provider's satisfaction of the requirements set forth in this Section upon any request by Health Plan.

2.2 **Credentialing Requirements.** Provider shall comply fully with Health Plan credentialing requirements applicable to Provider and health care personnel employed by or contracted with Provider. Provider shall promptly notify Health Plan of any material changes in Provider's certification, licensure, or other qualification status. To the extent Provider operates a facility that provides services subject to review and accreditation by a recognized accrediting body under the then-current Credentialing requirements, Provider shall obtain and maintain such accreditation at all times during the term of this Agreement and shall notify Health Plan within three (3) business days following Provider's receipt of any notice regarding an adverse action related to any restrictions upon, or any suspension or loss of, such accreditation. Subject to Applicable Law, this Agreement shall immediately terminate upon the expiration, surrender, revocation, restriction, or

suspension of such accreditation.

2.3 **Delegation of Credentialing.** If the credentialing and re-credentialing process is delegated to Provider, the following terms and conditions shall apply and be required of Provider and further detailed in the separate Delegation Agreement:

A. Provider shall conduct credentialing and re-credentialing pursuant to the Credentialing and Re-credentialing Procedure for Provider's professional personnel as set forth in the Credentialing Delegation Agreement.

B. If Provider's professional personnel ceases to satisfy the Health Plan credentialing criteria detailed in the Credentialing Delegation Agreement including, without limitation, the failure by Provider's professional personnel to maintain the required professional liability coverage in force, Provider shall immediately terminate such Provider as a Participating Provider and provide Health Plan with notice of such termination.

C. Health Plan reserves the right to credential or re-credential any Provider and Provider shall provide Health Plan with the credentialing information sufficient to credential or re-credential such Provider.

D. After the implementation of the delegation of credentialing, Health Plan shall have the right to audit the Provider credentialing process to verify compliance with the terms of this Agreement. Audits shall be conducted in accordance with the standards of the American Accreditation HealthCare Commission/URAC ("URAC") and Joint Commission on the Accreditation of Healthcare Organizations ("JCAHO") if applicable.

E. If Provider delegates credentialing to any other entity, such entity shall execute a delegation of credentialing agreement with Provider substantially in the form of the Health Plan Credentialing Delegation Agreement and such agreement shall be in compliance with URAC and JCAHO Standards if applicable.

F. Provider must notify Health Plan of any sub-delegation of services prior to implementation. Health Plan retains the right to approve or deny any sub-delegation under the terms of this section.

2.4 **Member Verification.** Pursuant to the then-current Health Plan rules and procedures, Provider shall establish a person's status as a Member prior to rendering services. In the case of an Emergency Condition or in case Provider is unable to establish a person's status as a Member prior to rendering service, Provider shall establish the person's status as a Member in accordance with applicable Health Plan procedures. Health Plan shall communicate to Provider in a timely manner all material modifications to then-current coverage verification procedures. Nothing contained in this Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for emergency room services provided in accordance with the Federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such services.

2.5 **Prior Authorization.** All elective inpatient admissions and designated outpatient services that must be pre-authorized to determine medical necessity and appropriate site of care. Pre-authorization must be requested according to Health Plan's *Pre-Authorization and Concurrent Review Guidelines* at least **fourteen (14) business days** prior to the proposed service. Requests for procedures/services needed on an emergency basis must be made within **48 hours** of admission. All emergency care is subject to review by Health Plan for medical necessity. If medical necessity is not established, payment will be denied

2.6 **Providing Covered Services.** Provider agrees to participate in the Health Plan products listed on the Provider Reimbursement Exhibit A and/or otherwise identified as a Health Plan product in which Provider is participating. Health Plan may amend products listed in Exhibit A to include any new products upon sixty (60) days' notice to Provider. Provider retains the right to opt out of any new product offerings upon thirty (30) day notice to Health Plan.

Provider shall follow the authorization and referral procedures set forth in the Provider Manual for the authorization and payment of Covered Services. Provider shall furnish Covered Services personally (in the case of a physician) or through qualified personnel and, where applicable, appropriately credentialed health care professionals. Provider shall furnish to Members only such Covered Services as Provider is legally qualified to provide and as are consistent with Provider's customary practice and staff credentials. Provider shall consult with and seek further authorization from Health Plan or Health Plan designee depending on the Health Plan product if it is believed that additional treatment or tests are needed beyond those initially authorized. Provider understands and agrees that Health Plan's authorization of services does not constitute a guarantee of Health Plan's payment for such services. Covered Services may be subject to Medical Necessity criteria in order to be payable by the Health Plan. Provider shall provide Covered Services in a manner consistent with the terms and conditions of this Agreement, Applicable Laws, and the policies and procedures of Health Plan. Specific coverage rules will be defined in the Provider Manual. Provider shall render care and treat Members with respect, dignity, and give consideration for the privacy of all Members. For a Member's inpatient stay, Provider shall, and shall cause the Participating Providers employed by or under contract with Provider to comply with all utilization review and quality improvement program requirements applicable to such stay under then-current Health Plan policies and procedures and Applicable Laws.

2.7 **Panel Status (Open and Closed).** A provider participating in Health Plan must provide services to all eligible members enrolled in Health Plan and assigned to said provider, unless or until such time as provider notifies Health Plan to close panel status to preclude additional members from selecting provider. If Provider maintains an open Panel Status with other health plans, Provider will also maintain an open Panel Status with Health Plan. Provider must submit in writing at least thirty (30) days a request for consideration to close panel. Health Plan will respond to request no later than (90) ninety days after request has been received.

2.8 **Health Plan Administrative Programs.** Provider shall comply with Health Plan's or its designee's quality management, medical management, network management, Member education, Member grievance, claims processing and administration, clinical and non-clinical performance measurement and improvement programs, and other policies, procedures, and corrective measures established by or on behalf of Health Plan in order to effect the terms and provisions of this Agreement.

2.9 **Health Plan Designation of Panel Providers.** Provider acknowledges Health Plan's authority to designate specific hospitals, facilities, agencies, physicians, and other Providers as preferred or exclusive Participating Providers of Covered Services for Members, and shall cooperate with Health Plan in the designation and utilization of such Participating Providers.

2.10 **Changes in Provider Status.** Provider shall notify Health Plan thirty (30) days prior to any change in business name, Provider name, treatment location, phone numbers, tax identification number, NPI number, or any other information listed in Exhibit B that will published in the Provider Directory.

Provider shall notify Health Plan within five (5) days of any of the following occurrences:

A. Any change in Provider's ownership status, business, or range of services or treatments offered.

B. Any termination or substantial reduction in the amount of Provider's liability insurance coverage.

C. Any material reduction in services or any other situation which may substantially interfere with Provider's performance of any duties and obligations under this Agreement.

Provider shall provide Health Plan with copies of any written materials relating to any of the foregoing when requested by Health Plan.

2.11 **Identifying Information.** Provider shall provide to Health Plan all identifying information, including, but not limited to, name, address, central telephone number, tax ID number, NPI numbers, and office hours as applicable. Provider shall follow Health Plan's policy to provide reasonable advance notice of, and in the format requested by, Health Plan as required for changes in such information.

2.12 **Nondiscrimination.** Provider shall provide services to Members in the same manner and in accordance with the same standards offered to all of Provider's patients. Provider, in accordance with the provisions, spirit, and intent of this Agreement, shall not differentiate or discriminate in the treatment of the Member or in the quality of services rendered to Members on the basis of race, creed, color, national origin, sex, age, religion, sexual orientation, veteran status, disability, place of residence, health status, source of payment, or credit history.

2.13 **Health Improvement Programs.** Provider shall encourage Member participation in various health education, health maintenance, and disease management programs offered by and through Health Plan and shall promote Members' adoption of healthy behaviors. Provider shall comply with NCQA, HEDIS and other quality and accreditation program requirements to improve the health status of the Member.

2.14 **Cost-Effective Care.** Provider shall provide Covered Services in the most cost-effective, clinically appropriate setting and manner consistent with Health Plan guidelines and requirements. Provider shall promote and encourage appropriate use of primary care services in lieu of emergency room and urgent care facilities.

2.15 **Access to Covered Services.** Provider shall make necessary and appropriate arrangements to ensure the availability of Covered Services to Members twenty-four (24) hours per day and seven (7) days per week. With regard to physicians, physician groups, and other relevant providers, Provider will maintain appointment hours that are convenient to serve Members and appointment access, appointment wait times, and telephone answering standards that meet the requirements in the Provider Manual. A Primary Care Provider must provide live voice coverage after normal business hours or voicemail message where a live voice can be reached.

2.16 **Non-Covered Services.** It is recognized that Members may consent to receive services that are not Covered Services or are not authorized by Health Plan and, therefore, may be payable by Member. Provider is responsible for confirming all proposed services as Covered Services and for verifying proper authorization of such services prior to treating Member. When proposed services are not payable by Health Plan, Provider must inform Member in advance and document in writing Member's consent to be billed for the services.

2.17 **Responsibility for Medical Care Decisions.** Provider shall be solely responsible for all medical advice and all services provided by Provider to Members, and Provider acknowledges and agrees

that Health Plan will not be responsible or liable for the manner or method by which Provider provides services to Members. Provider acknowledges and agrees that Health Plan may deny payment for Provider services rendered to a Member it determines are not Medically Necessary, are not Covered Services, or are not otherwise provided in accordance with this Agreement. Neither such a denial nor any other action taken by Health Plan pursuant to a utilization review, referral, or discharge planning program shall operate to modify Provider's obligation to provide appropriate services to a Member under Applicable Law and any applicable code of professional responsibility.

2.18 **Continuity of Care.** Participating Health Care Provider will be available to provide or arrange for the provision of Covered Services on a twenty-four (24) hour, seven (7) days a week basis and in a manner that assures continuity of care, including periods after normal business hours, on weekends, holidays, or at times when Participating Health Care Provider is otherwise unavailable. During times of unavailability, Participating Health Care Provider shall make alternative coverage arrangements with other Participating Health Care Providers or non-Participating Health Care Providers ("Covering Health Care Providers") consistent with the terms and conditions of this Agreement and Program Requirements. Covering Health Care Providers shall be bound by the terms of this Agreement and Program Requirements; to the extent possible, Covering Health Care Providers shall be Participating Providers.

2.19 **Non-interference.** There is nothing in this Agreement to prohibit or otherwise restrict Provider from advising or advocating on behalf of Member about Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; the risks, benefits, and consequences of treatment or non-treatment; the opportunity for Member to participate in decisions regarding his or her health care, including the right to refuse treatment or to express preferences about future treatment decisions, regardless of cost or Health Plan benefit coverage limitations; or any information Member needs in order to decide among all relevant treatment options. Nothing in this Agreement shall be construed to prohibit or otherwise restrict Provider from advocating on behalf of a Member in any grievance or utilization review process or individual authorization process to obtain health care services deemed necessary by Provider or to refuse treatment or, express preferences about future treatment decisions. Nothing in this Agreement shall be construed to require Provider to take any action inconsistent with Provider's professional judgment concerning the medical treatment to be provided to Members. Provider will maintain the relationship of physician and patient with Member, without intervention in any manner by Health Plan or its agents or employees, and Provider will be solely responsible for all medical advice to and treatment of patients and for the performance of all medical services in accordance with accepted professional standards and practice.

2.20 **Treatment Sites.** Provider shall ensure that facilities in which Members will be received, screened, and treated, meet applicable State and local fire, safety, and sanitation codes.

2.21 **Referrals and Second Opinions.** In the event that a Member requests a referral or second opinion, or Provider believes a referral or second opinion is warranted, or the Provider deems it necessary to refer the Member to another health care provider for some other reason, Provider shall refer the Member to a Participating Provider. If there is no Participating Provider that is qualified and available, Provider will assist Member with a request to the Health Plan for the Member to obtain services from a provider who is not a Participating Provider. Health Plan shall not unreasonably deny any such request.

2.22 **Hospital Admissions.** Except in Emergency Conditions, Provider shall only admit Members to participating hospitals for inpatient services, or with prior approval of Health Plan, to non-participating hospitals.

2.23 **Acceptance of Referrals and Patients.** Participating Health Care Provider agrees to accept referrals of Covered Persons from other Participating and non-Participating Providers, consistent with medical appropriateness and in accordance with Program Requirements and the applicable Coverage Plan.

2.24 **Delegated Responsibilities.** Provider and his/her/its delegates, including subcontractors or other downstream entities to which Provider delegates responsibilities under the Agreement, shall perform such responsibilities in accordance with Applicable Laws and in accordance with instructions and requirements promulgated by the Department of Health and Human Services ("HHS") and the State of Indiana. Health Plan shall be responsible for overseeing and is ultimately accountable for the performance of Provider and delegates with regard to delegated responsibilities referenced in this Agreement. If Provider or delegate fails to perform delegated services, reporting, or disclosure responsibilities in a satisfactory manner, Health Plan shall retain the right to terminate this Agreement in accordance with Termination provisions set forth herein. Health Plan shall retain the right to approve, suspend, or terminate all such delegated arrangements.

2.25 **Quality and Utilization Management.** Provider agrees to participate in applicable quality and utilization management programs for Health Plan to administer its health benefits program in accordance with Health Plan's and any applicable payer or government entity's requirements.

2.26 **Member Transfers.** Provider agrees to cooperate with Health Plan when it is determined that an immediate transfer of a Member to another Provider is required to ensure Member health and safety. Provider agrees to transfer Member in the most cost-effective quality manner that adheres to Health Plan prior authorization requirements.

2.27 **Publication and Use of Provider Information.** For the term of this Agreement, Provider agrees that Health Plan may use, disclose, publish, and display information and disclaimers, as applicable, relating to Provider. Reasonable efforts will be used to protect any of Provider's proprietary information disclosed to group customers with the use of a confidentiality statement.

2.28 **Directories.** Health Plan is permitted to use Participating Health Care Provider's name, office address, credentials and specialty, if applicable, in its marketing and Covered Person materials, such as in directories which list Participating Providers.

3. PROVIDER'S REPRESENTATIONS AND WARRANTIES

3.1 **Provider Status.** Provider hereby represents and warrants as follows:

A. Provider has the power and authority to enter into this Agreement.

B. Provider is legally organized and operated to provide the services contemplated under this Agreement.

C. Provider is not in violation of any licensure requirement applicable to Provider under Applicable Law or Health Plan requirements.

D. Provider has not been excluded from participation in Medicare, Medicaid, or any other federal health care program.

E. Provider is capable of providing, as of the date of this Agreement, and at all times during the term of this Agreement, all data related to the services provided under this Agreement as required under Applicable Laws and Health Plan requirements, including without limitation, all data required under the Health Employer Data and Information Set ("HEDIS") and NCQA requirements.

F. Within three (3) business days, Provider will notify Health Plan of any change in status in any of the circumstances referenced in this paragraph, or any other regulatory issue affecting its participation in any product hereunder.

3.2 **Debarment and Suspension.** Provider certifies that neither Provider nor any of its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Agreement by any Federal agency or by any department, agency, or political subdivision of the State. The term "principal" for purposes of this Section means all officers, directors, owners, partners, key employees, or other persons with primary management or supervisory responsibilities, or a person who has a critical influence on or substantive control over the operations of Provider. Provider further certifies that Provider has verified the suspension and debarment status of all subcontractors receiving funds under this Agreement and is solely responsible for any paybacks and/or penalties that might arise from noncompliance. In addition, Provider shall not employ nor contract for the provision of Provider Services under this Agreement with any individual excluded from participation in the Medicare and Medicaid programs under Section 1128 or 1128A of the Social Security Act, and is not excluded from any other State or Federal health care program. Provider shall review the Department of Health and Human Services Office of the Inspector General exclusion database and verify as required by CMS guidelines that all persons it employs or contracts with for services hereunder are in good standing. Within three (3) business days, Provider shall provide Health Plan notice if any person Provider employs or with whom Provider contracts is debarred, suspended, or excluded from any State or Federal health care program.

3.3 **Provider Information and Documentation.** Provider further represents and warrants that all information provided by Provider to Health Plan prior to the execution of this Agreement on Provider's participation application and all information provided thereafter during the term of this Agreement, including without limitation, information relating to insurance coverage, quality improvement, credentialing, change of ownership of Provider, and availability of medical care by Provider to Members, is to the best of Provider's knowledge true and correct. Provider shall provide Health Plan with written notice of any changes to such information within three (3) business days of such a change. Provider agrees to indemnify Health Plan for any and all damages that Health Plan may incur as a result of its reliance on the information provided on Provider's application.

3.4 **Provider Affiliation and Privileges.** Provider, in the case of a solo provider, and all providers employed by or under contract with Provider, in the case of a physician group, shall maintain in effect practice privileges or relationship privileges for one or more participating hospitals. Provider shall notify Health Plan within twenty-four (24) hours; (i) in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility; or (ii) proceedings are initiated that may reasonably be expected to result in such a revocation, limitation, surrender, or, suspension.

3.5 **Participating Physician Group Requirements.** If Provider is a physician group, Provider shall cause all providers employed by or under contract with Provider to comply with all terms and conditions of this Agreement. All providers within a physician group providing services to Health Plan members must accept the designated fee schedule attached within for all services provided. Notwithstanding the foregoing, Provider acknowledges and agrees that Health Plan is not obligated to accept as Participating Providers all providers employed by or under contract with Provider.

If provider is a hospital and/or inpatient facility, or if Provider group contains hospital based providers, Provider will assist Health Plan efforts to contract any hospital-based, independent

providers affiliated with Provider in order to become Participating Providers, including anesthesia, emergency medicine, laboratory services, pathology, and radiology.

3.6 **Responses to Requests for Information.** Provider shall implement and maintain a system to respond to requests for information, concerns, and complaints from Members, regulators, and representatives of Health Plan and in doing so shall cooperate with representatives of Health Plan in responding to them.

4. INSURANCE

4.1 **Coverages.** Provider shall either receive written permission from Health Plan to self-insure or shall purchase and maintain from insurers authorized to conduct business in the State of Indiana, at Provider's sole cost and expense, throughout the term of this Agreement, the following insurance coverages:

A. **Professional Liability.** Provider shall maintain professional liability insurance coverage in an amount no less than that which is required to qualify as a health care provider under the Indiana Medical Malpractice Act, IC 34-18-1-1 et seq. In the event Provider is not a qualified health care provider under the Indiana Medical Malpractice Act and is not entitled to coverage with the Indiana Patient Compensation Fund, Provider shall purchase and maintain coverage of no less than One Million Dollars ($1,000,000) per occurrence and Three Million Dollars ($3,000,000) per annual aggregate. If Provider is an entity, or is a covered employee or contractor of an entity, that has been deemed eligible for coverage under the Federal Tort Claims Act, then proof of current coverage shall be accepted as sufficient professional liability coverage under this Section.

B. **Workers' Compensation.** Provider shall maintain workers' compensation insurance or self-insurance for its employees and such other persons as required by Applicable Law, as the same may be amended from time to time.

C. **General Liability and Property Damage.** Provider shall maintain General liability insurance (including, but not limited to, automobile and broad form contractual coverage) against liability for bodily injury or death of any person and property damages covering such party and its subcontractors' principal place of business. The minimum amount of coverage shall be One Million Dollars ($1,000,000) for each occurrence and Three Million Dollars ($3,000,000) in the annual aggregate.

4.2 **Proof of Insurance.** Provider shall notify Health Plan within five (5) days in writing in the event any of the foregoing insurance coverages are cancelled, not renewed, changed, or amended. Provider shall, from time to time, upon Health Plan's request, furnish written evidence that the required insurance coverages are in full force and effect and valid and existing in accordance with the provisions of this Agreement.

4.3 **Subcontracted Provider Insurance Coverage Requirements.** Provider shall cause each provider with whom the Provider contracts for services that may be provided to a Member to carry insurance coverage in the types and amounts, and to provide proof of insurance, as set forth in this Section.

5. HEALTH PLAN'S OBLIGATIONS

5.1 **Member Identification.** Health Plan will use reasonable efforts to offer a means of identifying Members either by issuing a paper, plastic, or other identification document to the Member 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 Health Services are

rendered, but shall include information necessary to contact Health Plan to determine a Member's participation and 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.

Health Plan Programs. Health Plan shall develop and coordinate quality management, medical management, network management, Member education, and Member grievance programs for the purpose of administering the Health Benefit Plans, Networks, and products in which Provider is participating.

5.2 **Coverage Determinations.** Health Plan or its designated representative shall have sole authority to determine the obligation of Health Plan/Payor to reimburse Provider pursuant to this Agreement. The determination may be conditioned upon Health Plan's/Payor's (or its designated representative) determination of: (i) what is a Covered Service; (ii) what is medically necessary; (iii) what is an Emergency Condition; (iv) who is a Member; (v) the amount and application of Member Cost Share; (vi) Coordination of Benefits and, (vii) the Network of Participating Providers/hospitals that may provide Covered Services to Members. Provider agrees that such determinations may vary by Health Benefit Plan, product, and Payor and within a particular Payor's various Health Benefits Plans.

5.3 **Credentialing/Professional Review.** Health Plan shall review the applications and credentials of health care providers applying for affiliation with Health Plan. Health Plan shall develop and coordinate review activities related to credentialing, quality management, and medical management as described in the Provider Manual. Health Plan reserves the right to refuse or terminate the participation status of any provider or Participating Provider based on failure to meet Health Plan's credentialing standards and/or cooperate with Health Plan's quality and medical management programs.

5.4 **Claims Adjudication.** Health Plan or its designee shall receive, process, and pay in a timely manner claims for Covered Services rendered by Provider in accordance with the procedures as set forth in the Provider Manual and terms of this Agreement. Health Plan shall work diligently with Provider to resolve any perceived lack of timeliness with respect to claims payment under this Agreement.

5.5 **Information Services.** Health Plan shall provide inquiry services for Members, providers, and the general public.

5.6 **Establishment of Network.** Health Plan shall establish contractual arrangements with hospitals, facilities, agencies, physicians, and other providers, and may designate certain providers as preferred or exclusive Participating Providers of Covered Services. Health Plan will publish listings of Participating Providers and will update such listings from time to time.

5.7 **Member Grievance, Appeal, and Fair Hearing Procedures.** Health Plan will have a Member grievance, appeal, and fair hearing process in accordance with the appropriate Federal, State, or employer requirements.

5.8 **Granting Access to Provider's Services.**

A. Health Plan shall not lease, rent, or otherwise grant access to the provider's services under this Agreement to a third party with the exception of the following entities: (1) an employer or another entity providing coverage for health care services to the employer's or entity's employees or members and the entity has a contract with the Health Plan or the Health

Plan's affiliate for the administration or processing of claims for payment or service provided under the contract; (2) an affiliate or subsidiary of Health Plan; (3) an entity providing administrative services to or receiving administration services from Health Plan or an affiliate or subsidiary of Health Plan; (4) a Payor or third party administrator or another entity that administers claims on behalf of a Payor; (5) a preferred provider organization or preferred provider network, including without limitation a physician-hospital organization; or, (6) an entity engaged in the electronic claims transport between the Health Plan and provider.

B. If Health Plan grants a third party access to provider's services in accordance with this subsection, such third party must comply with all applicable terms of this Agreement. Health Plan shall make available to provider, through a website or toll-free telephone number, a listing of the third parties to which access to provider's health care services have been granted. Health Plan shall update the list at least semi-annually.

C. As of the Effective Date of this Agreement, Health Plan will grant access to provider's services to the preferred provider organizations, preferred provider networks, and/or physician-hospital organizations as set forth in an exhibit to this Agreement (if applicable and as agreed upon by the parties).

D. Health Plan shall ensure that any explanations of benefits or remittance advice furnished to the provider identify the contractual source of any discount that applies.

E. Subject to any continuity of care obligations as set forth in this Agreement or Applicable Law, any rights or responsibilities granted to a third party pursuant to this subsection shall terminate at such time that this Agreement terminates.

6. SUBMISSION OF CLAIMS/BILLING

6.1 **Claims.** Provider shall submit Clean Claims to Health Plan or its designee for billable Covered Services in accordance with the procedures identified in the Provider Manual and within ninety (90) days in which member services have been rendered. Any change to the claim submission process will be communicated to Provider through the designated web location or updates. Provider shall submit Claims using the appropriate designated National Provider Identifier number either electronically using Health Plan specified formats, or in written form on industry standard claim forms. All Claims shall include appropriate coding based on established clinical edit rules, including the proper use and combination of billing codes. Electronic claims submission will be preferred over hard copy formats. Claims shall be submitted not later than ninety (90) days after the date of service.

If Health Plan denies a claim that results in a partial or no payment, provider is may appeal the denial, submitted with supporting documentation, no more than ninety (90) days from the date of the original denial. Health Plan shall respond to the appeal request within thirty (30) days of receipt of appeal review.

Provider recognizes that failure to file Claims within the prescribed time limits will render the Claim unpayable. Billing of Members for Claims denied or recovered under this Section is prohibited by the Member hold harmless provisions set forth herein.

6.2 **Payment for Covered Services.** Clean Claims for Covered Services shall be paid the lesser of the Provider's Billed Charges or in accordance with payment rates and methodology identified in attachments and applicable payment exhibit(s) to this Agreement. Hospital Provider will not be reimbursed for a readmission as defined herein at any other facility under common ownership.

Payments for Self Insurer Claims are contingent upon Health Plan receiving scheduled payments from Self Insurer group. In event of Self Insurer defaulting on payments, Provider will seek Claims payment directly from Self Insurer.

6.3 **Audit of Claims/Medical Records.** Health Plan conducts an unbundling audit and appropriate use of billing codes audit of all submitted Claims to ensure appropriate coding based on established clinical edit rules. In the event the audit identifies an improper use or combination of billing codes, certain billed service(s) may be denied. All services denied in accordance with this provision are subject to Member hold harmless provisions set forth in the Agreement. Medical record audits may also be conducted by Health Plan.

6.4 **Coordination of Benefits/Subrogation.** Participating Health Care Provider shall assist Covered Persons to process forms and file claims for Coordination of Benefits and coverage by third parties. In addition, Participating Health Care Provider agrees to notify Health Plan if a Covered Person's Coverage Plan appears to be secondary in priority compared to another health plan or source of coverage and to pursue coverage from that source prior to seeking payment from Health Plan and/or Self Insurers, as applicable.

In the event that a Covered Person is entitled to coverage for health care services from another health plan (excluding workers' compensation coverage and Medicare) that is required under applicable rules governing the Coordination of Benefits to cover, as the primary payor, the costs of health care services, and Participating Health Care Provider is compensated on a fee for service or similar basis pursuant to this Agreement, Health Plan and/or Self Insurer, as applicable, shall be entitled to reduce any compensation due Participating Health Care Provider to take into account the coverage provided by the other health plan. Payment for claims for which Health Plan is liable as secondary payor shall be limited to an amount that, when added to the amount paid by the primary payor, does not exceed the fees set forth herein. Under no circumstances shall Participating Health Care Provider bill, charge or otherwise seek reimbursement from Covered Persons for any remaining difference between the fees set forth herein and Participating Health Care Provider's charge for the applicable service.

In the event that (i) a Covered Person is entitled to coverage for health care services under a Workers' Compensation Law or similar law covering injuries or conditions received as a result of employment, (ii) the applicable Coverage Plan provides coverage for injuries or conditions that are inflicted during the course of employment, and (iii) Participating Health Care Provider is compensated on a fee for service or similar basis, Health Plan and/or Self Insurer, as applicable, shall be entitled to reduce any compensation due Participating Health Care Provider to take into account the coverage available under the Workers' Compensation Law or similar law. Under no circumstances shall Participating Health Care Provider bill, charge or otherwise seek reimbursement from Covered Persons for any remaining difference between the fees set forth herein and Participating Health Care Provider's charge for the applicable service.

In the event that (i) a Covered Person is a Medicare beneficiary, (ii) Medicare is liable for the costs of health care services before Health Plan and/or Self Insurer, as applicable, and (iii) Participating Health Care Provider is compensated on a fee for service or similar basis pursuant to this Agreement, Health Plan and/or Self Insurer, as applicable, shall be liable only for the deductible and coinsurance amounts required by Medicare minus any Cost Sharing Amounts imposed by the applicable Coverage Plan. In no event, however, shall the amount due Participating Health Care Provider under this Section 4.4.4 exceed the Medicare allowable charge or the amount Participating Health Care Provider would be compensated under this Agreement if the Coverage Plan was the primary payor. Participating Health Care Provider may either accept assignment of Medicare

benefits from the Covered Person or file a claim with Medicare directly.

In the event that Participating Health Care Provider is compensated by a third party for services rendered to Covered Persons entitled to coverage under an Indiana State Medicaid program, Participating Health Care Provider shall maintain readily identifiable books and records of any compensation received on behalf of Covered Persons by such third parties. Participating Health Care Provider shall make those books and records available to Health Plan, appropriate state and federal authorities and/or their authorized representatives, including, but not limited to, the Indiana State Department of Health and the Comptroller of the State of Indiana, immediately upon request.

Participating Health Care Provider agrees to refund Health Plan and/or Self Insurer, as applicable, if he/she/it receives payment from another source of coverage when Participating Health Care Provider has already been compensated for rendering the particular treatment to the Covered Person pursuant to this Agreement.

6.5 **Statutory Health Benefits.** Provider shall provide Covered Services to Members even though there may be liability to another party under workers' compensation, occupational disease, or other statutory coverage. Provider shall bill the appropriate responsible party for Covered Services and shall provide information to Health Plan regarding the applicability of such statutory coverage.

6.6 **Payment in Full.** Provider agrees to accept as payment in full, in all circumstances, the applicable Health Plan Rate, given that such payment is in the form of a Member Cost Share, a payment by Health Plan, or payment by another source such as Coordination Of Benefits. In no event shall Health Plan be obligated to pay Provider or any person acting on Provider's behalf for services that are not Covered Services, or any amounts in excess of the Health Plan Rate less Member Cost Shares, or payment by another source as stated above. Also, in no event shall Provider bill a Member or any other person or entity for payment of the difference between the Health Plan Rate and Provider's Billed Charges. Provider agrees not to waive and to use reasonable efforts to collect Member Cost Shares from Members at the time Covered Services are rendered or as soon thereafter as practical and convenient for Provider and Member. Provider agrees to make reasonable efforts to verify Member Cost Share prior to billing any Member. Notwithstanding the foregoing, Provider may waive a Member Cost Share only in accordance with Provider's established financial hardship policy, which shall apply the same hardship standards to all Members, including Medicare Members, and other patients. Provider shall provide Health Plan with its financial hardship policy upon request.

6.7 **Member Hold Harmless.** Provider hereby agrees that in no circumstance including, but not limited to, nonpayment by Health Plan, insolvency of Health Plan or Payor, or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than the Health Plan for services provided pursuant to this Agreement, except for non-covered benefits as described in Section 2.16. This Section shall not prohibit collection of any applicable Member Cost Shares billed in accordance with the terms of the Health Benefit Plan. Provider further agrees that this Section shall survive the termination of this Agreement regardless of the cause of such termination and shall be construed to be for the benefit of Health Plan's Members, and that this Section supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and Member or persons acting on Member's behalf, unless otherwise expressly provided in this Agreement. To the extent required by Applicable Law, Provider acknowledges and agrees that in the event Provider brings a legal action against a Member for amounts owed by Health Plan, Provider is liable to the Member for any costs and attorney's fees incurred by the Member in defending against Provider's claims in violation of this subsection. Notwithstanding the foregoing, Provider shall not be liable for Member's costs and attorney's fees provided that

Provider can demonstrate a reasonable basis for believing at the time the legal action was brought and while the legal action was maintained that Health Plan did not owe the amounts the Provider sought to collect from Member.

6.8 **Prior Determination/Authorization of Covered Services.** Unless otherwise stated in Member's Health Benefit Plan or prior determination and authorization by Health Plan or Payor, Provider will make no charge and render no bill to Health Plan, Member, or Member's guarantor for services unless such services are certified as Medically Necessary and not Investigational/Experimental/Off-label according to the terms of the utilization management Program or Health Benefit Plan. Provider agrees that it will not bill or charge Health Plan, Member, or Member's guarantor for any penalty or reduction in benefits required under a Member's Health Benefit Plan for failure to request Medical Necessity pre-authorization or pre-certification of services or any extension of such services.

6.9 **Hold Harmless for Non-Covered Services Rendered to Members.** In the event Provider provides non-Covered Services of any type to a Member (including services deemed not Medically Necessary), Provider shall, prior to the provision of such non-Covered Services, notify such Member in writing by utilizing the providers general consent form: (i) of the services to be provided; (ii) that Health Plan will not pay for or be liable for said services; and, (iii) that Member will be financially liable for such services. Such notice must also contain the date and time such services are to be rendered as well as a description and an estimate of cost of such services. Provider shall have Member sign an acknowledgement that he or she understands these terms contained in the notice. If such Member is so advised and the notice and acknowledgement is signed, Provider may bill such Member for the services. If Member is not so advised, or if the notice/acknowledgement is not signed by Member, then Provider may not bill Member for such services. Provider shall make such written notice/acknowledgement a part of Member's medical record. Upon request, copies of the written notice/acknowledgement shall be provided to Health Plan by Provider. Nothing in the preceding sentences shall permit Provider to bill any Health Plan for any such services. Any such written notice/acknowledgement must be obtained on a case-by-case basis.

6.10 **Adjustments for Incorrect Payments.** If Provider determines a Claim to be overpaid by Health Plan, Provider must promptly notify the Health Plan and reimburse excess payment. If Health Plan determines that an overpayment has occurred, Health Plan may recover overpayments made to Provider by giving written notice within one hundred twenty (120) after the payment was initially made. Participating Providers shall refund overpayments within thirty (30) days of notice from Health Plan. Health Plan or its designee may recover overpayments through remittance adjustment or other recovery action, subject to the restrictions set forth in the Provider Manual, if Provider fails to appeal overpayment determination or if payment is not received within the thirty (30) day notice period.

If Provider determines that Health Plan has underpaid a Claim, Provider shall provide written notice to Health Plan within one hundred twenty (120) after the payment was initially made and Health Plan shall respond to Provider appeal within thirty (30) days. If Health Plan determines the Claim was not paid correctly, Health Plan shall remit correct payment to Provider within thirty (30) days of receiving notice from Provider.

6.11 **Preventable Adverse Events.** Notwithstanding any provision in this Agreement to the contrary, when any surgery or procedure is performed on the wrong patient, performed on the wrong body part, the wrong surgery or procedure is performed, or any other preventable events as described in the Provider Manual occur, for any such "Preventable Adverse Event," Provider shall neither bill, nor seek to collect from, nor accept any payment from, Health Plan or Member for such events. If

Provider receives any payment from Health Plan or Member for a Preventable Adverse Event, Provider shall refund such payment to the person or entity making the payment within thirty (30) days of becoming aware of such receipt. Furthermore, Provider shall cooperate with Health Plan, to the extent reasonable, in any Health Plan initiative designed to help analyze or reduce such Preventable Adverse Events.

6.12 **Basis to Dispute Claims by Health Plan.** Situations in which claims may be partially or totally disputed by Health Plan or Payor include, without limitation; (i) circumstances involving good faith questions concerning the manner in which the Claim was completed or submitted; (ii) the eligibility of a person for coverage; (iii) the responsibility of another Payor for all or part of the claim; (iv) the amount of the claim or the amount currently due under the claim; (v) the benefits covered; (vi) the manner in which services were accessed or provided; (vii) the applicability of Coordination Of Benefits; (viii) Payor's intention to conduct a retrospective review of services identified on the Claim; (ix) non-payment of the Member's or applicable group's premium; or, (x) the applicability of a preexisting condition if and as permitted by Applicable Law. All such situations shall be supported by specific information available for review by Provider as outlined in the Provider Manual.

7. CONFIDENTIALITY/RECORDS

7.1 **Proprietary Information.** All information and material provided by either party in contemplation of or in connection with this Agreement remains proprietary to the disclosing party. Neither party shall disclose any information proprietary to the other, or use such information or material except: (i) as otherwise set forth in this Agreement; (ii) as may be required to perform obligations hereunder; (iii) as required to deliver Health Services or administer a Health Benefit Plan; (iv) to Health Plan or its designees; (v) upon the express written consent of the parties; or, (vi) as required by Applicable Law, except that either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information.

7.2 **Medical Records.** Provider shall maintain standard medical records for Members as may be reasonably requested to fulfill the purposes of this Agreement and as required under Applicable Laws. Provider must maintain Members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and audit processes, facilitates an accurate system for follow-up treatment, and records all medical services that the Member received. Provider shall keep such medical records as required by Applicable Laws. Medical records must be legible, signed, and dated. Medical record information must be protected by Provider as required under Applicable Law. Provider shall share a Member's medical records, and forward medical records and clinical information in a timely manner to other health care providers treating a Member, at no cost to Health Plan, Member, or other treating healthcare providers. For any other requested copies of medical records by a Member, Provider shall provide a copy at copying rates equivalent to Indiana Code 16-39-9.

7.3 **Health Plan Access to and Requests for Provider Records.** Provider shall comply with all applicable State and Federal record keeping requirements, and as set forth in the Provider Manual, shall permit Health Plan or its designees to have, with appropriate working space and without charge, on site access to and the right to examine, audit, photocopy, 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 Health Plan in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, Medical Necessity,

appropriateness of care, accuracy of payment, compliance with this Agreement, and for research. In lieu of onsite access, at Health Plan's request, Provider shall submit records to Health Plan, the Member, or their respective designees via photocopy or electronic transmittal at no charge. Provider shall make such records available to the State and Federal authorities involved in assessing quality of care or investigating Member grievances or complaints.

Provider shall maintain and make available, upon request and at no charge, Participating Health Care Provider's books, records and papers and Covered Person medical records that relate to the provision of health care services to Covered Persons and copies thereof to Health Plan, appropriate state and federal authorities and their authorized representatives, for purposes that include, but are not limited to, determining payment issues; facilitating audits; assessing quality of care, quality improvement or Medical Necessity; complying with various reporting requirements, e.g. HEDIS and NCQA, outcome studies and demand management programs; and determining the appropriateness of care provided to Covered Persons. Participating Health Care Provider further agrees to provide Covered Persons, or their duly authorized representatives, copies of their medical records promptly upon written request. Provider acknowledges that, consistent with applicable law, the consent contained in Covered Person's Coverage Plan is sufficient consent for the disclosure of the Covered Person's medical records to Health Plan. Upon request, Health Plan shall be permitted to review and audit such records at the Provider's office and to inspect Provider's facilities. Provider agrees to make such records and facilities available, upon request, to appropriate state and federal authorities and their authorized representatives, including, but not limited to, the Indiana Department of Health, for the purposes of inspection and photocopying, at no charge to such regulatory authorities. Provider acknowledges and agrees that Health Plan, or its designee, may use statistical samples and other appropriate external audit and fraud and abuse detection practices and methods in conducting audits pursuant to this Section.

Provider agrees to assist Health Plan in the orderly transfer of a Covered Person's health care records to his or her new health care provider in the event of the termination or non-renewal of this Agreement.

This Section shall survive the termination of this Agreement.

7.4 **Obligation to Protect Records.** Provider acknowledges that protected health information (PHI) (as defined at 45 CFR §160.103) within its possession is subject to protection in accordance with Applicable Law. Provider agrees to abide by Applicable Laws regarding the privacy, confidentiality, security, integrity, use and disclosure of Member information and Medical Records and other PHI and enrollment information, and to safeguard the privacy, confidentiality, and security of any such information. Safeguarding shall include measures to protect the security of PHI when it is in use, in transit, stored, or destroyed. Provider shall follow Health Plan policies specifying the purposes for which PHI will be used and disclosed.

A. **Patient Medical Records Privacy.** Provider shall safeguard the privacy of all information that identifies a particular Member and abide by all applicable federal and state laws and regulations regarding confidentiality and disclosure of mental health records, medical records, other health information and enrollment and Member information. Information from, or copies of, medical, enrollment and other records may be released only to authorized individuals in accordance with applicable federal and state laws and regulations. Plan shall secure a signed release from a Member prior to disclosure of the Member's medical records and health information. Plan and Provider shall take precautions to ensure that unauthorized individuals cannot gain access to or alter patient records.

B. **Subcontractor Access to Records.** Provider and Health Plan each agree to require all subcontractors and agents to comply with Applicable Laws regarding privacy of medical information, including signing business associate agreements as required. Provider agrees to ensure that all downstream entities and their agents with access to PHI agree in writing to protect PHI that is handled outside of the United States of America or the United States Territories. Such written agreements shall specifically govern the use and disclosure of PHI and shall comply with HIPAA's business associate agreement requirements at 45 CFR § 164.504(e). Nothing in this Section shall limit Health Plan's right to approve subcontracts or assignments as provided elsewhere in this Agreement.

7.5 **Government and Accrediting Agency Access.** If and as required by Applicable Law, Provider shall retain and provide access to, and agrees that Health Plan may release to, or allow audit by, applicable regulatory agencies, accrediting agencies, and their authorized representatives, all information and records or copies thereof within the possession of Provider related to any Member or this Agreement in compliance with Applicable Law, for the longest of: (i) ten (10) years from last day of the calendar year to which the record relates; (ii) ten (10) years following the completion of any CMS audit pertaining to the calendar year to which the record relates; or, (iii) such longer period as required by Applicable Law.

7.6 **Cooperation with Reporting Requirements.** Provider agrees to cooperate with Health Plan and to assist in compliance with all requirements of Applicable Law, to gather and report on Provider and its operations, including requirements to provide information on encounters, cost of operations, patterns of utilization, the availability, accessibility, and acceptability of services, and Member health status. Provider shall certify the accuracy of its records as required by a Payor or Applicable Law. Provider agrees to allow Health Plan to use Provider performance data.

7.7 **Advance Directives.** Provider acknowledges that each Member has the right to accept or refuse treatment and execute advance directives pursuant to Applicable Law. Provider shall document in Members' medical records whether or not the Member has executed an advance directive and/or a health care proxy, and if so, maintain a copy; not condition the provision of care or otherwise discriminate against Member based on whether or not Member has an advance directive; and, take any other steps reasonably available to determine if the Member has an advance directive.

8. COMMUNICATIONS

8.1 **With External Authorities.** Provider may communicate with State or Federal authorities specifically with regard to Health Plan's performance under this Agreement only after exhausting the appeals process of Health Plan.

8.2 **Proprietary Information.** All information and materials provided, directly or indirectly, by Health Plan to Provider (including without limitation, contracts, fee schedules, procedures, manuals, operations manuals and/or software) shall remain proprietary to Health Plan. Provider shall not disclose or permit the disclosure of any such information or materials or use them except as provided in this Agreement.

8.3 **Provider Information.** All proprietary information and materials of Provider that are provided, directly or indirectly, by Provider to Health Plan shall remain proprietary to Provider. Health Plan shall not disclose or permit the disclosure of any such information or materials or use them except as provided in this Agreement.

8.4 **Provider Listing.** Provider acknowledges and agrees that Health Plan and shall be entitled to use: (i) the name(s), business address(es), and phone number(s) of Provider; and, (ii) in addition to the foregoing, information about education, specialty, subspecialty, licensure, certification, hospital

affiliation, office hours, languages spoken, and any other demographic information for any individual Participating Provider employed by or under contract with Provider to provide services under this Agreement, for the purposes of enrolling and referring Members, marketing, complying with Applicable Law, reporting, and otherwise carrying out the terms and conditions of this Agreement.

9. RELATIONSHIP OF THE PARTIES

9.1 **Relationship of the Parties.** For purposes of this Agreement, Health Plan and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement. In no way shall Health Plan be construed to be providers of Health Services or responsible for the provision of such Health Services. Provider shall be solely responsible to the Member for treatment and medical care with respect to the provision of Health Services.

9.2 **Contracting Party.** If Provider is a partnership, corporation, or any other entity other than an individual, all references herein to "Provider" shall also mean and refer to each individual within such entity who has applied for and been accepted by Health Plan as a Network/Participating Provider.

10. INDEMNIFICATION AND LIMITATION OF LIABILITY

10.1 **Indemnification by Provider.** Provider agrees to indemnify, defend, and hold harmless Health Plan and their respective officers, employees, and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with claims for damages of any nature whatsoever, including but not limited to, bodily injury, death, personal injury, or property damage arising from Provider's or its subcontractor's delivery of health care services or Provider's or its subcontractor's performance or failure to perform Provider's obligations under this Agreement.

10.2 **Indemnification by Health Plan.** Health Plan agrees to indemnify, defend, and hold harmless Provider and, if Provider is an entity, its officers, employees, and agents from and against any and all liability, loss, claim, damage or expense, including defense costs and legal fees, incurred in connection with claims for damages of any nature whatsoever, arising from Health Plan's performance or failure to perform its obligations under this Agreement.

10.3 **Limitation.** Notwithstanding the foregoing Sections 10.1 and 10.2, this Section is not intended, and shall not be interpreted in any instance, to (i) reduce insurance coverage to which either party is otherwise entitled, by way of any exclusion for contractually assumed liability or otherwise; (ii) limit the availability of any right, to the extent applicable, to the protections and limitations to the exposure and liability of either party as a qualified health care provider under the Indiana Medical Malpractice Act; or (iii) waive rights of either party available under the Federal Torts Claims Act. In addition, regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special, or punitive damages, whether arising in contract, tort (including negligence), or otherwise, regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall

Health Plan be liable to Provider for any extra contractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

10.4 **Notification of Action.** Each party will promptly, but in no event later than ten (10) days, notify the other party in writing of any complaint to or from any State insurance department, any other State or Federal regulatory agency, or of any litigation (or threat of litigation) of which that party becomes aware that relates to any matter covered by this Agreement. Each party will promptly, but in no event later than ten (10) days, forward to the other party all summonses, complaints, and notices of claims received by that party.

10.5 **Responsibility for Acts and Medical Decisions of Provider.** Nothing in this Agreement shall be construed as making Health Plan legally liable to any Member or other third party for the acts or omissions of Provider, including without limitation, the acts or omissions of Provider relating to the medical care provided or the professional medical judgment of Provider. Provider shall not be deemed to be an employee, agent (ostensible or otherwise), or representative of the State or Health Plan for any purpose. Provider acknowledges and agrees that Health Plan shall not be liable under any circumstances for any act or omission of Provider relating to the medical care provided by, or the professional medical judgment of, Provider.

10.6 **Period of Limitations.** Unless otherwise provided for in this Agreement, neither party shall commence any action at law or equity, against the other to recover on any legal or equitable claim arising out of this Agreement more than two (2) years after the events which gave rise to such claim, unless compliance with this Section would compel a party to violate the terms of the Health Benefit Plan. The deadline for initiating an action shall not be tolled by the appeal process or any other administrative process.

10.7 **Survival.** The terms of this Section 10 shall survive the termination or expiration of this Agreement.

11. TERM AND TERMINATION

11.1 **Term of Agreement.** This Agreement shall have an initial term of one (1) year, commencing on the Effective Date. Thereafter, this Agreement shall automatically renew for term of one (1) year each. Notwithstanding the foregoing, this Agreement may terminate in accordance with the Termination sections below.

11.2 **Termination Without Cause.** Either party may terminate this Agreement or Provider's participation in a Network(s) without cause at any time by giving at least ninety (90) days prior written notice of termination to the other party after the initial Term. Such termination shall be effective as of the end of any annual term. Notwithstanding the forgoing, nothing shall prevent termination at any time upon the mutual agreement of the parties.

11.3 **Breach of Agreement.** Except for circumstances giving rise to the Termination With Cause, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than thirty (30) days after such notice of termination.

11.4 **Termination With Cause.**

A. This Agreement may be terminated immediately by Health Plan if:

(1) Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part.

(2) Provider commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Health Plan or to a third party.

(3) Provider files for bankruptcy, or makes an assignment for the benefit of its creditors without Health Plan's written consent, or if a receiver is appointed.

(4) Provider's insurance coverage as required by this Agreement lapses for any reason.

(5) Provider fails to maintain compliance with Health Plan's credentialing standards or other applicable standards of participation.

(6) Health Plan reasonably believes, based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized.

(7) Provider has been abusive to a Member, a Health Plan employee, or a representative of either.

(8) Provider and/or his/her/its employees, contractors, subcontractors, or agents are identified as ineligible persons on the General Services Administration list of Parties Excluded from Federal Programs and/or HHS Office of Inspector General List of Excluded Individuals/Entities, and in the case of an employee, contractor, subcontractor, or agent, fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement.

(9) Provider is convicted of a felony or misdemeanor (other than minor traffic offenses).

B. This Agreement may be terminated immediately by Provider if:

(1) Health Plan commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part.

(2) Health Plan commits a fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party.

(3) Health Plan files for bankruptcy, or if a receiver is appointed.

C. When applicable, Health Plan reserves the right to terminate individual providers under the terms hereof while continuing the Agreement for one or more providers in a group.

D. This Agreement will immediately cease to be effective for any individual provider covered under the Agreement, or the Provider group in its entirety, if an individual Provider, facility, or group of Providers fail to satisfactorily complete and pass the Health Plan's initial credentialing process or subsequent recredentialing activities.

11.5 **Transactions Prior to Termination.** Termination shall have no effect on the rights and obligations of the parties arising out of any transaction occurring prior to the date of such termination.

11.6 **Continuance of Care Upon Termination.** Unless otherwise set forth in the Health Benefit Plan, or required by statute or regulation, continuance of care upon termination shall apply as follows: Provider shall, upon termination of this Agreement for reasons other than the grounds set forth in the "Termination With Cause" Section of this Agreement, continue to provide and be compensated for Covered Services rendered to Members under the terms and conditions of this Agreement until the earlier of ninety (90) days or such time that: (i) the Member has completed the course of treatment and if applicable, was discharged from hospital; or (ii) reasonable and medically appropriate arrangements have been made for a new Network/Participating Provider to render Health Services to the Member; or (iii) unless a breach of contract was the cause of termination, in which case Member will be moved to a new participating Provider. Notwithstanding the foregoing, for Members who have entered the second or third trimester of pregnancy at the time of such termination or are defined as terminally ill under § 1861(dd)(3)(A) of the Social Security Act at the time of such termination, this Section and all other provisions of this Agreement shall remain in effect for such pregnant Members through the provision of postpartum care directly related to their delivery, and for such terminally ill Members for the remainder of their life or when coverage terminates for care directly related to the treatment of the terminal illness.

11.7 **Notice Requirements Prior to Termination.** Provider must give Health Plan not less than ninety (90) days' notice prior to any termination of this Agreement, unless Provider provides thirty percent (30%) or more of Health Plan's services, in which event Provider must give at least one hundred twenty (120) days' prior notice of termination.

11.8 **Survival.** In the event of termination of the Agreement, the following provisions shall survive:

A. Payment in Full and Hold Harmless (Sections 6.6, 6.7).

B. Adjustments for Incorrect Payments (Section 6.10).

C. Confidentiality/Records (7).

D. Indemnification and Limitation of Liability (10).

E. Continuance of Care Upon Termination (Section 11.6).

12. GENERAL PROVISIONS

12.1 **Amendment.** Health Plan retains the right to amend this Agreement as required by Applicable Law at any time. Health Plan may make other amendments at any time by providing Provider with a written copy of the applicable amendment at least thirty (30) days prior to the effective date of the amendment. If Provider is unwilling to accept the amendment, Provider may terminate this Agreement by giving Health Plan ninety (90) days written notice of termination no later than fifteen (15) days after the Health Plan notice has been issued. During the termination notice period, provider shall not accept new members as patients unless provider provides notice to Health Plan within 15 days. Notwithstanding, Provider and Health Plan may mutually agree to terminate this Agreement upon a date earlier than such ninety (90) day period. If Provider gives Health Plan notice of its intent to terminate this Agreement in accordance with this Section, then Health Plan shall not require Provider to comply with the proposed amendment. If Provider gives Health Plan notice of its intent to terminate this Agreement, then prior to providing any services to a Member,

shall notify Member that this Agreement is or will be terminated. If Provider does not give Health Plan notice of termination within the fifteen (15) day period, then the amendment will become effective upon the expiration of the original thirty (30) day notice period.

12.2 **Assignment.** This Agreement shall be binding upon and inure to the benefit of the respective legal successors and assignees of the parties. However, neither this Agreement nor any rights or obligations hereunder may be assigned, either by operation of law or otherwise, or transferred in whole or in part, without the prior written consent of the other party, except that Health Plan retains the right to assign, either by operation of law or otherwise, or transfer in whole or in part, this Agreement to an affiliate of Health Plan, or to delegate any rights or obligations under this Agreement to a designee.

12.3 **Scope/Change in Status.** Provider shall provide Health Plan with fifteen (15) days prior written notice of a change in (i) any providers who are part of the group, if applicable, and any new providers must meet Health Plan's credentialing standards prior to being designated as a Network/Participating Provider; or (ii) any new physical location, tax identification number, mailing address, or similar demographic information.

12.4 **Definitions.** Unless otherwise specifically noted, the definitions as set forth in this Agreement will have the same meaning when used in any attachment and the Provider Manual.

12.5 **Entire Agreement.** This Agreement (including items incorporated herein by reference) constitutes the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there are any inconsistencies between any provisions in this Agreement and in the Provider Manual, the provisions in this Agreement will take precedence.

12.6 **Force Majeure.** Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder for any reason beyond his/her/its reasonable control, including without limitation, acts of God, acts of any public enemy, floods, statutory or other laws, regulations, rules, or orders of the Federal, State, or local government or any agency thereof.

12.7 **Compliance with State and Federal Laws.** Health Plan and Provider agree to comply with all requirements of the law relating to their obligations under this Agreement. From time to time legislative bodies, boards, departments, or agencies may enact, issue, or amend laws, rules, or regulations pertinent to this Agreement. Both parties agree to immediately abide by all said laws, rules, or regulations to the extent applicable, and to cooperate with the other to carry out any responsibilities placed upon the other by said laws, rules, or regulations, subject to the other's right to terminate as set forth under this Agreement. In the event of a conflict between this Section and any other provision in this Agreement, this Section shall control.

12.8 **Off-Shore Contracting.** Off-shore contracting is not permitted under the agreement**.**

12.9 **Governing Law.** This Agreement shall be governed by and construed in accordance with the laws of the State of Indiana, unless such State laws are otherwise preempted by Federal law. However, coverage issues specific to a Health Benefit Plan are governed by the State laws where the Health Benefit Plan is issued, unless such State laws are otherwise preempted by Federal law.

12.10 **Intent of the Parties.** It is the intent of the parties that this Agreement is to be effective only in regard to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a beneficiary of this Agreement, except to the extent Health Plan utilizes a designee, which in such event shall

give rights only within the scope of such designation, and to the extent specified in the Payment in Full and Hold Harmless Sections of this Agreement.

12.11 **Non-Exclusive Participation.** None of the provisions of this Agreement shall prevent Provider or Health Plan from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Health Plan does not warrant or guarantee that Provider will be utilized by any particular number of Members.

12.12 **Notice.** Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by a nationally-recognized overnight courier (such as FedEx), by hand, or by certified mail unless otherwise specified in this agreement. Provider shall be sent to Health Plan's address as set forth on the signature page. Notice shall be effective upon the marked date associated with the corresponding delivery method noted above, or the date of delivery if delivered by hand and marked with that same date.

12.13 **Severability.** In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

12.14 **Waiver.** Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

12.15 **Abandonment.** Nothing herein shall be construed as authorizing or permitting Provider to abandon any patient.

12.16 **Signing Authority.** 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.

12.17 **Resolution of Disputes.**

A. If any controversy, claim or dispute arises between the parties out of or relating to this Agreement including, without limitation, the breach, termination, enforceability, scope or validity of this Agreement (a "Dispute"), the parties shall first attempt to resolve the Dispute through negotiation.

B. If the parties are unable to resolve the Dispute through negotiation within thirty (30) calendar days after the complaining party first gave the other party written notice of the Dispute, the parties shall attempt in good faith to resolve the Dispute by non-binding mediation before a mediator to be mutually agreed upon by the parties The mediation shall take place at a location in the Indianapolis, Indiana area, agreed upon by the parties. Each party shall bear its own costs, but costs of the mediator(s) shall be borne equally by the

parties.

C. In the event the Dispute cannot be resolved through non-binding mediation after sixty (60) calendar days after the complaining party first gave the other party written notice of the Dispute, the Dispute shall be determined by binding arbitration to be conducted in a location in Indianapolis, Indiana to be mutually agreed upon by the parties under the Rules of Procedure for Arbitration of the American Health Lawyers Association, Alternative Dispute Resolution Service. Unless otherwise agreed upon by the parties in writing, the Dispute shall be determined by a panel of three (3) arbitrators who are members of the American Health Lawyers Association who are current members of the AHLA panel of Dispute Resolvers and who are attorneys that are familiar with issues relating to payment for health professional or hospital services by health care plans. Each party shall appoint one arbitrator and the third shall be mutually selected by the two (2) arbitrators appointed by the parties. Discovery in arbitration shall be limited to an exchange of directly related documents; provided, however, that for claims for over $1,000,000 the parties shall be entitled to discovery in accordance with the Federal Rules of Civil Procedure as determined by the arbitrators. The arbitrability of claims shall be governed by the Federal Arbitration Act, and all arbitrable claims shall be governed by the requirements of this Dispute Resolution Procedure and the Federal Arbitration Act. The arbitrators shall base their award on the law and the cases that would apply if the dispute were decided by a court of competent jurisdiction. The arbitrators' award shall include the findings of fact and conclusions of law on which it is based. All fees and expenses of the arbitration shall be borne by the parties equally; provided that each party shall bear the expense of its own counsel, experts, witnesses and preparation and presentation of proofs except to the extent the parties are entitled to attorney's fees and/or costs under applicable law. The parties further agree that no other party shall be entitled to join in any arbitration proceeding and that, unless mutually agreed upon by the parties in writing, class action arbitrations are expressly prohibited. Except as required in accordance with paragraphs D and G of this Section 12.17, infra, the parties and the arbitrators shall keep confidential and not disclose to third parties any information obtained in connection with the arbitration process, including the resolution of the Dispute. Nothing contained in this Section 12.17 shall prevent either party from seeking a temporary restraining order and/or preliminary injunction from a court of competent jurisdiction in order to maintain the status quo pending arbitration to the extent such party would be entitled to such injunction under applicable law. Further, the arbitrators shall have the authority to enter any permanent injunction against a party, subject to paragraph E, below, to the extent that the Party would be entitled to a permanent injunction in a court of competent jurisdiction under applicable law.

D. Upon application by either party to a court for an order confirming, modifying or vacating an arbitrators' determination and award and/or injunction under paragraph C of this Section 12.17, above, the court shall have the power to review de novo, whether, as a matter of law based upon the findings of fact determined by the arbitrators, the award should be confirmed, modified or vacated in order to correct any errors of law. In order to effectuate such judicial review limited to issues of law, the parties shall stipulate to the court that the findings of fact made by the arbitrator shall be final and binding upon the parties and shall serve as the facts to be submitted and relied upon by the court in determining the extent to which the award should be confirmed, modified or vacated. The foregoing right to seek the modification or vacation of the arbitrators' award based upon erroneous conclusions of law, shall be in addition to, and not in lieu of, the rights set forth in the Federal Arbitration Act. Any application by a party to any court to confirm, modify or vacate an arbitration

award shall be governed exclusively by this paragraph, and the Federal Arbitration Act. If either party fails to proceed with arbitration (to the extent mandated by paragraph C, above), fails to comply with the arbitration award or is unsuccessful in vacating or modifying the award pursuant to an application or petition for judicial review pursuant to this paragraph, the other party shall be entitled to awarded costs, including reasonable attorney's fees, paid or incurred in successfully compelling arbitration or defending against the attempt to stay, vacate or modify the arbitration award and/or successfully defending or enforcing the award.

E. Notwithstanding the above, the following matters shall not be subject to subparagraphs A., B., C., and D. of this Section 12.17: (i) matters that require mutual consent under the terms of this Agreement; (ii) determinations made by Health Plan that an item or service is or is not a Covered Service or that a person is not a Covered Person in accordance with the terms and conditions of the applicable Coverage Plan; and (iii) matters which are subject to review by an independent third party pursuant to the State of Indiana.

F. The parties acknowledge that the Laws of the State of Indiana, provide, in certain instances, Covered Persons and health care providers the right to seek review by a third party of final determinations that were made by Health Plan that an item or service is not a Covered Service. Upon request, Health Plan shall provide participating Health Care Provider a copy of the standard description of the external review process that is prepared by the State of Indiana Insurance Department and Department of Health, as amended.

SIGNATURES ON FOLLOWING PAGE

Health Plans

IN WITNESS WHEREOF, the parties have executed this Agreement as of the dates listed below.

Indiana University Health Plan Services, LLC		**Centrality Behavioral Support Training LLC dba Centrality LLC, a Centria Company**	
By:	Duane Schmitz Digitally signed by Duane Schmitz Date: 2020.09.16 14:07:42 -04'00'	By:	Paul McDonald
Printed:	Duane Schmitz	Printed:	Paul McDonald
Title	Vice President, Network Management	Title	CFO
Date:		Date:	9/14/2020
		Tax ID:	46-4197524
		Group NPI:	1912329020

Health Plan address for any notices:	**Provider address for any notices:**
IUHP, Network Management	Centrality LLC, a Centria Company
950 N. Meridian Street, Suite 200	965 Emerson Parkway, Suite H1
Indianapolis, IN 46204	Greenwood, IN 46143

Health Plans

EXHIBIT A

HEALTH PLAN PRODUCTS

- Commercial Product
- Medicare Advantage Product

EXHIBIT A.1

PHYSICIAN/PROVIDER REIMBURSEMENT

A. Contract Rates

Commercial, Medicare Advantage

Commercial

Commercial Health Plan Rate:

Reimbursement for Covered Services furnished by Provider to Covered Person, the contract rate shall be the lesser of: (i) Provider's Billed Charges, (ii) One Hundred Ten Percent (110%) of the Health Plan Medicare fee schedule for services not listed in the Health Plan ABA Fee Schedule or, (iii) One Hundred Percent (100%) of the Health Plan ABA Fee Schedule in effect on the date of service and specific to the services rendered. The Health Plan Medicare fee schedule is based on the CMS/Medicare RBRVS relative values.

Reimbursement for Covered Services furnished by Mid-level providers (including but not limited to Nurse Practitioners, Certified Nurse Midwives, Certified Register Nurse Anesthetists, Clinical Nurse Specialists, and Physician Assistants) will be reimbursed at Eighty Five Percent (85%) of the contracted allowable rate or in accordance with an alternative Medicare reduction, less any applicable Co-payment, Coinsurance, and/or Deductible unless otherwise documented.

Health Plan ABA Fee Schedule:

Service Code	Reimbursement Rate
97151	$30.91
97152	$25.31
97153	$25.31
97154	$5.14
97155	$26.41
97156	$24.75
97157	$5.14
97158	$25.31
0362T	$25.31
0373T	$50.62

Medicare Advantage

Medicare Advantage Health Plan Rate:

Reimbursement for Covered Services furnished by Medicare Advantage Provider to Covered Persons, the contract rate shall be the lesser of: (i) Provider's Billed Charges, or (ii) One Hundred Percent (100%) of the Health Plan Medicare fee schedule in effect on the date of service and specific to the services rendered and shall include reductions to CMS prospective payment to Health Plan related to budget deficits. The Health Plan Medicare fee schedule is based on the CMS/Medicare RBRVS relative values.

Reimbursement for Covered Services furnished by Mid-level providers (including but not limited to Nurse Practitioners, Certified Nurse Midwives, Certified Register Nurse Anesthetists, Clinical

Nurse Specialists, and Physician Assistants) will be reimbursed at Eighty Five Percent (85%) of the contracted allowable rate or in accordance with an alternative Medicare reduction, less any applicable Co-payment, Coinsurance, and/or Deductible unless otherwise documented.

Additional Fee Provisions:

Alternate Fee Sources. In the event there is no published CMS fee amount for a particular CPT/HCPCS code, an alternate (or "gap fill") fee source may be used to supply the Contract Rate for that CPT/HCPCS code. Unless specifically stated otherwise, the Contract Rate for such alternative fee source shall be Thirty Five Percent (35%) of Participating Provider's Allowable Charge for the CPT/HCPCS code. At such time in the future as CMS publishes its own RBRVS value for that CPT/HCPCS code, Payor will use the CMS fee amount for that code and no longer use the alternate Fee Source.

Code Change Updates. Updates to billing-related codes (e.g., CPT, HCPCS, ICD-10, DRG, and revenue codes) shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following ninety (90) days after publication by the governmental agency, CMS; or (ii) the effective date of such code updates as determined by such governmental agency. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

Health Plans

EXHIBIT B

PROVIDER LOCATIONS

Group NPI	Group or Facility Name	Address and General Phone	Remit Address and Phone
1912329020	Centrality LLC, a Centria Company	965 Emerson Parkway, Suite H1, Greenwood, IN 46143; phone 248-299-0030; fax 248-912-1566	27777 Inkster Road, Suite 100, Farmington Hills, MI 48334; phone 248-299-0030; fax 248-912-1566

Provider shall notify Health Plan thirty (30) days prior to changes in any of the location or demographic information above.

Health Plans

MEDICARE ADVANTAGE ADDENDUM

Medicare Advantage Participating Provider Requirements

1. Books and Records; Governmental Audits and Inspections

A Participating Provider that participates in a Medicare Advantage plan ("Medicare Advantage Provider") shall maintain all books, contracts, documents, papers, medical record patient care documentation, and any other records that pertain to any aspect of services performed for Members for ten (10) years or the date of completion of any Federal or State government audit, whichever is later. Medicare Advantage Provider shall retain such records beyond such period upon direction from CMS or other government agency. Medicare Advantage Provider acknowledges and agrees that, as a contractor of Health Plan, Medicare Advantage Provider shall give Health Plan, HHS, the Comptroller General, the General Accounting Office, other federal agencies and state and local regulatory agencies and their designees the right to inspect, evaluate and audit any pertinent contracts, books, documents papers and records involving any aspects of services performed for Members for a period of the (10) years from the final date of the contract between CMS and Health Plan or the date of completion of an audit, whichever is later. The right to audit records of Health Plan and Medicare Advantage Provider may be extended if CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies Health Plan or Medicare Advantage Provider at least thirty (30) days prior to the normal disposition date or if there is a reasonable possibility of fraud. Medicare Advantage Provider's obligation hereunder shall survive termination or expiration of this Agreement. [42 CFR §§ 422.504(e)(2)-(4); 42 CFR § 422.504(i)(2)]

2. Privacy and Confidentiality Safeguards

Health Plan and Medicare Advantage Provider shall safeguard the privacy of all information that identifies a particular Member and abide by all Applicable Laws regarding confidentiality and disclosure of mental health records, medical records, other health information, and enrollment and Member information. Information from, or copies of, medical, enrollment and other records may be released only to authorized individuals in accordance with Applicable Laws. Health Plan shall secure a signed release from a Member prior to disclosure of the Member's medical records and health information. Health Plan and Medicare Advantage Provider shall take reasonable precautions to ensure that unauthorized individuals cannot gain access to or alter patient records. [42 CFR§ 422.118]

3. Prompt Payment

Health Plan shall use best efforts to pay a majority of Clean Claims for Covered Services rendered by Medicare Advantage Provider within thirty (30) days of receipt, and all Clean Claims within forty-five (45) days of receipt. For purposes of this provision, a Clean Claim is one with no defect or lack of any substantiating documentation, including the substantiating documentation needed to meet the requirements for encounter data, or particular circumstances requiring special treatment that prevents timely payment; and a Claim that otherwise conforms to the clean claim requirement for equivalent claims under original Medicare. No compensation hereunder shall include any kickbacks, bribes, or rebates as defined by Applicable Laws.

4. Hold Harmless

Medicare Advantage Provider shall not hold any Member liable for payment of any fees that are the legal obligation of Health Plan in accordance with 42 CFR § 422.504(g)(1)(i). In no event, including but not limited to, non-payment by Health Plan, Health Plan's insolvency, or breach of this Agreement, shall Medicare Advantage Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against, a Member or person other than Health Plan acting on a Member's behalf, for services provided pursuant to this

Agreement. The foregoing shall not prohibit collection of supplemental charges or copayments on Health Plan's behalf made in accordance with the terms of any agreement between Health Plan and its Members. Furthermore, the foregoing shall not prohibit the collection of charges for services rendered by Medicare Advantage Provider but not covered under the Subscriber or Member Agreement and Benefits Schedule. Medicare Advantage Provider further agrees that (1) this Section shall survive the termination of this Agreement, regardless of the cause giving rise to the termination and shall be construed to be for the benefit of Members; and (2) this Section supersedes any oral or written contrary agreement now existing or hereafter entered into between Medicare Advantage Provider and Member or persons acting on Member's behalf. [42 CFR § 422.504(g)(1)]

5. Compliance with Federal Law

Medicare Advantage Provider shall comply with all Applicable Laws, including but not limited to, Medicare, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, the Rehabilitation Act of 1973, and all other laws applicable to recipients of federal funds. [42 CFR§ 422.504(h)(1)]

6. Delegated Duties

If delegated by Health Plan, Medicare Advantage Provider shall perform all delegated activities such as claims payment, utilization review, quality assurance, or credentialing, in a manner consistent with Applicable Laws, Health Plan's contract with CMS, CMS instructions, and any delegation agreement entered into with Health Plan. Medicare Advantage Provider shall be delegated only those activities specified in this Agreement and any delegation agreement. All delegated activities shall be monitored by Health Plan on an ongoing basis. Medicare Advantage Provider acknowledges that Health Plan is ultimately accountable for any delegated activity and shall have the right to revoke any delegated activity or take corrective action against Medicare Advantage Provider in the event that Medicare Advantage Provider is not performing the delegated activity or submitting regular reports to Health Plan on the delegated activity in accordance with the terms of the Agreement or any delegation agreement. In the event credentialing of subcontractors is delegated to Medicare Advantage Provider, Medicare Advantage Provider's credentialing process shall be reviewed and approved by Health Plan prior to delegation and Health Plan retains the ultimate right to approve, suspend, or terminate any subcontractor. [42 CFR § 422.504(i)]

7. Oversight by Health Plan

Medicare Advantage Provider acknowledges that Health Plan oversees and is ultimately accountable to CMS for compliance with the functions and responsibilities described in Applicable Laws, Health Plan's contract with CMS, and CMS instructions. [42 CFR §422.504(i)(3)(ii))]

8. Compliance with Medicare Laws/Regulations, Policies and Procedures, and Provider Manual

Medicare Advantage Provider shall comply with and require its subcontractors to comply with all applicable Medicare laws, regulations, and CMS instructions and contract obligations in this Addendum and the Agreement. Provider further agrees to comply with Health Plan's policies, Provider Manual, procedures, and instructions, including CMS marketing rules. This shall include cooperation and compliance with Health Plan's appeal and grievance procedures. 42 CFR § 422.504(i).

9. Member Medical Records

Member medical and other records shall be maintained by Medicare Advantage Provider in an accurate and timely manner and in accordance with accepted industry standards and Applicable Laws. Members shall be given timely access to their medical records and information that pertains

to them. Any charges to Members for copies of records shall not exceed the reasonable and customary charges in the professional community. [42 CFR§422.118]

10. Non Discrimination

Neither Health Plan nor Medicare Advantage Provider shall discriminate, deny, limit, or condition the coverage or furnishing of covered serves to Members on the basis of any factor related to health status, including but not limited to, medical condition, including mental and physical illness, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, or disability [42 CFR §422.110a)]. Medicare Advantage Provider agrees to render Medicare Covered Services to Members in accordance with prevailing community medical standards and by applying the same standards to Medicare Members that it applies to other patients. Members shall receive services without regards to race, color, religion, origin, income, handicap, sex or age. [42 CFR § 422.504]

11. Notice of Exclusion

Medicare Advantage Provider shall inform Health Plan immediately upon exclusion from participation in the Medicare program under section 1128 or 1128A of the Social Security Act ("SSA"), and acknowledges that Health Plan is prohibited by Federal law from contracting with a Medicare Advantage Provider excluded from participation in the Medicare program under section 1128 or 1128A of the SSA, as amended. This shall include all subcontractors of Medicare Advantage Provider. [42 CFR § 422.752(a)(8)]

12. Self-Referral

Medicare Advantage Provider acknowledges that Members are entitled under Federal regulation to directly access, through self-referral, screening mammography and influenza vaccination services, and that Health Plan cannot prohibit direct access to these services. Medicare Advantage Provider shall cooperate with Health Plan's procedures to comply with this regulation. [42 CFR § 422.100(g)]

13. Cost Sharing for Certain Services

Medicare Advantage Provider acknowledges that Health Plan is prohibited by Federal regulation from imposing cost-sharing on Members for influenza and pneumococcal vaccines, and that Plan cannot impose cost-sharing on Members for such services. Medicare Advantage Provider shall cooperate with Health Plan's procedures to comply with this regulation. [42 CFR § 422.100(g)(2)]

14. Complex Medical Conditions

Health Plan is required to have procedures to identify Members with complex or serious medical conditions, assess those conditions using medical procedures to diagnose and monitor the conditions on an ongoing basis, and establish, implement, and periodically update treatment plans for those Members. Medicare Advantage Provider shall cooperate with Health Plan's procedures to comply with this regulation. [42 CFR §422.112 (a)]

15. Access to Care

Medicare Advantage Provider shall furnish to Members timely access to care and services that meet or exceed standards established by CMS. Medicare Advantage Provider shall cooperate in Health Plan's efforts to monitor timely access to care and services and comply with any necessary corrective action plans to ensure compliance with standards established by CMS. [42 CFR § 422.112(a)(6)]

16. Effective Medical Care

Medicare Advantage Provider shall abide by Health Plan's procedures to ensure effective and continuous patient care and quality review, including Health Plan's procedures to ensure the

performance of a health assessment of all new Members within ninety (90) days of their effective date of enrollment, the maintenance of Members' health records according to professional standards, and the exchange information in an appropriate and confidential manner. [42 CFR § 422.112(b)]

17. Care Standards

Medicare Advantage Provider shall provide all Covered Services to Members in a manner consistent with professionally recognized standards of health care [42 CFR §422.504(a)]. Provider shall comply with Health Plan's standards for access to care. Provider shall provide treatment information in a culturally-competent manner, including the option of no treatment. Provider must provide Members with disabilities effective communication to assist them in making medical decisions regarding their treatment options. [42 CFR § 422.504]

18. Continuation of Care

Medicare Advantage Provider shall continue to provide Covered Services to Members in the event of Health Plan's insolvency, discontinuance of operations, or termination of its contract with CMS, for the duration of the contract period for which CMS payments have been made to Health Plan, and for Members who are hospitalized, until such time as the Member is appropriately discharged from hospital. [42 CFR § 422.504(g)]

19. Federal Funds Recognition

Medicare Advantage Provider acknowledges that Medicare Advantage Provider is receiving Federal funds from Health Plan and is subject to laws and regulations applicable to individuals/entities claiming and receiving Federal funds. [42 CFR §422.504(h)]

20. Encounter Information

Subject to applicable patient confidentiality laws and regulations, Medicare Advantage Provider shall submit to Health Plan or their designees, within thirty (30) calendar days of any request, medical records necessary to characterize the content/purpose of each encounter with a Member. In the event Medicare Advantage Provider is paid under a capitated arrangement with Health Plan, Medicare Advantage Provider shall submit to Health Plan or its designee, within thirty (30) calendar days of any request, all encounter data, including medical records, necessary to characterize the content/purpose of each encounter with a Member in such frequency, formats, and type as reasonably requested by Health Plan for compliance with reporting requirements of Federal and State government agencies and Health Plan's utilization programs. Upon request by Health Plan or CMS, Medicare Advantage Provider shall certify to CMS the accuracy, completeness, and truthfulness of the encounter data submitted to Health Plan or its designee. [42 CFR § 422.504(a)(8); 42 CFR § 422.504(l)(2); 42 CFR § 422.504(l)(3)]

21. Compliance with Quality Review, Improvement Progress, and Utilization Review

Medicare Advantage Provider shall cooperate with an independent quality review and improvement organization's activities pertaining to the provision of services to Members [42 CFR §422.154(a)]. Medicare Advantage Provider shall comply with Health Plan's medical policy and programs for quality assurance and performance improvement, medical management, and utilization review. Health Plan shall consult with Medicare Advantage Provider in developing, reviewing, or updating such policies and programs and communicating them to other contracted Medicare Advantage Providers in accordance with federal laws and regulations. A copy of all such programs shall be provided by Health Plan to Medicare Advantage Provider. [42 CFR § 422.202; 42 CFR § 422.504]

22. Termination of Participation

In the event Health Plan suspends and/or terminates the participation of Medicare Advantage Provider, Health Plan shall deliver written notice to Medicare Advantage Provider of the reasons(s)

for the suspension and/or termination, including if relevant, the standards and profiling data used to evaluate Medicare Advantage Provider and the number and mix of Medicare Advantage Providers needed by Health Plan. The notice shall also include the right to appeal the action taken by Health Plan and the process and timing for requesting a hearing in accordance with Health Plan's policies and procedures. Medicare Advantage Provider acknowledges that if Health Plan suspends and/or terminates the participation of Medicare Advantage Provider with Health Plan because of deficiencies in the quality of care, Health Plan is required by Federal regulations to provide written notice of such action to licensing or disciplinary bodies or to other appropriate authorities. [42 CFR § 422.562]

23. Notice of Termination

Health Plan shall provide Medicare Advantage Provider written notice of termination as specified in the Agreement, except in the event of exclusion from Medicare or any other Federal health care program, in which case termination shall be immediate. [42 CFR § 422.562]

24. Cooperation with Appeals and Grievance

Medicare Advantage Provider shall cooperate with Health Plan in the implementation of Health Plan's grievance and appeals procedures, including Health Plan's Medicare Member grievance, appeals, and expedited appeals procedures, as set forth in the Agreement and Provider Manual, and will assist Health Plan in taking appropriate corrective action and gathering and forwarding Member documentation to Health Plan in a timely manner. Medicare Advantage Provider will comply with all final determinations made by Health Plan, CMS, CMS's contracted independent agency, or the local peer review organization ("PRO") pursuant to such grievance and appeals procedures. Medicare Advantage Provider understands that Members are entitled to appeal denial and discharge decisions to an independent entity contracted by CMS or to the PRO. Upon request by Health Plan, Medicare Advantage Provider shall promptly deliver to a Member any required denial letter. Medicare Advantage Provider shall cooperate in the delivery of notice of discharge and Medicare appeal rights or other materials from Health Plan containing Members' appeal rights and with the parties responsible for performing the review and reconsideration. In addition, Medicare Advantage Provider shall notify Health Plan promptly of any decision by Medicare Advantage Provider not to furnish to a Member Health Services requested by a Member or to terminate or discontinue Health Services being provided to a Member which termination or discontinuation is contrary to the Member's wishes and of any Member grievances and appeals known to Medicare Advantage Provider. Health Plan and the PRO will review Members' grievances concerning quality of care. Upon request of Health Plan, Medicare Advantage Provider shall investigate and respond promptly to all quality issues related to care provided to Members and cooperate with the PRO and Health Plan to resolve such issues in the best interest of Members. [42 CFR §422.562(a)]

25. Participating Provider Referrals

Medicare Advantage Provider shall refer Members to Participating Providers and treat Members at Participating Providers, unless otherwise expressly authorized by Health Plan prior to any such referral. If Medicare Advantage Provider does not have admitting privileges at a Participating Provider, Medicare Advantage Provider shall refer the Member to a Participating Medicare Advantage Provider with admitting privileges at a Participating Provider. In the event Medicare Advantage Provider refers a Member to or treats a Member at a non-participating provider, Health Plan shall not be responsible for payment to Medicare Advantage Provider for Medicare Advantage Provider's services, and Medicare Advantage Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person acting on the Member's behalf for Medicare Advantage Provider's services. The

requirements of this paragraph shall not apply to any emergency medical treatment of a Member. [42 CFR § 422.100(b)]

26. Noninterference with Medical Care

Medicare Advantage Provider shall at all times provide treatment to Members in a manner consistent with sound medical judgment and practice. Health Plan shall not require Medicare Advantage Provider to take any action inconsistent with his/her/its professional judgment concerning the medical care and treatment to be provided to Members. However, Health Plan reserves the right to make coverage decisions when a dispute exists between the Member and the Medicare Advantage Provider regarding the Medical Necessity of a Covered Service. Medicare Advantage Provider will maintain the relationship of physician and patient with Medicare members, without intervention in any manner by Health Plan or employees, and Medicare Advantage Provider will be solely responsible for all medical advice to and treatment of his/her/its patients and for the performance of all medical services in accordance with accepted professional standards and practices. Medicare Advantage Provider shall be free to communicate with patients regarding the treatment options available to them, including medication treatment options, regardless of benefit coverage limitations, and shall also be free to discuss compensation arrangements with patients. [42 CFR § 422.206]

27. Dual Eligible

For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Medicare Advantage Provider will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Medicare Advantage Provider may not impose cost sharing that exceeds the amount of cost sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Medicare Advantage Provider will accept the Medicare Advantage plan payment as payment in full, or bill the appropriate state source. [42 CFR § 422.107]

28. Subcontractors

In the event Medicare Advantage Provider uses subcontractors to perform any services under the Agreement or this Addendum, Medicare Advantage Provider shall require such subcontractor to comply with all of the Medicare Advantage Provider's obligations in the Agreement and this Addendum and include a prompt payment provision. Such contract shall provide for a specific term and be dated and signed by the Medicare Advantage Provider and subcontractor. [42 CFR § 422.504]

29. Risk Adjustment Data Validation Audits

Records requested by Health Plan or CMS for purposes of validation of risk adjustment shall be provided promptly and without cost to Health Plan. Medicare Advantage Provider shall also provide whatever other information is necessary to meet the reporting requirements and in the format required by the Health Plan in accordance with CMS requirements or Health Plan requirements. Medicare Advantage Provider agrees to certify the accuracy, completeness, and truthfulness of the Risk Adjustment Data that it provides to Health Plan for submission to CMS. [42 CFR § 422.310]

30. Compliance Training and Education

Medicare Advantage Provider agrees to cooperate with and participate in all compliance training provided by the Health Plan, including but not limited to, Fraud and Abuse and False Claims training/education. [42 CFR § 422.503]

31. Conflict

In the case of any conflict between the terms and provisions of the Agreement and this Addendum, the terms and provisions of this Addendum shall prevail.