Online resources to help you do business with us

Once you've successfully completed credentialing and contracting, you'll be part of our network.

You'll have access to:

- Our secure provider website
- Our **participation criteria**
- Electronic communications – including our **provider newsletters**
- Our **online office manual** for health care professionals
- Online transactions (claims submission and status, authorizations and referrals, and eligibility)
- Electronic funds transfer – direct deposit into your bank account

When you become a network provider, you'll get a provider identification number (PIN). We use this number to identify you and/or your office.

Our secure provider website and provider manual also feature information about our clinical practice guidelines, behavioral health screening programs, member rights and responsibilities statement and quality management programs.

Aetna Medicare Advantage products (if applicable)

If you participate in any of our Medicare Advantage products, you and your Downstream Entities must comply with all Medicare Compliance Program requirements. You can find information on our First Tier, Downstream and Related entity ("FDR") Medicare Compliance Program in our **online office manual** for health care professionals.

We're here to help

We look forward to a successful relationship with you. If you have questions after reviewing this information, give us a call:

- **1-800-624-0756** for HMO-based and Medicare Advantage plans
- **1-888-MDAetna (1-888-632-3862)** for all other benefits plans

Note: HIPAA regulations require that you include National Provider Identification numbers on all electronic claims, claims status inquiries, authorizations and referrals, eligibility and transactions.

Acknowledge receipt of this document by signing here: Paul McDonald

Paul McDonald (Aug 15, 2019)

Instructions to eSign: *Check here if you have read the information below* ☑

For information on selecting the "Product categories" on page 1 of the agreement, simply use the links below for each product:	**PRODUCT CATEGORIES**
http://firsthealth.coventryhealthcare.com/about-first-health/index.htm	Medical Rental Network
https://www.coventrywcs.com/content/Menu/Home.html	Workers' Compensation Network
https://coventrywcs.com/content/Menu/Home/Markets/Auto_Solutions.html	Auto Network

If for some reason you do not wish to sign this agreement then you must follow these steps:

1. While you are in the contract and prompted to sign electronically, you will see on the upper left side a drop down menu called "**Alternative actions**". Click on this option and select "**I will not e-sign**".
2. A pop-up box will open. In the box labeled "Please enter the reason for declining below," explain why you don't want to sign and return the agreement. After adding your message, be sure to click on the click on the "**Decline**" button. (*The message will then be sent to Aetna.)*

AETNA USE ONLY Once you're approved as a network provider, we'll complete the following information:	
Contract Effective Date: (You can begin to see members on this date.)	10/15/2019
Aetna PIN#: (Please enter on all correspondence.)	9469517
Practice location (state):	AZ
Aetna payer ID#	**60054**
Go to our website:	**aetna.com, Health Care Professionals**
Call us:	**1-800-624-0756** (for HMO-based and Medicare Advantage plans) or **1-888-632-3862** (for all other plans)

Get connected to Aetna

Use this checklist during your first 30 days of participation. These simple steps can help you get off to a smooth start:

☐ **Register for our secure provider website**
- Go to **aetna.com**, select "HealthCare Professionals" then hit the "Log In/Register" button at top of page. Under "Don't have an account?" click on "Register here."

☐ **Enroll in electronic funds transfer (EFT) online if you didn't when you completed your contract**
EFT can streamline your current processes and lower administrative costs.
- Please see the enclosed EFT Enrollment application

☐ **Visit our Health Care Professionals page for helpful information**
- Go to **aetna.com**. From the home page, select "Health Care Professionals."
  - Click on **education and manuals**

☐ **View our digital ID card help guide**

☐ **How to check network status**
Use this tool for step-by-step guidance on how to check your network status.
- You can view the reference guide **here**

Aexcel® information
Your agreement with us allows for your inclusion in Aetna specialty programs. One of these programs is Aexcel (our physician performance program). Aexcel includes public reporting and network tiering. We evaluate certain physicians (in select specialties and markets) against specific clinical quality and efficiency standards. We include physicians who meet the standards in the performance network. We share your evaluation results and network status with Aetna members in our online directory. **Click here** for details about Aexcel.

Ohio providers
The Ohio Legislature amended Ohio Revised Code 3901.381—effective October 16, 2010 – to require a third party payer (such as Aetna) to transmit payment electronically to a contracted provider who submits an electronic claim. To get started, complete the ERA/EFT enrollment form located at **www.aetnapaperlessoffice.com**. Fax the completed ERA/EFT enrollment form to **1-860-754-9122**. Our standard turnaround time for processing is three weeks (15 business days). Once your enrollment is complete, you'll get confirmation and begin receiving payments directly to your bank account. If you decide EFT isn't for you, search for the "Refusal to Enroll in Electronic Funds Transfer (EFT)" form located on **aetna.com**. Complete and fax it to **1-614-933-7066**.

PROVIDER AGREEMENT

Aetna Network Services LLC, on behalf of itself and its Affiliates ("Company"), and Centria Healthcare, LLC**,** 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 signature sheet and the **General Terms and Conditions** 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 the list is contained in the Agreement.

	PRODUCT CATEGORIES
✓	Commercial Health
	Medicare
	Medical Rental Network
	Workers' Compensation Network
	Auto Network
N/A	Institutes of Excellence® (IOE) Transplant Program (subject to separate approval by Company)

EFFECTIVE DATE: October 15, 2019

TERM: This Agreement begins on the Effective Date, continues for an initial term of three (3) years, 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.

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

PROVIDER

By: Paul McDonald
Paul McDonald (Aug 15, 2019)

Printed Name: Paul McDonald

Title: CFO

Date: Aug 15, 2019

FEDERAL TAX I.D. NUMBER: 27-1402749

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

Provider contract notice address:

27777 Inkster Road
Suite 100
Farmington Hills, MI 48334

Provider contract notice email address:

contracts@centriahealthcare.com

COMPANY

By: Antonio Rocchino
Antonio Rocchino (Sep 19, 2019)

Printed Name: Antonio Rocchino

Title: Sr. Director of Network Management

Date: Sep 19, 2019

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

Aetna Behavioral Health
1425 Union Meeting Road
PO Box 5
Blue Bell PA 19422

☑

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: (a) 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; (b) 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; (c) change in the ownership or management of Provider; and (d) 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 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 or 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 practice, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider until the earlier of such time as: (a) Company and Provider negotiate and implement new mutually agreeable rates for that Participating Provider under this Agreement; or (b) Company terminates that Participating Provider's network participation with at least one hundred and eighty (180) days prior written notice to Provider and the 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** (e.g., no ID cards for Workers' Compensation Plans), 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 or 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) or specialty program. 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: (i) to governmental authorities having jurisdiction; (ii) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (iii) 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. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

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

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

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

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

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

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Relationship**. 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 other 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 other 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: (i) 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 (ii) 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 and Mediation**. 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. **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. This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

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

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

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

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

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

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

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

APPENDIX 1 - DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity, except for MHNet Inc., 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 who is employed by or contracted with Provider or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

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

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

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

Party. Company or Provider, as applicable.

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

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

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

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

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

State Compliance Addendum

ARIZONA

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.

2.2 Claims Payment

The last clause in the first sentence of Section 2.2 Claims Payment, shall be deleted and replaced with the following:

"within thirty (30) days or such time as permitted by Applicable Law of actual receipt by Company of a Clean Claim."

5.4 Obligations Following Termination

The following shall be added to the end of Section 5.4 Obligations Following Termination:

"In the event of insolvency of a Company affiliate that is an HMO, Provider agrees to provide services to HMO Members at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after the HMO is declared insolvent, until the earliest of the following: (a) the expiration of the period during which the HMO is required to continue benefits as described in ARS 20-1069, subsection A: the duration of the contract period under the Member's health plan or sixty (60) days from the date insolvency is declared, whichever is longer (for Members confined on the date of insolvency in an inpatient facility this period would last at least until their discharge); (b) a notification from the receiver pursuant to ARS 20-1069, subsection F or a determination by the court that the insolvent HMO cannot provide adequate assurance it will be able to pay contract providers' claims for covered services that were rendered after the HMO is declared insolvent; (c) a determination by the court that the insolvent HMO is unable to pay contract providers' claims for covered services that were rendered after the HMO is declared insolvent; (d) a determination by the court that continuation of the contract would constitute undue hardship to the provider: and (e) a determination by the court that the HMO has satisfied its obligation to all enrollees under its health care plans. In the event of insolvency of a Company affiliate that is other than an HMO, then in addition to other obligations set forth in this Section 5.4, Provider shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined in an inpatient facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. This provision shall be construed to be for the benefit of Members. If required by law, no modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies."

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. 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: Many Member ID cards for Commercial Health Products also include the National Advantage Program (NAP) logo. In those circumstances, the rates listed on the Service and Rate Schedule applicable to the Commercial Health Product (other than NAP) will apply. If no NAP logo is included on a Member's ID card, the rates listed on the Service and Rate Schedule for Commercial Health Products will apply to Members in the following order: (1) the rate for the Member's Commercial Health Product, if a rate applicable to that product is listed (as long as the Member may access Provider for any level of in-network benefits); (2) the NAP rate, if a rate specific to NAP is listed OR the rate applicable to the non-gated Aetna Open Choice/PPO product, if a NAP rate is not listed.

BEHAVIORAL HEALTH PROVIDER
SERVICES AND RATE SCHEDULE

RATE:

Payment Details:

Service	Billing Codes	Rates
Behavior identification assessment by MD or QHP - per 15 mins	**CPT4 Codes:** 97151	$17.00 Per Unit
Behavior identification supporting assessment - one tech - per 15 mins	**CPT4 Codes:** 97152	$13.00 Per Unit
Behavior identification supporting assessment - multiple components - per 15 mins	**CPT4 Codes:** 0362T	$13.00 Per Unit
Adaptive behavior treatment by protocol by tech - per 15 mins	**CPT4 Codes:** 97153	$13.00 Per Unit
Adaptive behavior treatment with protocol modification - multiple components - per 15 mins	**CPT4 Codes:** 0373T	$25.00 Per Unit
Adaptive behavior treatment with protocol modification by MD or QHP - per 15 mins	**CPT4 Codes:** 97155	$17.00 Per Unit
Group adaptive behavior treatment by protocol by tech - per 15 mins	**CPT4 Codes:** 97154	$13.00 Per Unit
Group adaptive behavior treatment with protocol modification by MD or QHP- per 15 mins	**CPT4 Codes:** 97158	$17.00 Per Unit
Family adaptive behavior treatment guidance by MD or QHP - per 15 mins	**CPT4 Codes:** 97156	$17.00 Per Unit
Multiple-family group adaptive behavior treatment guidance by MD or QHP - per 15 mins	**CPT4 Codes:** 97157	$17.00 Per Unit
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 Physician, regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or (ii) an individual Member has selected a Primary Care Physician. Examples of Gated Commercial Health Products include, but are not limited to: HMO (Health Maintenance Organization), POS (Point of Service), EPO (Exclusive Provider Organization). In some circumstances, certain Commercial Health Products (e.g., FEHB 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 Physician 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 and Aetna Student Health), Aetna Signature Administrators®, joint claims administration, Meritain/Meritain shared administrative services, Passport to Healthcare® and National Advantage. In some circumstances, certain Commercial Health Products (e.g., FEHB 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 required by law, payment for services of Clinical Psychologists, Psychiatric Nurses and any other Licensed Master Level Practitioner (Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may be less than Company's then current payment methodology for Behavioral Health physician services.

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) 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.

e) 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.

f) Certain Plans may cover Telemedicine for specific services. For those Plans the rates for covered Telemedicine services will be a percentage of the rates set forth in this Schedule, unless other rates are required by applicable law. Such percentage(s), as well as 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.

g) 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

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

i) 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.

Coding

j) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new and/or changes to existing codes. Such updates may include assignment and/or reassignment to Service Groupings for new and/or existing codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period. Unless otherwise specified, the reimbursement for new, replacement, reassigned, or modified code(s) will be paid on the same basis or at a comparable rate as set forth within this Schedule.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

Behavioral Health
Service and Pay to (Remittance) Location Form

Listed below is each participating provider* with the corresponding physical service location, pay to (remittance) address and telephone numbers:

***Upon written notice from Provider, Company may agree to add new or relocating facilities, locations or providers to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Provider.**

Provider Name: Centria Healthcare, LLC

A. Service Location Name:		**Pay to (Remittance) Name:**	
Street	2338 West Royal Palm Road	Address	27777 Inkster Road
Suite #	Suite J	Suite #	Suite 100
City	Phoenix	City	Farmington Hills
State, Zip	AZ, 85021	State, Zip	MI, 48334
Phone #	480 939 4431	Phone #	248 299 0030
Fax #	248 912 1566	Fax #	248 912 1566
Email Address	jlundin@centriahealthcare.com	Email Address	jlundin@centriahealthcare.com
Tax ID #	E 271402749	NPI: 1053641498	NPI Type: 2
Handicap accessible (Y or N)		Y	

Company Use Only: PIN #: 9469517 PVN #: _____ Provider Type: BHG

B. Service Location Name:		**Pay to (Remittance) Name :**	
Street		Address	
Suite #		Suite #	
City		City	
State, Zip		State, Zip	
Phone #		Phone #	
Fax #		Fax #	
Email Address		Email Address	
Tax ID #		NPI:	NPI Type:
Handicap accessible (Y or N)			

Company Use Only: PIN #: _____ PVN #: _____ Provider Type: _____

C. Service Location Name:		**Pay to (Remittance) Name :**	
Street		Address	

Suite #		Suite #	
City		City	
State, Zip		State, Zip	
Phone #		Phone #	
Fax #		Fax #	
Email Address		Email Address	
Tax ID #		NPI:	NPI Type:
Handicap accessible (Y or N)			

Company Use Only: **PIN #: _____** **PVN #: _____** **Provider Type: _____**

D. Service Location Name:		**Pay to (Remittance) Name :**	
Street		Address	
Suite #		Suite #	
City		City	
State, Zip		State, Zip	
Phone #		Phone #	
Fax #		Fax #	
Email Address		Email Address	
Tax ID #		NPI:	NPI Type:
Handicap accessible (Y or N)			

Company Use Only: **PIN #: _____** **PVN #: _____** **Provider Type: _____**

E. Service Location Name:		**Pay to (Remittance) Name :**	
Street		Address	
Suite #		Suite #	
City		City	
State, Zip		State, Zip	
Phone #		Phone #	
Fax #		Fax #	
Email Address		Email Address	
Tax ID #		NPI:	NPI Type:
Handicap accessible (Y or N)			

Company Use Only: **PIN #: _____** **PVN #: _____** **Provider Type: _____**

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®

   In the event that Provider participates in a Medical Rental Product under a separate agreement with a Company Affiliate (e.g., Cofinity, Inc.), such other agreement shall govern the terms of participation in that network, unless Company specifically notifies Provider otherwise in writing. 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.directprovider.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 Medical Rental Products 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 regards 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. This may include zero dollar $(0.00) payments.

4. Termination. Without limiting the termination rights of the parties under the Agreement, effective twelve (12) months from the effective date of this Addendum, either party may terminate this Addendum (and related rate schedule(s)), without cause, upon ninety (90) days prior written notice to the other.

5. Other Provisions. Notwithstanding anything to the contrary in the Agreement, Company may, in its discretion, sell, lease, transfer, rent or otherwise convey 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.

6. 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.

7. 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-9 (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) Rates for services of Clinical Psychologists, Psychiatric Nurses and any other Licensed Master Level Practitioner (Clinical Social Workers, Licensed Professional Counselors, Marriage/Family Therapists, Psychological Examiner, Drug and Alcohol Counselor, Pastoral Counselor) may be less than Company's then current pricing methodology for Behavioral Health physician services.

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.

Coding

f) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new and/or changes to existing codes. Such updates may include assignment and/or reassignment to Service Groupings for new and/or existing codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be priced according to the standards and coding set for the prior period. Unless otherwise specified, the reimbursement for new, replacement, reassigned, or modified code(s) will be paid on the same basis or at a comparable rate as set forth within this Schedule.

   Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

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.

1/1/2019 Arizona - Behavioral Health

State	Product	Service Code	Physician (1)	Clinical Psychologist (2)	Other Therapists (3)	Psychiatric Nurse/Physician Assistant/Nurse Practitioner (4, 5, 6)	Location Specific
AZ	All Products	90785	$14.63	$14.63	$10.97	$12.44	
AZ	All Products	90791	$151.41	$151.41	$113.56	$128.70	
AZ	All Products	90792	$151.41	$0.00	$0.00	$128.70	
AZ	All Products	90832	$75.71	$75.71	$56.78	$64.35	
AZ	All Products	90833	$81.11	$0.00	$0.00	$68.94	
AZ	All Products	90834	$113.56	$113.56	$85.17	$96.53	
AZ	All Products	90836	$124.37	$0.00	$0.00	$105.71	
AZ	All Products	90837	$131.58	$131.58	$98.69	$111.84	
AZ	All Products	90838	$143.03	$0.00	$0.00	$121.58	
AZ	All Products	90839	$151.41	$151.41	$113.56	$128.70	
AZ	All Products	90840	$75.71	$75.71	$56.78	$64.35	
AZ	All Products	90846	$116.80	$116.80	$93.01	$99.28	
AZ	All Products	90847	$116.80	$116.80	$93.01	$99.28	
AZ	All Products	90849	$48.67	$48.67	$43.26	$43.26	
AZ	All Products	90853	$48.67	$48.67	$43.26	$43.26	
AZ	All Products	90870	$175.50	$0.00	$0.00	$151.41	
AZ	All Products	90880	$113.56	$113.56	$85.17	$96.53	
AZ	All Products	90901	$86.52	$86.52	$64.89	$73.54	
AZ	All Products	96112	$136.01	$136.01	$102.01	$115.61	Office
AZ	All Products	96112	$136.01	$136.01	$102.01	$115.61	Non-Office
AZ	All Products	96113	$60.71	$60.71	$45.53	$51.60	Office
AZ	All Products	96113	$60.71	$60.71	$45.53	$51.60	Non-Office
AZ	All Products	96116	$94.13	$94.13	$0.00	$87.74	Office
AZ	All Products	96116	$94.13	$94.13	$0.00	$87.60	Non-Office
AZ	All Products	96121	$82.58	$82.58	$61.93	$70.19	Office
AZ	All Products	96121	$82.58	$82.58	$61.93	$70.19	Non-Office
AZ	All Products	96130	$117.66	$117.66	$88.25	$100.01	Office
AZ	All Products	96130	$117.66	$117.66	$88.25	$100.01	Non-Office
AZ	All Products	96131	$89.54	$89.54	$67.15	$76.11	Office
AZ	All Products	96131	$89.54	$89.54	$67.15	$76.11	Non-Office
AZ	All Products	96132	$132.06	$132.06	$99.04	$112.25	Office
AZ	All Products	96132	$132.06	$132.06	$99.04	$112.25	Non-Office
AZ	All Products	96133	$100.74	$100.74	$75.55	$85.63	Office
AZ	All Products	96133	$100.74	$100.74	$75.55	$85.63	Non-Office
AZ	All Products	96136	$46.97	$46.97	$35.23	$39.92	Office
AZ	All Products	96136	$46.97	$46.97	$35.23	$39.92	Non-Office
AZ	All Products	96137	$43.42	$43.42	$32.57	$36.91	Office
AZ	All Products	96137	$43.42	$43.42	$32.57	$36.91	Non-Office
AZ	All Products	96138	$37.74	$37.74	$28.31	$32.08	
AZ	All Products	96139	$37.74	$37.74	$28.31	$32.08	
AZ	All Products	96146	$2.05	$2.05	$1.54	$1.74	
AZ	All Products	99058	$196.83	$196.83	$147.62	$167.31	
AZ	All Products	99201	$44.30	$0.00	$0.00	$37.66	Office
AZ	All Products	99201	$44.30	$0.00	$0.00	$37.66	Non-Office
AZ	All Products	99202	$74.68	$0.00	$0.00	$63.48	Office
AZ	All Products	99202	$74.68	$0.00	$0.00	$63.48	Non-Office
AZ	All Products	99203	$107.36	$0.00	$0.00	$91.26	Office
AZ	All Products	99203	$107.36	$0.00	$0.00	$91.26	Non-Office
AZ	All Products	99204	$164.00	$0.00	$0.00	$139.40	Office
AZ	All Products	99204	$164.00	$0.00	$0.00	$139.40	Non-Office
AZ	All Products	99205	$206.37	$0.00	$0.00	$175.41	Office
AZ	All Products	99205	$206.37	$0.00	$0.00	$175.41	Non-Office
AZ	All Products	99211	$21.46	$0.00	$0.00	$18.24	Office
AZ	All Products	99211	$21.46	$0.00	$0.00	$18.24	Non-Office
AZ	All Products	99212	$43.65	$0.00	$0.00	$37.10	Office

1/1/2019 Arizona - Behavioral Health

State	Product	Service Code	Physician (1)	Clinical Psychologist (2)	Other Therapists (3)	Psychiatric Nurse/Physician Assistant/Nurse Practitioner (4, 5, 6)	Location Specific
AZ	All Products	99212	$43.65	$0.00	$0.00	$37.10	Non-Office
AZ	All Products	99213	$72.68	$0.00	$0.00	$61.78	Office
AZ	All Products	99213	$72.68	$0.00	$0.00	$61.78	Non-Office
AZ	All Products	99214	$107.34	$0.00	$0.00	$91.24	Office
AZ	All Products	99214	$107.34	$0.00	$0.00	$91.24	Non-Office
AZ	All Products	99215	$144.78	$0.00	$0.00	$123.06	Office
AZ	All Products	99215	$144.78	$0.00	$0.00	$123.06	Non-Office
AZ	All Products	99217	$73.25	$0.00	$0.00	$62.26	
AZ	All Products	99218	$100.14	$0.00	$0.00	$85.12	
AZ	All Products	99219	$136.36	$0.00	$0.00	$115.91	
AZ	All Products	99220	$186.70	$0.00	$0.00	$158.70	
AZ	All Products	99221	$140.60	$0.00	$0.00	$140.60	
AZ	All Products	99222	$140.60	$0.00	$0.00	$140.60	
AZ	All Products	99223	$203.24	$0.00	$0.00	$172.75	
AZ	All Products	99224	$40.00	$0.00	$0.00	$34.00	
AZ	All Products	99225	$73.37	$0.00	$0.00	$62.36	
AZ	All Products	99226	$105.26	$0.00	$0.00	$89.47	
AZ	All Products	99231	$86.52	$0.00	$0.00	$86.52	
AZ	All Products	99232	$86.52	$0.00	$0.00	$86.52	
AZ	All Products	99233	$104.52	$0.00	$0.00	$88.84	
AZ	All Products	99234	$133.47	$0.00	$0.00	$113.45	
AZ	All Products	99235	$169.69	$0.00	$0.00	$144.24	
AZ	All Products	99236	$218.98	$0.00	$0.00	$186.13	
AZ	All Products	99238	$86.52	$0.00	$0.00	$86.52	
AZ	All Products	99239	$108.01	$0.00	$0.00	$91.81	
AZ	All Products	99241	$135.19	$0.00	$0.00	$114.91	Office
AZ	All Products	99241	$135.19	$0.00	$0.00	$114.91	Non-Office
AZ	All Products	99242	$135.19	$0.00	$0.00	$114.91	Office
AZ	All Products	99242	$135.19	$0.00	$0.00	$114.91	Non-Office
AZ	All Products	99243	$135.19	$0.00	$0.00	$114.91	Office
AZ	All Products	99243	$135.19	$0.00	$0.00	$114.91	Non-Office
AZ	All Products	99244	$182.64	$0.00	$0.00	$155.24	Office
AZ	All Products	99244	$182.64	$0.00	$0.00	$155.24	Non-Office
AZ	All Products	99245	$222.72	$0.00	$0.00	$189.31	Office
AZ	All Products	99245	$222.72	$0.00	$0.00	$189.31	Non-Office
AZ	All Products	99251	$135.19	$0.00	$0.00	$114.91	
AZ	All Products	99252	$135.19	$0.00	$0.00	$114.91	
AZ	All Products	99253	$135.19	$0.00	$0.00	$114.91	
AZ	All Products	99254	$167.44	$0.00	$0.00	$142.32	

1/1/2019 Arizona - Behavioral Health

State	Product	Service Code	Physician (1)	Clinical Psychologist (2)	Other Therapists (3)	Psychiatric Nurse/Physician Assistant/Nurse Practitioner (4, 5, 6)	Location Specific
AZ	All Products	99255	$201.54	$0.00	$0.00	$171.31	
AZ	All Products	99281	$60.56	$0.00	$0.00	$60.56	
AZ	All Products	99282	$60.56	$0.00	$0.00	$60.56	
AZ	All Products	99283	$61.98	$0.00	$0.00	$60.56	
AZ	All Products	99284	$121.13	$0.00	$0.00	$121.13	
AZ	All Products	99285	$173.22	$0.00	$0.00	$147.24	
AZ	All Products	99304	$91.36	$0.00	$0.00	$77.66	
AZ	All Products	99305	$130.70	$0.00	$0.00	$111.10	
AZ	All Products	99306	$167.25	$0.00	$0.00	$142.16	
AZ	All Products	99307	$44.59	$0.00	$0.00	$37.90	
AZ	All Products	99308	$69.33	$0.00	$0.00	$58.93	
AZ	All Products	99309	$91.61	$0.00	$0.00	$77.87	
AZ	All Products	99310	$136.24	$0.00	$0.00	$115.80	
AZ	All Products	99315	$72.95	$0.00	$0.00	$62.01	
AZ	All Products	99316	$106.21	$0.00	$0.00	$90.28	
AZ	All Products	99318	$96.32	$0.00	$0.00	$81.87	
AZ	All Products	99324	$55.24	$0.00	$0.00	$46.95	
AZ	All Products	99325	$80.44	$0.00	$0.00	$68.37	
AZ	All Products	99326	$139.63	$0.00	$0.00	$118.69	
AZ	All Products	99327	$186.69	$0.00	$0.00	$158.69	
AZ	All Products	99328	$218.66	$0.00	$0.00	$185.86	
AZ	All Products	99334	$60.20	$0.00	$0.00	$51.17	
AZ	All Products	99335	$94.93	$0.00	$0.00	$80.69	
AZ	All Products	99336	$135.61	$0.00	$0.00	$115.27	
AZ	All Products	99337	$193.76	$0.00	$0.00	$164.70	
AZ	All Products	99341	$54.89	$0.00	$0.00	$46.66	
AZ	All Products	99342	$79.69	$0.00	$0.00	$67.74	
AZ	All Products	99343	$130.74	$0.00	$0.00	$111.13	
AZ	All Products	99344	$183.11	$0.00	$0.00	$155.64	
AZ	All Products	99345	$222.36	$0.00	$0.00	$189.01	
AZ	All Products	99347	$55.23	$0.00	$0.00	$46.95	
AZ	All Products	99348	$84.28	$0.00	$0.00	$71.64	
AZ	All Products	99349	$128.88	$0.00	$0.00	$109.55	
AZ	All Products	99350	$179.17	$0.00	$0.00	$152.29	
AZ	All Products	99408	$35.44	$35.44	$26.58	$30.12	Office
AZ	All Products	99408	$35.44	$35.44	$26.58	$30.12	Non-Office
AZ	All Products	99409	$68.78	$68.78	$51.59	$58.46	Office
AZ	All Products	99409	$68.78	$68.78	$51.59	$58.46	Non-Office
AZ	All Products	99484	$47.63	$47.63	$35.72	$40.49	Office
AZ	All Products	99484	$47.63	$47.63	$35.72	$40.49	Non-Office
AZ	All Products	99492	$157.83	$157.83	$118.37	$134.16	Office
AZ	All Products	99492	$157.83	$157.83	$118.37	$134.16	Non-Office
AZ	All Products	99493	$126.25	$126.25	$94.69	$107.31	Office
AZ	All Products	99493	$126.25	$126.25	$94.69	$107.31	Non-Office
AZ	All Products	99494	$65.28	$65.28	$48.96	$55.49	Office
AZ	All Products	99494	$65.28	$65.28	$48.96	$55.49	Non-Office

1. Physician is defined as licensed as a Psychiatrist, Child Psychiatrist, Child and Adolescent Psychiatrist, Geriatric Psychiatrist, 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.

1/1/2019 Arizona - Behavioral Health

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 received 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.