PROVIDER AGREEMENT

Aetna Network Services LLC, on behalf of itself and its Affiliates ("Company"), and _____**,** on behalf of itself and any and all of its Group Providers and locations ("Provider"), are entering into this Provider Agreement (the "Agreement"), as of the Effective Date listed below.

The Agreement includes this cover/signature page, the **General Terms and Conditions** and **Definitions** that follow. It also includes one or more of the following parts:

i) **State Compliance Addenda** that contain state-specific requirements for various Product Categories;
ii) **Product Addenda** that include additional requirements for specific Product Categories;
iii) **Service and Rate Schedules** that go along with the various Product Addenda;
iv) **Appendices** and/or other attachments containing definitions and/or other information.

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

	PRODUCT CATEGORIES
✓	Commercial Health
✓	Medicare
✓	Medical Rental Network
	Institutes of Excellence® (IOE) Transplant Program (subject to separate approval by Company)

EFFECTIVE DATE: (or later date that credentialing is complete) (the "Effective Date") _____

TERM: This Agreement begins on the Effective Date, continues for an initial term of three (3), and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term, or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least ninety (90) days advance written notice to the other Party. Additional termination provisions are included in the Agreement.

GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

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

(a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS).

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies.

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (ii) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (iii) change in the ownership or management of Provider; and (iv) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

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

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

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

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum)).

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within one hundred and twenty (120) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission.

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment or payment/claim denial dispute, within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for

the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims.

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims.

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider , the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Provider with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.

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

2.0 COMPANY OBLIGATIONS

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

(a) unless an exception is stated in the applicable **Product Addendum**, Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans.

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement.

(d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

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

(a) when it is the Payer, to pay Provider for Covered Services rendered to Members; and
(b) when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services,

within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Provider acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Provider, as appropriate, in collecting payments from Payers.

3.0 NETWORK PARTICIPATION

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

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

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

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

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

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) as required by Applicable Law; (b) to governmental authorities having jurisdiction; (c) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (d) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Provider will keep the rates and the development of rates and other terms of this Agreement confidential; provided, however, that nothing herein shall be deemed to prohibit Provider and Company/or a Payer from disclosing rates/and other information as required by Applicable Law (e.g., to promote transparency in pricing and quality information). Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

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

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent.

6.3 **Interference with Contractual Relations**. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution** Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not

limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum** and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.4 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.5 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Additionally, Company may amend this Agreement, upon at least ninety (90) days prior written notice to Provider. If Provider is not willing to accept an Amendment that is not required by Applicable Law, it may terminate the Agreement, with at least sixty (60) days written notice to Company in advance of the effective date of the Amendment.

8.6 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail, nationally recognized courier, or electronic mail (with proof of delivery in any case), to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

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

DEFINITIONS

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

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

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

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

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

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

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

Party. Company or Provider, as applicable.

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

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

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

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

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

MEDICARE ADVANTAGE PRODUCT ADDENDUM

The terms of this Medicare Advantage Product Addendum ("Addendum") apply to Provider's participation in the Medicare Advantage Product as described below. All terms and conditions of the Agreement not in conflict with the terms and conditions set forth in this Addendum shall apply to this Addendum. In the event of a conflict between the terms of the Agreement and this Addendum, the terms of this Addendum shall apply. All terms not capitalized herein shall have the meanings ascribed to them in the Agreement. The term "Applicable Law" or "applicable law" as used in the Agreement shall include, as it relates to this Addendum, all applicable orders, directives, instructions, sub-regulatory guidance, and other requirements of any Official, including requirements for Medicare Advantage plans that pertain to participation as a First Tier or Downstream Entity in the Medicare Advantage Program.

1. DESCRIPTION. The Medicare Advantage Product includes the Medicare Advantage ("MA") plan(s) offered, administered and/or serviced by Company for Medicare beneficiaries in connection with a contract with the Centers for Medicare and Medicaid Services ("CMS") pursuant to Part C of Title XVIII of the Social Security Act ("Company's Medicare Plans"). Nothing herein requires that Provider be included in or designated as a Participating Provider in all MA plan(s)/plan variations or network(s) or in any specific geographic location(s).

2. PAYMENT.

A. Reimbursement. Reimbursement under this Addendum shall be made in accordance with the applicable Service and Rate Schedule in the Agreement. Provider acknowledges that payments made to Provider by Company are made in whole or in part with Federal funds and subject Provider to those laws applicable to individuals/entities receiving Federal funds. [45 C.F.R. part 84 and 45 C.F.R. part 91].

B. Prompt Pay. Company shall pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500. Company shall pay Provider as set forth in the applicable Service and Rate Schedule in the Agreement and in accordance with 42 CFR § 422.520(b).

C. Overpayments. Company shall have the right to pursue overpayments from Provider within three (3) years from the claim payment date.

D. Medicare Payment Adjustment. Company shall not pay any amounts beyond the amounts set forth in the applicable Service and Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or Applicable Law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment and shall continue to adjust payments to Provider until the earlier of the date (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment. Medicare Payment Adjustments do not include performance-based incentive payments made under traditional Medicare as the result of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") and its implementing regulations, as may be amended from time to time.

3. ASSIGNMENT. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Addendum, along with the underlying Agreement and any Service and Rate Schedules

applicable to participation in Company's Medicare Plans, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of Company's Medicare Plans, Company may also create and assign to the purchaser a duplicate of this Addendum along with the underlying Agreement and any Service and Rate Schedules applicable to participation in Company's Medicare Plans. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

4. SUBCONTRACTING. Provider shall require all of its subcontractors, if any, to comply with Applicable Law.

A. **Contract Requirements.** Provider shall include in Provider's contracts with subcontractors all contractual and legal obligations required to appear in such contracts under Applicable Law. To the extent CMS requires additional provisions to be included in such subcontracts, Provider shall amend its contracts accordingly.

B. **Delegation.** If Provider delegates to a subcontractor a service required by this Agreement, and the service is required under the terms of Company's CMS Contract, Provider's subcontract shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. If Company delegates a function to Provider, Company retains the right to approve, suspend or terminate such delegation. In addition, Provider shall prohibit its subcontractors from further subcontracting or delegating services required under the terms of Company's CMS Contract without prior written consent from Company.

5. COMPLIANCE OBLIGATIONS

A. Compliance with CMS Contract, Law. Any services performed by Provider or its subcontractors for Company's Medicare Plans shall be consistent with Company's obligations under its CMS Contract and comply with Applicable Law. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 C.F.R. § 423.505(i)(3)(iii)] [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 C.F.R. § 423.505(i)(4)(iv)].

B. Compliance with Medicare Policies Provider shall comply with Policies applicable to Company's Medicare Plans, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes. [42 C.F.R. § 422.503] and [42 C.F.R. § 422.504] and [Medicare Managed Care Manual, Chapter 11, Section 100.4].

C. Grievances/Appeals. Provider agrees to cooperate with Company in resolving Medicare complaints, appeals, and grievances in accordance with Applicable Law. [42 C.F.R. § 422.504(a)(7)].

D. Offshore Services. If Provider (or its subcontractors) provides services for Company's Medicare Plans that involve the receipt, processing, transferring, handling, storing or accessing of Protected Health Information ("PHI") Offshore ("Offshore Services"), Provider agrees to complete Company's Offshore Services Attestation prior to the commencement of Offshore Services, within fifteen (15) days of a material change in scope or delivery of Offshore Services, and no less than annually. [42 C.F.R. §§ 422.504(i)(4) and (5)]. If Provider maintains existing Offshore Services on the effective date of this Addendum, Provider shall complete Company's Offshore Services Attestation within fifteen (15) days of such effective date. Notwithstanding the foregoing, in the event Provider (or its subcontractors) provides services for a Company Medicare Plan that is a Dual Eligible Special Needs Plan (DSNP) and the state in which the DSNP Medicare Members reside prohibits the offshoring of DSNP Medicare Member data through policy, regulation, statute, or the State Medicaid Agency Contract (SMAC) with Company, then Provider (or its subcontractors) must comply with the state requirement to keep DSNP Medicare Member data onshore in accordance with the policy, regulation, statute, or SMAC.

E. Excluded Entities. Provider agrees that no person or entity that provides services, directly or indirectly, for Company's Medicare Plans, may be an Excluded Entity under Section 1128 or 1128A of the Social Security Act. Provider shall screen the Exclusion Lists prior to initially hiring/contracting and monthly thereafter to

ensure no employee or subcontractor appears on Exclusion Lists. If any employee or subcontractor appears on an Exclusion List or is otherwise prohibited from receiving payment under the Medicare program by Federal law, Provider will remove such individual or entity from any direct or indirect work on Company's Medicare Plans and promptly notify Company of the same.

F. Compliance Program and Anti-Fraud Initiatives. Provider shall maintain an effective compliance program to prevent, detect, and correct: (1) non-compliance with CMS's program requirements and (2) fraud waste and abuse ("FWA"). Such compliance program shall include dissemination to employees and Downstream Entities of (a) written policies and/or standards of conduct articulating the entity's commitment to compliance with Applicable Law, initially within ninety (90) days of hire/contracting, and at least annually thereafter; (b) communications regarding the obligation to report potential non-compliance or FWA issues (internally and to payers, including Company, as applicable), and a no-tolerance policy for retaliation or retribution for good faith reporting, and reporting mechanisms to employees and Downstream Entities and (c) appropriate training and education to ensure familiarity with and compliance with the compliance program. Provider, through its compliance program shall establish and maintain a process to: oversee and ensure that employees and Downstream Entities perform applicable services for Company's Medicare Plans consistent with this Agreement and Applicable Law and shall require implementation of disciplinary actions and corrective actions up to terminations where needed to ensure such compliance. Provider shall require that any Downstream Entity maintains an effective compliance program consistent with the requirements of this section. [42 C.F.R. §§ 422.504(i)(2)(i) and (iv)] and [42 C.F.R. §423.505].

G. Home Infusion Drugs. If Provider dispenses home infusion drugs that are covered under both Medicare Part B and Medicare Part D to a Medicare Member and such Medicare Member has MA-PD coverage offered by Company ("Home Infusion Drug") then Provider agrees that the home infusion drugs section in the Provider Manual shall, as required by Applicable Law, be considered a part of this Agreement. If Provider dispenses Home Infusion Drugs to a Medicare Member that are covered under the Medicare Member's Plan, then Provider agrees that the Home Infusion Drug provisions in the Provider Manual shall, as required by Applicable Law, be considered a part of this Addendum.

H. Marketing. Provider shall comply with the Medicare Communications and Marketing Guidelines ("MCMGs") as codified in 42 CFR 422.2260-422.2266 and 422.2274 and 423.2260-422.2266 and 423.2274 and shall remain neutral when assisting Medicare beneficiaries with enrollment decisions.

I. Provider Directory. Provider shall promptly provide Company with notice of any changes in Provider information set forth in Company's provider directory, including Provider's ability to accept new patients, the closing of a Provider's panel, the retirement or a provider leaving the group, or other similar changes at least thirty (30) days prior to the effective date of the change or no later than 10 days after such event. Provider shall respond to requests from Company for updated directory information within ten (10) calendar days of receipt of such request. [42 CFR §422.111(b)(3)] and [Medicare Managed Care Manual, Chpt. 4, § 110.2].

6. MEDICARE MEMBER PROTECTIONS.

A. Hold Harmless. Provider shall not hold Medicare Members liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)].

B. Continuation of Benefits. If Company's CMS Contract terminates or Company becomes insolvent or fails to make payment under this Agreement, Provider shall continue to provide Covered Services to Medicare Members who are hospitalized through the date of discharge and shall be prohibited from billing Medicare Members for such Covered Services. [42 C.F.R. § 422.504(g)(2)(i) and (ii)].

C. Non-Covered Services. Provider must hold Medicare Members harmless for the cost of non-covered services, except for normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles), unless the Medicare Member has received a pre-service organization determination notice of denial from Company before such services are rendered by Provider. This restriction on holding a Medicare Member financially responsible for non-covered services does not apply in instances where a service is never covered by Medicare

under any circumstance. [CMS, Memorandum to Medicare Advantage Plans, et. al, "Improper Use of Advance Notices of Non-coverage" (May 5, 2014).] [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 C.F.R. §423.505(i)(3)(i)].

D. Dual Eligible Cost Share. Provider shall not hold Medicare Members eligible for both Medicare and Medicaid liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Provider shall 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. Provider will: (1) accept Company's payment as payment in full, or (2) bill the appropriate state source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(iii)].

7. RECORDS AND AUDIT.

A. Maintenance of Records. Provider shall preserve records applicable to Medicare Members and to Company's Medicare Plans, including its compliance with Applicable Law and this Agreement for the longer of: (i) the period of time required by state and federal law, or (ii) ten (10) years. In addition, to the extent applicable, Provider shall comply with 42 C.F.R. §422.2480(c) and maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Plans and/or evidence needed by Company and/or Officials to validate MLRs (collectively, "MLR Records") for ten years from the year in which such MLRs are filed by Company.

B. Audit. Provider agrees that Officials, including but not limited to HHS, the Comptroller General, or their designees have the right to directly or indirectly audit, evaluate, and inspect any pertinent information possessed by Provider or its Downstream Entities and relating to Company's Medicare Plans and any CMS Contract for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of First Tier and Downstream Entities) (collectively, "Records") through 10 years from the final date of the Final Contract Period of the CMS Contract or from the date of Completion of Audit, whichever is later. Provider shall make best efforts to notify Company within two (2) business days of any request by an Official, or their designees, to audit or evaluate Provider Records, and to the extent feasible, shall provide Company the right to participate in any such evaluation of Provider. [42 C.F.R. §§ 422.504(i)(2)(i), (ii), and (iv)] and [42 C.F.R. § 423.505(i)(2)(i), (ii), and (iv)].

C. Confidentiality and Accuracy of Records. Provider will comply with the confidentiality and Medicare Member record accuracy requirements, including: (1) abiding by all federal and state laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with Applicable Law, or pursuant to valid court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Medicare Members to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR § 423.136].

D. Submission and Certification of Encounter Data. Provider acknowledges that Company is required to provide CMS, other Officials and accrediting organizations with encounter data, including medical records and claims data. Provider shall routinely provide such encounter data to Company in the form and manner requested by Company. Provider certifies that such encounter data shall be accurate, complete and truthful to the best of its knowledge and belief. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data. Provider acknowledges its coding of claims and documentation to support such is relied on by CMS for audits and payment calculations. Provider shall routinely provide education and oversight to its staff that support coding and documentation and for its third-party billers, as applicable, on coding and documentation. Provider agrees to participate in Company's training and education on coding, from time to time. In the alternative, Provider may provide similar coding and documentation training and certify such to Company provided the training complies with CMS and other required coding guidance. If there are issues or patterns and practice that need to be corrected as determined by audits, including those by CMS such as for RADV audits, OIG audits, Company audits or audits by other

governmental regulators, Provider agrees to fully cooperate and comply with Company's recommendations including completing any corrective action plans, participating in training and education or offering its own training and education as well as correcting its coding, clams and documentation.

E. Company Oversight/Information and Records. Provider acknowledges and agrees that Company shall monitor, shall have the right to audit, and remains accountable for, the functions and responsibilities performed by Provider for Company's Medicare Plans. Accordingly, in addition to specific requirements for information and records set forth in this Addendum, Provider agrees to promptly provide to Company any information and records, including without limit, MLR Records, if applicable, and information and records that are reasonably needed by Company: (1) for administration of Company's Medicare Plans, (2) to monitor and audit performance of Provider and its subcontractors with this Agreement, Applicable Law, and requirements of accreditation agencies, including information regarding Provider's oversight and monitoring of its Downstream Entities (including a summary of any results of such activities), and (3) to fulfill any reporting requirements Company may have to CMS or other Officials, including information about any physician incentive plan that Provider may have relating to this Agreement. Provider shall complete an attestation from Company to confirm its compliance with requirements of this Agreement as it relates to Company's Medicare Plans upon request and agrees that Company may require corrective actions in the event of non-compliance with the requirements of this Agreement. Ultimately, should Company determine such noncompliance has not been or is not capable of being corrected to Company's satisfaction, Company may terminate Provider's participation in Company's Medicare Plans in accordance with the terms of the Agreement.

8. TERMINATION. This Addendum may be terminated on its own without respect to the remainder of the Agreement, with or without cause, by either Party in accordance with the termination provisions of the underlying Agreement, except that no termination of this Medicare Addendum shall occur without cause or for convenience with less than ninety (90) days advance notice to the other party. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement. If this Addendum is terminated by either Party, Provider shall no longer participate in Company's Medicare Plans as of the effective date of the termination.

9. DEFINITIONS:

A. CMS Contract: The contract(s) with CMS governing Company's Medicare Plans.

B. Completion of Audit: Completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of Company or of any First Tier, Downstream, or Related Entity.

C. Downstream Entity: Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with Company's Medicare Plans, below the level of the arrangement between an MA organization and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

D. Excluded Entity: A person or entity listed on the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") List of Excluded Individuals and Entities and the General Services Administration System for Awards Management ("SAM") or appearing on the Federal Preclusion List.

E. Exclusion Lists: Collectively, the HHS OIG List of Excluded Individuals and Entities and the SAM.

F. Final Contract Period: The final term of the applicable CMS Contract governing Company's Medicare Plan(s).

G. First Tier Entity: Any party that enters into a written arrangement, acceptable to CMS, with an MA organization to provide administrative services or health care services for Medicare Members.

H. Medicare Member: A Medicare Advantage eligible individual who has enrolled in a Company Medicare Plan.

I. Officials: Federal and state regulatory agencies or officials with jurisdiction, including but not limited to CMS, HHS, the Comptroller General and their designees

J. Offshore: Physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands)

K. Policies: Company's policies and procedures that relate to this Agreement, including, but not limited to, participation criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. This includes but is not specifically limited to Medicare Policies.

L. Provider Manual: Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers, including but not limited to Medicare specific content.

BEHAVIORAL HEALTH PROVIDER
SERVICES AND RATE SCHEDULE

RATE:

Payment Details:

Service	Billing Codes	Rates
All Services not otherwise identified		100% of Aetna Market Fee Schedule

SERVICES:

Provider will provide services which are within the scope of and appropriate to the Provider's license and certification to practice.

RATE TERMS AND CONDITIONS:

Definitions

"Aetna Market Fee Schedule" (AMFS) **–** A fee schedule that is based upon the contracted location where services are performed. Company may periodically update this fee schedule.

"Gatekeeper products" – For purposes of this Service and Rate Schedule, Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which encourage or promote the use of a Primary Care Provider, regardless of whether (i) selection of a Primary Care Provider is mandatory or voluntary under the terms of the Plan; or (ii) an individual Member has selected a Primary Care Provider. Examples of Gated Commercial Health Products include, but are not limited to: HMO (Health Maintenance Organization), POS (Point of Service) (e.g., *Managed Choice POS*, *Aetna Choice POS II*), EPO (Exclusive Provider Organization). In some circumstances, certain Commercial Health Products (e.g., FEHB plans, student health plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Non-Gatekeeper products" – For purposes of this Service and Rate Schedule, Non-Gatekeeper products refer to Commercial Health Products offered, administered and/or serviced by Company which do not allow for the designation and/or use of a Primary Care Provider in the administration of the product. Examples of Non-Gated Commercial Health Products include, but are not limited to: PPO (e.g., *Open Choice PPO*), Aetna Signature Administrators®, Passport to Healthcare® and the National Advantage program. In some circumstances, certain Commercial Health Products (e.g., FEHB plans, student health plans) may be available on both a "Gatekeeper" and "Non-Gatekeeper" basis.

"Telemedicine" Telemedicine is the delivery of clinical medicine via real-time telecommunications such as telephone, the Internet, or other communications networks or devices that do not involve direct patient contact. For purposes of this Schedule, Telemedicine includes only those services that are included in and provided in compliance with Company Policies.

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full. Company will pay the lesser of the contracted rate or eligible billed charges.

b) Unless otherwise required by Applicable Law, reimbursement for qualified behavioral healthcare providers and Licensed Master Level Practitioner (e.g., Clinical Psychologist, Psychiatric Nurses, Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may differ, based on our then current reimbursement policies, as updated from time to time, at Company's discretion**.**

c) As of the Effective Date of the Agreement, Company allows charges per standard policy guidelines for the services billed for a non-recognized provider type (unable to practice independently) if the following conditions are met:

- the non-recognized provider is employed by and works under the direct supervision of a legally qualified practitioner, and
- the non-recognized provider is licensed and qualified to provide services by either degree or professional credentials, and
- the services are prescribed or recommended by a participating provider, and
- the contract covers the services, and
- the services are billed by the non-recognized provider's employer/ supervising practitioner.

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

d) CPT-4 codes included in the Professional Component of this Agreement apply to the services rendered and are not limited to the specialty of the performing provider.

e) Unless prohibited by Applicable Law, Company may, at its sole discretion, upon thirty (30) days prior written notice to Provider reduce the rates for Covered Services by ten percent (10%) for a three (3) month period should Provider fail to provide timely notice of change in Provider information to Company as required and set forth in the Agreement, e.g., changes in notice address, location, staff and demographics.

f) Those items marked as "Paid In Addition to" will not be included in the rate calculation for services contracted with a "Rate Applies to Entire Bill" methodology and will be reviewed and priced individually according to their contracted rate.

g) Certain Plans may cover Telemedicine for specific services. For those Plans, the rates for covered Telemedicine services will be as set forth in this Schedule, unless other rates are required by applicable law and/or Company's then-current Policies. The list of applicable services that may be provided through Telemedicine will be listed in Company Policies. Telemedicine services must be provided in accordance with Company Policies (including, but not limited to the Participation Criteria) and there will be no coverage for Telemedicine services not provided in accordance with Company Policies.

h) The parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (e.g., MIPS, APM).

Billing

i) Provider must designate the codes set forth in this Rate Schedule when billing.

j) Company shall not pay any amounts beyond the amounts set forth in the applicable Service & Rate Schedule, including but not limited to any incentive payments that may be payable under traditional Medicare, except as expressly required by the Agreement or applicable law. Further, the Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment

Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Provider will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Provider on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjust payments to Provider until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment. Medicare Payment Adjustments do not include performance-based incentive payments made under traditional Medicare as the result of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and its implementing regulations, as may be amended from time to time.

COMMERCIAL HEALTH PRODUCT ADDENDUM

The term Commercial Health Product means those commercial health products, benefit plans, programs, and networks offered, administered and/or serviced by Company.

It includes Federal Employee Health Benefit Programs (FEHB) and other Office of Personnel Management (OPM) plans and both full or partially insured plans, as well as self-funded plans administered and/or serviced by Company, whether group or individual. Examples of Commercial Health Products include, but are not limited to: *HMO, PPO, EPO, POS, QPOS, Elect Choice, Open Choice, Managed Choice POS, Aetna Choice POS II, Aetna Select, Aetna Student Health, indemnity plans with network incentives, Aetna Signature Administrators®, Joint Claims Administration, Meritain/Meritain Shared Administrative Services, Passport to Healthcare® and National Advantage Program*.

Nothing in this Addendum requires Company to include Provider in any specific Commercial Health Product(s). Provider's participation may be terminated by Company from one or more Commercial Health Products with ninety (90) days' prior written notice to Provider, without affecting participation in any other Commercial Health Products or other Product Categories.

Note:
If the Member's Plan includes the NAP Program, Company may apply the commercial product rates listed on the Commercial Health Product Service and Rate Schedule. Not all Member ID cards for Plans that include NAP list the NAP logo.

MEDICAL RENTAL PRODUCTS ADDENDUM

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

2. Designation of Medical Rental Products. Company designates the following as Medical Rental Products as of the Effective Date:

   First Health®

   Any specialty program agreements (e.g., Institutes of Excellence™ Transplant Program contracts) between Provider and Company or its Affiliates shall continue to apply to services rendered under such specialty program(s) unless Company specifically notifies Provider otherwise in writing. The First Health client list is available at www.firsthealth.com. Once you have registered then select "Client List."

3. Payment. In consideration of Provider's agreement to provide Covered Services to Members of Medical Rental Products in accordance with this Medical Rental Products Addendum ("Addendum") and the Agreement, Provider shall be paid according to the terms set forth in Service and Contract Rate Schedule attached to the Agreement. Provider understands and agrees that the utilization management/claims management, appeal and/or other policies of the applicable Payer (which may differ from Company's policies) shall apply. Provider also understands that certain Payers for Medical Rental Products may include or exclude certain experimental and/or investigational services as Covered Services under their Plans, even if those services are treated differently by Company or other Payers under other Product Addenda. Provider understands and agrees that the applicable Payer (subject to applicable Member copayments, coinsurance and deductibles) and not Company is responsible for paying Provider claims and fees for Covered Services related to the Medical Rental Products and that, in no event, shall Company be responsible for funding claims or paying provider, in whole or in part. Provider agrees that it shall not file suit against Company as a result of any Payer's or Member's nonpayment or underpayment. In regard to any Covered Service with no Contract Rate in this Exhibit, compensation for such services shall be at the rate established by the Centers for Medicare and Medicaid Services (CMS). If CMS does not have a rate, the compensation amount will be determined by Company, utilizing legacy payments for that service, medical director valuations and/or other pricing file tools, but in no case shall such compensation exceed 70% of billed charges.

4. Other Provisions. Notwithstanding anything to the contrary in the Agreement, Company may, in its discretion, sell, lease, transfer, rent or grant access to any third parties the benefits of the Agreement and may eliminate and/or designate new Medical Rental Products under this Addendum. Nothing in the Agreement or this Addendum shall require Company to designate (or continue to designate) Provider as a participating network provider for all or any specific Medical Rental Products, Payers, and/or geographic locations.

5. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Addendum, along with the underlying Agreement and any Service and Rate Schedules applicable to participation in Company's Medical Rental Products/lines of business and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of Company's Medical Rental Products/lines of business, Company may also create and assign to the purchaser a duplicate of this Addendum along with the underlying Agreement and any Service and Rate Schedules applicable to participation in Company's Medical

Rental Products/lines of business. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

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

BEHAVIORAL HEALTH MEDICAL
RENTAL PRODUCTS SERVICE RATE SCHEDULE

For Covered Services rendered to a Member, Provider will accept the lesser of (i) the rate listed in the grid below or (ii) 70% of Eligible Billed Charges.

RATE:

Service	Billing Codes	Rates
All Services not otherwise identified		100% of Aetna Market Fee Schedule

SERVICES:

Provider will provide services which are within the scope of and appropriate to the Provider's license and certification to practice.

SERVICE AND RATE TERMS AND CONDITIONS:

Definitions

"Aetna Market Fee Schedule" (AMFS) – A fee schedule that is based upon the contracted location where services are performed. Company may periodically update this fee schedule.

"Eligible Billed Charge" - the amount billed by Provider for a Covered Service less charges due to the application of billing, coding, reimbursement criteria, standards, or guidelines in accordance with applicable Policies of Company, Customer or Payor.

"Service Groupings" A grouping of codes (e.g., HCPCS, CPT4, ICD-10 (or successor standard)) that are considered similar services and are contracted at one rate under the Behavioral Health Medical Rental Products Service and Rate Schedule

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax. For procedures and/or services not specifically listed above, Provider agrees to accept then current Aetna Market Fee Schedule or the percentage defined of Eligible Billed Charges as payment in full.

b) Unless otherwise required by Applicable Law, reimbursement for qualified behavioral healthcare providers and Licensed Master Level Practitioner (e.g., Clinical Psychologist, Psychiatric Nurses, Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may differ, based on our then current reimbursement policies, as updated from time to time, at Company's discretion**.**

c) CPT-4 codes included in the Professional Component of this Agreement apply to the services rendered and are not limited to the specialty of the performing provider.

d) Those items marked as "Paid In Addition to" will not be included in the rate calculation for services contracted with a "Rate Applies to Entire Bill" methodology and will be reviewed and priced individually according to their rate.

Billing

e) Provider must designate the codes set forth in this Behavioral Health Medical Rental Products Service and Rate Schedule when billing.

Notwithstanding anything to the contrary in this Behavioral Health Medical Rental Products Service and Rate Schedule, the terms of this Medical Rental Products Service and Rate Schedule have been subject to negotiation and in no case shall compensation for any Covered Service exceed the Eligible Billed Charge.

State Compliance Addendum

MICHIGAN

The State Compliance Addendum attached to this Agreement, is expressly incorporated into this Agreement and is binding upon the Parties to this Agreement. In the event of any inconsistent or contrary language between the State Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the State Compliance Addendum shall prevail, but, if applicable, only with respect to a particular line of business (e.g., fully-insured HMO) and/or Product.

No State-specific requirements.

8/1/2022 Michigan - Behavioral Health - Eastern Market

State	Product	Service Code	Physician (1, 7)	Clinical Psychologist (2)	Other Therapists (3)	Psychiatric Nurse/Physician Assistant/Nurse Practitioner (4, 5, 6, 7)	Location Specific
MI	All Products	90785	$16.36	$16.36	$12.27	$13.91	
MI	All Products	90791	$153.73	$153.73	$115.30	$130.67	
MI	All Products	90792	$169.82	$0.00	$0.00	$144.35	
MI	All Products	90832	$75.32	$75.32	$56.49	$64.02	
MI	All Products	90833	$78.00	$0.00	$0.00	$66.30	
MI	All Products	90834	$114.40	$114.40	$85.80	$97.24	
MI	All Products	90836	$126.88	$0.00	$0.00	$107.85	
MI	All Products	90837	$168.48	$168.48	$126.36	$143.21	
MI	All Products	90838	$183.04	$0.00	$0.00	$155.58	
MI	All Products	90839	$156.00	$156.00	$117.00	$132.60	
MI	All Products	90840	$74.94	$74.94	$56.21	$63.70	
MI	All Products	90846	$114.40	$114.40	$85.80	$97.24	
MI	All Products	90847	$117.81	$117.81	$88.36	$100.14	
MI	All Products	90849	$46.80	$46.80	$45.76	$45.76	
MI	All Products	90853	$46.80	$46.80	$45.76	$45.76	
MI	All Products	90867	$285.55	$285.55	$214.16	$242.72	Office
MI	All Products	90867	$285.55	$285.55	$214.16	$242.72	Non-Office
MI	All Products	90868	$239.20	$239.20	$179.40	$203.32	Office
MI	All Products	90868	$239.20	$239.20	$179.40	$203.32	Non-Office
MI	All Products	90869	$260.71	$260.71	$195.53	$221.60	Office
MI	All Products	90869	$260.71	$260.71	$195.53	$221.60	Non-Office
MI	All Products	90870	$188.87	$188.87	$141.66	$160.54	
MI	All Products	90880	$117.61	$117.61	$88.21	$99.97	
MI	All Products	90901	$87.36	$87.36	$68.64	$74.26	
MI	All Products	96112	$156.34	$156.34	$117.26	$132.89	Office
MI	All Products	96112	$156.34	$156.34	$117.26	$132.89	Non-Office
MI	All Products	96113	$69.98	$69.98	$52.49	$59.48	Office
MI	All Products	96113	$69.98	$69.98	$52.49	$59.48	Non-Office
MI	All Products	96116	$110.87	$110.87	$91.52	$94.24	Office
MI	All Products	96116	$110.87	$110.87	$91.52	$94.24	Non-Office
MI	All Products	96121	$96.36	$96.36	$72.27	$81.90	Office
MI	All Products	96121	$96.36	$96.36	$72.27	$81.90	Non-Office
MI	All Products	96130	$135.34	$135.34	$101.50	$115.03	Office
MI	All Products	96130	$135.34	$135.34	$101.50	$115.03	Non-Office
MI	All Products	96131	$104.64	$104.64	$78.48	$88.95	Office
MI	All Products	96131	$104.64	$104.64	$78.48	$88.95	Non-Office
MI	All Products	96132	$150.99	$150.99	$113.24	$128.34	Office
MI	All Products	96132	$150.99	$150.99	$113.24	$128.34	Non-Office
MI	All Products	96133	$113.78	$113.78	$85.33	$96.71	Office
MI	All Products	96133	$113.78	$113.78	$85.33	$96.71	Non-Office
MI	All Products	96136	$52.99	$52.99	$39.74	$45.04	Office
MI	All Products	96136	$52.99	$52.99	$39.74	$45.04	Non-Office
MI	All Products	96137	$48.39	$48.39	$36.29	$41.13	Office
MI	All Products	96137	$48.39	$48.39	$36.29	$41.13	Non-Office
MI	All Products	96138	$42.13	$42.13	$31.60	$35.81	Office
MI	All Products	96138	$42.13	$42.13	$31.60	$35.81	Non-Office
MI	All Products	96139	$42.13	$42.13	$31.60	$35.81	Office
MI	All Products	96139	$42.13	$42.13	$31.60	$35.81	Non-Office
MI	All Products	96146	$2.61	$2.61	$1.96	$2.22	Office
MI	All Products	96146	$2.61	$2.61	$1.96	$2.22	Non-Office
MI	All Products	99058	$30.00	$30.00	$30.00	$30.00	Office
MI	All Products	99058	$30.00	$30.00	$30.00	$30.00	Non-Office
MI	All Products	99202	$84.78	$0.00	$0.00	$72.06	Office
MI	All Products	99202	$84.78	$0.00	$0.00	$72.06	Non-Office
MI	All Products	99203	$122.75	$0.00	$0.00	$104.34	Office
MI	All Products	99203	$122.75	$0.00	$0.00	$104.34	Non-Office
MI	All Products	99204	$188.07	$0.00	$0.00	$159.86	Office
MI	All Products	99204	$188.07	$0.00	$0.00	$159.86	Non-Office
MI	All Products	99205	$235.68	$0.00	$0.00	$200.33	Office
MI	All Products	99205	$235.68	$0.00	$0.00	$200.33	Non-Office
MI	All Products	99211	$25.28	$0.00	$0.00	$21.49	Office
MI	All Products	99211	$25.28	$0.00	$0.00	$21.49	Non-Office
MI	All Products	99212	$55.84	$0.00	$0.00	$47.46	Office

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State	Product	Service Code	Physician (1, 7)	Clinical Psychologist (2)	Other Therapists (3)	Psychiatric Nurse/Physician Assistant/Nurse Practitioner (4, 5, 6, 7)	Location Specific
MI	All Products	99212	$55.84	$0.00	$0.00	$47.46	Non-Office
MI	All Products	99213	$91.20	$0.00	$0.00	$77.52	Office
MI	All Products	99213	$91.20	$0.00	$0.00	$77.52	Non-Office
MI	All Products	99214	$129.37	$0.00	$0.00	$109.96	Office
MI	All Products	99214	$129.37	$0.00	$0.00	$109.96	Non-Office
MI	All Products	99215	$180.95	$0.00	$0.00	$153.81	Office
MI	All Products	99215	$180.95	$0.00	$0.00	$153.81	Non-Office
MI	All Products	99217	$83.12	$0.00	$0.00	$70.65	Office
MI	All Products	99217	$83.12	$0.00	$0.00	$70.65	Non-Office
MI	All Products	99218	$114.72	$0.00	$0.00	$97.51	Office
MI	All Products	99218	$114.72	$0.00	$0.00	$97.51	Non-Office
MI	All Products	99219	$155.31	$0.00	$0.00	$132.02	Office
MI	All Products	99219	$155.31	$0.00	$0.00	$132.02	Non-Office
MI	All Products	99220	$212.32	$0.00	$0.00	$180.47	Office
MI	All Products	99220	$212.32	$0.00	$0.00	$180.47	Non-Office
MI	All Products	99221	$135.20	$0.00	$0.00	$135.20	Office
MI	All Products	99221	$135.20	$0.00	$0.00	$135.20	Non-Office
MI	All Products	99222	$157.47	$0.00	$0.00	$133.85	Office
MI	All Products	99222	$157.47	$0.00	$0.00	$133.85	Non-Office
MI	All Products	99223	$231.73	$0.00	$0.00	$196.97	Office
MI	All Products	99223	$231.73	$0.00	$0.00	$196.97	Non-Office
MI	All Products	99224	$45.70	$0.00	$0.00	$38.84	Office
MI	All Products	99224	$45.70	$0.00	$0.00	$38.84	Non-Office
MI	All Products	99225	$83.17	$0.00	$0.00	$70.69	Office
MI	All Products	99225	$83.17	$0.00	$0.00	$70.69	Non-Office
MI	All Products	99226	$119.35	$0.00	$0.00	$101.45	Office
MI	All Products	99226	$119.35	$0.00	$0.00	$101.45	Non-Office
MI	All Products	99231	$83.20	$0.00	$0.00	$83.20	Office
MI	All Products	99231	$83.20	$0.00	$0.00	$83.20	Non-Office
MI	All Products	99232	$83.20	$0.00	$0.00	$83.20	Office
MI	All Products	99232	$83.20	$0.00	$0.00	$83.20	Non-Office
MI	All Products	99233	$118.85	$0.00	$0.00	$101.02	Office
MI	All Products	99233	$118.85	$0.00	$0.00	$101.02	Non-Office
MI	All Products	99234	$154.32	$0.00	$0.00	$131.17	Office
MI	All Products	99234	$154.32	$0.00	$0.00	$131.17	Non-Office
MI	All Products	99235	$193.06	$0.00	$0.00	$164.10	Office
MI	All Products	99235	$193.06	$0.00	$0.00	$164.10	Non-Office
MI	All Products	99236	$248.90	$0.00	$0.00	$211.57	Office
MI	All Products	99236	$248.90	$0.00	$0.00	$211.57	Non-Office
MI	All Products	99238	$83.20	$0.00	$0.00	$83.20	Office
MI	All Products	99238	$83.20	$0.00	$0.00	$83.20	Non-Office
MI	All Products	99239	$122.13	$0.00	$0.00	$103.81	Office
MI	All Products	99239	$122.13	$0.00	$0.00	$103.81	Non-Office
MI	All Products	99241	$125.00	$0.00	$0.00	$106.25	Office
MI	All Products	99241	$125.00	$0.00	$0.00	$106.25	Non-Office
MI	All Products	99242	$125.00	$0.00	$0.00	$106.25	Office
MI	All Products	99242	$125.00	$0.00	$0.00	$106.25	Non-Office
MI	All Products	99243	$134.31	$0.00	$0.00	$114.16	Office
MI	All Products	99243	$134.31	$0.00	$0.00	$114.16	Non-Office
MI	All Products	99244	$201.95	$0.00	$0.00	$171.66	Office
MI	All Products	99244	$201.95	$0.00	$0.00	$171.66	Non-Office
MI	All Products	99245	$245.88	$0.00	$0.00	$209.00	Office
MI	All Products	99245	$245.88	$0.00	$0.00	$209.00	Non-Office
MI	All Products	99251	$125.00	$0.00	$0.00	$106.25	Office
MI	All Products	99251	$125.00	$0.00	$0.00	$106.25	Non-Office
MI	All Products	99252	$125.00	$0.00	$0.00	$106.25	Office
MI	All Products	99252	$125.00	$0.00	$0.00	$106.25	Non-Office
MI	All Products	99253	$130.00	$0.00	$0.00	$110.50	Office
MI	All Products	99253	$130.00	$0.00	$0.00	$110.50	Non-Office
MI	All Products	99254	$186.12	$0.00	$0.00	$158.20	Office

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State	Product	Service Code	Physician (1, 7)	Clinical Psychologist (2)	Other Therapists (3)	Psychiatric Nurse/Physician Assistant/Nurse Practitioner (4, 5, 6, 7)	Location Specific
MI	All Products	99254	$186.12	$0.00	$0.00	$158.20	Non-Office
MI	All Products	99255	$223.70	$0.00	$0.00	$190.15	Office
MI	All Products	99255	$223.70	$0.00	$0.00	$190.15	Non-Office
MI	All Products	99281	$58.24	$0.00	$0.00	$58.24	Office
MI	All Products	99281	$58.24	$0.00	$0.00	$58.24	Non-Office
MI	All Products	99282	$58.24	$0.00	$0.00	$58.24	Office
MI	All Products	99282	$58.24	$0.00	$0.00	$58.24	Non-Office
MI	All Products	99283	$74.41	$0.00	$0.00	$63.25	Office
MI	All Products	99283	$74.41	$0.00	$0.00	$63.25	Non-Office
MI	All Products	99284	$137.50	$0.00	$0.00	$116.87	Office
MI	All Products	99284	$137.50	$0.00	$0.00	$116.87	Non-Office
MI	All Products	99285	$200.19	$0.00	$0.00	$170.16	Office
MI	All Products	99285	$200.19	$0.00	$0.00	$170.16	Non-Office
MI	All Products	99304	$105.94	$0.00	$0.00	$90.05	Office
MI	All Products	99304	$105.94	$0.00	$0.00	$90.05	Non-Office
MI	All Products	99305	$151.10	$0.00	$0.00	$128.44	Office
MI	All Products	99305	$151.10	$0.00	$0.00	$128.44	Non-Office
MI	All Products	99306	$190.86	$0.00	$0.00	$162.23	Office
MI	All Products	99306	$190.86	$0.00	$0.00	$162.23	Non-Office
MI	All Products	99307	$50.45	$0.00	$0.00	$42.88	Office
MI	All Products	99307	$50.45	$0.00	$0.00	$42.88	Non-Office
MI	All Products	99308	$78.54	$0.00	$0.00	$66.76	Office
MI	All Products	99308	$78.54	$0.00	$0.00	$66.76	Non-Office
MI	All Products	99309	$103.91	$0.00	$0.00	$88.32	Office
MI	All Products	99309	$103.91	$0.00	$0.00	$88.32	Non-Office
MI	All Products	99310	$154.38	$0.00	$0.00	$131.22	Office
MI	All Products	99310	$154.38	$0.00	$0.00	$131.22	Non-Office
MI	All Products	99315	$82.72	$0.00	$0.00	$70.31	Office
MI	All Products	99315	$82.72	$0.00	$0.00	$70.31	Non-Office
MI	All Products	99316	$120.47	$0.00	$0.00	$102.40	Office
MI	All Products	99316	$120.47	$0.00	$0.00	$102.40	Non-Office
MI	All Products	99318	$109.00	$0.00	$0.00	$92.65	Office
MI	All Products	99318	$109.00	$0.00	$0.00	$92.65	Non-Office
MI	All Products	99324	$63.15	$0.00	$0.00	$53.68	Office
MI	All Products	99324	$63.15	$0.00	$0.00	$53.68	Non-Office
MI	All Products	99325	$91.85	$0.00	$0.00	$78.07	Office
MI	All Products	99325	$91.85	$0.00	$0.00	$78.07	Non-Office
MI	All Products	99326	$158.26	$0.00	$0.00	$134.52	Office
MI	All Products	99326	$158.26	$0.00	$0.00	$134.52	Non-Office
MI	All Products	99327	$211.72	$0.00	$0.00	$179.96	Office
MI	All Products	99327	$211.72	$0.00	$0.00	$179.96	Non-Office
MI	All Products	99328	$247.64	$0.00	$0.00	$210.50	Office
MI	All Products	99328	$247.64	$0.00	$0.00	$210.50	Non-Office
MI	All Products	99334	$68.68	$0.00	$0.00	$58.38	Office
MI	All Products	99334	$68.68	$0.00	$0.00	$58.38	Non-Office
MI	All Products	99335	$107.46	$0.00	$0.00	$91.34	Office
MI	All Products	99335	$107.46	$0.00	$0.00	$91.34	Non-Office
MI	All Products	99336	$153.93	$0.00	$0.00	$130.84	Office
MI	All Products	99336	$153.93	$0.00	$0.00	$130.84	Non-Office
MI	All Products	99337	$219.79	$0.00	$0.00	$186.82	Office
MI	All Products	99337	$219.79	$0.00	$0.00	$186.82	Non-Office
MI	All Products	99341	$62.75	$0.00	$0.00	$53.34	Office
MI	All Products	99341	$62.75	$0.00	$0.00	$53.34	Non-Office
MI	All Products	99342	$90.90	$0.00	$0.00	$77.26	Office
MI	All Products	99342	$90.90	$0.00	$0.00	$77.26	Non-Office
MI	All Products	99343	$148.81	$0.00	$0.00	$126.49	Office
MI	All Products	99343	$148.81	$0.00	$0.00	$126.49	Non-Office
MI	All Products	99344	$207.82	$0.00	$0.00	$176.65	Office
MI	All Products	99344	$207.82	$0.00	$0.00	$176.65	Non-Office
MI	All Products	99345	$252.72	$0.00	$0.00	$214.81	Office
MI	All Products	99345	$252.72	$0.00	$0.00	$214.81	Non-Office
MI	All Products	99347	$63.15	$0.00	$0.00	$53.68	Office
MI	All Products	99347	$63.15	$0.00	$0.00	$53.68	Non-Office
MI	All Products	99348	$95.78	$0.00	$0.00	$81.42	Office
MI	All Products	99348	$95.78	$0.00	$0.00	$81.42	Non-Office
MI	All Products	99349	$146.24	$0.00	$0.00	$124.31	Office
MI	All Products	99349	$146.24	$0.00	$0.00	$124.31	Non-Office
MI	All Products	99350	$203.52	$0.00	$0.00	$172.99	Office
MI	All Products	99350	$203.52	$0.00	$0.00	$172.99	Non-Office
MI	All Products	99408	$39.44	$39.44	$29.58	$33.52	Office
MI	All Products	99408	$39.44	$39.44	$29.58	$33.52	Non-Office
MI	All Products	99409	$76.88	$76.88	$57.66	$65.35	Office
MI	All Products	99409	$76.88	$76.88	$57.66	$65.35	Non-Office
MI	All Products	99417	$37.41	$37.41	$28.06	$31.80	Office
MI	All Products	99417	$37.41	$37.41	$28.06	$31.80	Non-Office
MI	All Products	99484	$53.85	$53.85	$40.39	$45.77	Office
MI	All Products	99484	$53.85	$53.85	$40.39	$45.77	Non-Office
MI	All Products	99492	$177.95	$177.95	$133.47	$151.26	Office
MI	All Products	99492	$177.95	$177.95	$133.47	$151.26	Non-Office
MI	All Products	99493	$151.33	$151.33	$113.50	$128.63	Office
MI	All Products	99493	$151.33	$151.33	$113.50	$128.63	Non-Office
MI	All Products	99494	$73.66	$73.66	$55.25	$62.61	Office
MI	All Products	99494	$73.66	$73.66	$55.25	$62.61	Non-Office

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State	Product	Service Code	Physician (1, 7)	Clinical Psychologist (2)	Other Therapists (3)	Psychiatric Nurse/Physician Assistant/Nurse Practitioner (4, 5, 6, 7)	Location Specific
MI	All Products	G2067	$219.73				
MI	All Products	G2068	$272.75				
MI	All Products	G2069	$1,831.67				
MI	All Products	G2070	$5,549.24				
MI	All Products	G2071	$454.19				
MI	All Products	G2072	$5,782.13				
MI	All Products	G2073	$1,400.46				
MI	All Products	G2074	$171.88				
MI	All Products	G2076	$190.75				
MI	All Products	G2077	$117.22				
MI	All Products	G2078	$36.69				
MI	All Products	G2079	$89.71				
MI	All Products	G2080	$32.88				
MI	All Products	G2082	$785.82	$785.82	$785.82	$785.82	
MI	All Products	G2083	$1,147.72	$1,147.72	$1,147.72	$1,147.72	
MI	All Products	G2086	$434.00	$434.00	$434.00	$434.00	
MI	All Products	G2087	$387.52	$387.52	$387.52	$387.52	
MI	All Products	G2088	$73.11	$73.11	$73.11	$73.11	
MI	All Products	G2215	$94.00				
MI	All Products	G2216	$94.00				

Applied Behavioral Analysis

State	Product	Service Code	Rate
MI	All Products	0362T	$15.42
MI	All Products	0373T	$30.84
MI	All Products	97151	$20.79
MI	All Products	97152	$15.42
MI	All Products	97153	$15.42
MI	All Products	97154	$15.42
MI	All Products	97155	$20.80
MI	All Products	97156	$20.79
MI	All Products	97157	$20.79
MI	All Products	97158	$20.79

1. Physician is defined as licensed as a Psychiatrist, Child Psychiatrist, Child and Adolescent Psychiatrist, Geriatric Psychiatr or Addictionologist with a MD or DO degree

2. Clinical Psychologist is defined as licensed as a Clinical Psychologist with a PhD, Psy.D, EDD, EDE or EDS degree.

3. Other Therapists are defined as licensed Master Level Clinicians which included Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor. All providers must be appropriately licensed and a minimum Master Level in a behavioral health related program.

4. Psychiatric Nurse is defined as licensed as Psychiatric Nurse with a minimum of a APRN, MN, MS or MSN degree.

5. A Physician Assistant must be a registered Physician Assistant, have a bachelor or master's degree designed to prepare the provider in the specialty area to which the provider is applying, have a certificate of completion following training, be board certified by a certifying agency recognized by the state in which they practice or by Aetna and must be approved by the state to practice in the specialty area to which the provider is applying.

6. A Specialist Nurse Practitioner must be a registered nurse, have a minimum of a master's degree in nursing, have receiv post-graduate or graduate education designed to prepare the provider in the specialty area to which the provider is applying, be board certified by an agency as recognized by the state in which they practice or by an Aetna approved accrediting agency and state approved to practice in the role of an advanced practice registered nurse.

7. Providers must meet all certification requirements for medication assisted treatment in order to be eligible for the Medicatic assisted treatment services.

IN WITNESS WHEREOF, Company and Group have executed this Agreement intending to be effective as of the Effective Date notwithstanding execution at a different date(s).

PROVIDER

By: _____

Printed Name: _____

Title: _____

Date: _____

FEDERAL TAX I.D. NUMBER: _____

Aetna Behavior Health, LLC

By: _____

Printed Name: _____

Title: _____

Date: _____