PROVIDER AGREEMENT

Aetna Network Services LLC, on behalf of itself and its Affiliates ("Company"), and North Texas Ear, Nose and Throat Associates, PA dba NTENT**,** 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
	TX Health Care Network (Workers' Compensation)
	Auto Network
	Institutes of Excellence® (IOE) Transplant Program (subject to separate approval by Company)

EFFECTIVE DATE: July 1, 2019

TERM: This Agreement begins on the Effective Date, continues for an initial term of _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: Kathie Norris
Kathie Norris (May 21, 2019)

Printed Name: Kathie Norris

Title: Executive Director

Date: May 21, 2019

FEDERAL TAX I.D. NUMBER: 75-2626614

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

Provider contract notice address:
17300 Preston Road
Suite 160
Plano TX 75252

Provider contract notice email address: knorris@ntent.org

knorris@ntent.org

COMPANY

By: Lesley E. Scheske
Lesley E. Scheske (May 22, 2019)

Printed Name: Lesley E. Scheske

Title: Manager, Network Management

Date: May 22, 2019

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

Company:

2777 North Stemmons Frwy
Suite 1450
Dallas TX 75207

For Behavioral Health Providers:

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 geographic area listed on the Participation Area Schedule 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 have 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 Area. Defined in Section 1.1 and as outlined on the Participation Area Schedule attached to this Agreement.

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

TEXAS

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.

As required by Texas Insurance Code § 1458.101 and with respect to fully-insured Plans, Provider accepts participation in the following lines of business, as defined under such section, and compensated in accordance with the Product references as described below.

[Texas Dept. of Insurance lines of business	**Products**	**Product Compensation References –** Products are referenced in the Service and Rate Schedule as outlined below	**Product Compensation References –** Products *may* be referenced in the Services and Rate Schedule as outlined below	**Provider Acceptance Signature**
HMO	Commercial Health Benefit Product or Commercial Gated Health Benefit Product	Rate in the Service and Rate Schedule	Gatekeeper products	Kathie Norris Kathie Norris (May 21, 2019)
EPO	Commercial Health Benefit Product or Commercial Gated Health Benefit Product	Rate in the Service and Rate Schedule	Gatekeeper products	Kathie Norris Kathie Norris (May 21, 2019)
PPO	Commercial Health Benefit Product or Commercial Non-Gated Health Benefit Product	Rate in the Service and Rate Schedule	Non Gatekeeper products	Kathie Norris Kathie Norris (May 21, 2019)
Medicare	Government Programs	Government Programs	Government Programs	Kathie Norris Kathie Norris (May 21, 2019)

TERM

The following shall be added after the second sentence in TERM:

"Notices of renewal may be sent to Provider. In the event Provider has not responded or objects within sixty (60) days of receipt of such notice, the Agreement shall automatically renew."

1.1 General Obligations

The second clause in subsection (d) in Section 1.1 General Obligations shall be deleted and replaced with the following:

"unless otherwise permitted by Applicable Law, 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."

Subsection (l) of Section 1.1 General Obligations, shall be deleted and replaced with the following:

(l) unless such Covered Services are not available from a Participating Provider and for all Plans and except as prohibited by Applicable Law, 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. In accordance with 28 Texas Administration Code Section 3.3703 (27), except for instances of emergency care as defined under TX Insurance Code §1301.155(a), when referring Member to a facility for surgery Provider and/or Group Provider must: (a) notify Member of the possibility that out-of-network providers may provide treatment and that the Member can contact Company for more information; (b) notify Company that surgery has been recommended; and (c) notify Company of the facility that has been recommend for the surgery."

The following shall be added to the end of Section 1.1 General Obligations:

"(n) Provider shall retain in its records updated information for a Member concerning other health benefit plan coverage and to provide the information to Company on the form described by Applicable Law, and if a form is not described by Applicable Law, in the manner specified by Company."

(o) as required by Applicable Law, Provider shall post a notice to Members on the process for resolving complaints with Company including the Department of Insurance toll-free telephone number for filing complaints. Company shall not terminate or refuse to renew this Agreement or otherwise retaliate against Provider because Provider reasonably filed a complaint or an appeal on behalf of a Member."

(p) if Provider and/or Group Providers provide facility-based Provider Services at a facility that is a preferred provider for Company, Provider and/or Group Providers shall give notice to such facility as soon as reasonably practicable that Provider and/or Group Providers is also a preferred provider for Company.

(q) in accordance with 28 Texas Administration Code Section 3.3703 (28), except for instances of emergency care as defined under TX Insurance Code §1301.155(a), when scheduling surgery Provider shall: (a) notify the Member of the possibility that out-of-network providers may provide treatment and that the Member can contact Company for more information; and (b) notify Company that surgery has been scheduled."

(r) in the event of a systems failure, or a catastrophic event as defined by 28 Texas Administration Code Section 21.2803, that substantially interferes with the business operations of the Provider, Provider may submit non-electronic claims in accordance with the requirements in 28 Texas Administration Code Section 21.3701 and for the number of calendar days during which substantial interference with business operations occurs as of the date of the catastrophic event or systems failure. Provider shall provide written notice of the Provider's intent to submit non-electronic claims to the issuer of the health benefit plan within five calendar days of the catastrophic event or systems failure. A waiver of the electronic submission requirements may be requested by Provider in any of the following circumstances: (1) No method available for the submission of claims in electronic form. This exception applies to situations in which the federal standards for electronic submissions (45 C. F.R., Parts 160 and 162) do not support all of the information necessary to process the claim; (2) The operation of small provider practices. This exception applies to those providers with fewer than ten full-time-equivalent employees, consistent with 42 C. F.R. Section 424.32(d)(1)(viii); (3) Demonstrable undue hardship, including fiscal or operational hardship; or (4) Any other special circumstances that would justify a waiver. Provider's request for a waiver must be in writing, and must include documentation supporting the issuance of a waiver."

1.3 Compliance with Company Policies

The following shall be added after the second sentence of Section 1.3 Compliance with Company Policies:

If Provider objects to the material change, Provider shall provide written notice to Company within thirty (30) days following receipt thereof, and in the event that Provider reasonably believes that a material change is likely to have a material adverse financial impact upon Provider's practice, Provider shall specify in writing the specific bases demonstrating a likely material adverse financial impact on Provider's practice. Provider may then request that the Parties negotiate in good faith an appropriate amendment to this Agreement. If the parties are unable to negotiate any such amendment not more than thirty (30) days after receipt of a material change and Provider provides notice of termination of this Agreement not more than thirty (30) calendar days after receipt of a material change, then this Agreement shall terminate coincident with the effective date of the material change.

The following shall be added to the end of Section 1.3 Compliance with Company Policies:

"In addition, Provider shall participate in Company's preventive care program or implement an effective preventive care program consistent with Company's criteria and policies, for which Provider shall be compensated in accordance with the rates set forth in the **Service and Rate Schedule**."

1.4 Claims Submission and Payment

The following shall be added to the end of subsection (c) in Section 1.4 Claims Submission and Payment:

"This time limit for billing is ninety-five (95) days for Medicaid and CHIP plans. Except for Medicaid and CHIP plans, this requirement will be waived in the event Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside the control of Provider that resulted in the delayed submission."

The following shall be added to the end of subsection (f) in Section 1.4 Claims Submission and Payment:

"In the event Provider fails to return overpayments within forty-five (45) days of receipt, upon written notice from Company of such event, Provider shall pay a contracted penalty of 1.0% per month simple interest on the eligible, unrepaid portion of such overpayment, beginning on the forty-sixth (46^{th}) day after receipt of notice of such overpayment(s). If the overpayment request is mailed, the Provider's receipt date will be the fifth (5^{th}) calendar day following the postmark date. Company shall not be entitled to collect any other penalty, charge or fee, for Provider's failure to return overpayment of claims under any Full risk Plans. Company shall not be entitled to the contracted penalty for overpayments submitted in relation to Payer or plan sponsor Plans."

1.5 Member Billing

The following shall be added to the end of Section 1.5 Members Billing:

"As required by Texas Insurance Code Section 1661.005, if Provider receives an overpayment from a Member Provider must refund the amount of the overpayment to Member no later than the thirtieth (30^{th}) day after the date Provider determines that an overpayment has been made."

2.1 General Obligations

The following shall be added to the end of Section 2.1 General Obligations:

"(e) as required by Texas law, Company shall conduct quality assessment through a panel of at least three (3) Participating Providers."

2.2 Claims Payment

Section 2.2 Claims Payment shall be deleted and replaced with the following:

"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:

(c) when it is the Payer, to pay Provider for Covered Services rendered to Members; and
(d) 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.

Except for capitated services, in the event Company fails to pay Clean Claims within forty-five (45) days (or such time as permitted by Applicable Law) of receipt, Company shall pay a penalty as required by Applicable Law. In relation to full risk Plans, if Applicable Law does not require a penalty for Company's failure to pay a clean claim within the time period required by Applicable Law, then Provider shall not be entitled to billed charges or any penalty. Provider shall not be entitled to billed charges or any penalty for claims submitted in relation to Payer or plan sponsor Plans. (Plan sponsor Plans are not full risk Plans.) The receipt date for claims will be determined in accordance with Applicable Law.

Except as otherwise required under applicable Federal, or state law or regulation, or a Plan, if Company pays a claim and afterwards either –

2.2.1 Company discovers a possible underpayment to Provider within the time period for Provider to dispute payments stated in Section 1.4, or

2.2.2 Provider discovers a possible underpayment to Provider and gives prompt notice to Company within the time period for Provider to dispute payments stated in Section 1.4 (e),

then Company shall review the claim within forty-five (45) days of Company's discovery or Provider's notice, and shall pay any eligible unpaid portion of the claim. In relation to Full risk Plans, if Applicable Law does not require a penalty for Company's failure to pay a clean claim within the time period required by Applicable Law, then Provider shall not be entitled to billed charges or any penalty for a possible underpayment. Provider shall not be entitled to billed charges or any penalty for possible underpayment for claims submitted in relation to Payer or plan sponsor Plans. (Plan sponsor Plans are not Full risk Plans.)

When required, Company shall comply with all applicable statutes and rules pertaining to prompt payment of clean claims, including Texas Insurance Code Sections 1301.101-1301.109, Sections 1301.131-1301.138, Sections 843.336–843.353, and 28 Texas Administrative Code Sections 21.2801-21.2826, with respect to payment to a Participating Provider for Covered Services that are rendered to Members. In accordance with Texas Insurance Code Sections 843.323, 1301.0641 and 28 Texas Administrative Code Section 3.3703 (22), Company's clearinghouse may not refuse to process or pay an electronically submitted clean claim because the claim is submitted together with or in a batch submission with a claim that is not a clean claim.

In accordance with Applicable Law, including but not limited to Texas Insurance Code Section 1301.136 and Sec. 843.321:

(1) Provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the Provider will receive under the contract;
(2) Company or Company's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the Company receives the request;
(3) Company or Company's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to Provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules;
(4) The contract may be terminated by Provider on or before the 30th day after the date Provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans;
(5) Provider shall only use or disclose the information for the purpose of practice management, billing activities, and other business operations; and disclose the information to a governmental agency involved in the regulation of health care or insurance;

(6) Company shall, on request of Provider, provide the name, edition, and model version of the software that Company uses to determine bundling and unbundling of claims.

Provider shall use information technology as required under Texas Insurance Code Chapter 1661 unless Provider has received a waiver of any requirement for the use of information technology from Company as permitted by Texas Insurance Code Section 1661.055(c).

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. Where there is a Payer or plan sponsor, Company shall have no obligation to pay Provider in the event the Payer or plan sponsor or Member fails to pay Provider.

Company may propose changes in the capitation rate or the Service and Rates Schedule upon ninety (90) days written notice to Provider. If Provider is compensated in the form of capitation payments, said payments shall begin and selection of a Primary Care Provider by a member shall be in accordance with Applicable Law. If capitation applies, Company will comply with the requirements described in Texas Insurance Code Sections 843.315 and 843.316."

3.0 Network Participation

The following shall be added to the end of Section 3.0 Network Participation:

"Company may contract with a third party entity to provide access to the Company's rights and responsibilities under this Agreement. On the request of Provider Company will provide information necessary to determine whether a particular third party has been authorized to access Provider's health care services and contractual discounts."

5.0 Additional Termination/Suspension Rights and Obligations

The following shall be added under the heading of Section 5.0 Additional Termination/Suspension Rights and Obligations:

"Prior to termination initiated by Company and in accordance with Applicable Law, Company shall provide a written explanation of the reason(s) for termination, and upon request before the effective date, Provider shall be entitled to a review by an advisory panel."

5.4 Obligations Following Termination

The following shall be added after the first sentence of Section 5.4 Obligations Following Termination:

"Company shall reimburse Provider for Covered Services to any Member of special circumstance, such as a person who has a disability, acute condition, or life-threatening illness or is past the twenty-fourth week of pregnancy. "Special circumstances" means a condition such that Provider reasonably believes that discontinuing care by the Provider could cause harm to the patient. The special circumstance shall be identified by the Provider, who must request that the Member be permitted to continue treatment under the Provider's care and agree not to seek payment from the patient of any amounts for which the Member would not be responsible if the Provider were still a Participating Provider. This subsection does not extend the obligation of Company to reimburse the terminated Provider for ongoing treatment of a Member beyond the 90th day after the effective date of termination, or beyond nine months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness, except that the obligation to reimburse a Member who at the time of the termination is past the 24th week of pregnancy, extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery. Provider shall comply with Texas Insurance Code Sections 1301.152 - 1301.154."

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

"Upon notice of expiration or termination of this Agreement or of a Plan, Provider, upon the direction of Company and in accordance with applicable state law, shall provide reasonable advance notice of the impending termination to Members currently under the treatment of Provider."

6.1 Independent Contractor Status/Relationship

The following shall be added after the third sentence of Section 6.1 Independent Contractor Status/Relationship:

"In particular, medical necessity decisions are for compensation purposes only, and do not direct or limit the advice or care which Provider and/or Group Providers can or should provide in Provider's sole medical judgment."

The fourth (now fifth) sentence of Section 6.1 Independent Contractor Status/Relationship, shall be deleted and replaced with the following:

"Notwithstanding anything else in this section or this Agreement to the contrary, nothing shall require Provider and/or Group Providers to indemnify and hold harmless Company (including for costs and counsel fees) from any and all claims, liabilities and third party causes of action arising out of the Company's administration of Plans."

8.0 Miscellaneous

The following shall be added to the end of Section 8.0 Miscellaneous:

"8.8 Holding Members Harmless. Provider hereby agrees that in no event, including, but not limited to nonpayment by the HMO, HMO insolvency, or breach of this agreement, may Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against subscriber, enrollee, or persons other than the HMO acting on their behalf for services provided under this agreement. This provision does not prohibit collection of supplemental charges or copayments made in compliance with the terms of (applicable agreement) between HMO and subscriber or enrollee. Provider further agrees that: (A) this provision will survive the termination of this agreement regardless of the cause giving rise to termination and must be construed to be for the benefit of the HMO subscriber or enrollee; and (B) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Member, or persons acting on their behalf. Any modification, addition, or deletion to the provisions of this clause will be effective on a date no earlier than 15 days after the commissioner has received written notice of the proposed changes.

8.9 Delegation. To the extent Company delegates certain functions to Provider, such delegation shall be governed by a separate delegation agreement which shall be subject to the applicable requirements of Texas Insurance Code, Chapter 1272."

Appendix 1 - Definitions

The following definition shall be added to Appendix 1 – Definitions:

"Clean Claim. A clean claim is a claim that contains the information that is required by applicable Texas law and regulations adopted by the Commissioner of Insurance, and is submitted consistent with Company's established processing procedures to the extent Company establishes the information and processing procedure requirements consistent with applicable Texas law and regulations.

Policies

The following shall be added to the end of Policies:

"Precertification" when used in this Agreement, means the utilization review process to determine whether the requested service procedure, prescription drug, or medical service meets the Company's clinical criteria for coverage. Precertification does not mean verification which is defined by Texas law, as a reliable representation of payment of care or services to fully insured HMO and PPO members."

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.

MEDICARE ADVANTAGE PRODUCT ADDENDUM

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

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

2. PAYMENT.

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

B. Prompt Pay. In accordance with 42 C.F.R. § 422.520(b)(1), Company shall pay clean claims submitted by Provider for Covered Services provided to Medicare Members within thirty (30) calendar days of receipt. For purposes of this Addendum, the term "clean claim" shall have the meaning assigned in 42 C.F.R. §422.500.

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

D. Medicare Payment Adjustment. 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 the date (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment. Medicare Payment Adjustments do not include performance based incentive payments made under traditional Medicare as the result of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") and its implementing regulations, as may be amended from time to time.

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

assign to the purchaser a duplicate of this Addendum along with the underlying Agreement and any Service and Rate Schedules applicable to participation in Company's Medicare Plans. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

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

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

B. **Delegation.** If Provider delegates to a subcontractor a service required by this Agreement, and the service is required under the terms of Company's CMS Contract, Provider's subcontract shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the requirements described above. In the event that Company delegates a function to Provider, Company retains the right to approve, suspend or terminate such delegation.

5. COMPLIANCE OBLIGATIONS

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

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

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

D. Offshore Services. If Provider (or its subcontractors) provides services for Company's Medicare Plans that involve the receipt, processing, transferring, handling, storing or accessing of Protected Health Information ("PHI") Offshore ("Offshore Services"), Provider agrees to complete Company's Offshore Services Attestation prior to the commencement of Offshore Services (where possible), within fifteen (15) days of a material change in scope or delivery of Offshore Services, and no less than annually. [42 C.F.R. §§ 422.504(i)(4) and (5)].

E. Excluded Entities. Provider agrees that no person or entity that provides services, directly or indirectly, for Company's Medicare Plans, may be an Excluded Entity under Section 1128 or 1128A of the Social Security Act. Provider shall screen the Exclusion Lists prior to initially hiring/contracting and monthly thereafter to ensure no employee or subcontractor appears on Exclusion Lists. If any employee or subcontractor appears on an Exclusion List or is otherwise prohibited from receiving payment under the Medicare program by Federal law, Provider will remove such individual or entity from any direct or indirect work on Company's Medicare Plans and promptly notify Company of the same.

F. Compliance Program and Anti-Fraud Initiatives. Provider shall maintain an effective compliance program to prevent, detect, and correct: (1) non-compliance with CMS's program requirements and (2) fraud waste and abuse ("FWA"). Such compliance program shall include dissemination to employees and Downstream Entities of (a) written policies and/or standards of conduct articulating the entity's commitment

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

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

H. Marketing. Provider shall comply with the Medicare Communications and Marketing Guidelines ("MCMGs") and shall remain neutral when assisting Medicare beneficiaries with enrollment decisions. [Medicare Communications and Marketing Guidelines, as may be updated from time to time.].

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

6. MEDICARE MEMBER PROTECTIONS.

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

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

C. Non-Covered Services. Provider must hold Medicare Members harmless for the cost of non-covered services, except for normal cost-sharing amounts (i.e., copayments, coinsurance, and/or deductibles), unless the Medicare Member has received a pre-service organization determination notice of denial from Company before such services are rendered by Provider. This restriction on holding a Medicare Member financially responsible for non-covered services does not apply in instances where a service is never covered by Medicare under any circumstance. [CMS, Memorandum to Medicare Advantage Plans, et. al, "Improper Use of Advance Notices of Non-coverage" (May 5, 2014).] [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)] and [42 C.F.R. §423.505(i)(3)(i)].

D. Dual Eligible Cost Share. Provider shall not hold Medicare Members eligible for both Medicare and Medicaid liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Provider shall not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Provider will: (1) accept Company's payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(iii)]

7. RECORDS AND AUDIT.

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

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

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

D. Submission and Certification of Encounter Data. Provider acknowledges that Company is required to provide CMS, other Officials and accrediting organizations with encounter data, including medical records and claims data. Provider shall routinely provide such encounter data to Company in the form and manner requested by Company. Provider certifies that such encounter data shall be accurate, complete and truthful to the best of its knowledge and belief. Provider agrees to immediately notify Company if any encounter data that Provider submitted to Company for Medicare Members is inaccurate, incomplete or erroneous, and cooperate with Company to correct erroneous encounter data.

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

8. TERMINATION. This Addendum may be terminated on its own without respect to the remainder of the Agreement, with or without cause, by either Party in accordance with the termination provisions of the underlying Agreement, except that no termination of this Medicare Addendum shall occur without cause or for convenience with less than 90 days advance notice to the other party. This Addendum shall terminate automatically in the event that the underlying Agreement is terminated in accordance with the termination provisions of the Agreement.

9. DEFINITIONS:

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

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

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

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

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

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

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

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

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

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

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

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

SPECIALIST ENT PHYSICIAN
SERVICES AND RATE SCHEDULE INCLUDES Medicare

RATE:

Payment Details:

For Gatekeeper and Non-Gatekeeper products:

Service	Billing Codes	Rates
All Applicable Radiology CPT4 Codes	**CPT4 Codes:** 70010-79999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Radiology Services	**HCPC Codes:** R0070-R0076	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
All Applicable Laboratory CPT4 Codes	**CPT4 Codes:** 80047-89356	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Lab & Pathology Services	**HCPC Codes:** P2028-P9615	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** E0100-E8002	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** K0001-K0669	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Transportation	**HCPC Codes:** A0021-A0999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Supplies	**HCPC Codes:** A4206-A9999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Enteral & Perenteral	**HCPC Codes:** B4034-B9999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Immunizations	**CPT4 Codes:** 90281-90749	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Injectiable Drugs	**HCPC Codes:** J0120-J9999	100% of Aetna Market Fee Schedule
Surgery	**CPT4 Codes:** 10021-69990	150% of Then Current Dallas, TX RBRVS Based Fee Schedule
Hearing Aids	**HCPC Codes:** V5030, V5040, V5050, V5060, V5100, V5120, V5130, V5140, V5150, V5171, V5181, V5190, V5211, V5212, V5213, V5215, V5221, V5230, V5242-V5263, V5298	65% of Billed Charges to Max of $6000.00
All Services not otherwise identified		120% of Then Current Dallas, TX RBRVS Based Fee Schedule

For Government Programs products:

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

SERVICES:

Specialist will provide services that are within the scope of and appropriate to the Specialist's license and certification to practice. Moreover, Specialist agrees, with respect to all chronic biotherapies administered in Specialist's office to Members, to order the necessary specialty medications from a Participating specialty pharmacy provider. With respect to Members diagnosed with either Crohn's Disease or Immunodeficiency Syndrome or Infused Medications for Psoriasis and needing specialty medications for their conditions, Specialist shall in accordance with a Member's plan and unless prohibited by law, coordinate with Member's Participating specialty pharmacy provider to transition the drug and service authorization, drug distribution, clinical oversight and billing management of the specialty medications treating these conditions to the participating specialty pharmacy.

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.

"Then Current Dallas, TX RBRVS Based Fee Schedule" - A fee schedule created and maintained by Company for use in reimbursing covered services to providers. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS).
The rates contained in this schedule are consistent with Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB and DMEPOS), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. The coding and fees determined under this schedule are to remain fixed through the year, and, as a result, Company does not update the schedule more than once annually to reflect subsequent coding updates, changes in the RBRVS relative values, the CMS conversion factor or otherwise. Company will make its best effort to update the schedule annually by April 1st of each year. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the prior period. The effective date of the update will be communicated via a 90 day notification letter. Claims will be processed in accordance with Company guidelines.

"Aetna Medicare Market Fee Schedule Dallas" - A fee schedule created and maintained by Company for use in reimbursing covered services to Members under Company's Medicare Plans. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS), Anesthesia, and Average Sales price including immunizations (ASP). The rates contained in this schedule are set at varying percentages of Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB, DMEPOS, Anesthesia and ASP), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. ASP rates for immunizations and drugs are updated quarterly. Company plans to update the schedule within 60 days of the final rates and/or codes

being published by CMS. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the prior period. Claims will be processed in accordance with Company guidelines.

"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), PPO (Preferred 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.

"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 Services and Rate Schedule.

"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 85% of eligible billed charges.

b) Unless required by law, payment for services of Mid-level Practitioners (Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Registered Nurses) may be less than Physician services based on Company's then current payment policy.

c) 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.

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) 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.

f) Except where 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 twenty percent (20%) should Provider fail to refer Members to Participating Providers in the absence of either: 1) sound clinical reasons; 2) advance approval of Company; 3) the existence of an Emergency Services or exigent circumstances; or 4) if applicable, the Member's request for referral to an out of network provider after notice and informed consent of the patient has been documented, in writing. If Company imposes a reduction to the rates, Provider may request, no more than once every six (6) months, for Company to re-evaluate Provider's use of Participating Providers. If Company determines that Provider has consistently referred Members to Participating Providers for all Covered Services for the preceding six (6) month period, Company will eliminate the reduction within sixty (60) days after Company's determination.

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) Specialist 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).

SPECIALIST OCULOPLASTIC PHYSICIAN
SERVICES AND RATE SCHEDULE INCLUDES Medicare

RATE:

Payment Details:

For Gatekeeper and Non-Gatekeeper products:

Service	Billing Codes	Rates
All Applicable Radiology CPT4 Codes	**CPT4 Codes:** 70010-79999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Radiology Services	**HCPC Codes:** R0070-R0076	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
All Applicable Laboratory CPT4 Codes	**CPT4 Codes:** 80047-89356	85% of Then Current Fort Worth, TX RBRVS Based Fee Schedule
Lab & Pathology Services	**HCPC Codes:** P2028-P9615	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** E0100-E8002	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** K0001-K0669	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Transportation	**HCPC Codes:** A0021-A0999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Supplies	**HCPC Codes:** A4206-A9999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Injectiable Drugs	**HCPC Codes:** J0120-J9999	100% of Aetna Market Fee Schedule
Hearing Aids	**HCPC Codes:** V5030, V5040, V5050, V5060, V5100, V5120, V5130, V5140, V5150, V5171, V5181, V5190, V5211, V5212, V5213, V5215, V5221, V5230, V5242-V5263, V5298	65% of Billed Charges to Max of $6000.00
All Services not otherwise identified		120% of Then Current Dallas, TX RBRVS Based Fee Schedule

For Government Programs products:

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

SERVICES:

Specialist will provide services that are within the scope of and appropriate to the Specialist's license and certification to practice. Moreover, Specialist agrees, with respect to all chronic biotherapies administered in Specialist's office to Members, to order the necessary specialty medications from a Participating specialty pharmacy provider. With respect to Members diagnosed with either Crohn's Disease or Immunodeficiency Syndrome or Infused Medications for Psoriasis and needing specialty medications for their conditions, Specialist shall in accordance with a Member's plan and unless prohibited by law, coordinate with Member's Participating specialty pharmacy provider to transition the drug and service authorization, drug distribution, clinical oversight and billing management of the specialty medications treating these conditions to the participating specialty pharmacy.

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.

"Then Current Dallas, TX RBRVS Based Fee Schedule" - A fee schedule created and maintained by Company for use in reimbursing covered services to providers. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS).
The rates contained in this schedule are consistent with Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB and DMEPOS), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. The coding and fees determined under this schedule are to remain fixed through the year, and, as a result, Company does not update the schedule more than once annually to reflect subsequent coding updates, changes in the RBRVS relative values, the CMS conversion factor or otherwise. Company will make its best effort to update the schedule annually by April 1st of each year. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the prior period. The effective date of the update will be communicated via a 90 day notification letter. Claims will be processed in accordance with Company guidelines.

"Aetna Medicare Market Fee Schedule Dallas" - A fee schedule created and maintained by Company for use in reimbursing covered services to Members under Company's Medicare Plans. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS), Anesthesia, and Average Sales price including immunizations (ASP). The rates contained in this schedule are set at varying percentages of Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB, DMEPOS, Anesthesia and ASP), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. ASP rates for immunizations and drugs are updated quarterly. Company plans to update the schedule within 60 days of the final rates and/or codes being published by CMS. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the prior period. Claims will be processed in accordance with Company guidelines.

"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), PPO (Preferred 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.

"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 Services and Rate Schedule.

"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 85% of eligible billed charges.

b) Unless required by law, payment for services of Mid-level Practitioners (Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Registered Nurses) may be less than Physician services based on Company's then current payment policy.

c) 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.

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) 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.

f) Except where 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 twenty percent (20%) should Provider fail to refer Members to Participating Providers in the absence of either: 1) sound clinical reasons; 2) advance approval of Company; 3) the existence of an Emergency Services or exigent circumstances; or 4) if applicable, the Member's request for referral to an out of network provider after notice and informed consent of the patient

has been documented, in writing. If Company imposes a reduction to the rates, Provider may request, no more than once every six (6) months, for Company to re-evaluate Provider's use of Participating Providers. If Company determines that Provider has consistently referred Members to Participating Providers for all Covered Services for the preceding six (6) month period, Company will eliminate the reduction within sixty (60) days after Company's determination.

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) Specialist 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).

SPECIALIST ENT PHYSICIAN
SERVICES AND RATE SCHEDULE NO Medicare

RATE:

Payment Details:

For Gatekeeper and Non-Gatekeeper products:

Service	Billing Codes	Rates
All Applicable Radiology CPT4 Codes	**CPT4 Codes:** 70010-79999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Radiology Services	**HCPC Codes:** R0070-R0076	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
All Applicable Laboratory CPT4 Codes	**CPT4 Codes:** 80047-89356	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Lab & Pathology Services	**HCPC Codes:** P2028-P9615	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** E0100-E8002	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** K0001-K0669	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Transportation	**HCPC Codes:** A0021-A0999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Supplies	**HCPC Codes:** A4206-A9999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Enteral & Perenteral	**HCPC Codes:** B4034-B9999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Immunizations	**CPT4 Codes:** 90281-90749	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Injectiable Drugs	**HCPC Codes:** J0120-J9999	100% of Aetna Market Fee Schedule
Surgery	**CPT4 Codes:** 10021-69990	150% of Then Current Dallas, TX RBRVS Based Fee Schedule
Hearing Aids	**HCPC Codes:** V5030, V5040, V5050, V5060, V5100, V5120, V5130, V5140, V5150, V5171, V5181, V5190, V5211, V5212, V5213, V5215, V5221, V5230, V5242-V5263, V5298	65% of Billed Charges to Max of $6000.00
All Services not otherwise identified		120% of Then Current Dallas, TX RBRVS Based Fee Schedule

SERVICES:

Specialist will provide services that are within the scope of and appropriate to the Specialist's license and certification to practice. Moreover, Specialist agrees, with respect to all chronic biotherapies administered in Specialist's office to Members, to order the necessary specialty medications from a Participating specialty pharmacy provider. With respect to Members diagnosed with either Crohn's Disease or Immunodeficiency Syndrome or Infused Medications for Psoriasis and needing specialty medications for their conditions, Specialist shall in accordance with a Member's plan and unless prohibited by law, coordinate with Member's Participating specialty pharmacy provider to transition the drug and service authorization, drug distribution, clinical oversight and billing management of the specialty medications treating these conditions to the participating specialty pharmacy.

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.
"Then Current Dallas, TX RBRVS Based Fee Schedule" - A fee schedule created and maintained by Company for use in reimbursing covered services to providers. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS).
The rates contained in this schedule are consistent with Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB and DMEPOS), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. The coding and fees determined under this schedule are to remain fixed through the year, and, as a result, Company does not update the schedule more than once annually to reflect subsequent coding updates, changes in the RBRVS relative values, the CMS conversion factor or otherwise. Company will make its best effort to update the schedule annually by April 1st of each year. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the prior period. The effective date of the update will be communicated via a 90 day notification letter. Claims will be processed in accordance with Company guidelines.

"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), PPO (Preferred 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.

"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 Services and Rate Schedule.

"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 85% of eligible billed charges.

b) Unless required by law, payment for services of Mid-level Practitioners (Nurse Practitioners, Certified Nurse Midwives, Physician Assistants and Registered Nurses) may be less than Physician services based on Company's then current payment policy.

c) 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.

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) 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.

f) Except where 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 twenty percent (20%) should Provider fail to refer Members to Participating Providers in the absence of either: 1) sound clinical reasons; 2) advance approval of Company; 3) the existence of an Emergency Services or exigent circumstances; or 4) if applicable, the Member's request for referral to an out of network provider after notice and informed consent of the patient has been documented, in writing. If Company imposes a reduction to the rates, Provider may request, no more than once every six (6) months, for Company to re-evaluate Provider's use of Participating Providers. If Company determines that Provider has consistently referred Members to Participating Providers for all Covered Services for the preceding six (6) month period, Company will eliminate the reduction within sixty (60) days after Company's determination.

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) Specialist 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).

SPECIALIST OCULOPLASTIC PHYSICIAN
SERVICES AND RATE SCHEDULE NO Medicare

RATE:

Payment Details:

For Gatekeeper and Non-Gatekeeper products:

Service	Billing Codes	Rates
All Applicable Radiology CPT4 Codes	**CPT4 Codes:** 70010-79999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Radiology Services	**HCPC Codes:** R0070-R0076	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
All Applicable Laboratory CPT4 Codes	**CPT4 Codes:** 80047-89356	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Lab & Pathology Services	**HCPC Codes:** P2028-P9615	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** E0100-E8002	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Durable Medical Equipment	**HCPC Codes:** K0001-K0669	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Transportation	**HCPC Codes:** A0021-A0999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Supplies	**HCPC Codes:** A4206-A9999	85% of Then Current Dallas, TX RBRVS Based Fee Schedule
Injectiable Drugs	**HCPC Codes:** J0120-J9999	100% of Aetna Market Fee Schedule
Hearing Aids	**HCPC Codes:** V5030, V5040, V5050, V5060, V5100, V5120, V5130, V5140, V5150, V5171, V5181, V5190, V5211, V5212, V5213, V5215, V5221, V5230, V5242-V5263, V5298	65% of Billed Charges to Max of $6000.00
All Services not otherwise identified		120% of Then Current Dallas, TX RBRVS Based Fee Schedule

SERVICES:

Specialist will provide services that are within the scope of and appropriate to the Specialist's license and certification to practice. Moreover, Specialist agrees, with respect to all chronic biotherapies administered in

Specialist's office to Members, to order the necessary specialty medications from a Participating specialty pharmacy provider. With respect to Members diagnosed with either Crohn's Disease or Immunodeficiency Syndrome or Infused Medications for Psoriasis and needing specialty medications for their conditions, Specialist shall in accordance with a Member's plan and unless prohibited by law, coordinate with Member's Participating specialty pharmacy provider to transition the drug and service authorization, drug distribution, clinical oversight and billing management of the specialty medications treating these conditions to the participating specialty pharmacy.

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.
"Then Current Dallas, TX RBRVS Based Fee Schedule" - A fee schedule created and maintained by Company for use in reimbursing covered services to providers. The fee schedule includes rates as determined by the Centers for Medicare and Medicaid Services (CMS) using the Resource Based Relative Value Scale (RBRVS), the Clinical Laboratory Fee Schedule (CLAB), the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule including PEN (DMEPOS).
The rates contained in this schedule are consistent with Medicare's (CMS) amounts including but not limited to OPPS rates as published in the first quarter annually for the applicable CMS locality. Except for the categories listed above (i.e. CLAB and DMEPOS), the schedule does not provide fees for any codes for which RBRVS does not provide relative values. The coding and fees determined under this schedule are to remain fixed through the year, and, as a result, Company does not update the schedule more than once annually to reflect subsequent coding updates, changes in the RBRVS relative values, the CMS conversion factor or otherwise. Company will make its best effort to update the schedule annually by April 1st of each year. Until updates are complete, the procedure will be paid according to the standards, reimbursement and coding set for the prior period. The effective date of the update will be communicated via a 90 day notification letter. Claims will be processed in accordance with Company guidelines.

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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.

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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).

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: North Texas Ear, Nose and Throat Associates, PA dba NTENT

Service Location Name		**Pay to (Remittance) Name**	
		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	17300 Preston Road	Address	
Suite #	160	Suite #	
City	Dallas	City	
State, Zip	TX, 75252	State, Zip	
Phone #	972 599 7865	Phone #	
Fax #	972 525 8992	Fax #	
Email Address	knorris@ntent.org	Email Address	
Tax ID #	752626614	NPI: N/A	NPI Type: N/A
Hours of operation	8:00 AM – 5:00 PM		

Handicap Accessible YES__X__ NO___

Directory Inclusion YES____ NO___

Individual/Group License:
License #_____ License State_____ , License Type_____,
License Status _____and License expiration date _____

Hospital affiliation:
Hospital Name and address: _____

Individual/Group practitioners Hours of Operation:

Daytime Hours		
Day of week	Start A/P	Stop A/P
Sun		
Mon		
Tue		
Wed		
Thu		
Fri		
Sat		
Evening Hours		
Day of week	Start A/P	Stop A/P

Sun			
Mon			
Tue			
Wed			
Thu			
Fri			
Sat			

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

Service Location Name		**Pay to (Remittance) Name**	
		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street		Address	
Suite #		Suite #	
City		City	
State, Zip		State, Zip	
Phone #		Phone #	
Fax #		Fax #	
Email Address		Email Address	
Tax ID #		NPI:	NPI Type:
Hours of operation			

Handicap Accessible YES____ NO___

Directory Inclusion YES____ NO___

Individual/Group License:
License #_____ License State_____ , License Type_____,
License Status _____and License expiration date _____

Hospital affiliation:
Hospital Name and address: _____

Individual/Group practitioners Hours of Operation:

Daytime Hours		
Day of week	Start A/P	Stop A/P
Sun		
Mon		
Tue		
Wed		
Thu		
Fri		
Sat		
Evening Hours		
Day of week	Start A/P	Stop A/P

	Sun			
	Mon			
	Tue			
	Wed			
	Thu			
	Fri			
	Sat			

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

PARTICIPATION AREA SCHEDULE

Participating provider practice locations must be located within the areas listed in the table below.

Zip codes are required for those counties in which partial coverage is available. In the absence of delineation of non-covered zip codes, the entire county will be determined to be eligible for participating practice locations.

Contracted rates apply to all eligible services rendered to Members in accordance with Company's policies and procedures, regardless of whether the counties or zip codes are listed on the table below.

County	Zip codes covered/included	Zip codes excluded
Collin	ALL	NONE
Cooke	ALL	NONE
Dallas	ALL	NONE
Denton	ALL	NONE
Ellis	ALL	NONE
Erath	ALL	NONE
El Paso	ALL	NONE
Grayson	ALL	NONE
Hill	ALL	NONE
Hood	ALL	NONE
Hunt	ALL	NONE
Johnson	ALL	NONE
Kaufman	ALL	NONE
Parker	ALL	NONE
Rockwall	ALL	NONE
Somervell	ALL	NONE
Tarrant	ALL	NONE
Wise	ALL	NONE

Reminder: Online resources are here to help you

Each month we offer interactive, 45-minute webinars that walk you through how to use our online tools. You can view detailed information on the webinars and register **here**.

☐ On our **secure provider website** you can:

- Access our claims policies and code editing, and our clinical and payment policy lookup tool
- Sign up for electronic communications — including our provider newsletters
- Complete online transactions such as claims submission and status, authorizations, referrals, and eligibility

☐ Visit **aetna.com for Health Care Professionals** to:

- View **Aetna at a Glance** — a quick reference guide for health care professionals
- Find our **precertification information**, **clinical policy bulletins** and **health care professional forms**
- View our **participation criteria**
- Check out our **Aetna Benefits Products** and **Digital ID card help guide**
- Review our **online office manual** —which includes our **policies** and **procedures**
- **Find which networks you are in** — step-by-step guidance on how to check your network status

☐ If you haven't already - Sign up for **ERA, EFT and electronic EOBs** — including direct deposit to your account

- Use EnrollHub™, a CAQH Solution™, at **https://solutions.caqh.org**. Even if you use CAQH for credentialing, you'll need to enroll separately for the utility using the orange "Register Now" button. Enter your bank account information and choose to share it with all of the companies participating in the utility.

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. Information on our First Tier, Downstream and Related entity (FDR) Medicare Compliance Program can be found in our **online office manual** for health care professionals.

We're here to help

We look forward to our continued working relationship. If you have questions after reviewing our online information, call us at:

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

Aexcel® information

Your Aetna 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. **More Aexcel details here.** To opt out of Aexcel, contact your provider representative.

For Ohio providers only

Ohio Revised Code 3901.381 requires third-party payers, such as Aetna, to transmit payment electronically to contracted providers who submits an electronic claim. To enroll, complete an **ERA/EFT Enrollment Form**. Our standard processing time is 15 business days. Once your enrollment is complete, you'll receive confirmation and begin receiving electronic payments into your bank account. If you decide EFT isn't for you, you must complete the **Refusal to Enroll in Electronic Funds Transfer (EFT) Form** and fax to the phone number printed on the form.

Acknowledge receipt of this document by signing here: Kathie Norris

Kathie Norris (May 21, 2019)