Humana

ANCILLARY PARTICIPATION AGREEMENT

State: Ohio

COVER SHEET

Creation Date:
Icertis Contract Number: MERLIN ID:
Provider Name: Legal Name: DBA Name:

Federal Tax ID: EIN:

Optional Information:	
NPI:	Provider Specialty:

Contract Contact Information: Name:

Address Line 1:	
Address Line 2:	
City:	State: Zip:
Phone: Ext :	Fax:
Email:	

Address for Notice Name:

Address Line 1:	
Address Line 2:	
City: www	State: Zip:
Phone: Ext :	Fax:
Email:	

Contractor Information: Name:	
Address Line 1:	
Address Line 2:	
City:	State: Zip:
Phone: Ext	Fax:
Email:	

ANCILLARY PARTICIPATION AGREEMENT

This **Ancillary** Participation Agreement ("**Agreement**") is made and entered into by and between the party named on the signature page below (hereinafter referred to as **"Provider"**) and Humana Insurance Company and Humana Health Plan, Inc. and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**").

1. RELATIONSHIP OF THE PARTIES

1.1 In performance of their respective duties and obligations hereunder, **Humana** and **Provider**, and their respective employees and agents, are at all times acting and performing as independent contractors, and neither party, nor their respective employees and agents, shall be considered the partner, agent, servant, employee of, or joint venture with, the other party. Unless otherwise agreed to herein, the parties acknowledge and agree that neither **Provider** nor **Humana** will be liable for the activities of the other nor the agents and employees of the other, including but not limited to, any liabilities, losses, damages, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (i) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (ii) any negligent act or omission or other misconduct; (iii) the failure to comply with any applicable laws, rules or regulations; or (iv) any accident, injury or damage to persons or property. Notwithstanding anything to the contrary contained herein, **Provider** further agrees to and hereby does indemnify, defend and hold harmless **Humana** from any and all claims, judgments, costs, liabilities, damages and expenses whatsoever, including reasonable attorneys' fees, arising from any acts or omissions in the provision by **Provider** of Health Care Services to Members. This provision shall survive termination or expiration of this Agreement.

1.2 The parties agree that **Humana's** affiliates whose Members receive services hereunder do not assume joint responsibility or liability between or among such affiliates for the acts or omissions of such other affiliates.

2. SERVICES TO MEMBERS

2.1 Subject at all times to the terms of this Agreement, **Provider** agrees to provide or arrange for professional medical service and/or related Health Care Services to individuals designated by **Humana** (herein referred to as "Members") with an identification card or other means of identifying them as Members and covered under self-funded or insured health benefits plans to which **Provider** has agreed to participate as set forth in the product participation list attachment.

2.2 **Provider** further agrees to provide Health Care Services to individuals covered under other third party payors' (hereinafter referred to as "**Payor**" or "**Payors**") health benefits contracts (hereinafter referred to as **"Plan"** or "**Plans**") and agrees to comply with such Payors' policies and procedures. For Covered Services rendered to such individuals, **Provider** acknowledges and agrees that all rights and responsibilities arising with respect to benefits to such individuals shall be subject to the terms of the Payor Plan covering such individuals. Individuals covered under such Plans will have an identification card as a means of identifying the Payor Plan which provides coverage. Such identification cards will display a **Humana** logo and/or name.

2.3 For Covered Services provided to those individuals identified in Section 2.2 above, **Provider** will accept payments for Covered Services from Plans in accordance with the terms and conditions of this Agreement and the rates set forth in the Payment Attachment applicable to the type of Plan. **Provider** agrees that in no event, including, but not limited to, nonpayment by Payor, or Payor's insolvency, shall **Provider** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against **Humana** for services provided by **Provider** to such Plans' Members. This provision shall not prohibit collection by **Provider** from Plans' Members for non-covered services and/or Member cost share amounts in accordance with the terms of the applicable Member Plan. Payors Plans will provide appropriate steerage mechanisms including benefit designs and/or provider directory and web site listings to ensure their covered individuals have incentives to utilize **Provider's** services. All obligations of **Provider** under this

Agreement with respect to **Humana's** Members shall equally apply to the individuals identified in Section 2.2 above.

3. THIRD PARTY BENEFICIARIES

3.1 Except as is otherwise specifically provided in this Agreement, the parties have not created and do not intend to create by this Agreement any rights in other parties as third party beneficiaries of this Agreement, including, without limitation, Members.

4. SCOPE OF AGREEMENT

4.1 This Agreement sets forth the rights, responsibilities, terms and conditions governing: (i) the status of **Provider** and **Provider's** employees, subcontractors and independent contractors as health care providers (hereinafter referred to as "**Participating Providers**") providing Health Care Services; and (ii) **Provider's** provision of medical or related Health Care Services (hereinafter referred to as "**Provider Services**") to Members. All terms and conditions of this Agreement which are applicable to "**Provider**" are equally applicable to each Participating Provider, unless the context requires otherwise.

4.2 **Provider** acknowledges and agrees that its Participating Providers will abide by the terms and conditions of this Agreement. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between **Provider** and Members regarding the Members' medical conditions or treatment options, and **Provider** acknowledges that all patient care and related decisions are the sole responsibility of **Provider** and **Humana** does not dictate or control clinical decisions with respect to the medical care or treatment of Members. **Provider** agrees to provide **Humana**, upon request, with copies of orders from Member's attending physician.

4.3 **Provider** acknowledges and agrees that with respect to self-funded groups, unless otherwise provided herein, **Humana's** responsibilities hereunder are limited to provider network administration and/or claims processing.

5. ACQUISITIONS

5.1 This Section applies to any **Provider** acquisition through any means including, but not limited to, asset or stock purchase, merger, or consolidation (collectively, "**Acquisition**") of an ownership interest in a facility or other provider of whatever type or construction including, but not limited to, a (i) hospital, (ii) free standing ambulatory surgery center, (iii) radiology center, (iv) sleep center; or (v) physician, physician group, Independent Practice Association or Physician Hospital Organization (collectively, "**Entity**"). In the event of **Provider's** Acquisition of an Entity and such Entity has an agreement in effect with **Humana** for the provision of Health Care Services, then such Entity shall not become a participating provider with **Humana** under this Agreement but, rather, the existing separate agreement between **Humana** and such Entity will control for its duration. Furthermore, **Provider** shall not exercise any termination or nonrenewal right which may exist in the agreement between **Humana** and such Entity for a period of twelve (12) months subsequent to the effective date **Provider** acquires its ownership interest in such Entity.

5.2 In the event **Provider's** ownership, separate existence or entity construction (e.g., corporation, limited liability company, etc.) is altered or affected in any way as a result of acquisition, merger, consolidation or through any other means whatsoever (including, but not limited to, being merged into an affiliated entity), then this Agreement shall continue to control with respect to **Provider's** provision of Health Care Services to **Humana's** Members notwithstanding any contrary outcome which may otherwise be allowed or required by law. Furthermore, **Provider** agrees that it shall not exercise any termination or nonrenewal right which may otherwise exist in this Agreement for a period of twelve (12) months subsequent to the effective date of such transaction event.

6. TERM AND TERMINATION

6.1 The term of this Agreement shall commence on the date **Humana** inserts in this Agreement (the "**Effective Date**"). **Humana** has full authority to determine the Effective Date according to **Humana's** processing and/or credentialing requirements. The initial term of this Agreement shall be for Three (3) year(s). After the Initial Term, this Agreement shall automatically renew for

subsequent one (1) year terms unless either party provides written notice of non-renewal to the other party at least ninety (90) days prior to the end of the initial term or any subsequent renewal terms.

6.2 Notwithstanding anything to the contrary herein, after the Initial Term, either party may terminate this Agreement without cause at any time following the initial term of this Agreement by providing to the other party ninety (90) days prior written notice of termination.

6.3 **Humana** may terminate this Agreement immediately upon written notice to **Provider**, stating the cause for such termination, in the event: (i) **Provider's** or any Participating Provider's continued participation under this Agreement may adversely affect the health, safety or welfare of any Member or brings **Humana** or its health care networks into disrepute; (ii) **Provider** or any Participating Provider fails to meet **Humana's** credentialing or re-credentialing criteria; (iii) **Provider** or any Participating Provider is excluded from participation in any federal health care program; (iv) **Provider** voluntarily or involuntarily seeks protection from creditors through bankruptcy proceedings or engages in or acquiesces to receivership or assignment of accounts for the benefit of creditors; or (v) **Humana** loses its authority to do business in total or as to any limited segment of business, but then only as to that segment.

6.4 In the event of a breach of this Agreement by either party, the non-breaching party may terminate this Agreement upon at least sixty (60) days prior written notice to the breaching party, which notice shall specify in detail the nature of the alleged breach; provided, however, that if the alleged breach is susceptible to cure, the breaching party shall have thirty (30) days from the date of receipt of notice of termination to cure such breach, and if such breach is cured, then the notice of termination shall be void of and of no effect. If the breach is not cured within the thirty (30) day period, then the date of termination shall be that date set forth in the notice of termination. Notwithstanding the foregoing, any breach related to credentialing or re-credentialing, quality assurance issues or alleged breach regarding termination by **Humana** in the event that **Humana** determines that continued participation under this Agreement may affect adversely the health, safety or welfare of any Member or bring **Humana** or its health care networks into disrepute, shall not be subject to cure and shall be cause for immediate termination upon written notice to **Provider**.

6.5 **Provider** agrees that the notice of termination or expiration of this Agreement shall not relieve **Provider** of its obligation to provide or arrange for the provision of Provider Services through the effective date of termination or expiration of this Agreement.

6.6 **Provider** agrees that **Humana** may terminate **Provider** or an individual Participating Provider's participation from one or more line(s) of business and/or provider network(s) covered by this Agreement by providing ninety (90) days prior written notice to **Provider**. In such event, the affected **Provider** or Participating Provider(s) shall remain participating with respect to all other line(s) of business, if any, and/or provider network(s) covered by this Agreement.

7. POLICIES AND PROCEDURES

7.1 **Provider** agrees to comply with **Humana's** quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by **Humana** from time to time and, in addition, those policies and procedures which are set forth in **Humana's** Provider Manual for Physicians, Hospitals, and Other Health Care Providers, or its successor (hereinafter referred to as the **"Manual"**), and bulletins or other written materials that may be promulgated by **Humana** from time to time to supplement the Manual. The Manual and updated policies and procedures may be issued and distributed by **Humana** in electronic format. Paper copies may be obtained by **Provider** upon written request. Revisions to such policies and procedures shall become binding upon **Provider ninety** (**90**) days after such notice to **Provider** by mail or electronic means, or such other period of time as necessary for **Humana** to comply with any statutory, regulatory and/or accreditation requirements.

7.2 **Humana** shall maintain an authorization procedure for **Provider** to verify coverage of Members under a **Humana** health benefits contract.

7.3 Notwithstanding anything to the contrary in this Agreement or in the Member's health benefits contract**, Provider** shall obtain authorization from **Humana** prior to the provision of those services for which **Humana** requires prior authorization. Prior to rendering any non-emergent service, **Provider** is responsible for determining if such service requires prior authorization by reviewing

Humana's prior authorization requirements posted on http://www.humana.com/providers/ (or any subsequent location as may be specified in the Manual or otherwise by written notice) or by contacting **Humana's** customer service phone number, as indicated on Member's identification card.

8. CREDENTIALING AND PROFESSIONAL LIABILITY INSURANCE

8.1 Participation under this Agreement by **Provider** and Participating Providers is subject to the satisfaction of all applicable credentialing and re-credentialing standards established by **Humana**. **Provider** shall provide **Humana**, or its designee, information necessary to ensure compliance with such standards at no cost to **Humana** or its designee. **Provider** agrees to use electronic credentialing and recredentialing processes when administratively feasible.

8.2 **Provider** shall maintain, at no expense to **Humana**, policies of comprehensive general liability, professional liability, and workers' compensation coverage, insuring **Provider** and **Provider's** employees and agents against any claim or claims for damages arising as a result of injury to property or person, including death, occasioned directly or indirectly in connection with the provision of Health Care Services contemplated by this Agreement and/or the maintenance of **Provider's** facilities and equipment. Upon request, **Provider** shall provide **Humana** with evidence of said coverage. **Provider** shall within ten (10) business days following service upon **Provider**, or such other period of time as may be required by any applicable law, rule or regulation, notify **Humana** in writing of any Member lawsuit alleging malpractice involving a Member.

9. PROVISION OF MEDICAL SERVICES

9.1 **Provider** shall provide Members all available Health Care Services within the normal scope of and in accordance with **Provider's** licenses, certifications and privileges to provide certain services as delineated by **Humana**. **Provider** agrees to comply with all requests for information related to **Humana** determination of **Provider's** privileging status. **Provider** shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts related to the provision of Health Care Services for which privileges have not been granted to **Provider** by **Humana**.

9.2 **Provider** shall maintain all medical equipment including, but not limited to, imaging, diagnostic and/or therapeutic equipment (hereinafter referred to as "**Equipment**") in acceptable working order and condition and in accordance with the Equipment manufacturer's recommendations for scheduled service and maintenance. Such Equipment shall be located in areas that promote patient and employee safety. **Provider** shall provide **Humana** or its agents with access to such Equipment for inspection and an opportunity to review all records reflecting Equipment maintenance and service history. Such Equipment shall only be operated by qualified technicians with appropriate training and required licenses and certifications.

9.3 Equipment owned and/or operated by **Provider** shall comply with all standards for use of such Equipment and technician qualifications established by **Humana**. **Provider** agrees to comply with all requests for information related to Equipment and **Provider's** and/or **Provider's** staff, qualifications for use of same. In the event: (i) **Provider's** Equipment fails to meet **Humana's** standards; or (ii) **Provider** declines to comply with **Humana's** standards for use of Equipment, **Provider** agrees that it will not use such Equipment while providing Health Care Services to Members and shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts for Health Care Services with respect to such Equipment.

10. STANDARDS OF PROFESSIONAL PRACTICE

10.1 Health Care Services shall be made available to Members without differentiation or discrimination on the basis of type of health benefits plan, source of payment, employment status, socioeconomic status, sex, sexual preference, age, race, ethnicity, religion, national origin, health status, disability, military service or veterans' status. **Provider** shall provide Health Care Services to Members in the same manner as provided to its other patients and in accordance with prevailing practices and standards of care.

11. QUALITY AND UTILIZATION REVIEW DATA REQUESTED BY HUMANA

11.1 **Provider** agrees to participate in **Humana's** utilization review program, whether performed internally or by an external vendor of **Humana's** choosing, and to provide data requested by **Humana** to conduct quality and utilization review activities concerning **Humana** Members.

11.2 **Provider** agrees to obtain from Members authorization for **Humana's** review personnel to have access to Members during their term of treatment and to Members' medical records, and pursuant to such authorization, provide **Humana's** review personnel such access. **Provider** further agrees to furnish **Humana's** review personnel access to **Provider** and **Provider's** personnel during the term of a Member's treatment.

12. MEDICAL RECORDS

12.1 **Provider** shall prepare, maintain and retain as confidential the medical records of all Members receiving Health Care Services, and Members' other personally identifiable health information received from **Humana**, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which **Provider** is subject, and in accordance with accepted medical practice. **Provider** shall obtain authorization of Members permitting **Humana** or its designee, and/or any state or federal agency as permitted by law, to obtain a copy and have access, upon reasonable request, to any medical record of Member related to Health Care Services provided by **Provider** pursuant to applicable state and federal laws. Medical records shall be provided by **Provider** to **Humana** at no cost to **Humana** or the Member. **Provider** will use best efforts to provide medical records electronically. If **Provider** utilizes a vendor to provide medical records to **Humana**, **Provider** agrees **Humana** is only obligated to pay the vendor the amount specified for medical records in this Agreement and further agrees to require its vendor to accept that amount as payment in full. Any expense for Medical Records in excess of the fees outlined in this Agreement shall be the responsibility of the **Provider**. Upon the written request of **Humana** and unless applicable law requires otherwise, **Provider** shall provide an agreed upon, electronic, automated means, at no cost, for **Humana** or its designee to access Member clinical information including, but not limited to, medical records for all **Humana** health plan functions including but not limited to case management, utilization management, claims review and audit, and claims adjudication.

12.2 Upon request from **Humana** or a Member, **Provider** shall transfer a complete copy of the medical records of any Member transferred to another physician and/or facility for any reason, including termination or expiration of this Agreement. The copy and transfer of medical records shall be made at no cost to **Humana** or the Member and shall be made within a reasonable time following the request, but in no event more than five (5) business days, except in cases of emergency where the transfer shall be immediate. **Provider** agrees that such timely transfer of medical records is necessary to provide for the continuity of care for Members. **Provider** agrees to pay court costs and/or legal fees incurred by **Humana** or the Member to enforce the terms of this provision.

12.3 **Provider** and **Humana** agree, and **Humana** will require its designee to agree, to maintain the confidentiality of information maintained in the medical records of Members, and information obtained from **Humana** through the verification of Member eligibility, as required by law. This **Section 12.3** shall survive any expiration or termination of this Agreement, regardless of the cause.

13. GRIEVANCE AND APPEALS PROCESS/BINDING ARBITRATION

13.1 **Grievance and Appeals Internal Administrative Review.** **Provider** shall cooperate and participate with **Humana** in grievance and appeals procedures to resolve disputes that may arise between **Humana** and its Members. **Provider** and **Humana** further agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Provider** will first exhaust any internal **Humana** administrative review or appeal procedures prior to submitting any matters to binding arbitration.

13.2 **Agreement to Arbitrate.** The parties agree that any dispute arising out of their business relationship which cannot be settled by mutual agreement shall be submitted to final and binding arbitration under the Healthcare Payor Provider Arbitration Rules of the American Arbitration Association ("AAA"), including disputes concerning the scope, validity or applicability of this agreement to arbitrate ("**Arbitration Agreement**"). The parties agree that this Arbitration

Agreement is subject to, and shall be interpreted in accordance with, the Federal Arbitration Act, 9 U.S.C. §§ 1-16. No claim or allegation shall be excepted from this Arbitration Agreement, including alleged breaches of the Agreement, alleged violations of state or federal statutes or regulations, tort or other common law claims, and claims of any kind that a party to the Agreement has conspired or coordinated with, or aided and abetted, one or more third parties in violation of law. Without limiting the foregoing, this Arbitration Agreement requires arbitration of disputes involving antitrust, racketeering and similar claims. This Arbitration Agreement supersedes any prior arbitration agreement between the parties. The parties agree to arbitrate disputes arising from the parties' business relationship prior to the effective date of the Agreement under the terms of this arbitration provision. This Arbitration Agreement, however, does not revive any claims that were barred by the terms of prior contracts, by applicable statutes of limitations or otherwise.

13.3 **Arbitration Process.** The arbitration shall be conducted by one neutral arbitrator selected by the parties from the AAA National Healthcare Panel of arbitrators. The arbitrator shall have prior professional, business or academic experience in health care, managed care or health insurance matters. In the event of an arbitration of antitrust claims, the arbitrator shall have prior professional, business or academic experience in antitrust matters. The arbitration shall be conducted in a location selected by mutual agreement or, failing agreement, at a location selected by the AAA that is no more than fifty (50) miles from **Provider's** place of business. The cost of any arbitration proceeding(s) hereunder shall be borne equally by the parties. Each party shall be responsible for its own attorneys' fees and such other costs and expenses incurred related to the proceedings, except to the extent the applicable substantive law specifically provides otherwise.

13.4 **Joinder; Class Litigation.** Any arbitration under this Arbitration Agreement shall be solely between **Humana** and **Provider**, shall not be joined with another lawsuit, claim, dispute or arbitration commenced by any other person, and may not be maintained on behalf of any purported class.

13.5 **Expense of Compelling Arbitration.** If either party commences a judicial proceeding asserting claims subject to this Arbitration Agreement or refuses to participate in an arbitration commenced by the other party, and the other party obtains a judicial order compelling arbitration of such claims, the party that commenced the judicial proceeding or refused to participate in an arbitration in violation of this Arbitration Agreement shall pay the other party's costs incurred in obtaining an order compelling arbitration, including the other party's reasonable attorneys' fees.

13.6 **Judgment on the Decision and Award.** Judgment upon the decision and award rendered by an arbitrator under this Arbitration Agreement may be entered in any court having jurisdiction thereof

14. USE OF PROVIDER'S NAME

14.1 **Humana** may include the following information in any and all marketing and administrative materials published or distributed in any medium: **Provider's** name, the names of all Participating Providers, **Provider's** and Participating Providers' telephone numbers, addresses, available services, and **Provider's** Internet web-site address. **Humana** will provide **Provider** with access to such information or copies of such administrative or marketing materials upon request.

14.2 **Provider** may advertise or utilize marketing materials, logos, trade names, service marks, or other materials created or owned by **Humana** after obtaining **Humana's** written consent. **Provider** shall not acquire any right or title in or to such materials as a result of such permissive use.

14.3 **Provider** agrees to allow **Humana** to distribute a public announcement of **Provider's** affiliation with **Humana**.

15. PAYMENT

15.1 **Provider** shall accept payment from **Humana** for those Health Care Services provided to Members for which benefits are payable under a Member's health benefits contract (herein referred to as "**Covered Services**") provided to Member in accordance with the reimbursement terms in the Payment Attachment. **Provider** shall collect directly from Member any co-payment, coinsurance, or other Member cost share amounts (hereinafter referred to as "**Copayments**") applicable to the Covered Services provided and shall not waive, discount or rebate any such Copayments.

Payments made in accordance with the Payment Attachment less the Copayments owed by Members pursuant to their health benefits contracts shall be accepted by **Provider** as payment in full from **Humana** for all Covered Services. This provision shall not prohibit collection by **Provider** from Member for any services not covered under the terms of the applicable Member health benefits contract. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

15.2 **Provider** agrees that payment may not be made by **Humana** for Health Care Services rendered to Members which are determined by **Humana** not to be Medically Necessary. "**Medically Necessary**" (or "**Medical Necessity**"), unless otherwise defined in the applicable Member health benefits contract, means services or supplies provided by a licensed, certified or approved, as applicable, hospital, physician or other health care provider to identify or treat a condition, disease, ailment, sickness or bodily injury and which, in the opinion of **Humana**, are: (i) consistent with the symptoms, diagnosis and treatment of the condition, disease, ailment, sickness or bodily injury; (ii) appropriate with regard to standards of accepted medical practice; (iii) not primarily for the convenience of the patient or the hospital, physician, or other health care provider; (iv) the most appropriate and cost-effective supply, setting, or level of service which safely can be provided to the patient; and (v) substantiated by records and documentation maintained by the provider of services. When applied to an inpatient, it further means that the patient's symptoms or condition requires that the services or the supplies cannot be provided safely to the patient as an outpatient. Notwithstanding anything to the contrary in this Agreement, **Provider** agrees that in the event of a denial of payment for Health Care Services rendered to Members determined not to be Medically Necessary by **Humana**, that **Provider** shall not bill, charge, seek payment or have any recourse against Member for such services. Notwithstanding the immediately preceding sentence: a) **Provider** may bill a Member who is enrolled in a Commercial plan for services determined not to be Medically Necessary only if **Provider** provides the Member with advance written notice that: (i) identifies the proposed services, (ii) informs the Member that such services may be deemed by **Humana** to be not Medically Necessary, and (iii) provides an estimate of the cost to the Member for such services and the Member agrees in writing in advance of receiving such services to assume financial responsibility for such services; and b) **Provider** may bill a Member who is enrolled in a Medicare Advantage plan for services determined not to be Medically Necessary only if either: (i) the Member's plan's evidence of coverage states the specific service is never covered; or (ii) before providing the service: A) **Provider** requests an advance coverage determination ("ACD"); B) **Humana's** ACD determination is that the service is non-covered; and C) Member, nevertheless, agrees to receive the service and be responsible for payment of it; and, after providing the service: D) **Provider** submits a claim to **Humana** with a charge for that service reported as required by **Humana** policy.

15.3 **Provider** agrees that **Humana** may recover overpayments made to **Provider** by **Humana** by offsetting such amounts from later payments to **Provider**, including, without limitation, making retroactive adjustments to payments to **Provider** for errors and omissions relating to data entry errors and incorrectly submitted claims or incorrectly applied discounts. **Humana** shall provide **Provider** thirty (30) days advance written notice of **Humana's** intent to offset such amounts prior to deduction of any monies due. If **Provider** does not refund said monies or request review of the overpayments described in the notice within thirty (30) days following receipt of notice from **Humana**, **Humana** may without further notice to **Provider** deduct such amounts from later payments to **Provider**. **Humana** may make retroactive adjustments to payments for a period not to exceed eighteen (18) months from original date of payment or such other period as may be required or allowed by applicable law.

15.4 In the event **Humana** has access to **Provider's**, or a Participating Provider's, services through one or more other agreements or arrangements in addition to this Agreement, **Humana** will determine under which agreement payment for Covered Services will be made.

15.5 Nothing contained in this Agreement is intended by **Humana** to be a financial incentive or payment that directly or indirectly acts as an inducement for **Provider** to limit Medically Necessary services.

15.6 Notwithstanding any other reimbursement terms specified in this Agreement, for all Covered Services rendered to Medicare Advantage Members (including but not limited to Members enrolled in Medicare-Medicaid alignment plans or their equivalent) the reimbursement for which under this

Agreement is determined in whole or in part by a Medicare reimbursement methodology, the final payment amount to **Provider** as determined under this Agreement shall be reduced in the same manner as the reduction in the final payment amount that CMS is applying to provider payments in Medicare Parts A and/or B pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Control Act of 2011, or any successor legislation ("Sequestration"). This provision is effective April 1, 2013 and shall apply for the duration of the time in which Sequestration reductions apply to provider payments under Medicare Parts A and/or B.

16. SUBMISSION OF CLAIMS

16.1 **Provider** shall submit all claims and encounters to **Humana** or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") compliant 837 electronic format, or a UB-04 and/or a CMS 1500 paper format (in accordance with industry standard), or their successors. Claims and encounters will utilize HIPAA compliant Code Sets for all coded values. Claims shall include the **Provider's** NPI and the valid taxonomy code that most accurately describes the Health Care Services reported on the claim. Claims shall be submitted within ninety (90) days from the date of service or within the time specified by applicable state law. **Humana** may, in its sole discretion, deny payment for any claim(s) received by **Humana** after the later of ninety (90) days from the date of service, or the time specified by applicable state law. **Provider** acknowledges and agrees that at no time shall Members be responsible for any payments to **Provider** except for applicable Copayments and non-covered services provided to such Members.

16.2 **Humana** will process **Provider** claims which are accurate and complete in accordance with **Humana's** normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the Health Care Services provided to Members. These automated systems may result in an adjustment of the payment to the **Provider** for the Health Care Services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. **Provider** may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to **Humana**. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service. In no event may **Provider** bill a Member for any amount adjusted in payment.

16.3 Unless applicable law mandates submission may be in paper format, **Provider** shall submit all claims, encounters, and clinical data to **Humana** by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by **Humana**. **Provider** acknowledges that **Humana** may market certain products that will require electronic submission of claims and clinical data in order for **Provider** to participate. **Provider** shall notify **Humana** when they have completed their transition to Electronic Medical Records and agrees to provide information on the status to **Humana** upon request. Unless applicable law mandates submission may be in paper format, **Provider** shall submit to **Humana** all **Humana** required clinical data (including, but not limited to, laboratory data) by available electronic means within thirty (30) days of the date of service or within the time specified by applicable law.

17. COORDINATION OF BENEFITS

17.1 When a Member has coverage, other than with **Humana**, which requires or permits coordination of benefits from a third party payor in addition to **Humana**, **Humana** will coordinate its benefits with such other payor(s). In all cases, **Humana** will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, **Humana** will pay the lesser of: (i) the amount due under this Agreement; (ii) the amount due under this Agreement less the amount payable or to be paid by the other payor(s); or (iii) the difference between the primary Payor's allowed amount and the amount paid by the other payor(s). In no event, however, will **Humana**, when its plan is a secondary payor, pay an amount, which, when combined with payments from the other payor(s), exceeds the rates set out in this Agreement;

provided, however, if Medicare is the primary payer, **Humana** will, to the extent required by applicable law, regulation or Centers for Medicare and Medicaid Services ("**CMS**") Office of Inspector General ("**OIG**") guidance, pay **Provider** an amount up to the amount **Humana** would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

18. NO LIABILITY TO MEMBER FOR PAYMENT

18.1 **Provider** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Provider** or any Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Health Care Services provided by **Provider**. This provision shall not prohibit collection by **Provider** from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member health benefits contract.

18.2 **Provider** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Provider** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Provider**, and **Provider** shall obtain from such persons specific agreement to this provision.

18.3 Any modification to this **Section 18** shall not become effective unless approved by the Commissioner of Insurance, in the event such approval is required by applicable state law or regulation, or such changes are deemed approved in accordance with state law or regulation.

19. ACCESS TO INFORMATION

19.1 **Provider** agrees that **Humana** or its designee, or any state or federal regulatory agency as required by law, shall have reasonable access and an opportunity to examine **Provider's** financial and administrative records as they relate to Health Care Services provided to Members during normal business hours, on at least **seventy-two** (**72**) **hours** advance notice, or such shorter notice as may be imposed on **Humana** by a federal or state regulatory agency or accreditation organization.

20. NEW PRODUCT INTRODUCTION AND NETWORK SELECTION

20.1 From time to time during the term of this Agreement, **Humana** may develop or implement new products. Should **Humana** offer participation in any such new product to **Provider**, **Provider** shall be provided with ninety (90) days' written notice prior to the implementation of such new product. If **Provider** does not object in writing to its participation in such new product within such ninety (90) day notice period, **Provider** shall be deemed to have accepted participation in the new product. In the event **Provider** objects to its participation in a new product, the parties shall confer in good faith to reach agreement on the terms of **Provider's** participation. If agreement on such new product cannot be reached, such new product shall not apply to this Agreement.

20.2 **Humana** may in its discretion, establish, develop, manage and market provider networks in which **Provider** may not be selected to participate. In addition, **Provider** agrees to participate as a network provider in health benefits plans that **Humana** may establish, develop and/or manage that have varying Member Copayment obligations on services provided by **Humana** participating providers, including **Provider.**

21. ASSIGNMENT

21.1 The assignment by **Provider** of this Agreement or any interest hereunder shall require the prior written consent of **Humana**, which may be granted or withheld in **Humana's** sole discretion. Any attempt by **Provider** to assign this Agreement or any interest hereunder without complying with the terms of this section shall be void and of no effect, and **Humana**, at its option, may elect to terminate this Agreement upon thirty (30) days' written notice to **Provider**, without any further liability or obligation to **Provider**. Such right of termination shall be in addition to and not a limitation of any and all other remedies that may be available to **Humana** at law or in equity in connection

with such impermissible assignment. **Humana** may assign this Agreement in whole or in part to any purchaser of or successor to the assets or operations of **Humana**, or any affiliate of **Humana**, provided that the assignee agrees to assume **Humana's** obligations under this Agreement. For purposes of this Agreement, the term "assignment" shall include a change of control of **Provider** by (i) consolidation or merger with or into any entity that, giving effect to any such transaction, results in the beneficial owners of the outstanding voting securities or other ownership interests of **Provider** immediately prior to such transaction owning less than thirty-three percent (33%) of such securities or interests after such transaction; (ii) sale, transfer or other disposition of all or substantially all of the assets of **Provider**; or (iii) acquisition by any entity, or group of entities acting in concert, of beneficial ownership of thirty-three percent (33%) or more of the outstanding voting securities or other ownership interests of **Provider**.

22. COMPLIANCE WITH REGULATORY REQUIREMENTS

22.1 **Provider** acknowledges, understands and agrees that this Agreement may be subject to the review and approval of state regulatory agencies with regulatory authority over the subject matter of this Agreement. Any modification of this Agreement requested by such agencies or required by applicable law or regulations shall be incorporated herein as provided in **Section 24.10**, of this Agreement.

22.2 **Provider** and **Humana** agree to be bound by and comply with the provisions of all applicable state and/or federal laws, rules and regulations. The alleged failure by either party to comply with applicable state and federal laws or regulations shall not be construed as allowing either party a private right of action against the other in any court, administrative or arbitration proceeding in matters in which such right is not recognized or authorized by such law or regulation. If **Provider** violates any of the provisions of applicable state and/or federal laws, rules and regulations, or commits any act or engages in conduct for which **Provider's** or other Participating Providers' professional license, certification, registration or accreditation is revoked or suspended, or otherwise is restricted by any state licensing or certification agency by which **Provider** or Participating Providers are licensed or certified, **Humana** may immediately terminate this Agreement or any individual Participating Provider.

22.3 **Provider** shall procure and maintain for the term of this Agreement such accreditation, certification, licensure and/or registration as is required under all applicable state and federal laws and regulations, and further shall ensure appropriate accreditation, certification, licensure and/or registration of all of its Participating Providers required to be so accredited, certified, licensed and/or registered, in accordance with all applicable state and federal laws, rules and regulations. **Provider** shall notify **Humana** immediately of any suspensions, revocations, restrictions or any other changes in its or its Participating Providers' accreditation, certification, licensure or registration status.

23. DISPUTE RESOLUTION/LIMITATIONS ON PROCEEDINGS

23.1 **Provider** and **Humana** agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Provider** will first exhaust any internal **Humana** administrative review or appeal mechanisms prior to submitting any matters to binding arbitration.

23.2 **Provider** may contest the amount of the payment, denial or nonpayment of a claim only within a period of eighteen (18) months following the date such claim was paid, denied or not paid by the required date by **Humana**. In order to contest such payments, **Provider** shall provide to **Humana**, at a minimum, in a clear and acceptable written format, the following information: Member name and identification number, date of service, relationship of the Member to the patient, claim number, name of the provider of the services, charge amount, payment amount, the allegedly correct payment amount, difference between the amount paid and the allegedly correct payment amount, and a brief explanation of the basis for the contestation. **Humana** will review such contestation(s) and respond to **Provider** within sixty (60) days of the date of receipt by **Humana** of such contestation.

24. MISCELLANEOUS PROVISIONS

24.1 **SEVERABILITY.** If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be reformed, if possible, to conform to law, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

24.2 **GOVERNING LAW.** This Agreement shall be governed by and construed in accordance with the applicable laws of the state in which Health Care Services are provided. The parties agree that applicable state and/or federal laws and/or regulations may make it necessary to include in this Agreement specific provisions relevant to the subject matter contained herein. Such state law provisions, if any, are set forth in the State Law Coordinating Provisions Attachment. Such federal law provisions, if any, are set forth in the Medicare Advantage Provisions Attachment. The parties agree to comply with any and all such provisions and in the event of a conflict between the provisions in the State Law Coordinating Provisions Attachment and/or the Medicare Advantage Provisions Attachment and any other provisions in this Agreement, the provisions in those attachments, as applicable, shall control. In the event that state and/or federal laws, rules or regulations enacted after the Effective Date expressly require specific language be included in this Agreement, such provisions are hereby incorporated by reference without further notice by or action of the parties and such provisions shall be effective as of the effective date stated in such laws, rules or regulations.

24.3 **WAIVER.** The waiver, whether express or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent or continuing breach of the same provision. In addition, the waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy at any subsequent time if a condition of default continues or recurs.

24.4 **NOTICES.** Any notices, requests, demands or other communications, except notices of changes in policies and procedures pursuant to **Section 7**, required or permitted to be given under this Agreement shall be in writing and shall be deemed to have been given: (i) on the date of personal delivery; or (ii) provided such notice, request, demand or other communication is received by the party to which it is addressed in the ordinary course of delivery: (a) on the third day following deposit in the United States mail, postage prepaid, or by certified mail, return receipt requested; (b) on the date of transmission by facsimile transmission; or (c) on the date following delivery to a nationally recognized overnight courier service, each addressed to the other party at the address set forth below their respective signatures to this Agreement, or to such other person or entity as either party shall designate by written notice to the other in accordance herewith. **Humana** may also provide such notices to **Provider** by electronic means to the e-mail address of **Provider** set forth on the Cover Sheet to this Agreement or to other e-mail addresses **Provider** provides to **Humana** by notice as set forth herein. Unless a notice specifically limits its scope, notice to any one party included in the term "**Provider**" or "**Humana**" shall constitute notice to all parties included in the respective terms.

24.5 **CONFIDENTIALITY.** **Provider** agrees that the terms of this Agreement and information regarding any dispute arising out of this Agreement are confidential, and agrees not to disclose the terms of this Agreement nor information regarding any dispute arising out of this Agreement to any third party without the express written consent of **Humana**, except pursuant to a valid court order, or when disclosure is required by a governmental agency. Notwithstanding anything to the contrary herein, the parties acknowledge and agree that **Provider** may discuss the payment methodology included herein with Members requesting such information.

24.6 **COUNTERPARTS, HEADINGS AND CONSTRUCTION.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and all of which together constitute one and the same instrument. The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. Unless the context otherwise requires, when used in this Agreement, the singular shall include the plural, the plural shall include the singular, and all nouns, pronouns and any variations thereof shall be deemed to refer to the masculine, feminine or neuter, as the identity of the person or persons may require. It is the parties' desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the provision.

24.7 **INCORPORATION OF ATTACHMENTS.** All attachments attached hereto are incorporated herein by reference.

24.8 **FORCE MAJEURE.** Neither party to this Agreement shall be deemed to breach its obligations under this Agreement if that party's failure to perform under the terms of this Agreement is due to an act of God, riot, war or natural disaster.

24.9 **ENTIRE AGREEMENT.** This Agreement, including the attachments, addenda and amendments hereto and the documents incorporated herein, constitutes the entire agreement between **Humana** and **Provider** with respect to the subject matter hereof, and it supersedes any prior or contemporaneous agreements, oral or written, between **Humana** and **Provider**.

24.10 **MODIFICATION OF AGREEMENT.** This Agreement may be amended in writing as mutually agreed upon by **Provide**r and **Humana**. In addition, **Humana** may amend this Agreement upon ninety (90) days' written notice to **Provider**. Failure of **Provider** to object in writing to such amendment during the ninety (90) day notice period shall constitute acceptance of such amendment by **Provider**.

Each party to this Agreement represents that it has full power and authority to enter into this Agreement and the person signing below on behalf of either party represents that they have been duly authorized to enter into this Agreement on behalf of the party they represent. This Agreement is effective as of the Effective Date of .

PROVIDER
AUTHORIZED SIGNATORY

Legal Entity:

Provider DBA Name:

Signature:

Printed Name:

Title:

Date:

Tax ID:

HUMANA

Signature:

Printed Name:

Title:

Date:

Address For Notice:

Provider:

Humana:

Provider :	**Copy to**:
	Humana Inc
	Attn: Law Department
	P.O. Box 1438
	Louisville, Kentucky 40201-1438

PRODUCT PARTICIPATION LIST

ATTACHMENT

Provider agrees to participate in the health benefits plan(s) selected below, whether self-funded or fully insured, that are offered or administered by **Humana**.

Health Benefits Plan	**(Check only those which apply)**
Ohio Medicaid Plans	X

HUMANA'S UTILIZATION REVIEW PROGRAM

ATTACHMENT

Humana interventions can occur throughout the continuum of care. The channels for that engagement can include telephone, on-site engagement and written communication. **Provider** agrees to participate in and cooperate with **Humana's** utilization review program that includes, but is not limited to, the following processes:

1. **Provider** agrees to verify that the Member's physician has obtained pre-authorization approval of the admission from **Humana** for all non-emergency admissions and surgical cases.

2. **Provider** agrees to notify **Humana's** admission review department of all admissions within twenty-four (24) hours of admission.

3. **Provider** agrees to notify **Humana** on a daily basis, of Members who have been discharged or transferred from **Provider**.

4. **Provider** agrees to obtain authorization from Members at time of admission for the **Provider** to release medical records to **Humana** and for **Humana's** review personnel to review the Member's medical records during hospitalization and after discharge.

5. **Provider** agrees to allow **Humana** review personnel to have access to Member's medical records and to Members to undertake concurrent review. This access can be either telephonic or on site.

6. **Provider** agrees to cooperate with **Humana's** review personnel in discharge planning for Members.

7. **Provider** agrees to make adequate space available, when needed, in the medical records department for **Humana's** review personnel to carry out review activities or cooperate with telephonic reviews. **Provider** agrees to allow **Humana** access to electronic records when that is the only way to view a medical record.

8. Upon discharge of Members, **Provider** agrees to submit a completed claim form, in the format specified in the Agreement for each Member to **Humana** with the admitting and discharge diagnosis recorded and coded.

9. **Provider** agrees to allow **Humana's** review personnel to photocopy any portion of the medical records of Members.

10. **Provider** agrees to release copies of medical records to **Humana** of Members who have been discharged from **Provider** for retrospective review and special studies.

PROVIDER LOCATIONS

ATTACHMENT

(To be provided by **Provider** prior to execution of this Agreement)

The following is a list of **Provider's** locations, including address, tax identification number, specialty services available for each service location included in this Agreement and other **Provider** personnel who will be providing services to Humana Members under this Agreement. **Provider** shall provide **Humana** with no less than sixty (60) days prior written notice of any addition, change or closing of a location. Any such addition, change or closing shall not affect the other locations and shall be subject to **Humana's** approval, which shall not be unreasonably withheld. Failure to obtain **Humana's** prior approval may result, in **Humana's** sole and complete discretion, in the termination of such location from participation under this Agreement. **Provider** will provide updates of this listing to **Humana** on a quarterly basis.

Legal Name	Facility Type	DBA	Tax ID	Physical Address	City	State	Zip code

Ohio Department of Medicaid
Humana Health Plan of Ohio, Inc.
MEDICAID ADDENDUM

This Addendum supplements the Base Contract or Agreement between Humana Health Plan of Ohio, Inc. and insert provider legal entity name effective and runs concurrently with the terms of the Base Contract or Agreement *(hereinafter referred to as "Base Contract")*. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid members.

The provider will provide services to the following eligible Medicaid consumer populations as specified in Humana Health Plan of Ohio, Inc.'s Provider Agreement or contract with the Ohio Department of Medicaid **(select all that apply):**

☒ All Medicaid Managed Care Organization (MCO) members ☐ Medicaid Managed Care Single Case Agreement
☐ All MyCare Ohio plan (MCOP) members ☐ MyCare Ohio Single Case Agreement
☐ All OhioRise Members ☐ OhioRISE Single Case Agreement
☐ All Single Pharmacy Benefit Manager (SPBM) members

The provider agrees to provide services to the managed care entity's (MCE's) member(s) within the designated services area(s) as specified below **(select all that apply)**

MCO Service Area	**SPBM Service Area**	OhioRISE Service Area
☒ Statewide	☐ Statewide	☐ Statewide
MCOP Service Areas		
☐ Central ☐West Central ☐ East Central ☐ Northeast ☐ Northwest ☐ Southwest ☐ Northeast Central		

☐ *Not applicable (out-of-state provider)*
The provider must either be currently enrolled as a Medicaid provider and meet the qualifications specified in Ohio Administrative Code (OAC) rule 5160-26-05(C) or be in the process of enrolling as an Ohio Department of Medicaid (ODM) provider. ODM administered home and community based services (HCBS) waiver provider must be currently enrolled as an ODM provider with an active status in accordance with Agency 5160 of the Ohio Administrative Code.

ADDENDUM PROVISIONS
The provisions of this Medicaid Addendum supersede any language to the contrary which may appear elsewhere in the Base Contract.

A. All providers providing health care services to Humana Health Plan of Ohio, Inc.'s Medicaid members as specified above, including
providers operating under a single case agreement, agree to abide by all of the following specific terms:

1. The provider, acting within their scope of practice, will provide all specialties as identified in their ODM enrollment or the specialties enumerated in Attachment C of this Addendum. Any Amendment to Attachment C must be agreed to by both parties.

   i. Attachment C is not required for pharmacy providers when contracting with the SPBM.

   ii. For single case agreements, Attachment C only needs to be completed if the Base Contract does not specify the service being provided.

2. The terms of the Base Contract relating to the beginning date and expiration date or automatic renewal clause, as well as the applicable methods of extension, renegotiation, and termination apply to this Addendum.

3. The Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations and contractual obligations of the Managed Care Entity (MCE).

    i. ODM will notify the MCE and the MCE shall notify the provider of any changes in applicable state or federal law, regulations, waiver, or contractual obligation of the MCE

    ii. This Addendum shall be automatically amended to conform to such changes without the necessity for executing written amendments.

    iii. The MCE shall notify the provider of all applicable contractual obligations.

4. The procedures specified in the Base contract to be employed upon the ending, nonrenewal, or termination of the Base Contract apply to this Addendum, including an agreement to promptly supply all records necessary for the settlement of outstanding medical claims.

5. The provider will serve members through the last day of the Base Contract is in effect.

6. The provider shall be compensated pursuant to the method and in the amounts specified in the Base Contract.

7. The provider and all employees of the provider are duly registered, licensed, or certified under applicable state and federal statutes and regulations to provide the health care services that are the subject of the Base Contract, and that the provider and all employees of the provider are not excluded from participating in federally funded health care programs.

8. The provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status or ancestry, discriminate against any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

9. The provider shall not in any manner discriminate against, intimidate, or retaliate against any employee hired for the performance of services under the subcontract on account of race, color, religion, gender, sexual orientation, age, disability, national origin, military status, genetic information, health status or ancestry.

10. The provider will abide by the MCE's written policies regarding the False Claims Act and the detection and prevention of fraud, waste and abuse.

11. The provider shall not discriminate in the delivery of services based on the member's race, color, religion, gender, sexual orientations, age, disability, national origin, military status, genetic information, ancestry, health status or need for health services.

12. With the exception of any member co-payments the MCE has elected to implement in accordance with OAC rule 5160-26-12, the MCE's payment constitutes payment in full for any covered service and the provider will not charge the member or ODM any co-payment, cost sharing, down-payment, or similar charge refundable or otherwise. This agreement does not prohibit nursing facilities or home and community-based waiver providers from collecting patient liability payment from members as specified in OAC rules 5160:1-6-07 and 5160:1-6-07.1, or Federally qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) from submitting claims for supplemental payment to ODM as specified in OAC Chapter 5160-28.

    i. The MCE shall notify the provider whether the MCE elected to implement any member co-payments and, if applicable, under what circumstances member co-payments are imposed in accordance with OAC rule 5160-26-12.

ii. The provider agrees that member notification regarding any applicable co-payment amounts must be carried out in accordance with OAC rule 5160-26-12.

iii. In accordance with OAC rule 5160-26-12, members who are under the age of twenty-one are excluded from co-payment obligations.

13. The provider will not to hold liable ODM or any member(s) in the event the MCE cannot or will not pay for covered services performed by the provider pursuant to the Base Contract with the exceptions that:

i. FQHCs and RHCs may be reimbursed by ODM in the event of MCE insolvency.

ii. The provider may bill the member when the MCE denied prior authorization or referral for the services and the conditions described in OAC rule 5160-1-13.1 are met.

14. The provider will not bill members for missed appointments.

15. In accordance with OAC rule 5160-26-05, the provider agrees to identify, and where indicated arrange, for the following at no cost to the member:
    i. Sign language services; and
    ii. Oral interpretation and oral translation services.

16. The provider shall be bound by the standards of confidentiality outlined in OAC rule 5160-1-32 and 45 CFR Parts 160 and 164, including standards for unauthorized uses of or disclosures of protected health information (PHI).

17. The provider will not identify the addressee as a Medicaid consumer on the outside of the envelope when contacting members by mail.

18. The provider will immediately forward any information regarding a member appeal or grievance, as defined in OAC 5160-26-08.4 or 5160-58-08.4, to the MCE for processing.

19. The provider will release to the MCE, ODM, or ODM's designee(s) any information necessary for the MCE to perform any of its obligations under the MCE's provider agreement or contract with ODM, including but not limited to, compliance with reporting and quality assurance requirements.

20. The provider will supply, upon request, the business transaction information required under 42 CFR.455.105.

21. The provider will contact the MCE's designated twenty-four-hour post-stabilization services phone line to request authorization to provide post-stabilization services in accordance with OAC rule 5160-26-03 or OAC rule 5160-59-03.

22. All of the provider's applicable facilities and records will be open to inspection by the MCE, ODM, or ODM's designee(s), or other entities as specified in OAC rule 5160-26-06.

23. The Provider agrees to comply with the provisions for record keeping and auditing in accordance with OAC Chapter 5160-26.

24. The provider will retain and allow the MCE access to all member medical records for a period of not fewer than ten years from the date of service or until any audit initiated within the ten year period is completed and allow access to all record keeping, audits, financial records, and medical records to ODM or its designee or other entities as specified in OAC rule 5160-26-06. At least three of the ten year-period of documentation must be readily available.

25. The provider will make medical records for Medicaid eligible individuals available for transfer to new providers at no cost to the individual.

B. All participating providers providing health care services to Humana Health Plan of Ohio, Inc.'s members, as specified above, not including providers operating under a single case agreement, agree to abide by all of the following specific terms:

1. Not with standing item A.2 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:
   i. The provider gives the MCE at least 60 days prior notice in writing for the non-renewal or termination of the Base Contract, or the termination of any services for which the provider is contracted. The effective date of the non-renewal or termination of the Base Contract or any contracted services must be the last day of the month; or

   ii. ODM proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10, regardless whether

the action is appealed. The provider's non-renewal or termination written notice must be received by the MCE within 15 working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, the provider must extend the non-renewal or termination date to the last day of the subsequent month.

2. The provider will cooperate with the MCE's quality assessment and performance improvement (QAPI) program in all

the MCE's provider subcontract and employment agreements for physician and non-physician providers.

3. The provider will cooperate with the ODM external quality review as required by 42 C.F.R. 438.358, and on-site audits,

as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel, and other information in OAC Chapter 5160.

C. If applicable based on the service(s) being provided to Humana Health Plan of Ohio, Inc.'s member(s), as specified above, the provider agrees to abide by the following specific terms:

1. If the provider is a primary care provider (PCP), the provider will participate in the care coordination requirements outlined in OAC rule 5160-26-03.1 or OAC rule 5160-59-03.2.

2. ☐ Notwithstanding Items B.1 and C.4 of this Addendum in the event of a hospital provider's proposed non-renewal or termination of the Base Contract, the hospital provider will notify in writing all providers who have admitting privileges at the hospital of the impending non-renewal or termination of the Base Contract and the last date the hospital will provide services to members under the Base Contract. This notice must be sent at least forty-five days prior to the effective date of the proposed non-renewal or termination. If the hospital provider issues fewer than forty-five days prior notice to the MCE, the notice to providers, who have admitting privileges at the hospital, must be sent within one working day of the hospital provider issuing notice of non-renewal or termination of the Base Contract.

3. ☐ All laboratory testing sites providing services to members must have either a current Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver, certificate of accreditation, certificate of compliance, or a certificate of registration along with a CLIA identification number.

4. ☐ If the provider is a home health provider, the provider must meet the eligible provider requirements specified in OAC Chapter 5160-12 and comply with the requirements for home care dependent adults as specified in section 121.36 of Ohio Revised Code.

5. ☐ Any third party administrator (TPA) will include all elements of OAC rule 5160-26-05(D) in its subcontracts and will ensure that its subcontracted providers will forward information to ODM as requested.

6. ☐ Institutional providers will assure discharge planning begins upon the member's admission to the facility and discharge will not occur until there is a safe discharge plan in place, including identification of and arrangement for necessary community supports.

D. Humana Health Plan of Ohio, Inc. agrees to abide by the following specific terms:

1. The MCE shall disseminate written policies including detailed information about the False Claims Act and other provisions named in 42 U.S.C. Section 1396a(a)(68), any related State laws pertaining to civil or criminal penalties, whistleblower protections under such laws, as well as the MCE's policies and procedures for detecting and preventing fraud, waste and abuse.

2. The MCE will fulfill the provider's responsibility to mail or personally deliver notice of the member's right to request a state hearing whenever the provider bills a member due to the MCEs' denial of payment of a Medicaid service as specified in OAC rule 5160-26-08.4 and 5106-58-08.4, utilizing the procedures and forms as specified in OAC Chapter 5101:6-2.

3. The MCE will not prohibit, or otherwise restrict a provider, acting within lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:

   i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

   ii. Any information the member needs in order to decide among all relevant treatment options.

   iii. The risks, benefits, and consequences of treatment versus non-treatment.

   iv. The member'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.

4. Notwithstanding item A.2 of this Addendum, and with the exception of single case agreements, the MCE must give the provider at least sixty days prior notice in writing for the nonrenewal or termination of the Base Contract except in cases where an adverse finding by a regulatory agency health or safety risks dictate that the Base Contract be terminated sooner or when the Base Contract is temporary in accordance with 42 CFR 438.602 and the provider fails to enroll as an ODM provider within 120 calendar days.

Any changes to Attachments A, and/or C may be made without renegotiation of the Base Contract or this Addendum.

MCE Name: Humana	Provider Name: ABC Company
Signature:	Signature:
Printed Name:	Printed Name:
Title:	Title:
Date:	Date:

PAYMENT ATTACHMENT – OHIO MEDICAID

Provider agrees to accept as payment-in-full from **Humana** _____ percent (XX%) of the Ohio Medicaid Fee Schedule, or **Provider's** usual and customary charges, whichever is less, for Ohio Medicaid Covered Services rendered to **Humana's** Ohio Medicaid Members, less any applicable copayment, coinsurance, or deductible due from a Member.

For purposes of this Payment Attachment, as referenced in the immediately preceding paragraph, "Ohio Medicaid Fee Schedule" shall mean any Ohio Department of Medicaid ("ODM") "payment system(s)" established and determined by ODM in effect on the date of service the Covered Services are rendered.

Ohio Medicaid Required Provisions Attachment

The following additional provisions apply specifically to **Humana's** Ohio Medicaid products and plans and are hereby incorporated by reference into the Agreement. The provisions in this this Ohio Medicaid Required Provisions Attachment ("Attachment") are required by the Ohio Department of Medicaid ("ODM") to be included in agreements between **Humana** and **Provider**. In the event of a conflict between the terms and conditions of the Agreement and this Attachment, the terms and conditions of this Attachment shall control as they apply to **Humana's** Ohio Medicaid products and plans.

1. **Provider** agrees to comply with and abide by all applicable terms and conditions of the ODM Contract as well as all applicable state and federal laws, rules, regulations, and guidelines related to the Ohio Medicaid program. This Attachment shall automatically amend to conform to such rules without the necessity for executing written amendments.

2. **Provider** agrees to submit claims to ODM, using the **Humana** specific payor code that is unique and required for claim processing of **Humana's** Medicaid claims and can be located within Manual, orientation slides and/or provider resource guide.

3. **Provider** agrees to submit all claims pursuant to the national correct coding initiative and coding standards set forth in the guides and described in 45 CFR 162.1000 and 45 CFR 162.1002:

   (1) The healthcare common procedure coding system;
   (2) The current procedure terminology codebook;
   (3) The current dental terminology codebook; or
   (4) The international classification of diseases codebook.

4. Claims shall include the **Provider's** NPI and the valid taxonomy code that most accurately describes the health care services reported on the claim. **Provider** will must submit all claims as follows:

   (1) Original claim submissions:

   (a) claims other than inpatient hospital claims must be submitted to **Humana** within three hundred sixty five (365) days of the actual date the service was provided.
   (b) inpatient hospital claims must be received within three hundred sixty-five (365) days from the date of discharge.
   (c) claims received beyond three hundred sixty-five (365) days from the actual date of service or hospital discharge will be denied, see article 4 below, for the exception to this rule.
   (d) for purposes of this Agreement, the date of receipt is the date **Humana** receives the claim within its claim system.
   (e) claims with prior payment by Medicare or another insurance plan must be received within one hundred eighty (180) days from the date Medicare or the other insurance plan paid the claim.

5. **Provider** agrees to the following exceptions to timely filing requirements:

   (1) When submission of a claim is delayed due to the pendency of an administrative hearing decision by the Ohio department of job and family services (ODJFS) or an eligibility determination by a county department of job and family services (CDJFS), the claim must be received within one hundred eighty (180) days from the date of the administrative hearing decision by ODJFS or the eligibility determination by the CDJFS. Documentation showing the date of service and the administrative hearing decision or eligibility determination must be submitted with the claim. In no case shall a delay in processing eligibility information at the CDJFS (as required in rule 5101:1-38-01.2 of the Administrative Code) be a basis for denial of payment under this provision.

   (2) When a claim cannot be submitted to **ODM** within three hundred sixty-five (365) days of the actual date of service due to coordination of benefits delays with Medicare and/or other third party

payers, the claim must be received by **ODM** within one hundred eighty days from the date Medicare or the other insurance plan paid the claim.

(3) When a claim has been submitted and denied and is later found to meet the provisions in paragraph (E) (1) or (E)(2) of this rule, the claim may be resubmitted with documentation attached to support the delay in submission.

6. **Provider** shall submit any request for underpaid claims within one hundred eighty days (180) from the date **Humana** paid the claim.

7. In accordance with 42 CFR 438.608, **Provider** must report to **Humana** when it has received an overpayment, to return the overpayment to **Humana** within sixty (60) calendar days after the date on which the overpayment was identified, and to notify **Humana** in writing of the reason for the overpayment.

8. **Provider** agrees that **Humana** retains the right to recover any overpayments it identified arising out of provider fraud, waste, or abuse, as defined by OAC rule 5160-26-01, and per the terms of **Humana's** MCO Contract with ODM.

9. **Provider** agrees that a claim dispute is any **Provider** inquiry, complaint, or request for reconsideration ranging from general questions about a claim to disagreeing with a claim denial. While these disputes can come in through any avenue (e.g., provider call center, provider advocates, **Humana's** provider portal), they do not include inquiries that come through ODM's Provider Web portal (HealthTrack). **Provider** claims disputes do not include **Provider** disagreements with **Humana's** decision to deny, limit, reduce, suspend, or terminate a covered service for lack of medical necessity that are subject to external medical review.

10. **Provider** agrees to abide by **Humana's Provider** claim dispute resolution process to dispute adverse claims payment decisions made by **Humana**.

11. **Provider** shall file a written claim dispute no later than twelve (12) months from the date of service or sixty (60) calendar days after the payment, denial, or partial denial of a timely claim submission, whichever is later; or verbally and in writing, including through the provider portal.

12. **Humana** will:

a) convert a verbal dispute to writing and include a tracking number for **Provider**;
b) notify **Provider** (verbally or in writing) that the dispute has been received within five (5) business days of receipt of a dispute;
c) thoroughly investigate each provider claim dispute using applicable statutory, regulatory, and contractual provisions, collecting all pertinent facts from all parties and applying the **Humana's** written policies and procedures;
d) resolve and provide written notice to **Provider** of the disposition of all claim disputes within fifteen (15) business days of receipt of the dispute. Written notice is not required if the claim dispute was resolved with an initial phone call or in-person contact. When required, the written notice must include:

i) the nature of the dispute;
ii) the claim dispute tracking number;
iii) a summary of the pertinent facts and claim detail for claim related disputes;
iv) the specific statutory, regulatory, contractual, or policy references that support the resolution; and
v) next steps if **Provider** disagrees with the resolution.
vi) In the event additional time to resolve a dispute is needed past fifteen (15) business days then **Humana** must provide a status update to **Provider** every five (5) business days beginning on the15th business day until the dispute is resolved;
vi) reprocess and pay disputed claims, when the resolution determines they were paid/denied incorrectly, within thirty (30) calendar days of the written notice of the resolution unless a system fix is needed then additional time is allotted; and automatically apply the corrective action or claims resolution to correctly adjudicate all other provider claims affected by the same issue.

13. If there is any conflict between the Agreement and ORC 5160.34, the latter shall govern.

14. **Provider** agrees that beginning July 1, 2022, all credentialing responsibilities for **Humana's** Ohio Medicaid plan(s) will be the responsibility of ODM or ODM's designee.

15. If **Provider** is a hospital, **Provider** shall provide admission, discharge, and transfer (ADT) data to both health Information exchanges.

16. In order to update **Provider** information, **Provider** shall report to **Humana** and ODM alternative service locations.