# UNITED BEHAVIORAL HEALTH
# GROUP PARTICIPATING PROVIDER AGREEMENT

THIS AGREEMENT is between United Behavioral Health ("UBH") and the undersigned group provider (hereinafter referred to as the "Provider"). This Agreement will become effective upon the date set forth on the signature page of this Agreement or the date of first credentialed Group-based Provider whichever is later (the "Effective Date"). This Agreement sets forth the terms and conditions under which Provider shall participate in one or more networks developed by UBH as a Participating Provider of Covered Services to Members.

## ARTICLE 1
## Definitions

Any capitalized term herein shall have the meaning as set forth in this Agreement. Any undefined term herein shall have the meaning as defined in the Provider Manual, the Protocols, or as may be defined by applicable state or federal laws or regulations, as applicable.

**Affiliate:** Each and every entity or business concern with which UBH, directly or indirectly, in whole or in part, either: (i) owns or controls; (ii) is owned or controlled by; or (iii) is under common ownership or control.

**Benefit Plan:** The specific plan of benefits for health care coverage, including MHSA Services, for a particular Member that is provided, sponsored or administered by UBH directly or through its Affiliate, or through a network rental arrangement UBH may have with a third party, and contains the terms and conditions of a Member's coverage for MHSA Services, including applicable Member Expenses, exclusions and limitations, and all other provisions applicable to the coverage of such MHSA Services such as services rendered outside specified networks.

**CMHC:** A Community Mental Health Center.

**CMHC Provider:** An employee of a CMHC who provides mental health and/or substance abuse services, but is not a CMHC Supervising Provider.

**CMHC Supervising Provider:** A psychiatrist, psychologist, social worker, family or other therapist duly licensed and qualified in the state in which MHSA Services are provided to Members who practices as an employee of CMHC and has been approved as a CMHC Supervising Provider in writing by UBH.

**Covered Services:** MHSA Services that meet the terms and conditions for coverage pursuant to the Member's Benefit Plan, including such conditions as Medically Necessary and proper authorization, and in accordance with the Provider Manual, Protocols, and applicable laws and regulations.

**Customary Charge:** The fee for MHSA Services charged by Provider that does not exceed the fee Provider would ordinarily charge any other person regardless of whether the person is a Member.

**Emergency Services:** Unless otherwise defined by applicable state law, a serious health condition that arises suddenly and requires immediate care and treatment, generally received within twenty-four (24) hours of onset, to stabilize or avoid jeopardy to the life or health of a Member or, by actions of the Member, to the life or health of another. Emergency Services shall be available twenty-four (24) hours per day, seven (7) days per week.

**Fee Maximums:** The maximum amount Provider may receive as payment for provision of Covered Services to a Member, including Member Expenses, that are applicable to Provider pursuant to the Benefit Plan, as determined from time to time by UBH. UBH will advise Provider of the then-current Fee Maximums to Provider upon request.

**Group-based Provider:** A health care professional, CMHC Supervising Provider, psychiatrist, psychologist, therapist or other behavioral health professional who is employed by or under contract or supervision to render MHSA Services to Members.

**Group Participating Provider:** An entity, organization, group, partnership or affiliation however categorized, consisting of health care professionals, facilities, CMHC Supervising Providers, psychiatrists, psychologists, therapists or other behavioral health professionals that is duly licensed or certified to provided MHSA Services within the state such MHSA Services are provided, and who has a written Group Participating Provider Agreement in effect with UBH, directly or through another entity, to provide MHSA Services to Members.

**Medicaid:** A Medical Assistance Program providing health coverage benefits for low income persons pursuant to applicable state and federal laws and regulations.

**Medically Necessary:** Except as otherwise required by applicable state or federal law or regulations, for purposes of this Agreement, Medically Necessary means the term as it may be described in the Member's Benefit Plan for MHSA Services and which meets Payor's defined criteria for coverage as Covered Services. It may also, when applicable, have the meaning defined within the Protocols. Generally, however, Medically Necessary means treatment that is commonly recognized in the industry as consistent treatment that must be: (a) solely to treat the condition of the Member; (b) for the illness or injury of a diagnosis that is commonly recognized as a disease or injury; (c) reasonably expected to directly result in the restoration of health or function; (d) not experimental or investigational but is consistent with established and accepted national medical practice guidelines regarding type, frequency and duration of treatment; (e) without alternative treatment that is less intensive or invasive for the efficient treatment of the Member's condition; (f) not based on convenience for the Member; and (g) not otherwise excluded from the definition of Covered Services based upon the terms and conditions of the Member's Benefit Plan.

**Medicare:** Federally sponsored program providing health coverage benefits to individuals of qualifying age, disability, or disease.

**Member:** An individual who is eligible for, properly enrolled in, and covered under a Benefit Plan.

**Member Expenses:** Any amount of Customary Charges that are the Member's responsibility to pay Provider in accordance with the terms of the Member's Benefit Plan, including co-payments, co-insurance and deductible amounts.

**Mental Health and Substance Abuse Services ("MHSA Services"):** Health care services, treatment or supplies that are used to treat a mental health or substance abuse illness, condition or disease and which may be eligible for coverage under the Member's Benefit Plan.

**Payment Policies:** Guidelines adopted by UBH, from time to time, for calculating payment of claims under Benefit Plans.

**Payor:** The entity or person that has the financial responsibility for funding payment of Covered Services on behalf of a Member, and that is authorized to access MHSA Services in accordance with this Agreement.

**Protocols:** The programs, policies, protocols, processes, procedures, and requirements as such may change or be modified from time to time, and that are adopted by UBH or Payor, and which Provider agrees to follow as a condition of UBH accepting Provider as a Participating Provider, including, but not limited to, authorization procedures, credentialing and re-credentialing processes and plans, utilization management and care management processes, billing procedures, Payment Policies, providing or arranging for Emergency Services, quality improvement, peer review, on-site review, Member grievance and appeals processes, and any other policies, procedures, processes, activities or standards, wherever located as may apply to Provider's rights, obligations or responsibilities as a Provider of MHSA Services, whether in this Agreement, Provider Manual, or any other document as made accessible or available to Provider from time to time.

**Provider Manual:** A document or manual, however known or named, such as the Network Manual, containing the administrative policies, procedures and Protocols applicable to Benefit Plans provided, sponsored or administered by UBH or a Payor including, but not limited to, policies and procedures for credentialing, claims, quality improvement, and utilization management to which Provider is obligated.

## ARTICLE 2
## Duties of Provider

**2.1 Provision of MHSA Services.** Provider hereby acknowledges and agrees to cooperate and comply with all of the terms and conditions of the Provider Manual, Protocols, and this Agreement, and to dutifully perform as a Participating Provider for the provision of MHSA Services to Members within the UBH network(s) as designated

by UBH or Payor. At the request of a Payor, Provider or Group-based Provider may not be authorized to provide MHSA Services for some or all of Payor's Members. Provider shall otherwise accept Members as new patients on the same basis as Provider is accepting non-Members as new patients without regard to race, religion, gender, color, national origin, age or physical or mental health status, or on any other basis deemed unlawful under federal, state or local law. At all times, Provider shall require any employed or subcontracted health care professionals and facilities to comply with the terms and conditions of this Agreement, all Protocols of UBH and Payor, the Provider Manual, as well as the requirements of all applicable laws and regulations.

**2.2 Benefit Plan & Eligibility.** MHSA Services provided by Provider to a Member pursuant to this Agreement are subject to all the terms and conditions of the Member's Benefit Plan including eligibility of the Member on the date MHSA Services are provided to the Member. Provider shall make reasonable effort to verify Member's eligibility at time of service by following appropriate procedures, including without limitation, and at a minimum, the terms and conditions of this Agreement, Protocols, the Provider Manual, and review of the Member's Benefit Plan identification card. Provider however recognizes that the Member eligibility information may be inaccurate at the time Provider obtains verification and that the Member, or the MHSA Services provided to the Member, may later be determined to be ineligible for coverage and, except as otherwise required by law, not eligible for payment under this Agreement. Under such circumstances, Provider may then, except as otherwise stated herein, directly bill the Member or other responsible party for such MHSA Services.

**2.3 Provider Manual & Protocols.** Provider shall be bound by, accept, strictly comply with, and cooperate with, the requirements set forth in the Provider Manual, credentialing plan, and all Protocols, as amended or modified from time to time by UBH and/or Payor, all of which are hereby incorporated herein by reference as if set forth fully herein, including without limitation quality improvement activities. Provider acknowledges and agrees that the Provider Manual and/or Protocols may contain service and contract requirements of certain Payors to which Provider shall strictly comply. Provider's failure to comply with the Provider Manual, Protocols and any other standards, procedures or policies may result in loss of, or reduction of payment or reimbursement to Provider, termination of this Agreement or the imposition of other corrective action by UBH.

**2.4 Authorization Requirements.** Subject to all applicable terms and conditions, including without limitation Section 2.2 above, and in accordance with the Provider Manual, Protocols, and requirements of the Member's Benefit Plan regarding authorization, Provider must request authorization for MHSA Services from UBH either telephonically or by another approved and accepted method recognized by UBH before providing any MHSA Services to a Member as a Covered Service. Authorizations shall subsequently be confirmed by UBH in writing. Except as otherwise permitted herein, only Emergency Services will be eligible for retroactive authorization at the sole discretion of UBH or as required by applicable law. Any authorization resulting from wrongful, fraudulent or negligent actions of Provider or a breach of this Agreement shall be null and void as of the time given.

**2.5 Provider's Standard of Care.** Nothing in this Agreement, the Provider Manual, the Benefit Plan, or the Protocols, including without limitation, UBH's utilization management and quality assurance and improvement standards and procedures, shall dictate MHSA Services provided by Provider or otherwise diminish Provider's obligation to freely communicate with and/or provide MHSA Services to Members in accordance with the applicable standard of care.

**2.6 Continuity of Care; Referral to Other Health Professionals.** Provider shall furnish Covered Services in a manner providing continuity of care and ready referral of Members to other Participating Providers at times as may be appropriate and consistent with the standards of care in the community. If a Member requires additional services or evaluation, including Emergency Services, Provider agrees to refer Member to his/her primary care physician or another Participating Provider in accordance with the terms and conditions of Member's Benefit Plan. A Member requiring Emergency Services shall also be referred to the "9-1-1" emergency response system.

**2.7 Member Access to Care.** Provider shall ensure that Members have timely and reasonable access to MHSA Services and shall at all times be reasonably available to Members as is appropriate. If Provider is unavailable when Members call, instructions must be provided for the Member referring the Member to another Participating Provider or to his/her Benefit Plan. Provider shall arrange for an answering machine or service that shall provide the office hours and emergency information and be capable of receiving messages 24 hours a day.

**2.8 Employees and Contractors of Provider.** Provider will be responsible for and shall ensure that all of its employees and contractors are bound by, and meet the terms and conditions of, this Agreement, the Provider Manual and Protocols, at the time of providing Covered Services to Members. Failure of such employees or contractors to meet such terms and conditions, including without limitation, credentialing requirements, UBH may restrict them from providing Covered Services to Members.

**2.9 Credentialing.** Provider shall provide UBH with the criteria utilized by Provider pursuant to its applicable or required criteria to select and credential employed or subcontracted health care professionals, including, but not limited to, Group-based Providers. UBH shall have the right to audit such criteria upon reasonable advance written notice to Provider.

**2.10 Payment of Services.** All payments obligated by Payor shall be paid to Provider and Provider will be solely responsible for payments to its employees, contractors and Group-based Providers who may have provided MHSA Services. Provider agrees to defend, indemnify and hold UBH harmless for any claims, damages, actions, or judgments arising from any employee or contractor of Provider related to the provision of MHSA Services to Members.

## ARTICLE 3
## Payment Provisions

**3.1 Payment for Covered Services.** In accordance with the terms and conditions hereof, Payor shall pay Provider for Covered Services provided to a Member by Provider. Payment shall be the lesser of: (a) Provider's Customary Charge, less any applicable Member Expenses; or (b) the Fee Maximum for such MHSA Services, less any applicable Member Expenses, and in accordance with the Standard Payment Appendix(ces) attached hereto, if any.

Subject to the terms and conditions herein, the obligation for payment for Covered Services provided to a Member, less any applicable Member Expenses, is solely that of Payor. Additionally, UBH may arrange for claims processing services. When UBH is the Payor, UBH shall make obligated claim payments to Provider within 45 days (and shall use best efforts to encourage a third-party Payor to make payments within 45 days), or as otherwise required by law, of the date Payor receives all information necessary to process and pay a clean claim, except for claims for which there is coordination of benefits, Member Expense adjustments, disputes about coverage, systems failure or other such causes.

In the event a Member's Benefit Plan provides for a Member Expense whether stated as a flat fee or a percentage, the amount of the Member Expense shall be calculated in accordance with the Member's Benefit Plan or as determined by the Payor. The amount calculated pursuant to the preceding sentence shall be deducted from the amount Provider is to be paid for the Covered Services pursuant to this Agreement.

**3.2 Submission of Claims.** Provider shall submit claims for MHSA Services to UBH in a manner and format prescribed by UBH, whether in Protocols or otherwise, and which may be in an electronic format. All information necessary to process the claims must be received by UBH no more than 90 days from the date the MHSA Services are rendered. Provider agrees that claims received after this time period may be rejected for payment, at UBH's and/or Payor’s sole discretion.

Unless otherwise directed by UBH, Provider shall submit claims using current CMS (HCFA) 1500 or UB04 forms, whichever is appropriate, with applicable coding including, but not limited to, ICD9, CPT, Revenue and HCPCS coding. Provider shall include in a claim the Member number, Customary Charges for the MHSA Services rendered to a Member during a single instance of service, Provider's Federal Tax I.D. number and/or other identifiers requested by UBH.

Payor shall have the right to make, and Provider shall have the right to request, corrective adjustments to a previous payment; provided however, that Payor shall have no obligation to pay additional amounts after 12 months from the date the initial claim was paid.

**3.3 Payment in Full.** Provider shall accept as payment in full for Covered Services rendered to Members such amounts as are paid by Payor pursuant to this Agreement

and shall not bill Members for non-covered charges, other than Member Expenses, which result from Payor's reimbursement methodologies. In no event shall Provider bill a Member for the difference between Customary Charges and the amount Provider has agreed to accept as full reimbursement under this Agreement. Provider may collect Member Expenses from the Member. If Payor denies payment for services rendered by Provider on grounds that the services are not Medically Necessary, Provider shall not collect payment from the Member for the services unless the Member has knowledge of the determination of lack of Medical Necessity and has subsequently agreed in writing to be responsible for such charges and MHSA Services. Further, if any payment to Provider is denied, in part or full, due to Provider's failure to strictly comply with any term or condition in this Agreement, the Provider Manual, the Protocols, including without limitation, obtaining prior authorization, untimely filing of a claim, inaccurate or incorrect submission of or claim processing, or the insolvency of Payor pursuant to applicable law, it is agreed that Provider shall not, except for applicable Member Expenses, bill the Member or otherwise, directly or indirectly, seek or collect payment from the Member for any of the denied amounts. Any violation hereof by Provider shall be deemed a material breach. This provision shall apply regardless of whether any waiver or other document of any kind purporting to allow Provider to collect payment from the Member exists. These provisions shall survive the termination hereof and shall be construed to be for the benefit of the Member.

**3.4 Coordination of Benefits.** Provider shall be paid in accordance with Payor's coordination of benefits rules.

**3.5 Financial Responsibility.** In the event of a default (meaning a systematic failure by Payor to fund undisputed claim payments for Covered Services) by a Payor, except when due to the insolvency of Payor, UBH shall notify Provider in writing of such default following UBH's determination thereof. Any services which have been rendered by Provider prior to or after such notification, and which have not been paid for by Payor, shall be considered ineligible for reimbursement under this Agreement, and Provider may seek payment directly from the Payor and Member for such services.

**3.6 Member Protection Provision.** This provision supersedes and replaces the Financial Responsibility section (section 3.5 above) only in those cases where UBH, or its Affiliate, is the Payor, or when required by another specific Payor, or when required pursuant to applicable laws, statutes and regulations.

In no event, including, but not limited to, non-payment by Payor for MHSA Services rendered to Members by Provider, insolvency of Payor, or breach by UBH of any term or condition of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on behalf of the Member for MHSA Services eligible for reimbursement under this Agreement; provided, however, that Provider may collect from the Member, any Member Expenses or charges for services that are not covered as benefits under the Member's Benefit Plan.

The provisions of this Article shall apply to all Member protection provisions in this Agreement and shall: (a) apply to all MHSA Services rendered while this Agreement is in force; (b) survive the termination of this Agreement regardless of the cause of termination; (c) be construed to be for the benefit of the Members; and (d) except as otherwise stated in section 3.3, supersede any oral or written agreement, existing or subsequently entered into, between Provider and a Member or person acting on a Member's behalf, that requires the Member to pay for such MHSA Services.

**3.7 Contracted Rate for Members.** Provider agrees to continue to provide MHSA Services to Members who have exhausted his/her Covered Services under the Benefit Plan and agrees not to collect or charge more than the contracted rate for those MHSA Services. Provider may bill the Member directly for those MHSA Services for which there is no longer any coverage under the Benefit Plan, in accordance herewith.

## ARTICLE 4
## Laws, Regulations, and Licenses, and Liabilities of Parties

**4.1 Laws, Regulations and Licenses.** Provider shall maintain in good standing all federal, state and local licenses, certifications and permits -- without sanction, revocations, suspension, censure, probation or material restriction -- which are required to provide health care services according to the laws of the jurisdiction in which MHSA Services are provided, and shall comply with all applicable statutes and regulations. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members, including covering Providers, comply with this provision.

**4.2 Responsibility for Damages.** Any and all damages, claims, liabilities or judgments, attorney fees, which may arise as a result of Provider’s or its employee’s or contractor’s negligence or intentional wrongdoing shall be the sole responsibility of Provider.

**4.3 Provider Liability Insurance.** Provider shall procure and maintain, at Provider's sole expense, (a) medical malpractice or professional liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate if Provider is a Medical Doctor and $1,000,000 per occurrence and $1,000,000 in aggregate if Provider is not a Medical Doctor; and (b) comprehensive general and/or umbrella liability insurance in the amount of $1,000,000 per occurrence and $3,000,000 in aggregate. Provider shall also require that all health care professionals employed by or under contract with Provider to render MHSA Services to Members procure and maintain malpractice insurance, unless they are covered under Provider's insurance policies.

Provider's and other health care professionals' medical malpractice insurance shall be on either an “occurrence” or “claims made” basis provided that for a “claims made” policy, such policy must be written with an extended period reporting option under such terms and conditions as may be reasonably required by UBH. Prior to the Effective Date of this Agreement and at each policy renewal thereafter, Provider shall submit to UBH in writing evidence of insurance coverage.

## ARTICLE 5
## Notices

**5.1 Notices.** Provider shall notify UBH within ten (10) days of knowledge of any of the following:

(a) changes in liability insurance carriers, termination of, renewal of or any other material changes in Provider's liability insurance, including reduction of limits, erosion of aggregate, changes in retention or non-payment of premium;
(b) action which may result in or the actual suspension, sanction, revocation, condition, limitation, qualification or other material restriction on Provider's licenses, certifications or permits by any government or applicable accrediting or regulatory agency under which Provider is accredited or regulated by or authorized to provide health care services, including without limitation, any action concerning Provider's credentialing criteria or the performance of its employees, contractors or its Group-based Providers; or any suspension, revocation, condition, limitation, qualification or other material restriction of Provider's staff privileges at any licensed hospital, nursing home or other facility at which Provider has staff privileges during the term of this Agreement;
(c) a change in Provider's name, address, ownership or Federal Tax I.D. number;
(d) indictment, arrest or conviction for a felony or for any criminal charge related to the practice of Provider's profession;
(e) claims or legal actions for professional negligence or bankruptcy;
(f) provider's termination, for cause, from any other provider network offered by any plan, including, without limitation, any health care service plan, health maintenance organization, any health insurer, any preferred provider organization, any employer or any trust fund;
(g) any occurrence or condition that might materially impair the ability of Provider or Group-based Provider to perform its duties under this Agreement; or
(h) any condition or circumstance that may pose a direct threat to the safety of Provider, Providers' staff, Group-based Provider or Members.

Unless otherwise specified in this Agreement, each and every notice and communication to the other party shall be in writing. All written notices or communication shall be deemed to have been given when delivered in person; or, on the date mailed, if delivered by first-class mail, proper postage prepaid and properly addressed to the appropriate party at the address set forth at the signature portion of this Agreement or to another address of which sending party has been notified, including without limitation, to UBH's Network Manager at the applicable address for notice as identified in the Provider Manual or Protocols. The parties shall, by written notice, provide and update each other with the most current address and names of all parties or designees that should receive certain notices or communication.

## ARTICLE 6
## Records

**6.1 Confidentiality of Records.** UBH and Provider shall maintain the confidentiality of all Member information and records in accordance with all applicable state and federal laws, statutes and regulations, including without limitation, the Health Insurance Portability and Accountability Act.

**6.2 Maintenance of and UBH Access to Records.** Provider shall maintain adequate medical, treatment, financial and administrative records related to MHSA Services provided by Provider under this Agreement for a period and in a manner consistent with the standards of the community and in accordance with the Provider Manual, Protocols and all applicable state and federal laws, statutes and regulations.

In order to perform its utilization management and quality improvement activities, UBH shall have access to such information and records, including claim records, within 14 days from the date the request is made, except that in the case of an audit by UBH, such access shall be given at the time of the audit. If requested by UBH, Provider shall provide copies of such records free of charge. During the term of this Agreement UBH shall have access to and the right to audit information and records to the extent permitted by the Provider Manual, or as otherwise required by state or federal laws, statutes or regulations or regulatory authority. Said rights shall continue following the termination hereof for the longer of three years or for such period as may be permitted by applicable state or federal law, regulatory authority, or Protocols.

It is Provider's responsibility to obtain any Member's consent in order to provide UBH with requested information and records or copies of records and to allow UBH to release such information or records to Payors as necessary for the administration of the Benefit Plan or compliance with any state or federal laws, statutes and regulations applicable to the Payors.

Provider acknowledges that in receiving, storing, processing or otherwise dealing with information from UBH or Payor about Members, it is fully bound by the provisions of the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2; and Provider agrees that it will resist in judicial proceedings any effort to obtain access to information pertaining to patients otherwise than as expressly provided for in the federal confidentiality regulations, 42 CFR Part 2.

This section shall not be construed to grant UBH access to Provider's records that are created for purposes of assessing Provider's financial performance or for Provider's peer review activities, except to the extent the federal and/or state government and any of their authorized representatives have access to such records pursuant to Section 6.3.

**6.3 Government and Accrediting Agency Access to Records.** It is agreed that the federal, state and local government, or accrediting agencies including, but not limited to, the National Committee for Quality Assurance (the "NCQA"), and any of their

authorized representatives, shall have access to, and UBH and Provider are authorized to release, in accordance with applicable statutes and regulations, all information and records or copies of such, within the possession of UBH or Provider, which are pertinent to and involve transactions related to this Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to UBH, Payor or Provider. Such access shall be available and provided during the term of this Agreement and for three years following the termination hereof, or such longer period as may be identified in the Provider Manual or Protocols or as required by applicable state or federal laws, statutes or regulations.

## ARTICLE 7
## Resolution of Disputes

**7.1 Resolution of Disputes.** It is agreed that prior to any other remedy available to the parties, UBH, Payor and/or Provider shall provide written notice of any disputes or claims arising out of their business relationship (the "Dispute") to the other party within thirty (30) days of the final decision date, action, omission or cause from which the Dispute arose, whichever is later (the "Dispute Date"). If the Dispute pertains to a matter which is generally administered by certain UBH procedures, such as a credentialing or quality improvement plan, the procedures set forth in that plan must be fully exhausted by Provider before Provider may invoke his or her rights as described herein. After receipt of the written notice of the Dispute, the parties agree to work together in good faith to resolve the Dispute. If the parties are unable to resolve the Dispute within thirty (30) days following receipt of the notice of the Dispute, and if either UBH, Provider or Payor desires to pursue formal resolution of the Dispute, then said party shall issue a notice of arbitration to the other parties. It is agreed that the parties knowingly and voluntarily waive any right to a Dispute if arbitration is not initiated within one year after the Dispute Date.

Any arbitration proceeding under this Agreement shall be submitted to binding arbitration in accordance with the rules of the American Arbitration Association ("AAA"), and shall be conducted in a location agreed to by the parties or as selected by the AAA if the parties cannot agree on a location. The arbitrators may construe or interpret but shall not vary or ignore the terms of this Agreement, shall have no authority to award any punitive or exemplary damages, and shall be bound by controlling law. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

## ARTICLE 8
## Term and Termination

**8.1 Term.** This Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated in accordance with the provisions herein.

**8.2 Termination.** This Agreement may be terminated as follows:

(a) by mutual agreement of UBH and Provider;
(b) by either party upon 90 days prior written notice to the other party;
(c) by either party, in the event of a material breach of this Agreement by the other party, upon 30 days prior written notice to the other party. The written notice shall specify the precise nature of the breach. In the event the breaching party cures the breach to the reasonable satisfaction of the non-breaching party, within 30 days after the non-breaching party's written notice, this Agreement shall not terminate;
(d) by UBH immediately upon written notice to Provider, due to Provider's loss, suspension, restriction, probation, voluntary relinquishment, or any other adverse action taken against any of Provider's or Group-based Providers licenses or certifications, or loss of insurance required under this Agreement, or failure to materially perform its credentialing and/or supervision of its employees, contractors or Group-based Providers;
(e) by Provider upon 60 days prior written notice to UBH due to a unilateral amendment made to this Agreement pursuant to section 9.1;
(f) by UBH in accordance with its credentialing plan;
(g) by UBH immediately if UBH determines, in its sole discretion, that the health, safety or welfare of Members may be jeopardized by the continuation of this Agreement; or
(h) by UBH in accordance with the Provider Manual or Protocols.

During periods of notice of termination, UBH reserves the right to transfer Members to another Participating Provider, and Provider agrees to cooperate and assist with such transfers.

If Provider is terminated through the UBH credentialing or recredentialing process, this Agreement shall be deemed terminated as of the date Provider has been terminated pursuant to a final action resulting from that process.

**8.3 Information to Members.** Provider acknowledges and agrees that UBH has the right to inform Members of Provider's termination and/or the notice of termination to Provider, and agrees to cooperate with UBH in matters concerning the termination/transition, and agrees to hold UBH harmless for exercising its rights hereunder. Provider also agrees to clearly inform Members of Provider's impending non-participation status upon the earlier of Member's next appointment or prior to the effective termination date.

**8.4 Continuation of Services After Termination.** At the option of UBH, Provider shall continue to provide MHSA Services authorized by UBH to Members who are receiving such services from Provider as of the effective date of termination of this Agreement, until Member can be satisfactorily transferred to another Participating Provider. Payor shall continue to pay Provider for such services at Provider's contracted rate.

**8.5 Termination of Group-based Provider.** A Group-based Provider's participation with UBH may be individually terminated under the same conditions Provider's

participation may be terminated, as specified above. In addition, a Group-based Provider's participation with UBH may be terminated by UBH (a) immediately upon written notice to Provider due to Group-based Provider loss or suspension of licensure or certification; (b) failure to abide by established criteria as required by section 2.9; (c) loss of insurance as required under this Agreement; or (d) in accordance with UBH's credentialing process.

Furthermore, it is agreed that upon any such termination of a Group-based Provider pursuant to this section 8.5 that UBH shall deliver notice to Provider of such a termination, that Group-based Provider shall not provide MHSA Services to any Member as of the termination date of the Group-based Provider, unless otherwise agreed to by UBH in writing, and that this Agreement shall not be terminated, absent notice otherwise, upon the termination of any Group-based Provider.

## ARTICLE 9
## Miscellaneous

**9.1 Amendment.** UBH may amend this Agreement by sending notice of the amendment to Provider at least 30 days prior to its effective date. The Provider's signature is not required. It is agreed that this Agreement shall be automatically amended to comply with any and all applicable state or federal laws, regulations, statutes or the requirements of applicable regulatory authorities as of the effective date thereof, and which shall be deemed to be incorporated herein by reference as of its effective date. Likewise, if a Payor that is a governmental entity requires that certain provisions of this Agreement be removed, replaced, amended or that additional provisions be incorporated, such provisions shall be deemed to be removed, replaced, amended or additional provisions incorporated into this Agreement as of the effective date of such Payor requirement for all MHSA Services provided which are subject to such Payor requirements without the signature of Provider being required.

**9.2 Assignment.** UBH may assign all or any of its rights and responsibilities under this Agreement to any of its Affiliates. Provider may assign any of his or her rights and responsibilities under this Agreement to any person or entity only upon the prior written consent of UBH, which consent shall not be unreasonably withheld.

**9.3 Administrative Responsibilities.** UBH may delegate certain administrative responsibilities under this Agreement to another entity, including, but not limited to, its Affiliate or to Payor or its designee. In addition, certain Payor responsibilities may actually be performed by its designee.

**9.4 Relationship Between UBH and Provider.** The relationship between UBH and Provider is solely that of independent contractors and nothing in this Agreement or otherwise shall be construed or deemed to create any other relationship, including one of employment, agency, joint venture or partnership.

**9.5 Name, Symbol and Service Mark.** During the term of this Agreement, Provider, UBH and Payor shall have the right to use each other's name solely to make public

reference to Provider as a Participating Provider. Provider, UBH and Payor shall not otherwise use each other's name, symbol or service mark or that of their Affiliates without the prior written approval from the appropriate party.

**9.6 Confidentiality.** Neither party shall disclose to third parties any confidential or proprietary business information which it receives from the other party, including, but not limited to, financial statements, business plans, Protocols and programs; except that (a) Provider may disclose information to a Member relating to the Member's treatment plan and the payment methodology, but not specific rates; (b) UBH may disclose certain terms to Payors or designees that need the information to process claims or administer a Benefit Plan, and may file the form of this Agreement with any federal or state regulatory entity as may be required by applicable law; and (c) UBH shall be permitted to disclose, in its sole discretion, any other data or information that may be requested by applicable state and federal law, state regulations or governing agencies that pertain to this Agreement or that may relate to the enforcement of any right granted or term or condition of this Agreement.

**9.7 Communication.** UBH encourages Provider to discuss with Members treatment options and their associated risks and benefits, regardless of whether the treatment is covered under the Member's Benefit Plan. Nothing in this Agreement is intended to interfere with Provider's relationship with Members as patients of Provider, or with UBH's ability to administer its quality improvement, utilization management and credentialing programs.

**9.8 Effects of New Statutes and Regulations and Changes of Conditions.** The parties agree to re-negotiate this Agreement if either party would be materially adversely affected by continued performance as a result of a change in laws or regulations, a requirement that one party comply with an existing law or regulation contrary to the other party's prior reasonable understanding, or a change in UBH's arrangements with Payors. The party affected must promptly notify the other party of the change or required compliance and its desire to re-negotiate this Agreement. If a new agreement is not executed within 30 days of receipt of the re-negotiation notice, the party adversely affected shall have the right to terminate this Agreement upon 45 days prior written notice to the other party. Any such notice of termination must be given within 10 days following the expiration of the 30-day re-negotiation period.

**9.9 Appendices.** Additional and/or alternative provisions, if any, related to certain MHSA Services rendered by Provider to Members covered by certain Benefit Plans, rates, and fees are set for in the Appendices, Attachments and Addendum.

**9.10 Entire Agreement.** On the Effective Date, this Agreement supersedes and replaces any existing Provider Agreements between the parties related to the provision of MHSA Services, including any agreements between Provider and Affiliates of UBH for MHSA Services. This Agreement, together with any and all documents referenced herein, attachments, addenda, appendices, as may be amended or modified from time to time, whether contemporaneous or subsequently made pursuant to Section 9.1, are hereby incorporated herein by reference, and constitutes the entire agreement between

the parties in regard to its subject matter (herein collectively referred to as this "Agreement").

**9.11 Strict Compliance.** The waiver of strict compliance or performance of any of the terms or conditions of this Agreement, the Provider Manual or the Protocols or of any breach thereof shall not be held or deemed to be a waiver of any subsequent failure to comply strictly with or perform the same or any other term or condition thereof or any breach thereof.

**9.12 Severability.** Should any provision of this Agreement violate the law or be held invalid or unenforceable as written by a court of competent jurisdiction, then said provision along with the remainder of this Agreement shall nonetheless be enforceable to the extent allowable under applicable law by first modifying said provision to the extent permitted so as to comply with applicable law; otherwise said provision shall be deemed void to the extent of such prohibition without invalidating the remainder of this Agreement.

**9.13 Rules of Construction.** In the event of any conflict between the terms of this Agreement and the terms of any other agreement or any other controlling document or any applicable state or federal laws, statutes and regulations relating to the subject matter hereof, the terms, except as otherwise expressly stated herein, shall first be read together to the extent possible; otherwise the terms that afford the greater protections to first UBH and second to the Benefit Plan shall prevail over the conflicting term, to the extent permitted by and in accordance with and subject to applicable law, statutes or regulations. The remainder of the Agreement shall otherwise remain without invalidating or deleting the remainder of the conflicting provision or the Agreement.

**9.14 Governing Law.** This Agreement shall be governed by and construed in accordance with applicable state and federal laws, statutes and regulations, including without limitation, ERISA.

**9.15 Medicaid Members.** If a Medicaid Appendix is attached to this Agreement Provider agrees to provide MHSA Services to Members enrolled in a Benefit Plan for Medicaid recipients and to comply with any additional requirements set forth in the Medicaid Appendix.

**9.16 Medicare Members.** If a Medicare Appendix is attached to this Agreement, Provider agrees to provide MHSA Services under this Agreement, to Members who are enrolled in a Benefit Plan for Medicare beneficiaries and to cooperate and comply with the provisions set forth in the attached Medicare Advantage Addendum. Provider also understands that UBH's agreements with Participating Providers are subject to review and approval by the Centers for Medicare and Medicaid Services (“CMS”).

**9.17 Survival.** Upon any termination or expiration of this Agreement, the provisions herein which contemplates performance or observance subsequent to termination or expiration, including without limitation, sections 2.9, 2.10, 3.1, 3.2, 3.3, 3.6, 8.3, 8.4, 9.6

and Articles 6 and 7, shall survive and remain of full force and effect between the parties.

**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.**

**The Effective Date of this Agreement is: _____**
**(TO BE COMPLETED BY UBH ONLY)**

**UNITED BEHAVIORAL HEALTH**
P.O. Box 9472
Minneapolis, MN 55440-9472

Signature_____
Name _____
Title _____
Date_____

**NAME OF PROVIDER**
_____
_____
Attn: _____

Signature_____

Print Name_____

Title_____

Date_____

Federal Tax ID Number: _____

Medicare Number:_____

Medicaid Number:_____

NPI Number: _____

**UNITED BEHAVIORAL HEALTH**
**PROVIDER AGREEMENT**

## Ohio Regulatory Requirements Attachment

This Ohio Regulatory Requirements Attachment (the "Attachment") is made part of the Agreement entered into between United Behavioral Health ("UBH") and the health care professional named in the Agreement ("Provider").

This Attachment applies to all products or Benefit Plan sponsored, issued or administered by or accessed through UBH to the extent such products are subject to regulation under Ohio laws.

UBH and Provider each agree to be bound by the terms and conditions contained in this Attachment. In the event of a conflict or inconsistency between this Attachment and any term or condition contained in the Agreement, this Attachment shall control, except with regard to Benefit Plans outside the scope of this Attachment.

Except as otherwise defined in this Attachment all terms contained in the Attachment shall be as defined and set forth in the Agreement. Any undefined term herein shall have the meaning as defined in applicable state laws and regulations, as may be amended from time to time. Likewise, should any defined term herein conflict with applicable state law or regulations, the term as defined under applicable state law or regulation shall prevail.

**Provisions to Benefit Plans regulated by the State of Ohio and/or under Ohio HMO laws, as applicable.**

**1. Covered Services.** Provider acknowledges that Provider has received a description of the method by which Provider shall be notified of the specific health care services for which Provider is responsible, including any limitations or conditions on such services and, if Provider is a primary care provider, including whether Provider is required to provide or arrange for the provision of Covered Services twenty-four (24) hours per day, seven (7) days per week.

**2. Continuity of Care.** Subject to the conditions set forth below, for a period of thirty (30) days following termination of this Agreement due to UBH's insolvency or discontinuance of operations, Provider shall continue to provide Covered Services to Members as needed to complete any medically necessary procedures commenced but unfinished at the time of such termination. The completion of a medically necessary procedure shall include the rendering of all Covered Services that constitute medically necessary follow-up care for that procedure.

(a) Inpatient Care. If a Member is receiving necessary inpatient hospital care at the time of such termination, the provision of Covered Services under this Section shall remain subject to the limits, if any, contained in the Member's Benefit Plan with regard to inpatient hospital services.

(b) Limiting Events. Provider shall not be required to continue to provide Covered Services after the occurrence of any of the following:

(i) the end of the thirty (30)-day period following the entry of a liquidation order under Ohio Revised Code, Chapter 3903;

(ii) the end of the Member's period of coverage for a contractual prepayment or premium;

(iii) the Member obtains equivalent coverage with another health insuring corporation or insurer, or the Member's employer obtains such coverage for the Member;

(iv) the Member or the Member's employer terminates coverage under the Benefit Plan; or

(v) a liquidator effects a transfer of the UBH's obligations under this Agreement pursuant to Ohio Revised Code, Section 3903.21(A)(8).

**3. Administrative Policies and Procedures.** Provider acknowledges that Provider has received a clear statement of the rights and responsibilities of UBH and Provider with respect to UBH's administrative Protocols, including but not limited to payments systems, Care Coordination [SM]/utilization review, quality assurance, assessment and improvement programs, credentialing, confidentiality requirements and any applicable federal or state programs.

**4. Health Records.** Provider shall maintain all Member health records in the manner required under applicable state and federal law. Additionally, Provider shall maintain adequate medical, financial, and administrative records related to Covered Services rendered by Provider under this Agreement. In order to monitor and evaluate the quality of care, conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of Covered Services provided to Members, UBH shall have access to such information and records. Provider shall also make these records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating Member grievances or complaints.

**5. Confidentiality.** Any data or information pertaining to the diagnosis, treatment or health of any Member that is obtained by UBH from Member or from Provider shall be held in confidence and shall not be disclosed to any person except under the following circumstances: (a) to the extent that it may be necessary to carry out the purposes of Ohio Revised Code, Chapter 1751; (b) upon the express consent of the Member; (c) pursuant to applicable statute or court order for the production of evidence; or (d) in the event of claim litigation between the Member or Provider and UBH wherein such data or information is pertinent. Provider understands that UBH is entitled to claim any statutory privilege against disclosure that the provider who furnished the data or information to UBH is entitled to claim.

**6. Delivery of Covered Services.**

(a) Provider/Patient Relationship. Provider shall observe, protect and promote the rights of Members as patients. Nothing contained in this Agreement shall be construed to limit or otherwise restrict Provider's ethical and legal responsibility to fully advise Members about their medical condition and about medically appropriate treatment options.

(b) No Discrimination. Provider shall provide Covered Services without discrimination on the basis of a Member's participation in a Benefit Plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for Covered Services rendered to a Member.

**7. UBH Monitoring.** If Provider is a health care facility, Provider recognizes UBH's responsibility pursuant to applicable Ohio law to monitor and oversee the provision of Covered Services to Members.

**8. No Financial Inducement to Limit Medically Necessary Care.** Nothing in this Agreement shall be construed as an offer or inducement to reduce or limit medically necessary health care services to a Member.

**9. No Prohibited Penalties.** Provider and UBH agree that this Agreement does not contain any provision that shall be construed to penalize Provider for the following:

(a) assisting a Member to seek a reconsideration of UBH's decision to deny or limit benefits to a Member;

(b) principally advocating for medically necessary health care services; or

(c) providing information or testimony to a legislative or regulatory body or agency, unless such information or testimony is libelous, slanderous or discloses trade secrets that the Provider has no privilege or permission to disclose.

**10. Receipt of Information.** Provider acknowledges that prior to entering into this Agreement, UBH disclosed basic information to Provider as required by Ohio Revised Code, Section 1753.07. Provider further acknowledges that Provider has received (a) any material information affecting the Provider that is incorporated by reference into this Agreement, except such information that is otherwise available as a public record, and (b) UBH's applicable provider manuals and administrative manuals, if any.

**11. Intermediaries.** The provisions of this Section shall only apply if Provider is an intermediary organization, as defined under Ohio law.

(a) Approval of Providers and Facilities. UBH must approve or disapprove the participation of any provider or health care facility with which Provider contracts.

(b) Intermediary Contracts. Unless Provider is a health delivery network contracting solely with self-insured employers, any subcontract between Provider and a provider or health care facility shall contain all of the following:

(i) the requirements provided in Sections 1-13 of this Appendix;

(ii) an acknowledgement that UBH is a third party beneficiary; and

(iii) an acknowledgement of UBH's role in approving participation of the provider or health care facility as required this Section.

(c) Books and Records. Provider shall provide the Ohio Superintendent of Insurance with regulatory access to all books, records, financial information, and documents related to the provision of Covered Services to Members under this Agreement. Provider shall maintain such books, records, financial information, and documents at its principal place of business in the State of Ohio and preserve them for a period of at least three years following termination of this Agreement in a manner that facilitates regulatory review.

**12. Prompt Payment.** Provider, Payor and UBH shall comply with applicable sections of Ohio laws and regulations as they relate to the payment and processing of claims, including those set forth in Ohio Rev. Code §3901.381.

**13. Third-Party Access.** This Agreement is subject to a network rental arrangement in which one of the purposes of the Agreement is to sell, rent or give rights to Provider's services. UBH may give a third party access to Provider's services if:

a. The third party accessing Provider's services is an employer or other entity providing coverage for health care services to its employees or members and that third party has an agreement with UBH or an affiliate of UBH for the administration or processing of claims for payment for these health care services that are provided pursuant to UBH's Provider Agreement with Provider; or

b. The third party accessing Provider's services is an affiliate or subsidiary of UBH or is providing administrative services to, or receiving administrative services from, UBH or its affiliate or subsidiary; or

c. UBH's Provider Agreement specifically provides that it applies to network rental arrangements and states that one purpose of the Provider Agreement is selling, renting, or giving UBH's rights to Provider's services, including other preferred provider organizations, and the third party accessing Provider's services is any of the following:

1) A Payor or third-party administrator or other entity responsible for administering claims on behalf of the Payor;

2) A preferred provider organization or preferred provider network that receives access to Provider's services pursuant to an arrangement with the

preferred provider organization or preferred provider network in a contract with Provider that is in compliance with division (A)(1)(c) of this section and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with Provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement;

3) An entity that is engaged in the business of providing electronic claims transport between UBH and Payor or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with Provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement;

d. UBH shall maintain a web page that contains a listing of third parties that have access to Provider's services. This listing shall be updated at least every six months. In addition, UBH shall ensure that third parties that access Provider's services shall comply with all applicable terms and conditions of the Provider Agreement, including, but not limited to, the products for which Provider has agreed to provide services. Any third party that receives only administrative services from UBH shall be solely responsible for payment to Provider. Any information UBH provides to Provider on its web page shall be considered proprietary in nature and shall not be distribute by Provider.

e. UBH will require that any third party accessing Provider's services is obligated to comply with all of the applicable terms and conditions of the Provider Agreement including, but not limited to, the products for which Provider has agreed to provide services, except that Payor shall be solely responsible for payment to Provider.

**14. Network Participation.** UBH may not require Provider to participate in any additional networks other than the networks Provider has originally agreed to participate in. If Provider refuses to agree to participate in additional networks of UBH, UBH may terminate the Agreement upon written notice to Provider no sooner than 180 days from the date of Provider's refusal.

**15. Provider's Rights.** UBH shall not require Provider, as a condition of entering into the Provider Agreement, to waive or forego any rights or benefits expressly conferred upon Provider by state or federal law.

**16. Hold Harmless.** Provider agrees that in no event, including but not limited to nonpayment by the Health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall Provider bill, charge, collect a deposit from, see remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this

agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the health insuring corporation or its successor.

This provision shall survive the termination of this Agreement regardless of the reason for the termination, including the insolvency of the health insuring corporation.

**MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX**

**UNITED BEHAVIORAL HEALTH**

**THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX** ("Appendix") supplements and is made part of the provider agreement ("Agreement") between United Behavioral Health, its subsidiaries, and its affiliated companies (collectively, "Company") and the provider named in the Agreement ("Provider").

## SECTION 1
## APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; or (2) as required by applicable law.

## SECTION 2
## DEFINITIONS

For purposes of this Appendix, the following terms shall have the meanings set forth below.

**2.1 Benefit Plan:** A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer. Benefit Plan may also be referred to as benefit contract, benefit document, plan, or other similar term under the Agreement.

**2.2 CMS Contract:** A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.

**2.3 Cost Sharing:** Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments. Cost Sharing may also be referred to as patient expenses or other similar term under the Agreement.

**2.4 Covered Service:** A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer. A Covered Service may also be referred to as a health service or other similar term under the Agreement.

**2.5 Customer:** A person eligible and enrolled to receive coverage from a Payer for Covered Services. A Customer may also be referred to as an enrollee, member, patient, covered person, or other similar term under the Agreement.

**2.6 Dual Eligible Customer:** A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.

**2.7 Medicare Advantage Benefit Plans:** Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).

**2.8 Medicare Advantage Customer or MA Customer:** A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

**2.9 Medicare Advantage Organization or MA Organization:** For purposes of this Appendix, MA Organization is an appropriately licensed entity that has entered into: (a) a CMS Contract; and (b) a contract with Company, either directly or indirectly, under which Company provides certain administrative services for Benefit Plans sponsored, issued, or administered by MA Organization.

**2.10 Payer:** An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized to access Provider's services under the Agreement. A Payer may also be referred to as a payor, participating entity, or other similar term under the Agreement.

## SECTION 3
## PROVIDER REQUIREMENTS

**3.1 Data.** Provider shall submit to Company or MA Organization, as applicable, all risk adjustment data as defined in 42 CFR § 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to Company or MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

**3.2 Policies.** Provider shall comply with MA Organization's policies and procedures.

**3.3 Customer Protection.** Provider agrees that in no event, including but not limited to, non-payment by Company, MA Organization or an intermediary, insolvency of Company, MA Organization or an intermediary, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate. In the event of MA Organization's, Company's, or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of an MA Customer who is hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including Company or MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

**3.4 Dual Eligible Customers.** Provider agrees that in no event including, but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by Company of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, Company or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid.

**3.5 Eligibility.** Provider agrees to immediately notify Company and MA Organization in the event Provider is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. Provider shall not be eligible for payment from MA Organization after the date or during the time period specified by the applicable regulatory authorities. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that is or becomes excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is or becomes included on the preclusion list under Part 422 of the Code of Federal Regulations. MA Customers shall not have any financial liability and Provider shall not pursue MA Customers for financial liability for

services or items furnished by an individual or entity that is excluded from participation in any federal health care program under Section 1128 or 1128A of the Social Security Act or is included on the preclusion list under Part 422 of the Code of Federal Regulations. Provider shall be financially liable for those services or items after the date or during the time period specified by the applicable regulatory authorities.

**3.6 Laws.** Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.

**3.7 Federal Funds.** Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.

**3.8 CMS Contract**. Provider shall perform the services set forth in the Agreement in a manner consistent and compliant with MA Organization's contractual obligations under the CMS Contract.

**3.9 Records.**

(a) Privacy and Confidentiality; Customer Access. Provider shall safeguard MA Customer privacy and confidentiality including, but not limited to, the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.

(b) Retention. Provider shall maintain records and information related to the services provided under the Agreement including, but not limited to, MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for the longer of the following periods:

(i) in the case of records containing information related to the medical loss ratio information reported to CMS by the MA Organization, including, for example, information related to incurred claims and quality improvement activities, at least ten (10) years from the date such medical loss ratio information is reported to CMS by the MA Organization, or

(ii) in the case of all other records, at least ten (10) years from the final date of the CMS Contract period in effect at the time the records were created, or such longer period as required by law.

(c) Government Access to Records. Provider acknowledges and agrees that the U.S. Department of Health and Human Services, the Comptroller General, or their designees shall have the right (directly or through the MA Organization) to audit, evaluate, collect, and inspect any pertinent books, contracts, computer or other electronic systems (including medical records and documentation), and other records and information of Provider related to the CMS Contract. Provider shall make available to its premises, physical facilities, and equipment, records relating to MA Customers and any additional relevant information CMS may require. This right shall extend through the longer of the time periods identified in subsection 3.9(b)(i) and (ii), or ten (10) years from date of completion of any audit, whichever is later in time.

(d) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, collection and inspection rights identified in subsection 3.9(c) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation, collection, or inspection, and will conduct such audit, evaluation, collection, or inspection at a reasonable time and place. Provider shall submit medical records of MA Customers to the MA Organization as may be requested,

within the timeframes specified, for (i) the purpose of CMS audits of risk adjustment data, and (ii) other purposes medical records from providers are used by MA Organization, as specified by CMS.

**3.10 MA Organization Accountability; Delegated Activities.** Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that Company may sub-delegate to Provider. If Company has sub-delegated any of MA Organization's functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:

(a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.

(b) If Company has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization or its designee, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization or its designee.

(c) If Company has delegated to Provider the selection of health care providers to be participating providers in the MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.

(d) Provider acknowledges that MA Organization or its designee shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization and Company regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.

**3.11 Subcontracts.** If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms contained in this Appendix. Provider shall provide proof of such to Company or MA Organization upon request. Provider further agrees to promptly amend its agreements with subcontractors, in a manner consistent with the changes made to this Appendix by MA Organization or Company, to meet any additional CMS requirements that may apply to the services.

**3.12 Offshoring.** All services provided pursuant to the Agreement that are subject to this Appendix and that involve MA Customer's protected health information ("PHI") must be performed within the United States, the District of Columbia, or the United States territories, unless Provider previously notifies MA Organization in writing and submits required offshoring information to, and received approval from, MA Organization.

## SECTION 4
## OTHER

**4.1 Payment.** MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall promptly process and pay or deny them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.

**4.2 Regulatory Amendment.** Upon the request of MA Organization, Company may unilaterally amend this Appendix to comply with applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. Company or MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations, or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.

***PROVIDER SDF***

HEALTH CARE PROVIDER SUMMARY DISCLOSURE FORM

OPTUM

**OPTUM PARTICIPATING PROVIDER**

**I. Compensation and Payment**

Manner of Payment: **Fee for Service/Per Diem**

Reimbursement Methodology: **Please reference Article 3 – Payment Provisions of the Agreement or reference additional information on reimbursement methodology located in the Optum Network Manual. You can locate the Network Manual on Provider Express (www.providerexpress.com).**

Fee Schedule Information: **Please reference provided Outpatient Fee Schedule/Fee Maximum or Standard Payment Appendix.**

Reimbursement Policies: **Please reference Article 3 – Payment Provisions of the Agreement or reference additional information on reimbursement polices located in the Optum Network Manual. You can locate the Network Manual on providerexpress.com.**

**II. List of Networks**

☒ HMO
☒ Commercial Plan other than HMO
☒ Medicare
☒ Medicaid
☒ Workers' Compensation
☒ Network Rental/Lease Arrangements

☒ Narrow Network Relationship

**III. Duration of Contract & Termination**

**Duration:**

**Provider Participation Agreement – The Agreement shall begin on the Effective Date and it shall remain in effect for one year, and shall automatically renew for successive 1-year terms until it is terminated according to Article 8 of the Agreement.**

**Termination:**

**Please reference Article 8 of the Agreement. The Agreement may be terminated by Optum or Provider upon at least 90 days notification to the other party.**

**IV. Identity of person responsible for processing claims**

Optum and/or its Affiliates.
Refer to Member ID Card for mailing and electronic submission of claims.

**V. Dispute Resolution Process**

Refer to Appeals and Provider Dispute Resolution in the **Optum Network Manual.**

**VI. Subject and Order of Addenda**

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| ☒ Appendix 1 – Standard Payment Appendix, Outpatient Fee Schedule/Fee Maximum | ☒ Medicare Regulatory Appendix<br>☒ Medicaid Regulatory Appendix<br>☒ Ohio Regulatory Appendix |

**OHIO STATE PROGRAM**

**REGULATORY REQUIREMENTS APPENDIX**

**DOWNSTREAM PROVIDER**

**THIS OHIO STATE PROGRAM REGULATORY REQUIREMENTS APPENDIX** (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between United Behavioral Health ("Subcontractor"), and the provider named in the Agreement ("Provider").

## SECTION 1
## APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans under the State of Ohio Medicaid program, including Aged Blind and Disabled, and Covered Families and Children program (the "State Program"), as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit plans outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications.

## SECTION 2
## DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the applicable State Program, the definitions shall have the meaning set forth under the applicable State Program.

**2.1 Covered Person:** An individual who is currently enrolled with Health Plan for the provision of services under the State Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

**2.2 Covered Services:** Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage under the State Contract.

**2.3 Department:** The Ohio Department of Medicaid.

**2.4 Health Plan:** An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare Insurance Company or one of its Affiliates.

**2.5 State:** The State of Ohio or its designated regulatory agencies.

**2.6 State Contract:** Health Plan's contract ODM for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the applicable State Program.

**2.7 State Program:** The Aged, Blind, and Disabled and/or Covered Families and Children Medicaid Programs. For purposes of this Appendix, State Program may refer to the State agency(ies) responsible for administering the applicable State Program.

## SECTION 3
## PROVIDER REQUIREMENTS

The State Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Health Plan, Subcontractor and Provider agree to undertake, which include the following:

**3.1 Definitions Related to the Provision of Covered Services.** Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

i) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

ii) Emergency Services: Covered inpatient and outpatient services furnished by a provider qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

iii) HealthChek: Refers to the State Program also known as Early and Periodic Screening, Diagnosis and Treatment of Individuals under Age 21, refers to a program of comprehensive preventative health care services available to Covered Persons from birth through 21 years of age pursuant to 42 U.S.C. §§1396a(a)(43), 1396d(a) and (r) and 42 C.F.R. Part 441, Subpart B, whether or not such services are Covered Services. The HealthChek program is designated to maintain health by providing early intervention to discover and treat health problems.

iv) Medically Necessary or Medical Necessity:

Medically Necessary services are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A Medically Necessary service must:

a) Meet generally accepted standards of medical practice;
b) Be appropriate to the illness or injury for which it is performed as to type of service and expected outcome;
c) Be appropriate to the intensity of service and level of setting;
d) Provide unique, essential, and appropriate information when used for diagnostic purposes;
e) Be the lowest cost alternative that effectively addresses and treats the medical problem; and
f) Meet general principles regarding reimbursement for Medicaid covered services found in Ohio Admin. Code Chapter 5160.

**3.2 Medicaid or CHIP Participation.** Provider must be enrolled with the State as a Medicaid or CHIP provider, as applicable to participate in Health Plan's Medicaid or CHIP network. Upon notification from the State that Provider's enrollment has been denied or terminated, Subcontractor and Health Plan must terminate Provider immediately and will notify affected Covered Persons that Provider is no longer participating in the network. Subcontractor and Health Plan will exclude from its network any provider who is on the State's exclusion list or has been terminated or suspended from the Medicare, Medicaid or CHIP program in any state. Provider must meet all applicable credentialing criteria before being listed as a panel provider.

**3.3 Accessibility Standards.** Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

**3.4 Hours of Operation; Appointments.** Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries. As applicable, Provider will make Covered Services available 24 hours a day, 7 days a week when medically necessary.

**3.5 Hold Harmless.** Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor and/or Health Plan (as set forth in the Agreement) for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor and/or Health Plan, as applicable, cannot or will not pay for such Covered Services. In accordance with 42 CFR Part 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under

the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, the Department nor Covered Persons shall be in any manner liable for the debts and obligations of Subcontractor or Health Plan and under no circumstances shall Subcontractor, Health Plan, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

If the medical assistance services are not Covered Services, prior to providing the service, Provider shall inform the Covered Person of the non-covered service and have the Covered Person acknowledge the information. If the Covered Person still requests the service, Provider shall obtain such acknowledgement in writing prior to rendering the service. If Subcontractor or Health Plan determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

**3.6 Indemnification.** To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend and hold the Department and its employees harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including court costs and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors arising from the Agreement. The Department may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

**3.7 Provider Selection.** To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Subcontractor and/or Health Plan delegate credentialing to Provider, Subcontractor and/or Health Plan will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements.

**3.8 Restrictions on Referrals.** Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

**3.9 Subcontracts.** If Provider subcontracts or delegates any functions of the Agreement, in accordance with the terms of the Agreement, the subcontract or delegation must be in writing and include all of the requirements of this Appendix, and applicable requirements of the State Contract, and applicable laws and regulations. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by Subcontractor or Health Plan, to meet any additional State Program requirements that may apply to the services.

**3.10 Records Retention.** As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Provider shall retain all records including, as applicable, grievance and appeal records and any other records related to data, information, and documentation for a period of not less than 10 years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of 10 years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Subcontractor and Health Plan if the Agreement is continuous.

**3.11 Records Access.** Provider acknowledges and agrees that the State, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators.

**3.12 Government Audit; Investigations.** Provider acknowledges and agrees that the State, CMS, the Office of Inspector General, the Comptroller General, and the U.S. Department of Health and Human Services and their designees or their authorized representatives shall at any time, have the right to inspect, audit or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the terms of the State Contract and any other applicable rules, including the right to inspect and audit any records or documents of Provider and its subcontractors, and the right to inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the end date of the State Contract or from the date of completion of any audit, whichever is later. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

**3.13 Privacy; HIPAA.** Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR §438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. Provider shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in the Agreement. Provider agrees to be bound by the same standards of confidentiality that apply to the employees of ODM and the State of Ohio.

**3.14 Compliance with Law.** Provider shall comply with all applicable federal and State laws and regulations, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

i) Title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and Americans with Disabilities Act; section 1557 of the Patient Protection and Affordable Care Act; and their implementing regulations, as may be amended from time to time. Provider agrees it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the Provider Agreement on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information, or ancestry.

ii) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor." Provider agrees that in the performance of this Agreement or in the hiring of any employees for the performance of services under this Provider Agreement, Provider shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, health status, genetic information or ancestry, discriminate against any citizen of this State in the employment of a person qualified and available to perform the services to which the Agreement relates.

iii) If the Agreement is for an amount in excess of $100,000, Provider shall comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act, 42 U.S.C. 7401 et seq., and the Federal Water Pollution Control Act, as amended, 33 U.S.C. 1251 et seq. Any violations shall be reported to DHHS and the appropriate Regional Office of the Environmental Protection Agency.

**3.15 Physician Incentive Plans.** In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.3, 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Neither Subcontractor nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medically Necessary.

**3.16 Lobbying.** Provider agrees to comply with the following requirements related to lobbying:

i) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

**3.17 Excluded Individuals and Entities.** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals or owners, nor any providers, subcontractors or consultants with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

i) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

ii) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider is obligated under 42 CFR §1001.1901(b) to screen all employees, contractors, and/or subcontractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any Federal Health Care Programs (as defined in Section 1128B(f) of the Social Security Act). Provider shall not employ or contract with an individual or entity that has been excluded to provide items or Covered

Services under the Agreement. Provider shall immediately report to Subcontractor any exclusion information discovered. Provider acknowledges and agrees that civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services. Providers shall utilize available resources for identifying sanctioned providers, including, but not limited to, the Federal Office of Inspector General Provider Exclusion List, the ODM exclusion and termination database, and the discipline pages of the applicable state boards that license providers. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. Subcontractor will terminate the Agreement immediately and exclude from its network any provider who has been excluded from the Medicare or Medicaid program in any state.

**3.18 Disclosure.** Provider must be screened and enrolled into the State's Medicaid or CHIP program, as applicable, and submit disclosures to Department on ownership and control, significant business transactions, and persons convicted of crimes, including any required criminal background checks, in accordance with 42 CFR Part 455 Subparts B and E. Provider must submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information in accordance with 42 CFR 455.105. Additionally, Provider must cooperate with the Department for submission of fingerprints upon a request from the Department or CMS in accordance with 42 CFR 455.434.

**3.19 Cultural Competency and Access.** Provider shall participate in Subcontractor's, Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency, physical or mental disabilities, diverse cultural and ethnic backgrounds, and regardless of gender, sexual orientation or gender identity, and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

Provider shall provide physical access, reasonable accommodations, and accessible equipment for Covered Persons with physical or mental disabilities.

**3.20 Marketing.** As required under State or federal law or the State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Subcontractor and Health Plan to submit to the State Program for prior approval.

**3.21 Fraud, Waste and Abuse Prevention.** Provider shall cooperate fully with Subcontractor's and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist the Department and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with Subcontractor's and Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code), including, if any entity makes or receives annual payments under the State Program of at least $5,000,000, such entity must establish certain minimum written policies and information communicated through an employee handbook relating to the Federal False Claims Act in accordance with 42 CFR §438.600; (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

**3.22 Data; Reports.** Provider shall cooperate with and release to Subcontractor and/or Health Plan any information necessary for Subcontractor and/or Health Plan to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor and/or Health Plan, in the format specified by Subcontractor, Health Plan and/or the State. Such reports shall include child health check-up reporting, if applicable, as well as complete and accurate encounter data in accordance with the requirements of Subcontractor and/or Health Plan and the State. Data must be provided at the frequency and level of detail specified by Subcontractor, Health Plan or the State. By submitting data to Subcontractor and/or Health Plan, Provider represents and attests to Subcontractor, Health Plan and the State that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

**3.23 Encounter Data.** Provider agrees to cooperate with Subcontractor and/or Health Plan to comply with Subcontractor and/or Health Plan's obligation to prepare timely encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract. Encounter data must be provided within the timeframes specified and in a form that meets Subcontractor, Health Plan and State requirements. By submitting encounter data to Subcontractor and/or Health Plan, Provider represents to Subcontractor and/or Health Plan that the data is accurate, complete and truthful, and upon Subcontractor's and/or Health Plan's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.

**3.24 Claims Information.** Provider shall promptly submit to Subcontractor and/or Health Plan (as set forth in the Agreement) the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and, if applicable, shall seek such third party liability payment before submitting claims to Subcontractor and/or Health

Plan. Provider understands and agrees that each claim Provider submits to Subcontractor and/or Health Plan constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are (a) Medically Necessary; and (b) have been provided to the Covered Person prior to submitting the claim.

**3.25 Compliance with Medicaid Laws and Regulations.** Provider agrees to abide by the Medicaid laws, regulations and program instructions to the extent applicable to Provider in Provider's performance of the Agreement. Provider understands that payment of a claim by Subcontractor, Health Plan or the Department is conditioned upon the claim and the underlying transaction complying with such laws, regulations, and program instructions (including, but not limited to, federal requirements on fraud, waste and abuse, disclosure, debarment, termination and exclusion screening), and is conditioned on the Provider's compliance with all applicable conditions of participation in Medicaid. Provider understands and agrees that each claim the Provider submits to Subcontractor or Health Plan constitutes a certification that the Provider has complied with all applicable Medicaid laws, regulations and program instructions in connection with such claims and the services provided therein. Provider's payment of a claim will be denied if Provider is terminated or excluded from participation in federal healthcare programs. Provider's payment of a claim may be temporarily suspended if Subcontractor or Health Plan provides notice that a credible allegation of fraud exists and there is a pending investigation. Subcontractor and/or Health Plan performs coding edit procedures based primarily on National Correct Coding Initiative (NCCI) policies and other nationally recognized and validated policies. Provider agrees that it will provide medical records to Subcontractor and/or Health Plan upon its request in order to determine appropriateness of coding. Provider may dispute any temporarily suspended or adjusted payment consistent with the terms of the Agreement.

**3.26 Licensure.** Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with the Department that is terminated, suspended, denied, or not renewed as a result of any action of the Department, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons.

**3.27 Quality; Utilization Management.** Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor's and/or Health Plan's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and/or Health Plan or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by Subcontractor and/or Health Plan or Provider. Provider shall adhere to the quality assurance and utilization review standards of the

State Program and shall monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

**3.28 Transition of Covered Persons.** In the event of transitioning Covered Persons from other Medicaid managed care contractors or from fee-for-service care, Provider shall work with Subcontractor and Health Plan to ensure quality-driven health outcomes and care coordination for such Covered Persons to the extent required by the State Contract or otherwise required by law.

**3.29 Continuity of Care.** Provider shall cooperate with Subcontractor and Health Plan and provide Covered Persons with continuity of treatment, including coordination of care to the extent required under law and according to the terms of the Agreement, in the event Provider's participation with Health Plan terminates during the course of a Covered Person's treatment by Provider, except in the case of adverse reasons on the part of Provider.

**3.30 Advance Directives.** Provider shall comply with the advance directives requirements for hospitals, nursing facilities, providers of home and health care and personal care services, hospices, and HMOs as specified in 42 CFR Part 489, subpart I, and 42 CFR § 417.436(d).

**3.31 Termination.** In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and/or Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

**3.32 Complaints; Appeals.** Provider may file an appeal orally or in writing within ninety days from the date on the Notice of Action ("NOA"). The ninety day period begins on the day after the mailing date of the NOA. Subcontractor or Health Plan will ensure that oral filings are treated as appeals to establish the earliest possible filing date for the appeal. A provider acting on the Covered Person's behalf must have the Covered Person's written consent to file an appeal.

**3.33 Health Care Acquired/Preventable Conditions.** Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as defined in 42 CFR 447.26. The prohibition on payment for provider-preventable conditions shall not result in a loss of access to care of services for Medicaid consumers. As a condition of payment, Provider shall identify and report to Subcontractor and Health Plan any provider preventable conditions in accordance with 42 CFR Parts 438 and 434, including but not limited to 434.6.

**3.34 Clinical Laboratory Improvements Act (CLIA) certification or waiver.** As applicable, if Provider performs any laboratory tests on human specimens for the purpose of diagnosis and/or treatment, Provider agrees to acquire and maintain the appropriate CLIA certification or waiver for the type of laboratory testing performed. Provider further agrees to provide a copy of the certification if requested by Subcontractor or Health Plan. A State authorized license or permit that meets the CLIA requirements may be substituted for the CLIA certificate pursuant to State law. Medicare and Medicaid programs require the applicable CLIA certification or waiver for the type of services performed as a condition of payment. Provider must include the appropriate CLIA certificate or waiver number on claims submitted for payment for laboratory services.

**3.35 Non-Discrimination.** Provider will not discriminate against Covered Persons on the basis of race, color, national origin, sex, sexual orientation, gender identity, or disability and will not use any policy or practice that has the effect of discriminating on the basis of race, color, or national origin, sex, sexual orientation, gender identity, or disability.

**3.36 Health Records.** Provider agrees to cooperate with Subcontractor or Health Plan to maintain and share a health record of all services provided to a Covered Person, as appropriate and in accordance with applicable laws, regulations and professional standards.

**3.37 Overpayment.** Provider shall report to Subcontractor and/or Health Plan when it has received an overpayment and will return the overpayment to Subcontractor and/or Health Plan within 60 calendar days after the date on which the overpayment was identified. Provider will notify Subcontractor and/or Health Plan in writing of the reason for the overpayment.

## SECTION 4
## SUBCONTRACTOR AND/OR HEALTH PLAN REQUIREMENTS

**4.1 Prompt Payment.** Subcontractor or Health Plan shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to 42 CFR 447.46, 42 CFR 447.45(d) (2), 42 CFR 447.45(d) (3), 42 CFR 447.45(d) (5) and 42 CFR 447.45(d) (6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

**4.2 No Incentives to Limit Medically Necessary Services.** Neither Subcontractor nor Health Plan shall structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

**4.3 Provider Discrimination Prohibition.** Neither Subcontractor nor Health Plan shall discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Neither Subcontractor nor Health Plan shall discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor or Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere with measures established by Subcontractor and/or Health Plan that are designed to maintain quality of care practice standards and control costs.

**4.4 Communications with Covered Persons.** Neither Subcontractor nor Health Plan shall prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

i) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

ii) Any information the Covered Person needs in order to decide among all relevant treatment options;

iii) The risks, benefits, and consequences of treatment or non-treatment; or

iv) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

Neither Subcontractor nor Health Plan shall prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

**4.5 Termination, Revocation and Sanctions.** In addition to its termination rights under the Agreement, Subcontractor and/or Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Subcontractor's and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor and/or Health Plan shall also have the right to suspend, deny, and refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation.

**4.6 Informing Providers about HealthChek.** In addition to the HealthChek requirements specified in OAC Chapter 5160, Health Plan (or Subcontractor, on Health Plan's behalf) must:

i) Provide HealthChek education to all contracted providers on an annual basis which must include, at a minimum, the following:

a) The required components of a HealthChek exam as specified in Ohio Administrative Code Chapter 5160;

b) A list of the intervals at which individuals under age 21 should receive screening examinations, as indicated by the most recent version of the document "Recommendations for Preventive Pediatric Health Care" published by Bright Futures/American Academy of Pediatrics;

c) A statement that HealthChek includes a range of medically necessary screening, diagnosis and treatment services; and

d) A list of common billing codes and procedures related to the HealthChek services (e.g., immunizations, well child exams, laboratory tests, and screenings).

ii) Provide the above information on Health Plan's (or Subcontractor's, as applicable) Provider website.

## SECTION 5
## OTHER REQUIREMENTS

**5.1 Compliance with State Contract.** All tasks performed under the Agreement shall be performed in accordance with the requirements of the State Contract, as set forth in this Appendix, and OAC Chapter 5160, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan has provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

**5.2 Monitoring.** Subcontractor and/or Health Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Subcontractor and/or Health Plan shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Subcontractor and/or Health Plan shall take appropriate corrective action.

**5.3 Delegation.** The parties agree that, prior to execution of the Agreement, Subcontractor or Health Plan evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. Subcontractor or Health Plan shall have the right to revoke any function or activities delegated to Provider under the Agreement if in Subcontractor's or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate.

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**REGULATORY RIDER**
**TO THE**
**Applicable Government Sponsored Programs Regulatory Requirements Appendix (the "Appendix")**

**ADDITION OF CAPITATED FINANCIAL ALIGNMENT DEMONSTRATION PLAN PRODUCT AND OTHER GOVERNMENT PRODUCTS INTRODUCED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES**

**THIS REGULATORY RIDER** (this "Rider"), hereby unilaterally supplements and amends the Appendix as set forth herein. All defined terms shall have the meaning ascribed to them as set forth in this Rider or the underlying governing agreement (the "Agreement").

**WHEREAS**, the Centers for Medicare and Medicaid ("CMS") regulatorily requires all health plans to (i) add the capitated financial alignment demonstration plan product offering (also known as the Medicare & Medicaid Enrollees Healthcare Program product) ("MME Product") to the Agreement, (ii) to add new CMS product offerings as issued and awarded ("Other Government Programs") and (iii) ensure the administration of such product(s) is governed by the appropriate federal and state regulatory requirements; and

**WHEREAS,** the purpose of this Rider is to ensure all such applicable regulatory requirements of the Appendix govern the administration of the MME Product and Other Government Programs upon award to a health plan.

**NOW THEREFORE**, the Appendix is unilaterally supplemented and amended as follows:

1. This Rider hereby adds the MME Product and Other Government Programs as defined in the recital above to the Appendix. The parties to the Agreement agree to (i) abide by all of the terms and conditions in the Appendix that govern the parties' federal and state regulatory obligations to support the MME Product offering and Other Government Program offerings and (ii) further agree to amend the Agreement as necessary to comply with such obligations, if applicable.

2. The Appendix, as hereby amended, shall serve to supplement and amend the Agreement for purposes of the Health Plan benefit plan known as the MME Product and any awarded Other Government Programs.

3. The Appendix, as hereby amended, shall require that Medicare Parts A and B services must be provided at zero cost-sharing to beneficiaries enrolled in the MME Product.

4. Except as so amended, all other provisions of the Appendix shall remain in full force and effect. Any conflict between this Rider and the Appendix shall be resolved in favor of this Rider.