

**PROVIDER GROUP SERVICES AGREEMENT**  
**State Form Number: PGA2005MCA.US      Version: 06/01/2007**

This Provider Group Services Agreement ("Agreement") is by and between CIGNA HealthCare of Texas, Inc. ("CIGNA") and North Texas Ear, Nose & Throat Associates ("Group") and is effective on October 15, 2008 (the "Effective Date"). By entering into this Agreement, Group and its Represented Providers agree to provide Covered Services to Participants under the terms of this Agreement and the Administrative Guidelines. Definitions of terms for this Agreement are in Exhibit A.

**SECTION 1. DUTIES OF GROUP AND ITS REPRESENTED PROVIDERS**

**1.1      Standards.**

Represented Provider shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar Providers in the community, the requirements of applicable law, and the standards of applicable accreditation organizations. Represented Providers shall provide Covered Services to all Participants in the same manner, under the same standards, and with the same time availability as offered to other patients. Represented Providers shall not differentiate or discriminate in the treatment of any Participant because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran's status, handicap or source of payment.

**1.2      Accessibility.**

Represented Providers shall provide or arrange for the provision of necessary Covered Services to Participants 24 hours per day, 7 days per week. A Represented Provider may only close his/her patient panel in accordance with the Administrative Guidelines.

**1.3      Hospital Admissions.**

Group shall designate one or more hospitals that are Participating Providers where its Represented Providers will admit Participants under their care unless otherwise approved by CIGNA or its designee. Represented Providers will admit Participants only to hospitals that are Participating Providers except in the case of an emergency or as otherwise required by law.

**1.4      Insurance.**

Group and its Represented Providers shall maintain general and professional liability coverage in a form and amount acceptable to CIGNA, give CIGNA evidence of such coverage upon request and provide CIGNA with immediate written notice of a material modification or termination of such insurance.

**1.5      Represented Provider Agreements.**

Group represents and warrants that it is authorized to act on behalf of its Represented Providers and will provide evidence of such authority upon request. To the extent that Represented Providers are not employed by Group but are independently contracted with Group, Group shall maintain agreements with such Represented Providers

requiring the Represented Providers to comply with the terms and conditions of this Agreement to the extent applicable. The form of Groups' standard agreement with such Represented Physician shall contain all provisions required by applicable law and shall include a Participant and Payor hold harmless provision acceptable to CIGNA, consistent with applicable law and which provides, among other things, that Represented Providers shall look solely to Group for compensation for Covered Services if payments for Covered Services under this Agreement are directed to Group. Such form and any material amendments thereto must be approved in advance by CIGNA which approval shall not be unreasonably withheld. Upon request, Group shall make available to CIGNA and to any applicable regulatory authority a copy of each such Represented Physician agreement.

1.6 Changes to Represented Providers.

Group will provide CIGNA with 30 days advance written notice of the addition of new physicians to Group and 90 days advance written notice if a Represented Provider will cease to provide Covered Services to Participants under this Agreement. Notwithstanding the foregoing, in the event that the Represented Provider's participation under this Agreement is terminated for cause and Group cannot provide such 90 days advance notice, Group shall notify CIGNA in writing of such termination as soon as possible but no later than 5 days after learning of such termination.

1.7 Administrative Guidelines.

Group and its Represented Providers shall comply with the Administrative Guidelines. Some or all Administrative Guidelines may be communicated in the form of a provider reference manual, in other written materials distributed by CIGNA to Group and/or at a website identified by CIGNA. Administrative Guidelines may change from time to time. CIGNA will give Group advance notice of material changes to Administrative Guidelines.

1.8 Quality Management.

Group and its Represented Providers shall comply with the requirements of and participate in Quality Management as specified in the Administrative Guidelines. Represented Providers shall be credentialed and recertified in accordance with the procedures set forth in Exhibit B.

1.9 Utilization Management.

Group and its Represented Providers shall comply with the requirements of and participate in Utilization Management as specified in this Agreement and the Administrative Guidelines. Payment may be denied for failure to comply with such Utilization Management requirements, and Group and its Represented Providers shall not bill the Participant for any such denied payment. CIGNA's Utilization Management requirements include, but are not limited to, the following: a) precertification must be secured from CIGNA or its designee for those services and procedures for which it is required as specified in the Administrative Guidelines; b) Where precertification is not required for a hospital admission, including but not limited to emergency admissions, CIGNA or its designee must be notified within 24 hours after the admission; c) Group or

its Represented Providers must provide CIGNA or CIGNA's designee with all of the information requested by CIGNA or its designee to make its Utilization Management determinations within the timelines specified by CIGNA or its designee in such request; and d) Represented Providers must refer Participants to, or arrange for provision of Covered Services by, Participating Providers except in the case of an emergency or as otherwise required by law.

1.10 Records.

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

1.11 Cooperation with CIGNA and CIGNA Affiliates.

Group and its Represented Providers shall cooperate with CIGNA in the implementation of CIGNA's Participant appeal procedure. Group and its Represented Providers shall also cooperate with CIGNA and CIGNA Affiliates in implementing those policies and programs as may be reasonably requested by CIGNA or a CIGNA Affiliate for purposes of CIGNA's or the CIGNA Affiliate's business operations or required by CIGNA or a CIGNA Affiliate to comply with applicable law or accreditation requirements.

## SECTION 2. DUTIES OF CIGNA

2.1 Payors, Benefit Plan Types, Notice of Changes to Benefit Plan Types.

CIGNA may allow Payors to access Group's and its Represented Providers' services under this Agreement for the following Benefit Plan types: a) Benefit Plans where Participants are offered a network of Participating Providers and are required or given the option to select a Primary Care Physician; b) Benefit Plans where Participants are offered a network of Participating Providers and are not required or given the option to select a Primary Care Physician; and c) Benefit Plans where Participants are not offered a network of Participating Providers from which they may receive Covered Services. CIGNA will provide Group with advance notice if CIGNA changes this list of Benefit

Plan types for which Payors may access Group's Represented Providers' services under this Agreement.

2.2 Benefit Information

CIGNA will provide Group with access to benefit information concerning the type, scope and duration of benefits to which a Participant is entitled as specified in the Administrative Guidelines.

2.3 Participant and Participating Provider Identification

CIGNA will establish a system of Participant identification and will identify Participating Providers to those Payors and Participants who are offered a network of Participating Providers. However, CIGNA makes no representations or guarantees concerning the number of Participants that will be referred to Group and its Represented Providers as a result of this Agreement and reserves the right to direct Participants to selected Participating Providers and/or influence a Participant's choice of Participating Provider.

### SECTION 3. COMPENSATION

3.1 Payments.

Payments for services under this Agreement will be in accordance with the rates and terms set forth in Exhibit C. Payments shall be subject to the Payment Policies and minus any applicable Copayments, Coinsurance and Deductibles. The rates in this Agreement will be payment in full for all services furnished to Participants under this Agreement. Group and its Represented Providers shall submit claims for Covered Services at the location identified by CIGNA and in the manner and format specified in this Agreement and the Administrative Guidelines. Claims for Covered Services must be submitted within 180 days of the date of service or, if Payor is the secondary payor, within 180 days of the date of the explanation of payment from the primary payor. Claims received after this 180 day period may be denied except as provided in the Administrative Guidelines, and Group and its Represented Providers shall not bill CIGNA, the Payor or the Participant for those denied services. Amounts due and owing under this Agreement with respect to complete claims for Covered Services will be payable within the timeframes required by applicable law.

3.2 Underpayments.

If Group or a Represented Provider believes a Covered Service has been underpaid, Group or Represented Provider must submit a written request for an appeal or adjustment with CIGNA or its designee within 180 days from the date of Payor's payment or explanation of payment. The request must be submitted in accordance with the dispute resolution process set out in the Administrative Guidelines. Requests for appeals or adjustments submitted after this date may be denied for payment, and Group and its Represented Providers will not be permitted to bill CIGNA, the Payor or the Participant for those services.



- 3.3 Copayments, Coinsurance and Deductibles.  
Group and its Represented Providers may charge Participants applicable Copayments, Coinsurance and Deductibles in accordance with the process set out in the Administrative Guidelines.
- 3.4 Limitations On Billing Participants.  
Group and its Represented Providers shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Group's or a Represented Provider's failure to comply with the requirements of CIGNA's or its designee's Utilization Management Program or other Administrative Guidelines, failure to file a timely claim or appeal, or due to the application of the Payment Policies. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Group or its Represented Providers and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.
- 3.5 Billing Patients Who Cease to Be Participants.  
Group and its Represented Providers may bill a patient directly for any services provided following the date that patient ceases to be a Participant, and Payor has no obligation to pay for services for such patients.
- 3.6 NonMedically Necessary Services.  
Group and its Represented Providers shall not charge a Participant for a service that is not Medically Necessary unless, in advance of providing the service, Group or its Represented Provider has notified the Participant that the particular service will not be covered and the Participant acknowledges in writing that he or she will be responsible for payment for such service.
- 3.7 Reimbursement of Amounts Collected In Error.  
If Group or a Represented Provider collects payment from a Participant when not permitted to collect under either this Agreement or the Administrative Guidelines, Group or the Represented Provider must repay the amount within 4 weeks of a request from CIGNA or the Participant or of the date Group or the Represented Provider has knowledge of the error. If Group or Represented Provider fails to make the repayments, then CIGNA may (but is not obligated to) reimburse the Participant the amount inappropriately paid and then withhold this amount from future payments.
- 3.8 Overpayments.  
Group or Represented Provider shall refund to CIGNA any excess payment made by a Payor to Group or Represented Provider if Group or Represented Provider is for any reason overpaid for health care services or supplies. CIGNA may, at its option, deduct

the excess payment from other amounts payable, and Group will be notified of any such deduction as specified in the Administrative Guidelines.

3.9 Audits.

Upon reasonable notice and during regular business hours, CIGNA or its designee will have the right to review and make copies of all records maintained by Group or its Represented Providers with respect to all payments received by Group or its Represented Providers from all sources for Covered Services provided to Participants. CIGNA or its designee will have the right to conduct audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement. Any amounts determined to be due and owing as a result of such audits must be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder. This provision survives the termination of this Agreement.

3.10 Coordination of Benefits.

Certain claims for Covered Services are claims for which another payor may be primarily responsible under coordination of benefit rules. Group and its Represented Providers may pursue those claims in accordance with the process set out in the Administrative Guidelines. When a Participant's coverage under a Benefit Plan is secondary, Payor will pay an amount no greater than that which, when added to amounts payable from other sources under applicable coordination of benefits rules, equals 100% of the reimbursement for Covered Services under this Agreement.

3.11 Applicability of the Rates.

The rates in this Agreement apply to all services rendered to Participants in the Benefit Plan types covered by this Agreement, including services covered under a Participant's in-network or out-of-network benefits, and whether the Payor or Participant is financially responsible for payment.

3.12 Payment Policies.

Payments for Covered Services under this Agreement are subject to the Payment Policies. Those Policies may change from time to time. CIGNA will make information available about the Payment Policies upon request or at a website identified by CIGNA.

3.13 Excluded Services.

This Agreement excludes services that CIGNA has elected to obtain under an arrangement between CIGNA or a CIGNA Affiliate and a national or regional vendor or provider or a capitated provider, except as otherwise agreed by CIGNA. Group and its Represented Providers will not be reimbursed and will not bill Participants for any such excluded services. If CIGNA notifies Group that it no longer chooses to exclude a particular service from this Agreement, that service will no longer be excluded and those services will be reimbursed as specified in Exhibit C.

3.14 Laboratory Test Procedures.

Laboratory test procedures must be performed in a laboratory owned and operated by Group or the Represented Provider in order to be eligible for reimbursement. Laboratory test procedures not performed in a laboratory owned and operated by Group or the Represented Provider must be referred to a Participating laboratory Provider(s), and Group and its Represented Providers may not bill Participants for such services.

## SECTION 4. TERM AND TERMINATION

4.1 Term of This Agreement.

This Agreement shall be for an initial term of 3 year(s) commencing on the Effective Date and ending on the third anniversary of the Effective Date (the "Initial Term"). Thereafter, this Agreement shall continue from year to year unless terminated as set forth below.

4.2 How This Agreement Or A Represented Provider's Participation Can Be Terminated.

Either Group or CIGNA can terminate this Agreement at any time by providing at least 90 days advance written notice. Either Group or CIGNA can terminate this Agreement immediately if the other becomes insolvent. CIGNA can terminate a Represented Provider's participation upon 90 days advance written notice to Group. CIGNA can also terminate a Represented Physician's participation immediately (or upon such longer notice required by applicable law, if any) if such Represented Provider no longer maintains the licenses required to perform his/her duties under this Agreement, the Represented Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over the Represented Provider, or if the Represented Provider no longer satisfies CIGNA's credentialing requirements. Upon notice of termination of this Agreement or of Group's or a Represented Provider's participation with a particular Benefit Plan type, CIGNA will notify affected Participants of the termination to the extent required by law (if any) and applicable accrediting body requirements. The notification will occur prior to the effective date of the termination except if the termination is for cause or if Group does not provide CIGNA with sufficient advance notice, in which case, the notice will occur as soon as reasonably possible. Group will cooperate with CIGNA and provide CIGNA with a listing of Participants affected by the termination within 10 business days of the date of the notice of termination. Upon termination of this Agreement for any reason, the rights of each party terminate, except as provided in this Agreement. Termination will not release Group, Represented Providers or CIGNA from obligations under this Agreement prior to the effective date of termination.

4.3 Services Upon Termination.

If this Agreement is terminated without cause, Represented Providers shall continue to provide Covered Services for those Participants suffering from a chronic condition requiring continuity of care for whom an alternative means of receiving necessary care was not arranged at the time of such termination. Represented Providers shall continue to provide Covered Services to such Participants so long as the Participant retains

eligibility under a Benefit Plan, until the earlier of completion of such services or the assumption of treatment by another provider. Payment for Covered Services provided to any such Participant after termination of this Agreement in accordance with the terms of the Participant's Benefit Plan. If, after termination of this Agreement, Represented Provider determines that CIGNA has not used due diligence to arrange for alternative care, Represented Provider may terminate the physician-patient relationship. Represented Providers have no obligation under this Agreement to provide services to individuals who cease to be Participants.

## SECTION 5. GENERAL PROVISIONS

### 5.1 Confidentiality.

As a result of this Agreement, Group and Represented Providers may have access to certain of CIGNA's confidential and proprietary information. Group and Represented Providers shall hold such information, including the terms of this Agreement, in confidence and will not use or disclose such information to any person without the prior written consent of CIGNA except as may be required by law. This provision does not prohibit communications necessary or appropriate for the delivery of health care services, communications about coverage and coverage appeal rights or any other communications specifically protected under applicable law. This provision survives the termination of this Agreement.

### 5.2 Independent Parties.

Group and its Represented Providers are independent contractors. CIGNA and Group and its Represented Providers do not have an employer-employee, principal-agent, partnership, or similar relationship. Nothing in this Agreement, including Group and its Represented Providers participation in Quality Management and Utilization Management programs, nor any coverage determination made by CIGNA or a Payor, is intended to interfere with or affect a Represented Provider's independent medical judgment in providing health care services to his/her patients.

### 5.3 Internal Dispute Resolution.

Disputes that might arise between the parties regarding the performance or interpretation of the Agreement must first be resolved through the applicable internal dispute resolution process outlined in the Administrative Guidelines. In the event the dispute is not resolved through that process, either party can request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of such a request, either party may initiate arbitration by providing written notice to the other. With respect to a payment or termination dispute, Group or Represented Providers must submit a request for arbitration within 12 months of the date of the letter communicating the final decision under CIGNA's internal dispute resolution process unless applicable law specifically requires a longer time period to request arbitration. If arbitration is not requested within that 12 month period, CIGNA's final decision under its internal dispute resolution process will be binding on Group and its Represented Providers, and Group

and its Represented Provider shall not bill CIGNA, Payor or the Participant for any payment denied because of the failure to timely submit a request for arbitration.

5.4 Arbitration.

If the dispute is not resolved through CIGNA's internal dispute resolution process, either party can initiate arbitration by providing written notice to the other. If one of the parties initiates arbitration, the proceeding will be held in the jurisdiction of Group's domicile. The parties will jointly appoint a mutually acceptable arbitrator. If the parties are unable to agree upon such an arbitrator within 30 days after one of the parties has notified the other of the desire to submit a dispute for arbitration, then the parties will prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service (AHLA ADR Service) along with the appropriate administration fee. Under the Codes of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of 10 arbitrators along with a background and experience description, references and fee schedule for each. The 10 will be chosen by the AHLA ADR Service on the basis of their experience in the area of the dispute, geographic location and other criteria as indicated on the request form. The parties will review the qualifications of the 10 suggested arbitrators and rank them in order of preference from 1 to 9. Each party has the right to strike 1 of the names from the list. The person with the lowest total will be appointed to resolve the case. Each party will assume its own costs, but the compensation and expenses of the arbitrator and any administrative fees or costs will be borne equally by the parties. Arbitration is the exclusive remedy for the resolution of disputes under this Agreement. The decision of the arbitrator will be final, conclusive and binding, and no action at law or in equity may be instituted by CIGNA, Group or Represented Providers other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving other physicians or third parties, and that the arbitrator will be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction.

5.5 Material Adverse Change Amendments.

For amendments that are a material adverse change in the terms of this Agreement, CIGNA can amend this Agreement by providing 90 days advance written notice except if a shorter notice period is required to comply with changes in applicable law. The change will become effective at the end of the 90 day notice period or, if applicable, the shorter notice period required to comply with changes in applicable law. If Group objects to the material adverse change and notifies CIGNA of its intent to terminate within 30 days of the date of the notice of amendment, the termination will be effective at the end of the 90 day notice of the material adverse change or, if applicable, at the end of the shorter notice period required to comply with changes in applicable law, unless CIGNA agrees to retract the amendment, in which case the Agreement will remain in force without the proposed amendment.

5.6 All Other Amendments.

For amendments that are not material adverse changes in the terms of this Agreement, CIGNA can amend this Agreement by providing 30 days advance written notice to Group. Alternatively, both parties can agree in writing to amend this Agreement.

5.7 Assignment and Delegation.

Neither CIGNA, Group or Represented Providers may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to CIGNA includes any successor in interest and CIGNA may assign its duties, rights and interests under this Agreement in whole or in part to a CIGNA Affiliate or may delegate any and all of its duties to a third party in the ordinary course of business.

5.8 Use of Name.

Group and its Represented Providers agree that CIGNA may include descriptive information about Group and its Represented Providers in literature distributed to existing or potential Participants, Participating Providers and Payors. That information will include, but not be limited to, Group's and its Represented Providers' name, telephone number, address, and specialties. Group and its Represented Providers may identify themselves as a Participating Provider with respect to those Benefit Plan types in which Group and its Represented Providers participate with CIGNA. Group's and its Represented Providers' use of CIGNA's name or a CIGNA Affiliate's name, or any other use of Group's and its Represented Providers' name by CIGNA will be upon prior written approval or as the parties may agree.

5.9 Notices.

Any notice required under this Agreement must be in writing and sent by United States mail, postage prepaid, to CIGNA and Group at the addresses below. CIGNA may also notify Group by sending an electronic notice with automatic receipt verification to Group's e-mail address below. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

5.10 Governing Law/Regulatory Addenda.

Applicable federal law and the law of the jurisdiction where Group is domiciled governs this Agreement. One or more regulatory addenda may be attached to the Agreement setting out provisions that are required by law with respect to Covered Services rendered to certain Participants (i.e. Participants under an insured plan). These provisions are incorporated into this Agreement to the extent required by law and as specified in such Addenda.

- 5.11 Waiver of Breach/Severability/Entire Agreement/Copy of Original Agreement.  
If any party waives a breach of any provision of this Agreement, it will not operate as a waiver of any subsequent breach. If any portion of this Agreement is unenforceable for any reason, it will not affect the enforceability of any remaining portions. This Agreement, including any exhibits to this Agreement, contains all of the terms and conditions agreed upon and supersedes all other agreements between the parties, either oral or in writing, regarding the subject matter. A copy of this fully executed Agreement is an acceptable substitute for the original fully executed Agreement.

## AGREED AND ACCEPTED BY:

North Texas Ear, Nose & Throat Associates  
Address: 8440 Walnut Hill Lane, Suite 700, Dallas, TX, 75231,  
Email Address: \_\_\_\_\_

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_

National Provider Identifier: \_\_\_\_\_

CIGNA HealthCare of Texas, Inc.  
Address: 6600 Campus Circle Dr. E  
Irving, TX 75063  
Attention: AVP of Provider Contracting

By: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Title: \_\_\_\_\_

Date Signed: \_\_\_\_\_

All payments for the health care services provided under this Agreement should be made payable to the individual Represented Provider with that Represented Provider's individual taxpayer identification number as provided by Group or Represented Provider to CIGNA.

## EXHIBIT A DEFINITIONS

### Administrative Guidelines

means the rules, policies and procedures adopted by CIGNA or a Payor to be followed by Group and its Represented Providers in providing services and doing business with CIGNA and Payors under this Agreement.

### Benefit Plan

means a certificate of coverage, summary plan description or other document or agreement which specifies the health care services to be provided or reimbursed for the benefit of a Participant.

### CIGNA Affiliate

means any subsidiary or affiliate of CIGNA Corporation.

### Coinsurance

means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a percentage of the contracted reimbursement rate for such services or, if reimbursement is on a basis other than a fee-for-service amount, as a percentage of a CIGNA determined fee schedule or as a CIGNA determined percentage of actual charges.

### Copayment

means a payment that is the financial responsibility of the Participant under a Benefit Plan for Covered Services that is calculated as a fixed dollar amount.

### Covered Services

means those health care services for which a Participant is entitled to receive coverage under the terms and conditions of the Participant's Benefit Plan.

### Deductible

means a payment for Covered Services calculated as a fixed dollar amount that is the financial responsibility of the Participant under a Benefit Plan prior to qualifying for reimbursement for subsequent health care costs under the terms of a Benefit Plan.

### Medically Necessary/Medical Necessity

means services and supplies that satisfy the Medical Necessity requirements under the applicable Benefit Plan. No service is a Covered Service unless it is Medically Necessary.

### Participant

means any individual, or eligible dependent of such individual, whether referred to as "Insured", "Subscriber", "Member", "Participant", "Enrollee", "Dependent", or similar designation, who is eligible and enrolled to receive Covered Services.

**Participating Provider**

means a hospital, physician or group of physicians, or any other health care practitioner or entity that has a direct or indirect contractual arrangement with CIGNA to provide Covered Services with regard to the Benefit Plan covering the Participant.

**Payment Policies**

are the guidelines utilized for calculating payment of claims under this Agreement. Such guidelines include CIGNA's or its designee's standard claim coding and bundling methodology and claims processing policies and procedures.

**Payor**

means the person or entity obligated to a Participant to provide reimbursement for Covered Services under the Participant's Benefit Plan and which CIGNA has agreed may access services under this Agreement.

**Quality Management**

means the program described in the Administrative Guidelines relating to the quality of Covered Services provided to Participants.

**Represented Provider**

means a physician: (a) who is employed by, associated with or otherwise represented by Group; (b) who both Group and CIGNA have agreed may provide services pursuant to this Agreement; and (c) who has agreed to be subject to the requirements of this Agreement to the extent applicable to Represented Provider.

**Utilization Management**

means a process to review and determine whether certain health care services provided or to be provided are Medically Necessary and in accordance with the Administrative Guidelines.

## EXHIBIT B CREDENTIALING

1. Group shall be responsible for credentialing and recredentialing of all Represented Providers in accordance with CIGNA's standards for delegation of credentialing activities.
2. Group's credentialing/rec credentialing criteria shall, at a minimum, satisfy NCQA standards or the standards of another appropriate accrediting body designated by CIGNA, and the standards established by CIGNA. CIGNA reserves the right to disapprove, terminate or suspend any of Group's Represented Providers if a Represented Provider does not meet CIGNA's requirements.
3. Group shall rec credential Represented Providers within the timeframes required by NCQA or the standards of another appropriate accrediting body designated by CIGNA or as often as is mandated by applicable law, whichever is more frequent.
4. Group shall provide CIGNA with a summary of the credentials of each Represented Provider in a format acceptable to CIGNA and such other information as may reasonably be requested by CIGNA from time to time.
5. Group shall require Represented Providers to represent and warrant that the information contained in their applications for participation is true and accurate and to agree to notify Group promptly of any material change in the information on such application. Group shall, in turn, immediately notify CIGNA of all of such changes.
6. CIGNA may audit Group's credentialing/rec credentialing activities, including Group's credentialing/rec credentialing files. If CIGNA determines that Group cannot meet its credentialing obligations set forth herein, CIGNA may elect to assume responsibility for such activities. Group shall cooperate and provide to CIGNA any information necessary to perform such activities.
7. Group acknowledges that the credentialing and rec credentialing performed by Group pursuant to this Exhibit may be relied upon for Benefit Plans for which CIGNA or a CIGNA Affiliate contracts directly with Represented Providers.

## **ADDENDUM TO PROVIDER GROUP AGREEMENT FOR THE STATE OF TEXAS**

The provisions set forth in this Addendum are being added to the Agreement to comply with legislative and regulatory requirements of the State of Texas regarding provider contracts with providers rendering health care services in the State of Texas. To the extent that such Texas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

- (1) The definition for Emergency Services shall comply with Texas laws and regulations to the extent applicable.
- (2) To the extent applicable, CIGNA will comply with all applicable Texas statutes and rules pertaining to prompt payment of Clean Claims with respect to payment to Physician Group for Covered Services under the Agreement.
- (3) CIGNA's claims submission processes are set forth in CIGNA's provider reference manual, as amended from time to time.
- (4) To the extent applicable, CIGNA will not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted with or in a batch submission with a Clean Claim that is deficient. A "batch submission" is a group of electronic claims submitted for processing at the same time within HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.
- (5) Upon request and to the extent required by Texas law, CIGNA will provide Physician Group with the information necessary to determine that Physician is being compensated in accordance with the Agreement.
- (6) If Group is compensated on a discounted fee basis, the Participant's financial obligation for Deductibles or Coinsurance shall be determined based upon the discounted fee and not upon the full billed charge.
- (7) If a Represented Provider is a Primary Care Physician and is reimbursed on a capitated basis, Payor shall begin payment of capitated amounts to Group calculated from the date of a Participant's enrollment no later than the 60th day following the date the Participant has selected or has been assigned to Represented Provider. If selection or assignment does not occur at the time of enrollment, capitation which would otherwise have been paid to a selected Primary Care Physician had a selection been made shall be reserved as a capitation payable until such time as Participant makes a selection or CIGNA assigns a Primary Care Physician.
- (8) If a Participant does not select a Primary Care Physician at the time of application or enrollment, CIGNA may assign the Participant to a Primary Care Physician. If CIGNA

elects to assign a Participant to a Primary Care Physician, the assignment shall be made to a Primary Care Physician located within the zip code nearest the Participant's residence or place of employment and, to the extent practicable given the zip code limitation, shall be done in a manner that results in a fair and equal distribution of Participants among CIGNA's Primary Care Physicians in the applicable CIGNA network. CIGNA shall inform a Participant of the name, address and telephone number of the Primary Care Physician to whom the Participant has been assigned and of the Participant's right to select a different Primary Care Physician. A Participant shall have the right at any time to reject the Primary Care Physician assigned and to select another physician from the list of Primary Care Physicians for the applicable CIGNA network. An election by a Participant to reject an assigned physician shall not be counted as a change in providers under the Texas Insurance Code. CIGNA shall notify a Primary Care Physician of the selection of such Primary Care Physician by a Participant within 30 working days of the selection or assignment of the Participant to a Primary Care Physician by CIGNA.

- (9) Group acknowledges and agrees that the Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit Medically Necessary services. This provision shall not prohibit the savings from cost effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.
- (10) Group's Represented Providers shall post a notice to Participants at the Represented Physician's location on the process for resolving complaints with CIGNA. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints.
- (11) CIGNA shall not engage in any retaliatory action, including termination of or refusal to renew the Agreement, because Group or Represented Provider, on behalf of a Participant, reasonably filed a complaint against CIGNA or has appealed a decision of CIGNA.
- (12) (A) CIGNA will not as a condition of the Agreement or in any other manner prohibit, attempt to prohibit or discourage Group or a Represented Provider from discussing with or communicating in good faith to a Participant who is a current, prospective or former patient or a party designated by such Participant, with respect to: a) information or opinions regarding the Participant's health care including the Participant's medical condition or treatment options; b) information or opinions regarding the provisions, terms, requirements or services of the Participant's health benefit plan as they relate to the medical needs of the Participant; c) the fact that Represented Provider's contract with CIGNA has terminated or that Represented Provider will otherwise no longer be providing care for CIGNA Participants; or d) the fact that, if Medically Necessary Covered Services are not available through Participating Providers, CIGNA must, upon the request of Represented Provider, and

within time appropriate to the circumstances relating to the delivery of the services and the condition of the Participant, but in no event to exceed 5 business days after receipt of reasonably requested documentation, allow referral to a non-participating Provider.

- (B) CIGNA will not in any way penalize or terminate Group or a Represented Provider or refuse to compensate Group or a Represented Provider for Covered Services for communicating with a Participant who is a current, prospective or former patient, or a party designated by Participant, in any manner protected by this provision.
- (13) (A) If CIGNA terminates the Agreement with respect to a Group or a Represented Provider's participation in the Agreement, CIGNA shall give Group or Represented Provider not less than 90 days' prior written notice of the termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by CIGNA, such longer notification period will apply.
- (B) Notice and Hearing. If CIGNA should choose to terminate Group or a Represented Provider's participation under the Agreement, CIGNA will notify Group or a Represented Provider, as applicable, of this decision in writing. The notice will include the reason(s) for the termination and a notice of Group's or Represented Provider's right to request a hearing or review. On request and before the effective date of the termination, but within a period not to exceed 60 days, Group or Represented Provider, as applicable, shall be entitled to a review of the proposed termination by an advisory review panel.

When CIGNA chooses to terminate Group's or a Represented Provider's participation with respect to its commercial HMO plans, the advisory review panel shall be composed of physicians and providers appointed by CIGNA, including at least one representative in affected Group's or Represented Provider's specialty or a similar specialty, if available, who serve on a standing Quality Management committee or Utilization Management committee.

The decision of the advisory review panel must be considered but is not binding on CIGNA. On request, a copy of the recommendation of the advisory review panel and CIGNA's determination shall be given to Represented Provider or Group. If Represented Provider or Group is unsatisfied with the determination, Represented Provider or Group, as applicable, may appeal the decision further pursuant to the Dispute

Resolution procedures specified in the Agreement and Administrative Guidelines.

- (C) The requirements regarding notice and hearing set forth in subsection (B) above do not apply in the case of imminent harm to patient health, action against license to practice, or fraud.
- (D) (1) In the event the Agreement is terminated by Group or a Represented Provider's participation is terminated by Group or the Represented Provider, Group or the Represented Provider shall give reasonable advance notice of such termination to those Participants whom Represented Provider is currently treating and who are affected by the termination. CIGNA will provide assistance to Group and Represented Provider to the extent required by Texas law.
- (2) In the event the Agreement is terminated by CIGNA, CIGNA will notify those Participants whom Group or Represented Provider is currently treating and are affected by the termination at least 30 days before the effective date of such termination; provided, however, that such Participants may be notified immediately if the Agreement or the Represented Provider's participation is terminated for reasons related to imminent harm.
- (E) (1) If a Represented Provider's participation is terminated for reasons other than medical competence or professional conduct, Represented Provider shall continue to provide Covered Services for those Participants who retain eligibility under a Benefit Plan and whom 1) Represented Provider has identified to CIGNA as having special circumstances (i.e. persons with a disability, acute condition, life-threatening illness, past the 24th week of pregnancy or a condition such that Represented Provider reasonably believes that discontinuing care could cause harm to the Participant); and 2) Represented Provider has requested to continue treatment. Represented Provider shall be compensated for Covered Services provided pursuant to this provision in accordance with the compensation arrangements under the Agreement for a period of 9 months for those Participants diagnosed with a terminal illness at the time of termination of the Agreement, through delivery, immediate post-partum care and the follow-up checkup within the first 6 weeks of delivery for Participants past the 24th week of pregnancy at the time of termination, and for a period of 90 days following termination for all others.
- (2) Group and Represented Provider shall not seek payment from the Participant with respect to services rendered pursuant to this

provision of amounts for which the Participant would not be responsible if Represented Provider were still a Participating Provider.

- (14) Nothing in the Agreement shall be construed to require Group or Represented Provider to indemnify CIGNA for any tort liability resulting from acts or omissions of CIGNA.
- (15) Group and Represented Providers shall hold Participants harmless for payment of the cost of Covered Services in the event Payor fails to pay Group and Represented Providers for such Covered Services.
- (16) Nothing in this Agreement shall be construed to require a referring Represented Provider to bear the expenses of a referral for specialty care in or out of CIGNA's provider panel. Savings from cost-effective utilization of health services may, however, be shared with physicians and health care providers in the aggregate.
- (17) To the extent that CIGNA conducts, uses or relies upon economic profiling to terminate the Agreement, CIGNA shall make available to Group or Represented Provider, as applicable, on request the economic profile of Group or Represented Provider, including the written criteria by which Group's or Represented Provider's performance was measured. An economic profile will be adjusted to recognize the characteristics of Group's or Represented Provider's practice that may account for variations from expected costs.
- (18) Quality assessment (as that term is defined under Texas law) shall be conducted through a panel of not less than 3 physicians selected by CIGNA from among a list of participating Physicians which list is to be provided by participating Physicians in the applicable service area.

**CIGNA HealthCare****Exhibit C****Fee Schedule and Reimbursement Terms**

This is an Exhibit to an Agreement between:

Provider: North Texas Ear, Nose & Throat Associates

CIGNA Party: CIGNA HealthCare of Texas, Inc.

Effective Date: October 15, 2008

This Rate Exhibit:

Applies to: North Texas Ear, Nose & Throat Associates

Federal Tax ID: NTENT Represented Providers

National Provider Identifier: \_\_\_\_\_

Effective Date: October 15, 2008

**I. DEFINITIONS**

CIGNA Resource Based Relative Value Scale or CIGNA RBRVS means the methodology designated by CIGNA to produce the allowable fee for certain Covered Services rendered to Participants that uses the components of relative value units (RVU's), geographic practice cost indices (GPCI's), conversion factor and base relativity factors, as defined by CIGNA.

CIGNA Standard Fee Schedule means the standard CIGNA fee schedule in effect at the time of service and applicable to this Agreement for certain Covered Services provided to Participants. The CIGNA Standard Fee Schedule is subject to change. For workers' compensation Benefit Plans, the CIGNA Standard Fee Schedule shall not exceed the state fee schedule.

**II. FEE FOR SERVICE REIMBURSEMENT**

- A. Except as otherwise provided below, Covered Services will be reimbursed at the lesser of billed charges or the 2007 CIGNA RBRVS allowable fee, less applicable Copayments, Deductibles and Coinsurance. The 2007 CIGNA RBRVS allowable fees are fixed and, except for the addition of new codes and services or as otherwise provided in this Exhibit. The GPCI locality used for this agreement is Dallas, TX. Reimbursement for new codes shall be determined using the current RVUs at the time the new codes are added to the fee schedule, 2007 GPCIs, and 2007 conversion factor.
- B. CIGNA will apply the following base relativity factors in its CIGNA RBRVS calculation to the services specified below:

| CPT4 Procedure Code Group                                                                 | Base Relativity Factor |
|-------------------------------------------------------------------------------------------|------------------------|
| Surgery Codes                                                                             | 125%                   |
| Evaluation & Management Codes                                                             | 125%                   |
| Medicine Codes                                                                            | 125%                   |
| Radiology Codes, except high tech radiology including but not limited to MRI, PET and CAT | 95%                    |

C. The following Covered Services will be reimbursed at the lesser of billed charges or the applicable fee under the CIGNA Standard Fee Schedule, less applicable Copayments, Deductibles and Coinsurance:

1. Injectable drugs, immunizations, immunization administration, vaccines, physical therapy, toxoids; all high tech radiology including but not limited to CAT Scans, Magnetic Resonance Imaging, Positron Emission Tomography; pathology and laboratory services and routine venipuncture.
2. All procedure codes for Covered Services for which reimbursement has not been established above, including but not limited to those for unlisted procedures as well as new Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and/or American Society of Anesthesiologists (ASA) procedure codes, until such time as the applicable RVU's have been loaded into the appropriate claims systems.

D. Notwithstanding anything to the contrary set forth above, those services that are excluded from this Agreement under the Excluded Services section of the Agreement shall not be reimbursed and Participants shall not be billed for such services.

### Rates Only Amendment

WHEREAS, Cigna HealthCare of Texas Inc. ("Cigna") and North Texas Ear, Nose & Throat Associates have executed a participating provider Agreement dated 10/15/2008 (the "Agreement"); and

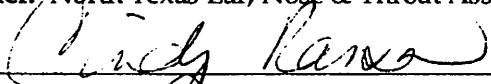
WHEREAS, Cigna and North Texas Ear, Nose & Throat Associates mutually desire to amend the Agreement;

NOW, THEREFORE, pursuant to the Amendment provisions of the Agreement and in consideration of the mutual promises contained herein, the parties hereby agree as follows:

1. The effective date of this Amendment is 5/1/2014.
2. The Rate Exhibit(s), Exhibit(s) C of the Agreement is/are replaced in its/their entirety by the attached Exhibits as of the effective date of this Amendment.
3. Except as modified herein, the Agreement remains in full force and effect. To the extent of a conflict between this Amendment and the Agreement, this Amendment shall control.
4. Any and all capitalized terms not defined herein shall have the same meaning as in the Agreement.

IN WITNESS WHEREOF, the parties have caused this Amendment to be executed by their duly authorized representatives below:

**Provider:** North Texas Ear, Nose & Throat Associates

By: 

Printed Name: Cindy LARSON

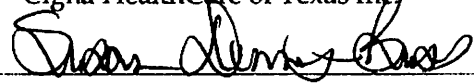
Title: Executive Director

Date: 3-19-24

Federal Tax ID: NTENT Represented Providers

NPID: \_\_\_\_\_

**Cigna:** Cigna HealthCare of Texas Inc.

By: 

Printed Name: Susan Dennis-Buss

Title: RVP, Delivery System Innovation and Collaboration

Date: 4/3/14

## Cigna

### Exhibit C Fee Schedule and Reimbursement Terms

This is an Exhibit to an Agreement between:  
Provider: North Texas Ear, Nose & Throat Associates  
Cigna Party: Cigna HealthCare of Texas, Inc.  
Effective Date: October 15, 2008  
This Rate Exhibit:  
Applies to: North Texas Ear, Nose & Throat Associates  
Federal Tax ID: NTENT Represented Providers  
National Provider Identifier: \_\_\_\_\_  
Effective Date: May 1, 2014

#### I. DEFINITIONS

Cigna Resource Based Relative Value Scale or Cigna RBRVS means the methodology designated by Cigna to produce the allowable fee for certain Covered Services rendered to Participants that uses the components of Relative Value Units (RVU's), geographic practice cost indices (GPCI's), conversion factor and base relativity factors, as defined by Cigna.

Cigna Standard Fee Schedule means the standard Cigna fee schedule in effect at the time of service and applicable to this Agreement for certain Covered Services provided to Participants. The Cigna Standard Fee Schedule is subject to change. For workers' compensation Benefit Plans, the Cigna Standard Fee Schedule shall not exceed the state fee schedule.

#### II. FEE FOR SERVICE REIMBURSEMENT

A. Except as otherwise provided below, Covered Services will be reimbursed at the lesser of billed charges or the 2012 Cigna RBRVS allowable fee, less applicable Copayments, Deductibles and Coinsurance. The 2012 Cigna RBRVS allowable fees are fixed and, except for the addition of new codes and services or as otherwise provided in this Exhibit, may only be changed through an amendment to this Agreement. The GPCI locality used for this Agreement is Dallas, TX. Reimbursement for new codes shall be determined using the current RVUs at the time the new codes are added to the fee schedule, 2012 GPCIs, and 2012 conversion factor.

##### B. Base Relativity Factor

1. Cigna will apply the following base relativity factors in its Cigna RBRVS calculation for the services specified below:

| Procedure Code Group              | Base Relativity Factor |
|-----------------------------------|------------------------|
| ENT Surgery Codes                 | 118 %                  |
| Surgery Codes                     | 120 %                  |
| Medicine Codes                    | 120 %                  |
| Evaluation and Management Codes   | 115 %                  |
| Office Visits and Consults        | 115 %                  |
| Immunization Administration Codes | 100 %                  |
| Radiology Codes                   | 85 %                   |

2. The following services are excluded from the reimbursement methodology described above, and such Covered Services will be reimbursed at the lesser of billed charges or the applicable fee under the Cigna Standard Fee Schedule, less applicable Copayments, Deductibles and Coinsurance:

Injectable drugs, immunizations, vaccines, physical therapy, routine venipuncture, toxoids and pathology and laboratory services as defined within the Current Procedural Terminology (CPT) coding system and published by the American Medical Association and as defined within the Healthcare Common Procedure Coding System (HCPCS) and published by the Centers for Medicare & Medicaid Services.

- C. Notwithstanding the above, upon 30 days advance notice, Cigna reserves the right to apply site of service claim adjudication and the applicable reimbursement when available and Cigna chooses to implement them.
- D. The following services are excluded from the reimbursement methodology described above, and such Covered Services will be reimbursed at the lesser of billed charges or the fee listed below, less applicable Copayments, Deductibles and Coinsurance. The services and fees for HCPCS codes listed below remain unchanged unless changed by amendment (i.e., changes to existing fees and/or the addition of fees for new codes). Any such amendment will be on a prospective basis only.

| Procedure Code/Modifier | Description                                                                                                                                                                        | Maximum Allowable Fee |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|
| 69801                   | LABYRINTHOTOMY, WITH OR WITHOUT CRYOSURGERY INCLUDING OTHER NONEXCISIONAL DESTRUCTIVE PROCEDURES OR PERFUSION OF VESTIBULOACTIVE DRUGS (SINGLE OR MULTIPLE PERFUSIONS); TRANSCANAL | \$307.67              |

|       |                                                                                                                                                                                                                             |          |
|-------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
| 99241 | OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING.                       | \$62.96  |
| 99242 | OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. | \$115.71 |
| 99243 | OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY.                                 | \$158.28 |
| 99244 | OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A                                                                                                 | \$231.67 |

|       |                                                                                                                                                                                                                                |          |
|-------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
|       | COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY.                                                                                                                                                 |          |
| 99245 | OFFICE CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY.                         | \$287.34 |
| 99251 | INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A PROBLEM FOCUSED HISTORY; A PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING.                     | \$58.60  |
| 99252 | INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: AN EXPANDED PROBLEM FOCUSED HISTORY; AN EXPANDED PROBLEM FOCUSED EXAMINATION; AND STRAIGHTFORWARD MEDICAL DECISION MAKING. | \$94.18  |
| 99253 | INPATIENT CONSULTATION FOR A                                                                                                                                                                                                   | \$139.24 |

|       |                                                                                                                                                                                                               |          |
|-------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------|
|       | NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A DETAILED HISTORY; A DETAILED EXAMINATION; AND MEDICAL DECISION MAKING OF LOW COMPLEXITY.                                             |          |
| 99254 | INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF MODERATE COMPLEXITY. | \$200.33 |
| 99255 | INPATIENT CONSULTATION FOR A NEW OR ESTABLISHED PATIENT, WHICH REQUIRES THESE THREE KEY COMPONENTS: A COMPREHENSIVE HISTORY; A COMPREHENSIVE EXAMINATION; AND MEDICAL DECISION MAKING OF HIGH COMPLEXITY.     | \$250.03 |

- E. All procedure codes for Covered Services for which reimbursement has not been established above, including but not limited to those for unlisted procedures as well as new Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS) and/or American Society of Anesthesiologists (ASA) procedure codes, will be paid at a 60 % reduction from billed charges, less applicable Copayments, Deductibles and Coinsurance, until such time as the applicable RVU's have been loaded into the appropriate claims systems.

**F. Notification**

Notwithstanding anything to the contrary set forth above, those services that are excluded from this Agreement under the Excluded Services section of the Agreement shall not be reimbursed and Participants shall not be billed for such services.

- G. The reimbursement terms set forth in this Exhibit are applicable to all services rendered as part of your practice or scope of license. Any services provided by an out of network provider or vendor as part of your practice or scope of license are not separately reimbursable.