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: Cindy Lanson

Printed Name: Cindy LANSON

Title: Executive Director

Date: 3-19-24

Federal Tax ID: NTENT Represented Providers

NPID: _____

Cigna: Cigna HealthCare of Texas Inc.

By: Susan Dennis-Russ

Printed Name: Susan Dennis-Russ

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.