PROVIDER AGREEMENT

AETNA BETTER HEALTH ADMINISTRATORS, LLC, on behalf of itself and its Affiliates ("Company"), and _____, on behalf of itself and any and all of its Group Providers and locations ("Provider"), are entering into this Provider Agreement (the "Agreement") as of the Effective Date listed below.

The Agreement includes this cover/signature page and the **General Terms and Conditions** and **Definitions** that follow, and the **Medicaid Product Addendum**. It also includes and incorporates one or more of the following parts: **Service and Rate Schedule(s)**, **State Compliance Addendum(a)**, other **Product Addendum(a)**, or other attachments or addenda.

PRODUCT CATEGORIES:
As of the Effective Date, Provider agrees to participate in each Product Category checked below. Important information on how Product Categories can be added to or deleted from this list is contained in the Agreement.

✓ **Medicaid Products (as defined in the Agreement)**

EFFECTIVE DATE: [DATE] (or later date that credentialing is complete) (the "Effective Date")

TERM: This Agreement begins on the Effective Date, continues for an initial term of one (1) year, and then automatically renews for consecutive one (1) year terms. The Agreement may be terminated by either Party at any time after the initial term or non-renewed at the end of the initial or any subsequent term, for any reason or no reason at all, with at least one hundred and twenty (120) days' advance written notice to the other Party. Additional termination provisions are included in the Agreement.

The undersigned representative of Provider has read and understood this Agreement, has had the opportunity to review it with an attorney of Provider's choice, and is authorized to bind Provider, including all Group Providers and Provider locations, to the terms of the Agreement.

PROVIDER	**COMPANY**
By:_____	**By:**_____
Printed Name:_____	**Printed Name:**_____
Title:_____	**Title:**_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

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

Provider:	**Company:**
_____	**Aetna Medicaid Administrators LLC**
_____	**c/o Aetna Inc.**
_____	**4500 E Cotton Center Blvd**
_____	**Phoenix, AZ 85040**
	ATTN: Ld Director, Network Management

GENERAL TERMS AND CONDITIONS

1.0 PROVIDER OBLIGATIONS

1.1 **General Obligations**. Provider agrees that it and all Group Providers will:

(a) provide Covered Services to Members according to generally accepted standards of care in the applicable geographic area and within the scope of its/their licenses and authorizations to practice;

(b) obtain and maintain all applicable license(s), certification(s), registration(s), authorization(s) and accreditation(s) required by Applicable Law;

(c) comply with all Applicable Law related to this Agreement and the provision of and payment for health care services; Provider represents that neither it nor any Group Provider has been excluded from participation in any Federal or state funded health program, or has a report filed in the National Practitioner Data Bank (NPDB);

(d) comply with Company's credentialing/recredentialing requirements and applicable Participation Criteria; Provider understands that no Group Provider may serve as a Participating Provider until that provider is fully credentialed and approved by the applicable peer review committee;

(e) require all Group Providers in all Provider locations, to provide Covered Services to Members in compliance with the terms of this Agreement; any exceptions must be approved in advance, in writing, by Company;

(f) obtain from Members any necessary consents or authorizations to the release of their medical information and records to governmental entities, Company and Payers, and their agents and representatives;

(g) obtain signed assignments of benefits from all Members authorizing payment for Provider's services to be made directly to Provider instead of to the Member, unless Company specifically directs otherwise or the applicable Plan requires otherwise;

(h) treat all Members with the same degree of care and skill as they treat patients who are not Members; Provider further agrees not to discriminate against Members in violation of Applicable Law or Company Policies;

(i) maintain an ongoing internal quality assurance/assessment program that includes, but is not limited to, the credentialing, supervision, monitoring and oversight of its employees and contractors providing services under this Agreement;

(j) cooperate promptly, during and after the term of this Agreement, with reasonable and lawful requests from Company and Payers for information and records related to this Agreement, as well as with all requests from governmental and/or accreditation agencies. Among other things, Provider agrees to provide Company and Payers with the information and records necessary for them to properly administer claims and the applicable Plan; resolve Member grievances, complaints and appeals; comply with reporting requirements related to the Affordable Care Act (ACA) (including, but not limited to, information related to the ACA's medical loss ratio requirements); perform quality management activities; and fulfill data collection and reporting requirements (e.g., HEDIS);

(k) not provide or accept any kickbacks or payments based on the number or value of referrals in violation of Applicable Law. Unless disclosed in advance to Company and the affected Member, Provider will not accept any referral from persons or entities that have a financial interest in Provider, or make any referrals to persons or entities in which Provider has a financial interest;

(l) refer Members only to other Participating Providers (including, but not limited to pharmaceutical providers and vendors), unless specifically authorized otherwise by Company and/or permitted by the applicable Plan and Company Policies;

(m) unless prohibited by Applicable Law or a violation of a specific peer review privilege, notify Company promptly about any: (i) material litigation brought against Provider or a Group Provider that is related to the provision of health care services to Members and/or that could reasonably have a material impact on the services that Provider renders to Members; (ii) claims against Provider or a Group Provider by governmental agencies including, but not limited to, any claims regarding fraud, abuse, self-referral, false claims, or kickbacks; (iii) change in the ownership or management of Provider; and (iv) material change in services provided by Provider or any loss, suspension or restriction of licensure, accreditation, registration or certification status of Provider or a Group Provider related to those services.

1.2 **Provider and Group Provider Contact and Service Information**. Provider agrees that it has provided Company with contact information, including, but not limited to, a list of Group Providers and Provider locations, that is complete and accurate as of the Effective Date. Provider will notify Company within ten (10) business days of all changes to the list of Group Providers, the services it/they provide and all contact and billing information for Provider and Group Providers. Provider understands that failure to keep all such information current and to periodically confirm its accuracy as reasonably requested by Company, will be a material breach of this Agreement. Company's additional requirements for updating information and the actions it may take if Provider fails to confirm its information are outlined in the Provider Manual and/or related Policies made available to Provider.

1.3 **Compliance with Company Policies**. Provider agrees to comply with Company Policies, including, but not limited, those contained in the Provider Manual, as modified by Company from time to time. If a change in a Company Policy would materially and adversely affect Provider's administration or rates under this Agreement, Company will send Provider at least ninety (90) days advance written notice of the Policy change. Provider understands that Policy changes will automatically take effect on the date specified, unless an earlier date is required by Applicable Law. Provider is encouraged to contact Company to discuss any questions or concerns with Company Policies or Policy changes.

1.4 **Claims Submission and Payment**. Subject to Applicable Law, Provider agrees:

(a) to accept the rates contained in the applicable Service and Rate Schedule(s), regardless of where services are provided, as payment in full for Covered Services (including for services that would be Covered Services but for the Member's exhaustion of benefits (e.g., above the annual maximum));

(b) that it is responsible for and will promptly pay all Group Providers for services rendered, and that it will require all Group Providers to look solely to Provider for payment;

(c) to submit complete, clean, electronic claims for Covered Services provided by Provider and Group Providers, containing all information needed to process the claims, within one hundred and twenty (120) days of the date of service or discharge, as applicable, or from the date of receipt of the primary payer's explanation of benefits if Company or Payer is the secondary payer. This requirement will be waived if Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside of Provider's control that resulted in a delayed submission;

(d) to respond within forty-five (45) days to Company or Payer requests for additional information regarding submitted claims;

(e) to notify Company of any underpayment or payment/claim denial dispute within one hundred and eighty (180) days from date of payment and to follow Company's dispute and appeal Policies for resolution;

(f) to notify Company promptly after becoming aware of any overpayment (e.g., a duplicate payment or payment for services rendered to a patient who was not a Member) and to cooperate with Company for the prompt return of any overpayment. In the event of Provider's failure to cooperate with this section, Company shall have the right to offset any overpaid amount against future claims;

(g) that Company and Payers will not be obligated to pay for claims not submitted, completed or disputed/appealed as required above, or that are billed in violation of Applicable Law, this Agreement or Company Policies, and that Members may not be billed for any such claims;

(h) in the event that Provider acquires or takes operational responsibility for another Participating Provider, the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider for the longer of: (i) one (1) year; or (ii) the expiration of the then current term of such agreement. Notwithstanding the foregoing, Company may notify Provider with at least sixty (60) days' prior written notice that the terms of this Agreement shall sooner apply to such Participating Provider.

1.5 **Member Billing**. Provider agrees that Members will not be billed or charged any amount for Covered Services, except for applicable copayments, coinsurance and deductible amounts. If services are not reimbursed because of Provider's failure to comply with its obligations under this Agreement (e.g., for late submission of claims), Members may not be billed for those services. A Member may be billed for services that are not Covered Services under the Member's Plan (including for services that are not considered "medically necessary" under a Plan) as long as the Member is informed that those services are not covered and has agreed, in advance, to pay for the services. This section will survive the termination of this Agreement.

2.0 COMPANY OBLIGATIONS

2.1 **General Obligations**. Company agrees that:

(a) unless an exception is stated in the applicable **Product Addendum** (e.g., no ID cards for Workers' Compensation Plans), Company or Payers will: (i) provide Members with a means to identify themselves to Provider; (ii) provide Provider with an explanation of provider payments, a general description of products and a listing of Participating Providers; (iii) provide Provider with a means to check Member eligibility; and (iv) include Provider in the Participating Provider directory(ies) for the applicable Plans;

(b) it, through its applicable Affiliate(s), will be appropriately licensed, where required, to offer, issue and/or administer Plans in the service areas covered by this Agreement;

(c) it is, and will remain throughout the term of this Agreement, in material compliance with Applicable Law related to its performance of its obligations under this Agreement;

(d) it will notify Provider of periodic updates to its Policies as required by this Agreement and make current Policies available to Providers through its provider websites or other commonly accepted media.

2.2 **Claims Payment**. Subject to Applicable Law, the terms of each applicable **Product Addendum(a) and Service and Rate Schedule(s)**, and Company's payment and review Policies (e.g., prepayment review of certain claims), and except for applicable Member copayments, coinsurance and deductibles, Company agrees:

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

(b) when it is not the Payer, to notify the Payer to forward payment to Provider for Covered Services,

within forty-five (45) days of receipt of a clean, complete, undisputed electronic claim. While Company may service or process payment for claims on behalf of Payers who are not Affiliates (e.g., self-funded plan sponsors), Provider acknowledges that Company has no legal or other responsibility for the payment of those claims. However, Company will use commercially reasonable efforts to assist Provider, as appropriate, in collecting payments from Payers.

3.0 NETWORK PARTICIPATION

Provider agrees that it and Group Providers will participate in the Product Categories checked on the signature sheet to this Agreement. Company has the right, upon ninety (90) days written notice to Provider, to:

(a) add Product Categories (e.g., Medicare or a new Product Category not existing as of the Effective Date); and

(b) add types of Plans (e.g., PPO, HMO) and/or specialty programs (e.g., disease management or women's health) in any Product Category.

Company will notify Provider of the rates that will apply for any addition and will, as necessary, send Provider a new or revised **Product Addendum** and **Service and Rate Schedule**.

Provider can decline any addition by notifying Company in writing, within thirty (30) days of receiving Company's notice. A variation of an existing Product Category, Plan type or specialty program at existing terms and rates will not be considered "an addition" under this section.

Company is not required to designate, include, or continue to include Provider, any specific Group Provider(s) or any specific Provider location(s) as a preferred provider or Participating Provider in any specific Product Category, Plan (or Plan variation), product, specialty program or geographic area. Company may operate networks in which Provider is not included, whether for specific Payers/customers or otherwise. In certain situations, Provider may treat a Member of a Plan or Product Category in which Provider does not participate (e.g., a Member traveling out of area, emergency services). In those situations, Company may apply rates and terms (e.g., no balance billing) that Provider has accepted under this Agreement for Covered Services provided to those Members. Not all Product Categories and Plan types are available in all geographic locations.

4.0 CONFIDENTIALITY

Company and Provider agree that Provider's medical records do not belong to Company. Company and Provider agree that the information contained in the claims Provider submits under this Agreement belongs to Company and/or the applicable Payer and may be used by Company and/or the applicable Payer for quality management, plan administration and other lawful purposes. Each Party will maintain and use confidential Member information and records in accordance with Applicable Law. Each Party agrees that the confidential and proprietary information of the other Party is the exclusive property of that other Party and, unless publicly available, each Party agrees to keep the confidential and proprietary information of the other Party strictly confidential and not to disclose it to any third party without the other Party's consent, except: (a) to governmental authorities having jurisdiction; (b) in the case of Company's disclosure, to Members, Payers, prospective or current customers, or consultants or vendors under contract with Company; and (c) in the case of Provider's/Group Providers' disclosure, to Members for the purpose of advising a Member of potential treatment options and costs. Except as otherwise required by Applicable Law, Provider will keep the rates and the development of rates and other terms of this Agreement confidential. However, Provider is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider and Group Providers are encouraged to communicate with patients about their treatment options, regardless of benefit coverage limitations. This section will survive the termination of this Agreement.

5.0 ADDITIONAL TERMINATION/SUSPENSION RIGHTS AND OBLIGATIONS

5.1 **Termination of Individual Group Providers**. Company may terminate the participation of one or more individual Group Providers or locations by providing Group with at least ninety (90) days written notice prior to the date of termination.

5.2 **Termination for Breach**. This Agreement may be terminated at any time by either Party upon at least sixty (60) days prior written notice of such termination to the other Party, upon such other Party's material breach of its obligations under this Agreement, unless such material breach is cured within sixty (60) days of the notice of termination.

5.3 **Immediate Termination or Suspension**. Company may terminate or suspend this Agreement with respect to Provider or any Group Provider or location, with written notice to Provider, due to: (a) Provider's or the applicable Group

Provider's failure to continue to meet the licensure and other requirements of the applicable Participation Criteria; (b) bankruptcy or receivership or an assignment by Provider for the benefit of creditors; (c) Provider's or the applicable Group Provider's indictment, arrest or conviction of a felony; or for any indictment, arrest or conviction of criminal charge related to fraud or in any way impairing Provider's or a Group Provider's practice of medicine; (d) the exclusion, debarment or suspension of Provider or a Group Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (e) change of control of Provider to an entity not acceptable to Company; (f) any false statement or material omission of Provider or a Group Provider in a network participation application and/or related materials; or (g) a determination by Company that Provider's continued participation in provider networks could reasonably result in harm to Members. To protect the interests of patients, including Members, Provider will provide immediate notice to Company of any of the events described in (a)-(f) above. Provider may terminate this Agreement, with written notice to Company due to: (x) Company's failure to continue to maintain the licensure and authorizations required for it to meet its obligations under this Agreement; or (y) Company's bankruptcy or receivership, or an assignment by Company for the benefit of creditors.

5.4 **Obligations Following Termination**. Upon termination of this Agreement for any reason, Provider agrees to provide services, at Company's discretion, to: (a) any Member under Provider's care who, at the time of the effective date of termination, is a registered bed patient at a hospital or facility, until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) in any other situation required by Applicable Law. The applicable **Service and Rate Schedule** will apply to all services provided under this section. Upon notice of termination of this Agreement or of participation in a Plan, Provider will cooperate with Company to transfer Members to other providers. Company may provide advance notice of the termination to Members.

5.5 **Obligations During Dispute Resolution Procedures**. In the event of any dispute between the Parties in which a party has provided notice of termination for breach under Section 5.2 above, and the dispute is required to be resolved or is submitted for resolution under Section 7.0 below, the termination of this Agreement shall cease and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

6.0 RELATIONSHIP OF THE PARTIES

6.1 **Independent Contractor Status/Indemnification**. Company and Provider are independent contractors, and not employees, agents or representatives of each other. Company and Provider will each be solely liable for its own activities and those of its employees and agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and/or Group Providers and that Policies do not dictate or control Provider's and/or Group Providers' clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless Company from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of Provider's and/or Group Providers' provision of care to Members. Company agrees to indemnify and hold harmless Provider and Group Providers from any and all third party claims, liabilities and causes of action (including, but not limited to, reasonable attorneys' fees) arising out of the Company's administration of Plans. This provision will survive the termination of this Agreement.

6.2 **Use of Name**. Provider agrees that its name and other identifying and descriptive material can be used in provider directories and in other materials and marketing literature of Company and Payers, including, but not limited to, in customer bids, requests for proposals, state license applications and/or other submissions. Provider will not use Company's or its Affiliates' or a Payer's names, logos, trademarks or service marks without Company's and/or the applicable Payer's prior written consent.

6.3 **Interference with Contractual Relations**. Provider will not engage in activities that would cause Company to lose existing or potential Members, including but not limited to, advising Company customers, Payers or other entities currently under contract with Company to cancel, or not renew their contracts. Except as required under this Agreement

or by a governmental authority or court of competent jurisdiction, Provider will not use or disclose to any third party, membership lists acquired during the term of this Agreement including, but not limited to, for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this section is intended or will be deemed to restrict: (a) any communication between Provider and a Member, or a party designated by a Member, that is determined by Provider to be necessary or appropriate for the diagnosis and care of the Member; or (b) notification of participation status with other insurers or plans. This section will survive the termination of this Agreement for a period of one (1) year following termination or expiration.

7.0 DISPUTE RESOLUTION

7.1 **Dispute Resolution**. Company will provide an internal mechanism under which Provider can raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider will exhaust Company's internal mechanism before instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held during this process will be treated as settlement negotiations and will be inadmissible into evidence in any court proceeding, except to prove the existence of a binding settlement agreement.

7.2 **Arbitration**. Any controversy or claim arising out of or relating to this Agreement, including breach, termination, or validity of the Agreement, except for injunctive relief or any other form of equitable relief, will be settled by confidential, binding arbitration, in accordance with the Commercial Rules of the American Arbitration Association (AAA). **COMPANY AND PROVIDER UNDERSTAND AND AGREE THAT, BY AGREEING TO THIS ARBITRATION PROVISION, EACH MAY BRING CLAIMS AGAINST THE OTHER ONLY IN THEIR INDIVIDUAL CAPACITY, AND NOT AS A PLAINTIFF OR CLASS MEMBER IN ANY PURPORTED CLASS OR REPRESENTATIVE PROCEEDING FOR ANY DISPUTE ARISING OUT OF OR RELATING TO THIS AGREEMENT.** The arbitrator may award only compensatory damages for breach of contract, and is not empowered to award punitive, exemplary or extra-contractual damages. Where a Party's claim is for greater than Ten Million Dollars ($10,000,000), a panel of three (3) arbitrators (one chosen by each Party and the third to be a former Federal district court judge agreed upon by the Parties) will preside over the matter, unless the Parties agree otherwise. If a Party's claim is for less than Ten Million Dollars ($10,000,000), a single (1) arbitrator will preside over the matter, unless the Parties agree otherwise. The arbitrator(s) are bound by the terms of this arbitration provision. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the award to a second arbitrator (the "Appeal Arbitrator"), designated in the same manner as the original, except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of dispute resolution discussions or an arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to dispute resolution discussions or arbitration, or reflecting the existence, content, record, status, or results of dispute resolution discussions or arbitration is confidential. The Parties are entitled to take discovery consistent with the Federal Rules of Civil Procedure (including, but not limited to, document requests, expert witness reports, interrogatories, requests for admission and depositions). This section will survive the termination of this Agreement.

8.0 MISCELLANEOUS

8.1 **Entire Agreement**. This Agreement and any addenda, schedules, exhibits or appendices to it constitutes the entire understanding of the Parties and supersedes any prior agreements related to the subject matter of this Agreement. If there is a conflict between the **General Terms and Conditions** and a **Product Addendum** or **Service and Rate Schedule**, the terms of the applicable **Product Addendum** and corresponding **Service and Rate Schedule** will prevail for that Product Category. If there is a conflict between an applicable **State Compliance Addendum (the most current**

version, which may be contained in the Provider Manual) and any other part of the Agreement, the terms of the **State Compliance Addendum** will prevail, but only with respect to the particular line of business (e.g., fully insured HMO) or Product Category.

8.2 **Waiver/Governing Law/Severability/No Third Party Beneficiaries/Headings**. The waiver by either Party of a breach or violation of any provision of this Agreement will not operate as or be construed to be a waiver of any subsequent breach of this Agreement. Except as otherwise required by Applicable Law, this Agreement will be governed in all respects by the laws of the state where Provider is located, without regard to such state's choice of law provisions. Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance will not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Other than as expressly set forth in this Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, but not limited to, Members. Headings in the Agreement are for convenience only and do not affect the meaning of the Agreement.

8.3 **Limitation of Liability**. A Party's liability, if any, for damages to the other Party related to this Agreement, will be limited to the damaged Party's actual damages. Neither Party will be liable to the other for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind. This section will survive the termination of this Agreement.

8.4 **Assignment**. Provider may not assign this Agreement without Company's prior written consent. Company may assign this Agreement, in whole or in part, from time to time. To support a partial assignment, Company may duplicate this Agreement, including one or more of the relevant **Product Addenda** and **Service and Rate Schedules**, and assign the duplicate while retaining all or part of the original. If Company sells all or a portion of a Product Category in which Provider participates (e.g., a line of business), Company may also create and assign to the purchaser a duplicate of this Agreement including the relevant **Product Addenda** and **Service and Rate Schedules**. If Company assigns this Agreement to any entity other than an Affiliate, Company will provide advance written notice to Provider.

8.5 **Amendments**. This Agreement will be deemed to be automatically amended to conform with all Applicable Law promulgated at any time by any state or Federal regulatory agency or governmental authority. Additionally, Company may amend this Agreement, upon at least ninety (90) days prior written notice to Provider. If Provider is not willing to accept an Amendment that is not required by Applicable Law, it may terminate the Agreement, with at least sixty (60) days written notice to Company in advance of the effective date of the Amendment.

8.6 **Notices**. Notices required to terminate or non-renew the Agreement or to decline participation in a new Product Category or Plan/program, must be sent by U.S. mail or nationally recognized courier, return receipt requested, to the applicable Party's most currently updated address. Any other notices required under this Agreement may be sent by letter, electronic mail or other generally accepted media, to the applicable Party's last updated address.

8.7 **Non-Exclusivity**. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose.

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DEFINITIONS

Affiliate. Any corporation, partnership or other legal entity that is directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company. Plans may be offered by separate Company Affiliates and each of those Affiliates is considered to be a Party to this Agreement.

Applicable Law. All applicable Federal and state laws, regulations and governmental directives related to this Agreement, as well as, with respect to Provider, applicable accreditation agency/organization requirements.

Covered Services. Those health care and related services for which a Member is entitled to receive coverage or program benefits under a Plan.

Group Provider. A health care provider: (a) employed by Provider; or (b) who, through a contract or arrangement with Provider, provides services to Members for which Provider is reimbursed under this Agreement or who otherwise bills for services under this Agreement, whether on a regular or on call basis. Group Provider includes all of the persons and entities that provide services to Members in any of Provider's practice arrangements or locations and under any of its tax identification numbers, unless specifically excluded, as explained in the Agreement.

Member. A person covered by or enrolled in a Plan. Member includes the subscriber and any of the subscriber's eligible dependents.

Participating Provider. A health care provider that participates in Company's participating provider network(s) for the applicable Plan.

Participation Criteria. The participation criteria (e.g., office standards, DEA requirements, etc.) that apply to various types of Participating Providers under Company Policies.

Party. Company or Provider, as applicable.

Payer. A person or entity that is authorized to access one or more networks of Participating Providers and that: (a) is financially responsible for funding or underwriting payments for benefits provided under a Plan; or (b) is not financially responsible to fund or underwrite benefits, but which contracts directly or indirectly with persons or entities that are financially responsible to pay for Covered Services provided to Members. Payers include, but are not limited to, Company, insurers, self-funded employers, third party administrators, labor unions, trusts, and associations.

Plan. A health care benefits plan or program for which Provider serves as a Participating Provider; the terms of each specific Plan are outlined in the applicable summary plan description, certificate of coverage, evidence of coverage, or other coverage or program document.

Policies. Company's policies and procedures that relate to this Agreement, including, but not limited to, Participation Criteria; Provider Manuals; clinical policy bulletins; credentialing/recredentialing, utilization management, quality management, audit, coordination of benefits, complaint and appeals, and other policies and procedures (as modified from time to time), that are made available to Provider electronically or through other commonly accepted media. Policies may vary by Affiliate, Product Category and/or Plan.

Product Category. A category of health benefit plans or products (e.g., Commercial Health, Medicare, Workers' Compensation) in which Provider participates under this Agreement, as more fully described on the applicable **Product Addendum(a)**.

Provider Manual. Company's handbook(s), manual(s) and guide(s) applicable to various types of Participating Providers and Product Categories.

MEDICAID PRODUCT ADDENDUM

For purposes of the Agreement and this Medicaid Product Addendum (this "Addendum"), the capitalized terms "Plan(s)" and "Product Category(ies)" shall each include "Medicaid Products", as defined in the **Service and Rate Schedule (Medicaid Products)**.

1. **Definitions**.

   a. Government Sponsor(s). A state agency or other governmental entity authorized to offer, issue, and/or administer a Medicaid Product, and which, to the extent applicable, has contracted with Company to operate and/or administer all or a portion of such Medicaid Product.

   b. State Contract(s). Company's contract(s) with Government Sponsor(s) to operate and/or administer one or more Medicaid Products.

2. **Payment for Covered Services**. The compensation set forth in the **Service and Rate Schedule (Medicaid Products)** shall *only* apply to services that Provider renders to Members covered under the Medicaid Products set forth therein. Provider acknowledges and agrees that if an Affiliate of Company is the Payer for a particular Medicaid Product, such Affiliate's duties, obligations, and liabilities under the Agreement shall be strictly limited to the services Provider renders to Members covered under that Medicaid Product.

3. **Overpayments to Provider**. If Provider identifies an overpayment that it received relating to any Medicaid Product, Provider shall comply with Section 6402(a) of the Patient Protection and Affordable Care Act (currently codified at 42 U.S.C. § 1320a-7k(d)) and its implementing regulations. In addition to Company's other overpayment-recovery rights, Company shall have the right to recover from Provider any payment that corresponds to services previously rendered to an individual whom Company later determines, based on information that was unavailable to Company at the time the service was rendered or authorization was provided, to have been ineligible for coverage under a Medicaid Product when Provider rendered such service.

4. **Medicaid Product/State Contract Requirements**. Because Company is a party to one or more State Contracts, Provider must comply with Applicable Law, with certain provisions of the State Contracts, and with certain other requirements that are uniquely applicable to the Medicaid Products. Some, but not all, of these provisions and requirements are set forth in the **State Compliance Addendum (Medicaid Products)** and/or the Provider Manual for the Medicaid Products, both of which are incorporated herein and binding on the Parties. Provider agrees that all provisions of this Addendum shall apply equally to any employees, independent contractors, and subcontractors that Provider engages in connection with the Medicaid Products, and Provider shall cause such employees, independent contractors, and subcontractors to comply with this Addendum, the State Contract(s), and Applicable Law. Any subcontract or delegation that Provider seeks to implement in connection with the Medicaid Products shall be subject to prior written approval by Company, shall be consistent with this Addendum, the State Contract(s), and Applicable Law, and may be revoked by Company or a Government Sponsor if the performance of the subcontractor or delegated person or entity is unsatisfactory. Provider acknowledges that the compensation it receives under this Addendum constitutes the receipt of federal funds.

5. **The Federal 21st Century Cures Act ("Cures Act")**. Provider acknowledges and agrees that because it furnishes items and services to, or orders, prescribes, refers, or certifies eligibility for services for, individuals who are eligible for Medicaid and who are enrolled with Company under a Medicaid Product, Provider shall maintain enrollment, in accordance with Section 5005 of the Cures Act, with the Medicaid program of the Government Sponsor of that Medicaid Product. If Provider fails to enroll in, is not accepted to, or is disenrolled or terminated from the Medicaid program of that Government Sponsor, Provider shall be terminated as a Participating Provider for that Medicaid Product.

6. **Government Approvals**. One or more Government Sponsors or other governmental authorities may recommend or require that the Parties enter into the Agreement, including this Addendum, prior to execution of a State Contract and/or prior to issuance to Company of one or more government approvals, consents, licenses, permissions, bid awards, or other authorizations (collectively, the "Government Approvals"). Provider acknowledges and agrees that all Company obligations to perform, and all rights of Provider, under the Agreement as it relates to the Medicaid Products are conditioned upon the receipt of all Government Approvals. The failure or inability of Company to obtain any Government

Approvals shall impose no liability on Company under the Agreement as it relates to the Medicaid Products. Furthermore, the Parties understand and agree that if this Agreement is executed prior to execution of a State Contract and/or prior to issuance to Company of Government Approvals, the **State Compliance Addendum (Medicaid Products)** may need to be added to this Agreement after execution. After issuance of the State Contract and/or Government Approvals, Company may, in its discretion: (a) unilaterally amend the Agreement to add the **State Compliance Addendum (Medicaid Products)**; and/or (b) incorporate the **State Compliance Addendum (Medicaid Products)** into the Provider Manual.

7. **Immediate Termination or Suspension Due to Termination of State Contract**. This Agreement and/or Addendum may be terminated or suspended by Company, upon notice to Provider and at Company's discretion, without liability to Company, if a State Contract expires or is suspended, withdrawn, or terminated.

8. **Termination of Medicaid Products**. Company may exercise its for cause and immediate termination rights in the Agreement as to, and may terminate without cause with ninety (90) days prior written notice, one or more specific Medicaid Products, in which case the Agreement between Company and Provider with respect to all other Medicaid Products shall remain in full force and effect. Company may exercise its termination rights under the Agreement with respect to this Addendum. In the event this Addendum is terminated for any reason, such termination shall not in and of itself constitute termination of any of Company's other products, plans or programs.

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SERVICE AND RATE SCHEDULE

(Medicaid Products)

1.0 PRODUCT / NETWORK PARTICIPATION

Provider shall be a Participating Provider in the network(s) of the following (all together, the "Medicaid Product(s)"):

A. The Medicaid and/or CHIP Plans and/or any other publicly funded or subsidized managed care programs for low-income, uninsured, underinsured or otherwise qualified individuals offered by Company within the State.

B. The fully integrated Medicare-Medicaid Plans (a/k/a MMPs) offered by Company within the State.

C. Any other Medicaid Products included in the **State Compliance Addendum (Medicaid Products)** incorporated into this Agreement.

2.0 SERVICES & COMPENSATION

Company, or the applicable Affiliate that is the Payer responsible for a particular Medicaid Product, shall compensate Provider for the Covered Services that Provider renders to Members covered under that Medicaid Product, and shall do so on a timely basis, consistent with the claims-payment procedure described in 42 U.S.C. § 1396a(a)(37)(A) and subject to the terms of the Agreement, according to the following rates *or* Provider's actual billed charges, whichever is less:

Medicaid and/or CHIP Plans:	Aetna Medicaid Market Fee Schedule
Medicare-Medicaid Plans:	Aetna Medicare-Medicaid Plan Market Fee Schedule

3.0 DEFINITIONS AND OTHER TERMS AND CONDITIONS

A. Aetna Medicaid Market Fee Schedule (AMMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable State Medicaid Fee Schedule.

B. Aetna Medicare-Medicaid Plan Market Fee Schedule (AMMPMFS) is defined as a fee schedule that is based upon the contracted location where service is performed and the applicable Medicare Allowable Payment (Inpatient Services), Medicare Allowable Payment (Outpatient Services), Dialysis Services Payment, Home Health Care Services Payment, or Medicare Physician Fee Schedule (as applicable).

C. Medicare Allowable Payment (Inpatient Services) is defined as the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Administrative Contractor (MAC) would make to the hospital, less (with respect to DRG-based payments) the payments for Operating Indirect Medical Education (IME), Direct Graduate Medical Education (DGME) and adjustments due to Company payment and processing guidelines. The current Medicare Allowable payment is final and is exclusive of cost settlements, reconciliations, or any other retroactive adjustments as completed by a MAC for both overpayments and underpayments.

D. Medicare Allowable Payment (Outpatient Services) is defined as the current payment that Provider will receive from Company for outpatient services or procedures, pursuant to the Outpatient Prospective Payment System (OPPS), where applicable payment for these services is geographically adjusted using the provider-specific wage index. The Medicare Allowable Payment (Outpatient Services) is subject to Company's payment and processing guidelines and is final and will not be impacted by cost settlements, reconciliations, or any other retroactive adjustments performed by a Medicare Administrative Contractor (MAC) for both overpayments and underpayments. Pursuant to CMS rules, specific revenue codes are packaged when billed without HCPCS codes. Payment for these dependent, ancillary, supportive, and adjunctive items and services is packaged into payment for the primary independent service reported with an applicable HCPCS codes. Therefore, separate payment will not be made for claims reported with these packaged revenue codes when billed without HCPCS codes. Consistent with this, Company will not make separate

payment(s) for packaged revenue codes. Company will follow the OPPS payment updates as published annually by CMS in the OPPS final rule.

E. Dialysis Services Payment is defined as the current payment that Provider will receive from Company for dialysis services based on CMS's ESRD Prospective Payment System (PPS).

F. Home Health Care Services Payment is defined as the current payment that Provider will receive from Company for home health care services based on the CMS Home Health prospective payment system (PPS).

G. Medicare Physician Fee Schedule (MFS) is defined as a fee schedule established by Company for use in payment to providers for Covered Services, which is based upon Centers for Medicare & Medicaid Services (CMS) Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) [including Outpatient Prospective Payment System (OPPS) cap rates]; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP)'. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within sixty (60) days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments. Company payment policies apply to services paid based upon the Medicare Physician Fee Schedule.

H. Medicare-Medicaid Plans. Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether CMS and other applicable Government Sponsors regard that service as a Medicare Covered Service or a Medicaid Covered Service when and as provided by a particular provider, and by a Member's benefit limits under each program. For Covered Services that are Medicare Covered Services when and as provided by Provider (inclusive of Member copayment or coinsurance), Company shall compensate Provider at the AMMPMFS rate. For Covered Services that are *only* covered under Medicaid when and as provided by Provider (such as, but not limited to, long-term care and home and community based waiver services), Company shall compensate Provider at the AMMFS rate. When a service is covered under *both* Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination-of-benefit principles, and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

I. Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Parties acknowledge that payments (including, but not limited to, those based on a percentage of Medicare) will not reflect CMS Quality Payment Program adjustment factors or incentive payments (*e.g.*, Merit-Based Incentive Payment System (MIPS), Alternate Payment Models (APM)).

J. Additional Compensation. Company may, from time to time and in its discretion, offer additional compensation to Provider in connection with Member health, quality improvement and/or care management services provided (e.g., additional well visit coverage for Members, enhanced care management outreach).

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PROVIDER PARTICIPATION AGREEMENT

COVER SHEET

General Information	
Provider or Medical Group Name as applicable:	
Federal Tax ID Number:	**Provider's CMS Designation:** ***If Provider has CMS Designation, please include copy of FI rate letter.**
Provider NPI: * **If Provider has multiple NPIs, please include explanation and claim samples**	**Practice Website:**

Service Address * If Provider has multiple addresses please attach a list with all addresses
Service Address:
City:
State:
Zip:
Contact Person Name:
Email Address:
Telephone Number:
Facsimile (FAX) Number:
County:

Remit Address
Address:
City:
State:
Zip:
Contact Person Name:
Email Address:
Telephone Number:
Facsimile (FAX) Number:

For Humana Behavioral Health Network Use Only
Nomination ☐Yes ☐No

PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement (hereinafter referred to as "**Agreement**") is made and entered into by and between the party named on the signature page below and Health Value Management, Inc. d/b/a Humana Behavioral Health Network (hereinafter referred to as "**HBHN**").

RELATIONSHIP OF THE PARTIES

1.1 In performance of their respective duties and obligations hereunder, **HBHN** 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 venturer with the other party. Unless otherwise agreed to herein, the parties acknowledge and agree that neither **Provider** nor **HBHN** 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 **HBHN** 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.

PROVIDER SERVICES TO MEMBERS

2.1 Subject at all times to the terms of this Agreement, **Provider** agrees to provide or arrange for professional mental and/or behavioral health service (hereinafter referred to as "**Health Care Services**") to individuals (hereinafter referred to as "**Members**") covered under designated self-funded employer sponsored plans and trusts, insurance policies, or other third party payors' health benefits contracts (hereinafter referred to as "**Plan**" or "**Plans**"). **HBHN** has created and markets a provider network for such other third party payor(s) (hereinafter referred to as "**Payor**" or "**Payors**") issuing and/or administering the Plans. Members shall have an identification card as a means of identifying the Payor Plan covering Member.

THIRD PARTY BENEFICIARIES

3.1 Except as is otherwise specifically provided in this Agreement with respect to Payors, 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.

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 and subcontractors as health care providers (hereinafter referred to as "**Participating Providers**") providing Health Care Services and (ii) **Provider's** provision of Health Care 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 all rights and responsibilities arising with respect to benefits to Members shall be subject to the terms of the Payor Plan covering the Member.

4.3 **Provider** acknowledges and agrees that **HBHN** does not by this Agreement guarantee a certain number of referrals of patients or a certain value or volume of business for **Provider**.

4.4 **Provider** represents and warrants that 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 that **HBHN** does not dictate or control **Provider's** clinical decisions with respect to the behavioral health care or treatment of Members.

ACQUISITIONS

5.1 This Section 5.1 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 psychiatric hospital, (iii) partial hospitalization center, (iv) intensive outpatient center, (v) substance abuse rehabilitation center, (vi) residential treatment center; or (vii) provider, provider 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 **HBHN** for the provision of Health Care Services, then such Entity shall not become a participating provider with **HBHN** under this Agreement but, rather, the existing separate agreement between **HBHN** 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 **HBHN** 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 Payor'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.

TERM AND TERMINATION OF AGREEMENT

6.1 The term of this Agreement shall commence on the date **HBHN** inserts in this Agreement (the "**Effective Date**"). **HBHN** has full authority to determine the Effective Date according to **HBHN's** processing and/or credentialing requirements. The initial term of this Agreement shall be for three (3) years. 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, either party may terminate this Agreement without cause at any time by providing to the other party ninety (90) days prior written notice of termination. **Provider** may terminate participation under this Agreement with respect to any Payor that fails to make payments to **Provider** for covered services, but only after written notice to **HBHN** providing at least sixty (60) days in which the Payor may avoid termination by curing the default in payment. Covered services (hereinafter referred to as "**Covered Services**") as used in this Agreement means those services, as determined by a Payor, for which benefits are payable under a Member's Plan. In the event of notice of such termination, **Provider** agrees to provide Health Care Services for existing patients who are Members as may be required by state or federal law. Payment to **Provider** for services provided to such Members following the notice of termination shall be made in accordance with the terms of this Agreement.

6.3 **HBHN** may terminate this Agreement immediately upon written notice, stating the cause for such termination in the event: (i) **HBHN** reasonably determines that **Provider's** or any other Participating

Provider's continued participation under this Agreement may adversely affect the health, safety or welfare of any Member or bring **HBHN** or its provider network into disrepute; (ii) **Provider** fails to meet **HBHN's** or Payors' credentialing or recredentialing criteria; (iii) **Provider** or other 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) **HBHN** 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 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 **HBHN** in the event that **HBHN** determines that continued participation under this Agreement may affect adversely the health, safety or welfare of any Member or bring **HBHN** or its health care networks into disrepute, shall not be subject to cure and shall be cause for immediate termination as set forth in the immediately preceding paragraph.

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

6.6 **Provider** agrees that **HBHN** 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.

POLICIES AND PROCEDURES

7.1 **Provider** agrees to cooperate with **HBHN** and Payors with respect to their quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management and other administrative policies and procedures established and revised from time to time by **HBHN** and Payors and in addition, those policies and procedures which are set forth in **HBHN's** Provider Manual, or its successor (hereinafter referred to as the **"Manual"**), and bulletins or other written materials that may be promulgated by **HBHN** from time to time to supplement the Manual. The Manual and policies and procedures are posted by electronic means on **HBHN's** web site, or are set out in bulletins or other written materials, current copies of which will be provided to **Provider** upon 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 **HBHN** to comply with any statutory, regulatory and/or accreditation requirements.

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 recredentialing standards established by **HBHN**. **Provider** shall provide **HBHN** or its designee the information necessary to ensure compliance with such standards at no cost to **HBHN**, or its designee. **Provider** agrees to the use of electronic credentialing and recredentialing processes when administratively feasible.

8.2 **Provider** shall maintain, at no expense to **HBHN** or Payors, such policies of comprehensive

general liability, professional liability, and workers' compensation coverage as required by law, 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 **HBHN** with evidence of said coverage. **Provider** shall within ten (10) business days following service upon **Provider**, or such lesser period of time as may be required by any applicable state statute, rule or regulation, notify **HBHN** in writing of any Member lawsuit alleging malpractice involving a Member.

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 **HBHN** and/or Payors. **Provider** agrees to comply with all requests for information related to **HBHN's** and/or Payors determination of **Provider's** privileging status. **Provider** shall not bill, charge, seek payment or have any recourse against **HBHN**, Payors, or Members for any amounts related to the provision of Health Care Services for which privileges have not been granted to **Provider** by **HBHN**.

9.2 **Provider** shall be reachable twenty-four (24) hours per day, seven (7) days per week. **Provider** shall be available for appointments with Covered Members within forty-eight (48) hours of a request in the case of an urgent appointment, within ten (10) business days of a request in the case of a routine appointment, and on the day of a request in the case of an Emergency or Emergency Medical Condition. **Provider** agrees that such availability requirements may be changed or amended by a Payor or in order to comply with NCQA standards. **Provider** shall arrange for coverage, by an Affiliated Provider or another Participating Provider if possible, in case of **Provider's** unavailability. **Provider** shall be responsible for ensuring that any such covering arrangement complies with the terms of this Agreement.

9.3 **Provider** shall maintain all office medical equipment including, but not limited to, imaging, diagnostic and/or therapeutic equipment (hereinafter collectively 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 **Provider's** office locations that promote patient and employee safety. **Provider** shall provide **HBHN** and/or Payors 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.

9.4 Equipment owned and/or operated by **Provider** shall comply with all standards for use of such Equipment and technician qualifications established by **HBHN** and/or Payors. In the event: (i) **Provider's** Equipment fails to meet **HBHN's** and/or Payor(s) standards; or (ii) **Provider** declines to comply with **HBHN's** and/or Payor(s) standards for use of Equipment, **Provider** agrees that it will not use such Equipment while providing services to Members and shall not bill, charge, seek payment or have any recourse against **HBHN**, Payors, or Members for any amounts for services with respect to such Equipment.

9.5 **Provider** agrees if **Provider** closes **Provider's** practice(s) to new patients, such closure will apply to all prospective patients without discrimination or regard to payor or source of payment for services. Should **Provider** subsequently re-open **Provider's** practice(s) to new patients, **Provider** agrees to accept Members as patients to the same extent and in the same manner as non-Member patients seeking **Provider's** services.

STANDARDS OF PROFESSIONAL PRACTICE

10.1 Health Care Services shall be made available to Members without discrimination on the basis of type of health benefits plan, source of payment, sex, age, race, color, religion, national origin, creed, ancestry, marital status, sexual orientation, health status or disability. **Provider** shall provide Health Care Services to Members in the same manner as provided to their other patients and in accordance with prevailing practices and standards of the profession.

QUALITY AND UTILIZATION REVIEW DATA REQUESTED BY HBHN

11.1 **Provider** agrees to participate in **HBHN's** and/or **Payor's** utilization review program. **Provider** agrees to comply with **HBHN's** and/or **Payor's** policies and procedures and to provide data requested by **HBHN** and/or **Payor** to conduct quality and utilization review activities concerning **HBHN** and/or **Payor** Members.

11.2 **Provider** agrees to obtain from Members authorization for **HBHN's** and/or **Payor's** review personnel to have access to Members during their term of treatment and to Members' medical records, and pursuant to such authorization, provide **HBHN's** and/or **Payor's** review personnel such access. **Provider** agrees to provide **HBHN** and/or **Payor** review personnel access to **Provider** and **Provider's** personnel during the term of a Member's inpatient stay.

11.3 **Provider** agrees to provide Health Care Services, which are appropriate and Medically Necessary and to document adequately in Members' medical records those Health Care Services rendered to Members. "**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, facility, physician or other health care provider to identify or treat a condition, disease, ailment, sickness or bodily injury and which, in the opinion of **HBHN**, 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 facility, 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. **Provider** agrees that in the event of a denial of payment for services rendered to Members determined not to be Medically Necessary by HBHN and/or Payor, that Provider shall not bill, charge, seek payment or have any recourse against Member for such services. Notwithstanding the immediately preceding sentence, **Provider** may bill the Member for services determined not to be Medically Necessary if **Provider** provides the Member with advance written notice that: (a) identifies the proposed services, (b) informs the Member that such services may be deemed by HBHN and/or Payor to be not Medically Necessary, and (c) 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.

11.4 The parties understand, acknowledge, and agree that: (i) **HBHN's** performance of utilization management functions pursuant to this Agreement is solely for the purpose of determining whether a service requested by or for a Covered Member qualifies as a Covered Service under the Covered Member's Plan; and (ii) **HBHN's** verification of Medical Necessity is only a verification that a service meets the definition of "Medically Necessary" under a Covered Member's Plan; and (iii) The activities described in this **Section 11** do not constitute the practice of medicine or any other act or practice prohibited by federal or state law; and (iv) a Covered Member may obtain any service from **Provider** regardless of whether such service is a Covered Service under the Covered Member's Plan.

11.5 **Provider** agrees that except in the case of an Emergency or an Emergency Medical Condition, **Provider** shall not treat, refer, admit, or transfer a Covered Member, unless prior approval has

been obtained from **HBHN** or a Payor. "**Emergency**" means, except for Medicare Covered Members or if otherwise defined by state law, the sudden onset of a mental and/or nervous condition manifesting itself by acute symptoms of sufficient severity, such that the absence of immediate medical or clinical attention could reasonably be expected to result in seriously jeopardizing or endangering the mental health or physical well-being of the individual or the physical well-being of a third party. "**Emergency Medical Condition**" means, with respect to Medicare Covered Members, 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: (i) placing the health of the individual (with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall be deemed to exist also for Medicare Covered Members receiving care outside of the Provider Network as long as transfer of the Medicare Covered Member to the Provider Network is precluded because of risk to the Medicare Covered Member's health or because transfer would be unreasonable given the distance involved in the transfer and the nature of the Medicare Covered Member's medical condition. **Provider** shall comply with **HBHN** or a Payor's pre-admission treatment plan certification requirements and subsequent treatment criteria for Covered Services, length of stay, number of units, and type of Covered Services for Plans sponsored by Payors.

11.6 In the case of an Emergency or Emergency Medical Condition, if clinically appropriate services are not available from **Provider** or a Participating Provider, **Provider** may refer Covered Member to a non-Participating Provider. **Provider** shall contact **HBHN** for authorization within twenty-four (24) hours of such referral, and within forty-eight (48) hours for authorization for continued care.

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 Payors, in a form, and for time periods required by applicable state and federal laws, licensing requirements and reimbursement rules and regulations to which **Provider** is subject and otherwise in accordance with accepted medical practice. **Provider** shall obtain authorization of Member permitting **HBHN**, the Member's Payor, 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** to any Member pursuant to applicable state and federal laws. Copies of records required for the processing of claims shall be made and provided by **Provider** at no cost to **HBHN**, Payor, or the Member.

12.2 Upon request from **HBHN**, Payor or a Member, **Provider** agrees to transfer the complete original or a complete acceptable copy of the medical records of any Member transferred to another health care provider or facility for any reason, including termination of this Agreement. The transfer of medical records shall be made at no cost to **HBHN**, Payor or the Member and shall be made within a reasonable time following the request, but in no event more than five (5) days except in cases of emergency. **Provider** agrees that such timely transfer of medical records is necessary to ensure the continuity of care for Members.

12.3 **Provider** and **HBHN** and/or **Payor** agree to maintain the confidentiality of information maintained in the medical records of Members, and information obtained from **HBHN** and/or **Payor** through the verification of Member eligibility, as required by law. This **Section 12** shall survive expiration or termination of this Agreement, regardless of the cause.

GRIEVANCE AND APPEALS PROCESS/BINDING ARBITRATION

13.1 **Grievance and Appeals; Internal Administrative Review.** **Provider** shall cooperate and participate with **HBHN** and/or Payor, as applicable, in grievance and appeals procedures, to resolve disputes that may arise between **HBHN**, Payors, **Provider**, and/or Members. **Provider** and **HBHN**

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 **HBHN** 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 a panel of arbitrators proposed by the AAA. The arbitrator shall have prior professional, business or academic experience in healthcare, 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. With respect to any arbitration proceeding between **HBHN** and **Provider** whereby **Provider** practices individually or in a provider group of less than six (6) providers, **HBHN** agrees that it shall refund any applicable filing fees or arbitrators' fees paid by such **Provider** in the event that **Provider** is the prevailing party with respect to any arbitration proceeding in which **Provider** purports to represent providers outside his or her provider group. 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 **HBHN** 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.

USE OF PROVIDER'S NAME

14.1 **HBHN** and Payors may include the information in any and all marketing and administrative materials published or distributed in any medium by Payors or **HBHN: Provider's** name, address, telephone number, address, office hours, type of practice or specialty, hospital affiliation, and the

names of all other Participating Providers, including Provider's, providing care at **Provider's** office, **Provider** internet website address, board certification, and other education and training history to appear in **HBHN's** roster of Participating Providers. **HBHN** will provide **Provider** with access to 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 **HBHN** or Payors after obtaining **HBHN** and/or Payor'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 **HBHN** to distribute a public announcement of **Provider's** affiliation with **HBHN**.

PAYMENT

15.1 **Provider** shall accept payment from **HBHN** and/or Payors for Health Care Services that are 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 Plans shall be accepted by **Provider** as payment in full from **HBHN** and/or Payors 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 Plan.

15.2 **Provider** agrees that payment may not be made by **HBHN** and/or Payors for Health Care Services rendered to Members which are determined by **HBHN** and/or Payors to be Health Care Services not covered under a Member's Plan. In the event of such determination by **HBHN** and/or Payor, **Provider** may pursue payment for such Health Care Services from the applicable Member**,** unless such Health Care Services are paid by **HBHN** and/or Payor.

15.3 **HBHN's** agreements with Payors require Payors to pay **Provider** for Covered Services in accordance with any applicable state prompt payment laws or regulations and, except for Member Copayments, **Provider** agrees to seek payment for such Health Care Services solely from Payors. **Provider** shall participate under the terms contained herein as a participating provider with respect to Payors that contract with **HBHN** for provider network administration and related services.

15.4 **Provider** agrees that **HBHN** and/or Payors may recover overpayment made to **Provider** by **HBHN** and/or Payors by offsetting such amounts from later payments to **Provider**, including making retroactive adjustments to payments to **Provider** for errors and omissions relating to data entry errors and incorrectly submitted claims or incorrectly applied discounts. **HBHN** and/or Payor shall provide **Provider** thirty (30) days advance written notice of **HBHN's** and/or Payor'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 notice within thirty (30) days following receipt of notice from **HBHN** and/or Payor, **Provider** agrees that **HBHN** and/or Payors may make adjustments to payments retroactive for a period not to exceed eighteen (18) months from original date of payment.

15.5 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.

SUBMISSION OF CLAIMS

16.1 **Provider** agrees to submit all claims and encounters to **HBHN** and/or Payors or their designees, as applicable, using a CMS 1500, its electronic equivalent, or its successor. 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. **HBHN** and/or Payors may, in their sole discretion, deny payment for any claim(s) received by **HBHN** and/or Payor 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 **HBHN** and/or Payor will process **Provider** claims which are accurate and complete in accordance with **HBHN's** and/or Payor'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 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. 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 **Provider** shall use best efforts to submit all claims and clinical data to **HBHN** and/or Payors or their designees by electronic means available and accepted as industry standards that are mutually agreeable and which may include claims clearinghouses or electronic data interface companies used by Payor. **Provider** acknowledges that **HBHN** and/or Payors may market certain products that will require electronic submission of claims and clinical data in order for **Provider** to participate.

COORDINATION OF BENEFITS

17.1 Payments for Covered Services provided to each Member are subject to coordination with other benefits payable or paid to or on behalf of the Member in accordance with applicable statutes, laws, rules and regulations and in accordance with its Plans. **Provider** shall collect information concerning duplicate coverage, workers' compensation, and personal injury liability at the time of admission or when services are rendered and provide such information to the applicable Payor. In the event that the applicable Payor is determined to be secondary with respect to Covered Services, **Provider** shall seek reimbursement pursuant to such other coverage prior to submitting a claim to such Payor. Any secondary payment shall be determined in accordance with applicable terms of a Payor's Plan in effect for such Covered Members, taking into account amounts billed to and that portion paid by the primary payor. **Provider** shall cooperate with **HBHN** and a Payor in administering coordination of benefits, subrogation, and other third party reimbursement provisions. To preserve any right that **Provider** may have to payment from a Payor of any residual amount after payment by such third party, **Provider** shall send to **HBHN** a copy of each claim submitted to a third party payor within sixty (60) days of the date that Provider receives payment from such third party payor.

NO LIABILITY TO MEMBER FOR PAYMENT

18.1 **Provider** hereby agrees that in no event, including, but not limited to, nonpayment by **HBHN** and/or Payor, or **HBHN's** and/or Payor's insolvency, shall **Provider** bill, charge, collect a deposit from,

seek compensation, remuneration or reimbursement from, or have any recourse against Members for Health Care Services provided by **Provider** to Members. Whenever **HBHN** and/or a Payor fails to meet its obligation to pay fees under this Agreement for Covered Services already rendered to a Covered Member, **HBHN** and/or Payor, rather than the Covered Member, shall be liable for such fees. This provision shall not prohibit collection by **Provider** from Member for non-covered services and/or Copayments in accordance with the terms of the applicable Member Plan.

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.

ACCESS TO INFORMATION

19.1 **Provider** agrees that **HBHN**, Payors, or their designees, 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 **HBHN** and/or **Payor** by a federal or state regulatory agency or accreditation organization.

NEW PRODUCT INTRODUCTION

20.1 From time to time during the term of this Agreement, **HBHN** and/or Payors may develop or implement new products. Should **HBHN** and/or Payor elect to offer any such new products to **Provider**, **Provider** shall be provided with ninety (90) days written notice from **HBHN** prior to the implementation of such new product. If **Provider** does not object in writing to the implementation of 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 any such new product, the parties shall confer in good faith to reach agreement on terms of **Provider's** participation. If such agreement cannot be reached, such new product shall not apply to this Agreement.

20.2 **HBHN** reserves the right, in its discretion, to develop and market provider networks in which **Provider** may not be selected to participate. The parties agree that this Agreement applies to those Members and Plans designated by **HBHN**.

ASSIGNMENT AND DELEGATION

21.1 The assignment by **Provider** of this Agreement or any interest hereunder shall require notice to and the written consent of **HBHN**. Any attempt by **Provider** to assign this Agreement or its interest hereunder without complying with the terms of this paragraph shall be void and of no effect, and **HBHN**, at its option, may elect to terminate this Agreement, in accordance with the terms of **Section 6** upon thirty (30) days written notice to **Provider**, without any further liability or obligation to **Provider**. **HBHN** may assign this Agreement in whole or in part to any purchaser of or successor to the assets or operations of **HBHN**, or to any affiliate of **HBHN**, provided that the assignee agrees to assume **HBHN's** obligations under this Agreement. Upon notice of an assignment by **HBHN**, **Provider** may terminate this Agreement upon thirty (30) days written notice to **HBHN**.

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 to which this Agreement may be subject. Any modification of this Agreement requested by such agencies

or required by applicable law or regulations shall be incorporated herein as provided in **Section 23.10**, of this Agreement.

22.2 **Provider** and **HBHN** agree to be bound by and comply with the provisions of all applicable state and 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 or administrative agency in matters in which such right is not recognized or authorized by such law or regulation. **Provider** and Participating Providers agree to procure and maintain for the term of this Agreement all license(s) and/or certification(s) as is required by applicable law and **HBHN's** policies and procedures. **Provider** shall notify **HBHN** immediately of any changes in licensure or certification status of **Provider** and other Participating Providers, as applicable. If **Provider** or any **Participating 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 Provider's license or certification is revoked or suspended, or otherwise is restricted by any state licensing or certification agency by which **Provider** or Participating Provider is licensed or certified, **HBHN** may immediately terminate this Agreement or any individual Participating Provider.

MISCELLANEOUS PROVISIONS

23.1 **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.

23.2 **GOVERNING LAW.** This Agreement shall be governed by and construed in accordance with the laws of the state in which Health Care Services are provided. The parties agree that applicable federal and state laws and 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 attached hereto. 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 any other provisions in this Agreement, the provisions in the state law coordinating provisions attachment shall control. In the event that state or federal laws or regulations enacted after the Effective Date expressly require specific language in such provisions 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.

23.3 **WAIVER.** The waiver, whether expressed 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.

23.4 **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, by certified mail, return receipt requested; (b) on the date of 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. **HBHN** may also provide such notices to **Provider** by electronic means to the email address of **Provider** set forth on the Cover

Sheet to this Agreement or to other email addresses **Provider** provides to **HBHN** by notice as set forth herein. Unless a notice specifically limits its scope, notice to any one party included in the term "**Provider**" or "**HBHN**" shall constitute notice to all parties included in the respective terms.

23.5 **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 **HBHN**, 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.

23.6 **COUNTERPARTS AND HEADINGS.** 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.

23.7 **INCORPORATION OF ATTACHMENTS.** All attachments attached hereto are incorporated herein by reference and made a part of this Agreement.

23.8 **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.

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

23.10 **MODIFICATION OF THIS AGREEMENT. Provider** acknowledges and agrees that this Agreement may be amended in writing as mutually agreed upon by the parties. In addition, **HBHN** may amend this Agreement upon ninety (90) days written notice to **Provider**. Failure of **Provider** to object to such amendment during the ninety (90) day notice period shall constitute acceptance of such amendment by **Provider**.

23.11 **MATERIAL ADVERSE CHANGES**. Notwithstanding anything to the contrary in this Agreement, in the event **HBHN** makes a material adverse change in the terms of this Agreement it shall provide at least ninety (90) days written notice to **Provider** of such change; except where a shorter notice period is required to comply with applicable law or regulation. If **Provider** objects to the change that is the subject of the notice, then **Provider** must within thirty (30) days of the date of the notice give written notice of termination of this Agreement which notice shall be effective at the end of the notice period of the material adverse change; provided, however, if **HBHN** provides written notice within sixty-five (65) days of the date of the original notice of the material adverse change that it will not implement such change as to **Provider**, then **Provider's** notice of termination shall be of no force or effect.

23.12 **SUBCONTRACTING PERFORMANCE**. **Provider** shall provide **HBHN** an executed letter of agreement for each Participating Provider who is a provider and who is subcontracted or independently contracted with **Provider** prior to the provision of Health Care Services by such Participating Provider to Members. Such Participating Providers, if any, who do not execute a letter

of agreement may not participate under this Agreement and may not be listed in **HBHN's** provider directories.

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	**Health Value Management, Inc. d/b/a Humana Behavioral Health Network**
Signature: _____	Signature: _____
Printed Name: _____	Printed Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

Address for Notice:

Provider:	**Humana:**
_____	Health Value Management, Inc. d/b/a Humana Behavioral Health Network
_____	Network Operations
_____	1100 Employers Blvd
_____	Green Bay, WI 54344

PLAN PARTICIPATION LIST
ATTACHMENT

Provider agrees to participate in the Plan(s) selected below, whether self-funded or fully insured, that are offered by **HBHN** and/or Payor:

PLANS	(Check only those Plans that apply)
Medicare PPO Plans*	NA
Medicare HMO Plans*	NA
Medicare POS Plans*	NA
Medicare Network Private Fee-For-Service Plans*	NA
SoonerSelect (Oklahoma Medicaid)	X

*__Providers__ must be ELIGIBLE to participate in Medicare to treat Humana Medicare Advantage Members.

STATE LAW COORDINATING PROVISIONS
ATTACHMENT

OKLAHOMA

HBHN and **Provider** agree that the following provisions are incorporated into this Agreement as they relate to Payors, Plans and/or Members and solely to the extent specifically required to ensure compliance with applicable state laws, rules and regulations. This page is intentionally left blank if there are no state laws, rules or regulations required for provider contracts at the time of execution of this Agreement.

(Intentionally Left Blank)

Exhibit 1

THIRD PARTIES

Provider acknowledges notice of and expressly authorizes the transfer of all payment/ reimbursement terms and obligations under the agreement to the Third Parties set out below:

MEDICARE ADVANTAGE PROVISIONS ATTACHMENT

Provider agrees to participate in **HBHN's** Medicare Advantage Network. **Provider** further agrees that the following additional provisions ("Medicare Advantage Provisions") relate specifically to Medicare Advantage products and plans and are hereby incorporated by reference into the Agreement.

a) **Provider** agrees to: (i) comply with all federal and state laws and administrative guidelines issued by CMS pertaining to confidentiality, privacy and disclosure of medical records or other health and enrollment information of Members, including, but not limited, to Standards for Privacy of Individually Identifiable Information promulgated to the Health Insurance Portability and Accountability Act (HIPAA), (ii) ensure that medical information (including prescription records) is transmitted only in accordance with applicable state or federal law, or pursuant to court orders or subpoenas, (iii) maintain all Member records and information in an accurate and timely manner, and (iv) allow timely access by Members to the records and information that pertain to them.

b) **HBHN** and **Provider** agree that Payor will process all claims for Covered Services which are accurate and complete within thirty (30) days from the date of receipt. Payor agrees to pay **Provider** in compliance with applicable state or federal law following its receipt of a "clean claim" for services provided to Payor's Members. For purposes of this provision, a clean claim shall mean a claim for health care services that has no defect or impropriety requiring special treatment that prevents timely payment by Payor.

c) **Provider** agrees that in no event (including, but not limited to, nonpayment by **HBHN**, Payor's or **HBHN's** insolvency or breach of this Agreement) shall **Provider** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons for any amount(s) other than **HBHN** (or the payor issuing the health benefits contract administered by **HBHN**) for Covered Services provided by **Provider** for which payment is the legal obligation of Payor. This provision shall not prohibit **Provider** from collecting supplemental charges, co-payments or deductibles in accordance with the terms of the applicable Member health benefits contract. **Provider** further agrees that: (i) this provision shall survive the expiration, non-renewal or termination of this Agreement regardless of the cause giving rise to the 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.

d) **Provider's** performance of services under the Agreement shall be consistent and in compliance with Payor's contractual obligations under its Medicare Advantage contract(s). **Provider** agrees to cooperate with Payor in its efforts to monitor compliance with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations from CMS applicable to **Provider**'s performance of services under the agreement. **Provider** further agrees to assist **HBHN** and/or Payor in complying with corrective action plans necessary for **HBHN** and/or Payor to comply with such rules and regulations. **Provider** shall maintain all licenses, permits and qualifications required under applicable laws and regulations for **Provider** to perform the services under the Agreement. Without limiting the above, **Provider** shall comply with Federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claim Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).

e) **Provider** agrees that nothing in the Agreement shall be construed as relieving Payor of its responsibility for performance of duties agreed to through Medicare Advantage contracts existing now or entered into in the future with CMS. **Provider** understands that **HBHN** is accountable to the Medicare Advantage Organization (MAO) for whom it's providing services, and that MAO is ultimately accountable to CMS.

f) **Provider** agrees to comply with and be subject to all applicable Medicare program laws, rules and regulations, reporting requirements, and CMS instructions as implemented and amended by CMS. This includes, without limitation, the rights of **HBHN** and/or Payor and applicable federal and state regulatory agencies' including, but not limited to, HHS, the Comptroller General or their designees rights to evaluate, inspect and audit **Provider**'s operations, books, records, and other documentation and pertinent information related to **Provider**'s obligations under the Agreement, as well as all other federal and state laws, rules and regulations applicable to individuals and entities receiving federal funds. **Provider** further agrees that HHS', the Comptroller General's, or their designees right to inspect, evaluate and audit any pertinent information for any particular contract period will exist through ten (10) years from the final date of the contract period between Medicare Advantage organization and CMS or from the date of completion of any audit, whichever is later, and agrees to cooperate, assist and provide information as requested by such entities.

g) **Provider** agrees to retain all contracts, books, documents, papers and other records related to the provision of services to Medicare Advantage Members and/or as related to **Provider's** obligations under the Agreement for a period of not less than ten (10) years from: (i) each successive December 31; or (ii) the end of the contract period between Medicare Advantage organization and CMS; or (iii) from the date of completion of any audit, whichever is later.

h) **Provider** agrees in the event certain identified activity(ies) have been delegated to **Provider** under the Agreement, any sub-delegation of the noted activity(ies) by **Provider** requires the prior written approval of **HBHN** and/or Payor, as applicable. Notwithstanding anything to the contrary in the Agreement, **HBHN** and/or Payor, as applicable, will monitor **Provider**'s performance of any delegated activity(ies) on an ongoing basis and hereby retains the right to modify, suspend or revoke such delegated activity(ies) in the event **HBHN**, Payor, and/or CMS determines, in their discretion, that **Provider** is not meeting or has failed to meet its obligations under the Agreement related to such delegated activity(ies). In the event that **HBHN** and/or Payor, as applicable, has delegated all or any part of the claims payment process to **Provider** under the Agreement, **Provider** shall comply with all prompt payment requirements to which **HBHN** and/or Payor is subject. **HBHN** agrees that it shall review the credentials of **Provider** or, if **HBHN** and/or Payor, as applicable, has delegated the credentialing process to **Provider**, **HBHN** and/or Payor, as applicable, shall review and approve **Provider**'s credentialing process and audit it on an ongoing basis.

i) **Provider** agrees to comply with **HBHN** and Payor's policies and procedures and complete general compliance training and fraud, waste, and abuse training as required by CMS.

j) **Provider** agrees to maintain full participation status in the federal Medicare program. This also includes all of **Provider**'s employees, subcontractors, and/or independent contractors who will provide services, including, without limitation, health care, utilization review, medical social work, and/or administrative services under the Agreement. **Provider** represents and warrants that **Provider** (or any of its staff) is not and has not been: (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. **Provider** shall notify **HBHN** immediately if, at any time during the term of the Agreement, **Provider** (or any of its staff) is: (i) sanctioned under or listed as debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services, or (ii) criminally convicted or has a civil judgment entered against it for fraudulent activities. **Provider** acknowledges that **Provider's** participation in **HBHN** shall be terminated if **Provider** (or any of its staff) is debarred, excluded or otherwise ineligible for participation in the Medicare program or any Federal program involving the provision of health care or prescription drug services.

k) **Provider** agrees that payment from **HBHN** and/or Payor, as applicable, for services rendered to Medicare Advantage Members is derived, in whole or in part, from federal funds received by Medicare Advantage organization from CMS.

l) **Provider** agrees to disclose to **HBHN** and/or Payor, upon request and within thirty (30) days or such lesser period of time required for **HBHN** and/or Payor to comply with all applicable state or federal laws, all of the terms and conditions of any payment arrangement that constitutes a "physician incentive plan" as defined by CMS and/or any federal law or regulation. Such disclosure should identify, at a minimum, whether services not furnished by the physician/provider are included, the type of incentive plan including the amount, identified as a percentage, of any withhold or bonus, the amount and type of any stop-loss coverage provided for or required of the physician/provider, and the patient panel size broken down by total Provider or individual physician/provider panel size, and by the type of insurance coverage (i.e., Commercial HMO, Medicare Advantage HMO, Medicare PPO, and Medicaid HMO).

m) **Provider** agrees that in the event of **HBHN** and/or Payor's insolvency or termination of contract(s) under a Medicare Advantage plan with CMS, benefits to Covered Members will continue through the period for which premium has been paid and benefits to Covered Members confined in an inpatient facility will continue until their discharge.

n) **Provider** agrees to provide or arrange for continued treatment, including, but not limited to, medication therapy, to Medicare Advantage Members upon expiration or termination of the Agreement. In accordance with all applicable state and federal laws, rules and/or regulations, treatment must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Medicare Advantage Member's course of treatment, or until **HBHN** and/or Payor, as applicable, has made arrangements for substitute care for the Medicare Advantage Member; and (ii) until the date of discharge for Medicare Advantage Members hospitalized on the effective date of termination or expiration of the Agreement. **Provider** agrees to accept as payment in full from Payor for Covered Services rendered to Covered Members under a Medicare Advantage plan, the rates set forth in the payment attachment, which are applicable to such Covered Members.

o) **Provider** agrees to cooperate with the activities and/or requests of any independent quality review and improvement organization utilized by and/or under contract with **HBHN** and/or Payor, as applicable, as related to the provision of services to Covered Members under a Medicare Advantage plan.

p) **Provider** agrees to cooperate with **HBHN** and/or Payor's health risk assessment program.

q) **Provider** agrees to provide to **HBHN** and/or Payor accurate and complete information regarding the provision of Covered Services by **Provider** to Members ("Data") on a complete CMS 1500 or UB 92 form, or their respective successor forms as may be required by CMS, or such other form as may be required by law when submitting claims and encounters in an electronic format, or such other format as is mutually agreed upon by both parties. The Data shall be provided to **HBHN** and/or Payor on or before the last day of each month for encounters occurring in the immediately preceding month, or such lesser period of time as may be required in the Agreement, or as is otherwise agreed upon by the parties in writing. The submission of the Data to **HBHN**, Payor and/or CMS shall include a certification from **Provider** that the Data is accurate, complete and truthful. In the event the Data is not submitted to **HBHN** and/or Payor by the date and in the form specified above, **HBHN** and/or Payor may, in its sole option, withhold payment otherwise required to be made under the terms of the Agreement until the Data is submitted to **HBHN** and/or Payor.

r) **Provider** agrees not to collect or attempt to collect copayments, coinsurance, deductibles or other cost-share amounts from any Medicare Advantage Member who has been designated as a Qualified Medicare Beneficiary ("**QMB**") by CMS.

s) **Provider** agrees to require its' employed and contracted health care providers and health care professionals providing services under the Agreement to comply with the terms and conditions of the Agreement. **Provider must** maintain written agreements with any employed and contracted health care providers and health care professionals, as applicable, that include terms and conditions that comply with the Medicare Advantage Provisions and all applicable requirements for provider agreements under state and federal laws, rules and regulations including, without limitation, the Medicare Advantage rules and regulations to which **HBHN** and/or Payor is subject. In the event of a conflict between the language of such downstream provider agreements and the Agreement, the language in the Agreement shall control.

t) With respect to any of Payor's Members who are eligible for both Medicare and Medicaid, **Provider** agrees that such Members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, with respect to such Members, **Provider** agrees to: (i) accept the payment amount from the Payor as payment in full, or (ii) bill the appropriate State source.

u) **Provider** certifies that **Provider** and its principals, employees, agents and subcontractors have not been excluded, suspended, or debarred from participation in any federally-funded health care program. **Provider** shall review the Office of Inspector General and General Services Administration exclusion files and verify on a monthly basis (or as often as required by CMS) that the persons it employs or contracts for the provision of services under the Agreement are in good standing. **Provider** shall notify **HBHN** immediately upon becoming aware that **Provider** or its principals, employees, agents, or subcontractors have been excluded, suspended, or debarred from participation in any federally-funded health care program.

v) Any provisions now or hereafter required to be included in the Agreement by applicable Federal or state laws and regulations or by CMS shall be binding upon and enforceable against the parties to the Agreement and be deemed incorporated herein, irrespective of whether or not such provisions are expressly set forth in this Attachment or elsewhere in the Agreement.

APPENDIX A

ADDITIONAL PROVISIONS APPLICABLE TO HBHN HEALTH PLAN PAYORS

The following additional provisions apply to health plans underwritten or administered by HBHN Insurance Company or its affiliates.

1. **Provider** agrees to comply with the policies and procedures set forth in the Manual regarding inpatient and outpatient admissions including, but not limited to, notifying **HBHN** of the admission or obtaining preadmission authorization as the Manual so requires. **Provider** recognizes that failure to comply with the Manual with respect to a Member admission could result in limitations on **HBHN's** ability to administer Members' benefits. In the event **Provider** fails to comply with the Manual regarding a Member inpatient or outpatient admission, **Provider's** claim will be pended and may either not be paid (if it is not Medically Necessary) or be subject to an administrative reduction in an amount equal to fifty percent (50%) of the allowed amount. **Provider** agrees it shall not balance bill the Member for the amount of the reduction in payment. In the event the reduction described herein is effected, the Member's Copayments, if any, will be adjusted accordingly.

OKLAHOMA MEDICAID PROVIDER REGULATORY ATTACHMENT

The following additional provisions apply specifically to Oklahoma Medicaid products and plans and are hereby incorporated by reference into the Agreement. The provisions in this Oklahoma Medicaid Provider Regulatory Attachment ("**Attachment**") are required by the Oklahoma Health Care Authority ("OHCA") to be included in provider agreements. 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.

DEFINITIONS FOR THIS ATTACHMENT:

Member - A person enrolled in a Payor Oklahoma Medicaid managed care plan.

Provider Agreement - The provider participation agreement between **HBHN** and **Provider** to serve Payor's Members. This Attachment is attached to the Agreement.

Contract - The agreement between Payor and OHCA for the provision of benefits to Members.

Covered Services - Services for which benefits are payable under a Oklahoma Medicaid managed care plan.

State – The State of Oklahoma.

GENERAL:

1. References to "**Provider**" or "**Providers**" herein are to the contracted provider of health care services as specified in the **Provider Agreement** and, as applicable, his/her/its employed or contracted providers who provide health care services under the **Provider Agreement**.

2. Notwithstanding anything to the contrary in the **Provider Agreement**, **HBHN** may modify this Attachment to include provision(s) required by OHCA by providing thirty (30) days' advance written notice to **Provider,** or any such shorter notice if required by OHCA. Upon the conclusion of the notice period, the provision(s) set forth in the notice shall be incorporated into the **Provider Agreement** as if fully set forth therein and shall be binding on the parties. Payor will secure OHCA's approval prior to any such updates becoming effective. A current version of this Attachment is available in the online Payor Oklahoma Medicaid Provider Manual.

3. **Provider** agrees to comply with all applicable terms and conditions of the **Contract** as well as all applicable OHCA and federal statutes, regulations, policies, procedures and rules.

4. **Provider** certifies that **Provider** and its principals, employees, agents and subcontractors have not been excluded, suspended, or debarred from participation in any federally funded health care program or the Oklahoma Medicaid program.

GENERAL REQUIRED PROVISIONS:

All **Providers** shall be subject to the following provisions:

5. Payor may deny, refuse to renew or terminate any **Provider Agreement** in accordance with the terms of the **Contract** and any applicable statutes and regulations.

6. In the event of termination of the Agreement, the **Provider** shall immediately make available to OHCA or its designated representative in a usable form any or all records whether medically or financially related to the terminated **Provider's** activities undertaken pursuant to the **Provider Agreement** and that the provision of such records shall be at no expense to OHCA.

7. OHCA shall have the right to direct **HBHN** and/or Payor to terminate any **Provider Agreement** if OHCA determines that termination is in the best interest of the State of Oklahoma.

8. **Provider** is not a third party beneficiary to the **Contract**. **Provider** shall be considered an independent contractor performing services as outlined in the **Contract**.

9. Any **Provider**, including **Providers** ordering or referring a **Covered Service**, must have an NPI, to the extent such **Provider** is not an atypical provider as defined by CMS.

10. **Providers** shall abide by Health Plan Enrollee/**Member** rights and responsibilities denoted in the **Contract**.

11. **Providers** shall display notices of Health Plan Enrollee Rights to Grievances, Appeals, and State Hearings in public areas of the **Provider's** facility/facilities in accordance with all **State** requirements and any subsequent amendments.

12. **Providers** shall provide physical access, reasonable accommodations, and accessible equipment for **Members** with physical or mental disabilities, in accordance with 42 C.F.R. § 438.206(c)(3).

13. **Providers** shall accommodate the presence of interpreters.

14. **Providers** shall render emergency services without the requirement of prior authorization.

15. **Member** information shall be kept confidential, as defined by **State** and federal laws, regulations and policy.

16. **Providers** shall maintain an adequate record system for recording services and all other commonly accepted information elements, including but not limited to: charges, dates and records necessary for evaluation of the quality, appropriateness and timeliness of services performed. **Members** and their representatives shall be given access to and can request copies of the **Members'** medical records to the extent and in the manner provided under **State** or federal law.

17. **Providers** shall maintain all records related to services provided to **Members** for a ten year period. In addition, **Providers** shall make all **Member** medical records or other service records available for any quality reviews that may be conducted by Payor, OHCA or its designated agent(s) during and after the term of the **Provider Agreement**.

18. In accordance with 42 C.F.R. § 438.208(b)(5), **Providers** shall furnish services to **Members** to maintain and share **Member** health records in accordance with professional standards.

19. If the **Provider** is eligible for participation in the Vaccines for Children program, **Provider** shall comply with all program requirements as defined by OHCA.

20. Authorized representatives of OHCA and other **State** or federal agencies shall have reasonable access to facilities and records for audit purposes during and after the term of the **Provider Agreement**.

21. **Provider** shall release to Payor any information necessary to monitor **Provider** performance on an ongoing and periodic basis.

22. **Providers** shall adhere to the responsibilities and prohibited activities regarding SoonerSelect program cost sharing. When the covered service provided requires a copayment, as allowed by Payor, the **Provider** may charge the **Member** only the amount of the allowed copayment, which cannot exceed the copayment amount allowed by OHCA. **Provider** shall accept payment made by Payor as payment in full for **Covered Services**, and the **Provider** shall not solicit or accept any surety or guarantee of payment from the **Member**, OHCA or the **State**.

23. **Providers** shall be obligated to identify **Member** third party liability coverage, including Medicare and long-term care insurance as applicable; and except as otherwise required, the **Provider** shall seek such third party liability payment before submitting claims to Payor.

24. Payor shall monitor utilization of the quality of services delivered under the **Provider Agreement**. **Providers** shall participate and cooperate with any internal and external QM/QI monitoring, utilization review, peer review and/or appeal procedures established by OHCA and/or Payor and shall participate in any corrective action processes that will be taken where necessary to improve quality of care.

25. **Providers** shall timely submit all reports, clinical information and encounter data required by Payor and OHCA.

26. **Provider** shall indemnify and hold OHCA harmless from all claims, losses or suits relating to activities undertaken by the **Provider** pursuant to the **Provider Agreement**.

27. **Providers** shall agree that no person, on the grounds of disability, age, race, color, religion, sex, sexual orientation, gender identity, or national origin, shall be excluded from participation in, or be denied benefits of Payor's program or otherwise subjected to discrimination in the performance of the **Provider Agreement** with **HBHN** or in the employment practices of the **Provider**.

28. **Providers** shall identify **Members** in a manner which will not result in discrimination against the **Member** in order to provide or coordinate the provision of **Covered Services**.

29. **Providers** shall not use discriminatory practices with regard to **Members** such as separate waiting rooms, separate appointment days or preference to private pay patients.

30. **Providers** shall take adequate steps to promote the delivery of services in a culturally competent manner to **Members**, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities and regardless of gender, sexual orientation or gender identity.

31. **Providers** shall comply with all **State** and federal law/requirements for database screening and criminal background checks of new hires and current employees and staff who have direct contact with **Members** and/or access to **Members'** Protected Health Information. **Providers** are prohibited from employing or contracting with individuals or entities that are excluded or debarred from participation in Medicare, Medicaid or any federal health care program as further detailed in Section "Prohibited Affiliations and Exclusions" of the **Contract**.

32. **Providers** shall conduct initial screenings and criminal background checks and comply with ongoing monitoring requirements of all employees and contractors in accordance with **State** and federal law. The **Provider** shall be required to immediately report to **HBHN** and/or Payor any exclusion information discovered.

33. OHCA shall have the right to deny enrollment or terminate a **Provider Agreement** with a **Provider** as provided under **State** and/or federal law.

34. OHCA shall have the right to amend these regulatory requirements as it deems necessary.

35. Any non-compete contractual provision (that prohibits **Provider** from entering into a contractual relationship with another managed care organization or Indian Managed Care Entity) between **Provider** and **HBHN** shall not apply to the Medicaid line of business.

36. Payor shall take no punitive action against a **Provider** who either requests an expedited resolution or supports a **Member's** grievance or appeal.

37. If **Provider** is considered a Patient Centered Medical Home ("PCMH"), **Provider** shall also be responsible for the following:

    a. Deliver primary care services and follow-up care;
    b. Utilize and practice evidence-based medicine and clinical decision supports;
    c. Make referrals for specialty care and other **Covered Services** and, when applicable, work with Payor to allow **Members** to directly access a specialist as appropriate for a **Member's** condition and identified needs;
    d. Maintain a current medical record for the **Member**;
    e. Use health information technology to support care delivery;
    f. Provide care coordination in accordance with the **Member's** care plan, as applicable based on Payor's Risk Stratification Level Framework, and in cooperation with **Member's** care manager;
    g. Ensure coordination and continuity of care with **Providers**, including but not limited to specialists and behavioral health **Providers**;
    h. Engage in active participation with the **Member** and the **Member's** family, authorized representative or personal support, when appropriate, in health care decision-making, feedback and care plan development;
    i. Provide access to medical care 24-hours per day, seven days a week, either directly or through coverage arrangements made with other **Providers**, clinics and/or local hospitals;
    j. Provide enhanced access to care, including extended office hours outside normal business hours and facilitating use of open scheduling and same-day appointments where possible; and
    k. Participate in continuous quality improvement and voluntary performance measures established by Payor and/or OHCA.

38. Behavioral Health **Providers** providing inpatient psychiatric services to **Members** shall schedule the **Member** for outpatient follow-up or continuing treatment prior to discharge from the inpatient setting with the outpatient treatment occurring within seven calendar days from the date of discharge.

39. Behavioral Health **Providers** shall complete the OHCA Customer Data Core (CDC) form located at http://www.odmhsas.org/picis/CDCPAForms/arc_CDCPA_Forms.htm as a condition of payment for services provided under the **Contract**.

40. Behavioral Health **Providers** shall provide treatment to pregnant **Members** who are intravenous drug users and all other pregnant substance users within 24 hours of assessment.

41. Payor shall obtain the appropriate **Member** releases to share clinical information and **Member** health records with community-based behavioral health **Providers**, as requested, consistent with all **State** and federal confidentiality requirements and in accordance with Payor policy and procedures.

42. **Providers** with laboratory testing sites shall either have a Clinical Laboratory Improvement Amendments (CLIA) certificate or waiver of a certificate of registration along with a CLIA identification number.

43. **Providers** with CMS certified Electronic Health Records (EHR) systems shall connect to the State Health Information Exchange (HIE) for the purpose of bi-directional health data exchange. **Providers** who do not have a certified EHR shall be required to use the State HIE provider portal to query patient data for enhanced patient care.

44. If **Provider** does not have an EHR, they must still sign a participation agreement with the State HIE and sign up for direct secure messaging services and portal access so that clinical information can be shared securely with other Providers in their community of care.

45. **Providers** shall sign a participation agreement with the State HIE within one month of contract signing.

46. Network hospitals, long term care facilities and emergency departments (EDs) shall send electronic patient event notifications of a patient's admission, discharge, and/or transfer (ADT) to the state HIE.

47. In accordance with § 1932 (b)(3)(A) of the Social Security Act, **HBHN** and/or Payor shall not prohibit or otherwise restrict **Providers** acting within the scope of the **Provider's** license from advising or advocating on behalf of Members for the following:

    a. Member health status, medical care or treatment options, including any alternative treatment that may be self-administered;
    b. Any information a Member needs to decide among all relevant treatment options;
    c. The risks, benefits and consequences of treatment or non-treatment; or
    d. Member's right to participate in decisions regarding Member's health care, including the right to refuse treatment and to express preferences about future treatment decisions.

48. **Provider** shall promptly submit all claims information needed to make payment within six months of the covered service being provided to a Member.

PAYMENT ATTACHMENT – OKLAHOMA MEDICAID

Provider agrees to accept as payment in full from Payor one hundred percent (100%) of the Oklahoma Medicaid Fee Schedule, or **Provider**'s usual and customary charges, whichever is less, for Oklahoma Medicaid **Covered Services** rendered to Payor Oklahoma Medicaid **Members**, less any applicable copayment, coinsurance, or deductible due from a **Member**.

For purposes of this Payment Attachment, "Oklahoma Medicaid Fee Schedule" shall mean the Medicaid fee-for-service fee schedule set and determined by the Oklahoma Health Care Authority ("OHCA")

In addition, **Provider** understands and agrees that the Oklahoma Medicaid Fee Schedule reimbursement rate shall be the reimbursement rate in effect on the date of service the **Covered Services** are rendered.

HEALTH VALUE MANAGEMENT
D/B/A HUMANA BEHAVIORAL HEALTH NETWORK
PROVIDER PAYMENT ATTACHMENT

Provider Name: _____

TIN#: _____

1. REIMBURSEMENT

A. Medicare Plans

Provider agrees to accept as payment in full from Payor for Covered Behavioral Health Services rendered to Members, the lesser of **Provider's** billed charges or the amount specified below, less any Copayments due from Member.

Provider Specialty:	Reimbursement:
Psychiatrist (MD or DO)	100% of **HBHN's** 005-731 fee schedule
Clinical Psychologist (PhD or PsyD); Independently Practicing Psychologist (IPP);	90% of **HBHN's** 005-731 fee schedule
Licensed Clinical Social Worker	85% of **HBHN's** 005-731 fee schedule
Psychiatric Mental Health Advanced Practice Registered Nurse (PMH-NP or PMH-CNS); Psychiatric Physician Assistant (PA-C)	90% of HBHN's 005-731 fee schedule

2. FEE SCHEDULE DESCRIPTION

Humana Behavioral Health Network's (005-731) fee schedule is based on the Medicare Resource-Based Relative Value Scale (RBRVS), fee schedule and payment systems for the state of Oklahoma, locality #04312-00, including the site-of-service payment differential, in effect as of the effective date of this Agreement and will change thereafter to reflect the annual updates to the schedule made by the Centers for Medicare and Medicaid Services ("**CMS**").

Additionally, **Humana Behavioral Health Network** will adjust the schedule to include and assign fees for services, which are not covered by RBRVS (hereinafter "**Gap Codes**"). In most cases, the Gap Codes are adjusted by **Humana Behavioral Health Network** using the relative value unit ("**RVU**") multiplied by Medicare's conversion factor and geographic factor to assign the fee.

Such annual updates by CMS and any corresponding adjustments by **Humana Behavioral Health Network** shall be incorporated herein without notice to the **Provider**, but will be available to the **Provider** upon request. **Humana Behavioral Health Network** may make other adjustments and modifications to the fee schedule. In such cases, **Humana Behavioral Health Network** will provide to **Provider** a ninety (90) day written notice prior to implementation.

3. **FEE SCHEDULE SAMPLES**

Humana Behavioral Health Network has provided a representative sample of these fee schedules to **Provider** prior to **Provider**'s execution of this Agreement, and thereafter will supply a sample upon written request by **Provider**. **Provider** hereby acknowledges receipt of fee schedule sample.

4. MISCELLANEOUS

Provider understands that Payor(s) may market or administer products that contain variable Copayment amounts due from the Member for Covered Services based on the medical specialty of certain **Provider**s and the unit costs or reimbursement rates provided for in **Provider** participation agreements. **Provider** agrees to participate in such products and to bill and accept as payment in full for Covered Services rendered to Members in such products the reimbursement rates set forth above less any Copayment amounts due from the Member.
In circumstances where the Member's Copayment for a Covered Service is equal to or greater than the rate set forth herein for that service, **Provider** agrees to accept as payment in full for the service the Member's Copayment, not to exceed the rates set forth herein. Furthermore, in such cases, **Provider** agrees to refund to Member the difference, if any, between the Copayment collected from the Member and such rate.

5. EXCLUSIONS

The parties agree the Agreement does not cover general medical services other than those commonly associated with mental health and/or chemical dependency treatment (where reimbursement is outlined in the attached fee schedule) and no payment will be made by Payor for same under the Agreement.

OWNERSHIP DISCLOSURE FORM

Provider:

_____

(Must be identical to the name shown on the Cover Sheet.)

STATUS:

_____ Sole Proprietorship

_____ Professional Association

_____ Partnership or Limited Liability Company

_____ Corporation

List names and addresses of all principals and indicate percent of ownership, if applicable. ("Principal" means any shareholder, officer, director, partner, member, manager, joint venturer or anyone else having an ownership in or managerial control over IPA.) Attach additional sheets if necessary.

_____

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What to expect as a participating provider with SoonerSelect and Humana Healthy Horizons in Oklahoma

Our healthcare provider partnerships allow us to deliver comprehensive, high-quality care to eligible Oklahoma residents with Medicaid coverage.

We support our provider partners through:

Dedicated and local support

Every provider will have a dedicated Medicaid Provider Relations representative to help conduct business with Humana.

Ease of doing business

Our processes are developed to be clear and intuitive. We will educate you on how to submit claims, manage prior authorizations and more.

Accessible tools and resources

We will show you how to access Humana tools and resources as well as partner with you to help you thrive in the SoonerSelect program.

To help healthcare providers transition to SoonerSelect, Humana will offer a series of provider onboarding and training opportunities. More information will be available through your Provider Relations representative and on **Humana.com**.

Questions?

- Call our Provider Helpline at **855-223-9868**.
- Physical health providers can email **OKMedicaidProviderRelations@humana.com**.
- Behavioral health providers can email **OKBHMedicaid@humana.com**.

Humana Healthy Horizons® in Oklahoma

311604OK0923 OKHM54TEN0923

Form **W-9**
(Rev. October 2018)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

► **Go to *www.irs.gov/FormW9* for instructions and the latest information.**

Give Form to the requester. Do not send to the IRS.

Print or type. See **Specific Instructions** on page 3.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification of the person whose name is entered on line 1. Check only **one** of the following seven boxes.

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=Partnership) ► _____

Note: Check the appropriate box in the line above for the tax classification of the single-member owner. Do not check LLC if the LLC is classified as a single-member LLC that is disregarded from the owner unless the owner of the LLC is another LLC that is **not** disregarded from the owner for U.S. federal tax purposes. Otherwise, a single-member LLC that is disregarded from the owner should check the appropriate box for the tax classification of its owner.

☐ Other (see instructions) ►

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.) See instructions.

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the instructions for Part I, later. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN,* later.

Note: If the account is in more than one name, see the instructions for line 1. Also see *What Name and Number To Give the Requester* for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions for Part II, later.

Sign Here	**Signature of U.S. person** ►	**Date** ►

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. For the latest information about developments related to Form W-9 and its instructions, such as legislation enacted after they were published, go to *www.irs.gov/FormW9.*

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following.

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See What is backup withholding, *later.*

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),

2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting,* later, for further information.

Note: If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States.

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Pub. 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items.

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.

2. The treaty article addressing the income.

3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.

4. The type and amount of income that qualifies for the exemption from tax.

5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 24% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,

2. You do not certify your TIN when required (see the instructions for Part II for details),

3. The IRS tells the requester that you furnished an incorrect TIN,

4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or

5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code,* later, and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships,* earlier.

What is FATCA Reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code,* later, and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account (other than an account maintained by a foreign financial institution (FFI)), list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9. If you are providing Form W-9 to an FFI to document a joint account, each holder of the account that is a U.S. person must provide a Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note: ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C corporation, or S corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box on line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box on line 3.

IF the entity/person on line 1 is a(n) . . .	THEN check the box for . . .
• Corporation	Corporation
• Individual • Sole proprietorship, or • Single-member limited liability company (LLC) owned by an individual and disregarded for U.S. federal tax purposes.	Individual/sole proprietor or single-member LLC
• LLC treated as a partnership for U.S. federal tax purposes, • LLC that has filed Form 8832 or 2553 to be taxed as a corporation, or • LLC that is disregarded as an entity separate from its owner but the owner is another LLC that is not disregarded for U.S. federal tax purposes.	Limited liability company and enter the appropriate tax classification. (P= Partnership; C= C corporation; or S= S corporation)
• Partnership	Partnership
• Trust/estate	Trust/estate

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space on line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note: You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns. If this address differs from the one the requester already has on file, write NEW at the top. If a new address is provided, there is still a chance the old address will be used until the payor changes your address in their records.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN.

If you are a single-member LLC that is disregarded as an entity separate from its owner, enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note: See *What Name and Number To Give the Requester,* later, for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.SSA.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/Businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. Go to *www.irs.gov/Forms* to view, download, or print Form W-7 and/or Form SS-4. Or, you can go to *www.irs.gov/OrderForms* to place an order and have Form W-7 and/or SS-4 mailed to you within 10 business days.

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note: Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if item 1, 4, or 5 below indicates otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code,* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), ABLE accounts (under section 529A), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account) other than an account maintained by an FFI	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Two or more U.S. persons (joint account maintained by an FFI)	Each holder of the account
4. Custodial account of a minor (Uniform Gift to Minors Act)	The minor[2]
5. a. The usual revocable savings trust (grantor is also trustee)	The grantor-trustee[1]
b. So-called trust account that is not a legal or valid trust under state law	The actual owner[1]
6. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
7. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
8. Disregarded entity not owned by an individual	The owner
9. A valid trust, estate, or pension trust	Legal entity[4]
10. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
11. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
12. Partnership or multi-member LLC	The partnership
13. A broker or registered nominee	The broker or nominee
14. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
15. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships,* earlier.

***Note:** The grantor also must provide a Form W-9 to trustee of trust.

Note: If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records From Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Pub. 5027, Identity Theft Information for Taxpayers.

Victims of identity theft who are experiencing economic harm or a systemic problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at *spam@uce.gov* or report them at *www.ftc.gov/complaint.* You can contact the FTC at *www.ftc.gov/idtheft* or 877-IDTHEFT (877-438-4338). If you have been the victim of identity theft, see *www.IdentityTheft.gov* and Pub. 5027.

Visit *www.irs.gov/IdentityTheft* to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See **Specific Instructions** on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here **Signature of U.S. person** ▶ **Date** ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

Note. If you are a U.S. person and a requester gives you a form other than Form W-9 to request your TIN, you must use the requester's form if it is substantially similar to this Form W-9.

Definition of a U.S. person. For federal tax purposes, you are considered a U.S. person if you are:

- An individual who is a U.S. citizen or U.S. resident alien;
- A partnership, corporation, company, or association created or organized in the United States or under the laws of the United States;
- An estate (other than a foreign estate); or
- A domestic trust (as defined in Regulations section 301.7701-7).

Special rules for partnerships. Partnerships that conduct a trade or business in the United States are generally required to pay a withholding tax under section 1446 on any foreign partners' share of effectively connected taxable income from such business. Further, in certain cases where a Form W-9 has not been received, the rules under section 1446 require a partnership to presume that a partner is a foreign person, and pay the section 1446 withholding tax. Therefore, if you are a U.S. person that is a partner in a partnership conducting a trade or business in the United States, provide Form W-9 to the partnership to establish your U.S. status and avoid section 1446 withholding on your share of partnership income.

In the cases below, the following person must give Form W-9 to the partnership for purposes of establishing its U.S. status and avoiding withholding on its allocable share of net income from the partnership conducting a trade or business in the United States:

- In the case of a disregarded entity with a U.S. owner, the U.S. owner of the disregarded entity and not the entity;
- In the case of a grantor trust with a U.S. grantor or other U.S. owner, generally, the U.S. grantor or other U.S. owner of the grantor trust and not the trust; and
- In the case of a U.S. trust (other than a grantor trust), the U.S. trust (other than a grantor trust) and not the beneficiaries of the trust.

Foreign person. If you are a foreign person or the U.S. branch of a foreign bank that has elected to be treated as a U.S. person, do not use Form W-9. Instead, use the appropriate Form W-8 or Form 8233 (see Publication 515, Withholding of Tax on Nonresident Aliens and Foreign Entities).

Nonresident alien who becomes a resident alien. Generally, only a nonresident alien individual may use the terms of a tax treaty to reduce or eliminate U.S. tax on certain types of income. However, most tax treaties contain a provision known as a "saving clause." Exceptions specified in the saving clause may permit an exemption from tax to continue for certain types of income even after the payee has otherwise become a U.S. resident alien for tax purposes.

If you are a U.S. resident alien who is relying on an exception contained in the saving clause of a tax treaty to claim an exemption from U.S. tax on certain types of income, you must attach a statement to Form W-9 that specifies the following five items:

1. The treaty country. Generally, this must be the same treaty under which you claimed exemption from tax as a nonresident alien.
2. The treaty article addressing the income.
3. The article number (or location) in the tax treaty that contains the saving clause and its exceptions.
4. The type and amount of income that qualifies for the exemption from tax.
5. Sufficient facts to justify the exemption from tax under the terms of the treaty article.

Example. Article 20 of the U.S.-China income tax treaty allows an exemption from tax for scholarship income received by a Chinese student temporarily present in the United States. Under U.S. law, this student will become a resident alien for tax purposes if his or her stay in the United States exceeds 5 calendar years. However, paragraph 2 of the first Protocol to the U.S.-China treaty (dated April 30, 1984) allows the provisions of Article 20 to continue to apply even after the Chinese student becomes a resident alien of the United States. A Chinese student who qualifies for this exception (under paragraph 2 of the first protocol) and is relying on this exception to claim an exemption from tax on his or her scholarship or fellowship income would attach to Form W-9 a statement that includes the information described above to support that exemption.

If you are a nonresident alien or a foreign entity, give the requester the appropriate completed Form W-8 or Form 8233.

Backup Withholding

What is backup withholding? Persons making certain payments to you must under certain conditions withhold and pay to the IRS 28% of such payments. This is called "backup withholding." Payments that may be subject to backup withholding include interest, tax-exempt interest, dividends, broker and barter exchange transactions, rents, royalties, nonemployee pay, payments made in settlement of payment card and third party network transactions, and certain payments from fishing boat operators. Real estate transactions are not subject to backup withholding.

You will not be subject to backup withholding on payments you receive if you give the requester your correct TIN, make the proper certifications, and report all your taxable interest and dividends on your tax return.

Payments you receive will be subject to backup withholding if:

1. You do not furnish your TIN to the requester,
2. You do not certify your TIN when required (see the Part II instructions on page 3 for details),
3. The IRS tells the requester that you furnished an incorrect TIN,
4. The IRS tells you that you are subject to backup withholding because you did not report all your interest and dividends on your tax return (for reportable interest and dividends only), or
5. You do not certify to the requester that you are not subject to backup withholding under 4 above (for reportable interest and dividend accounts opened after 1983 only).

Certain payees and payments are exempt from backup withholding. See *Exempt payee code* on page 3 and the separate Instructions for the Requester of Form W-9 for more information.

Also see *Special rules for partnerships* above.

What is FATCA reporting?

The Foreign Account Tax Compliance Act (FATCA) requires a participating foreign financial institution to report all United States account holders that are specified United States persons. Certain payees are exempt from FATCA reporting. See *Exemption from FATCA reporting code* on page 3 and the Instructions for the Requester of Form W-9 for more information.

Updating Your Information

You must provide updated information to any person to whom you claimed to be an exempt payee if you are no longer an exempt payee and anticipate receiving reportable payments in the future from this person. For example, you may need to provide updated information if you are a C corporation that elects to be an S corporation, or if you no longer are tax exempt. In addition, you must furnish a new Form W-9 if the name or TIN changes for the account; for example, if the grantor of a grantor trust dies.

Penalties

Failure to furnish TIN. If you fail to furnish your correct TIN to a requester, you are subject to a penalty of $50 for each such failure unless your failure is due to reasonable cause and not to willful neglect.

Civil penalty for false information with respect to withholding. If you make a false statement with no reasonable basis that results in no backup withholding, you are subject to a $500 penalty.

Criminal penalty for falsifying information. Willfully falsifying certifications or affirmations may subject you to criminal penalties including fines and/or imprisonment.

Misuse of TINs. If the requester discloses or uses TINs in violation of federal law, the requester may be subject to civil and criminal penalties.

Specific Instructions

Line 1

You must enter one of the following on this line; **do not** leave this line blank. The name should match the name on your tax return.

If this Form W-9 is for a joint account, list first, and then circle, the name of the person or entity whose number you entered in Part I of Form W-9.

a. **Individual.** Generally, enter the name shown on your tax return. If you have changed your last name without informing the Social Security Administration (SSA) of the name change, enter your first name, the last name as shown on your social security card, and your new last name.

Note. ITIN applicant: Enter your individual name as it was entered on your Form W-7 application, line 1a. This should also be the same as the name you entered on the Form 1040/1040A/1040EZ you filed with your application.

b. **Sole proprietor or single-member LLC.** Enter your individual name as shown on your 1040/1040A/1040EZ on line 1. You may enter your business, trade, or "doing business as" (DBA) name on line 2.

c. **Partnership, LLC that is not a single-member LLC, C Corporation, or S Corporation.** Enter the entity's name as shown on the entity's tax return on line 1 and any business, trade, or DBA name on line 2.

d. **Other entities.** Enter your name as shown on required U.S. federal tax documents on line 1. This name should match the name shown on the charter or other legal document creating the entity. You may enter any business, trade, or DBA name on line 2.

e. **Disregarded entity.** For U.S. federal tax purposes, an entity that is disregarded as an entity separate from its owner is treated as a "disregarded entity." See Regulations section 301.7701-2(c)(2)(iii). Enter the owner's name on line 1. The name of the entity entered on line 1 should never be a disregarded entity. The name on line 1 should be the name shown on the income tax return on which the income should be reported. For example, if a foreign LLC that is treated as a disregarded entity for U.S. federal tax purposes has a single owner that is a U.S. person, the U.S. owner's name is required to be provided on line 1. If the direct owner of the entity is also a disregarded entity, enter the first owner that is not disregarded for federal tax purposes. Enter the disregarded entity's name on line 2, "Business name/disregarded entity name." If the owner of the disregarded entity is a foreign person, the owner must complete an appropriate Form W-8 instead of a Form W-9. This is the case even if the foreign person has a U.S. TIN.

Line 2

If you have a business name, trade name, DBA name, or disregarded entity name, you may enter it on line 2.

Line 3

Check the appropriate box in line 3 for the U.S. federal tax classification of the person whose name is entered on line 1. Check only one box in line 3.

Limited Liability Company (LLC). If the name on line 1 is an LLC treated as a partnership for U.S. federal tax purposes, check the "Limited Liability Company" box and enter "P" in the space provided. If the LLC has filed Form 8832 or 2553 to be taxed as a corporation, check the "Limited Liability Company" box and in the space provided enter "C" for C corporation or "S" for S corporation. If it is a single-member LLC that is a disregarded entity, do not check the "Limited Liability Company" box; instead check the first box in line 3 "Individual/sole proprietor or single-member LLC."

Line 4, Exemptions

If you are exempt from backup withholding and/or FATCA reporting, enter in the appropriate space in line 4 any code(s) that may apply to you.

Exempt payee code.

- Generally, individuals (including sole proprietors) are not exempt from backup withholding.
- Except as provided below, corporations are exempt from backup withholding for certain payments, including interest and dividends.
- Corporations are not exempt from backup withholding for payments made in settlement of payment card or third party network transactions.
- Corporations are not exempt from backup withholding with respect to attorneys' fees or gross proceeds paid to attorneys, and corporations that provide medical or health care services are not exempt with respect to payments reportable on Form 1099-MISC.

The following codes identify payees that are exempt from backup withholding. Enter the appropriate code in the space in line 4.

1—An organization exempt from tax under section 501(a), any IRA, or a custodial account under section 403(b)(7) if the account satisfies the requirements of section 401(f)(2)

2—The United States or any of its agencies or instrumentalities

3—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

4—A foreign government or any of its political subdivisions, agencies, or instrumentalities

5—A corporation

6—A dealer in securities or commodities required to register in the United States, the District of Columbia, or a U.S. commonwealth or possession

7—A futures commission merchant registered with the Commodity Futures Trading Commission

8—A real estate investment trust

9—An entity registered at all times during the tax year under the Investment Company Act of 1940

10—A common trust fund operated by a bank under section 584(a)

11—A financial institution

12—A middleman known in the investment community as a nominee or custodian

13—A trust exempt from tax under section 664 or described in section 4947

The following chart shows types of payments that may be exempt from backup withholding. The chart applies to the exempt payees listed above, 1 through 13.

IF the payment is for . . .	THEN the payment is exempt for . . .
Interest and dividend payments	All exempt payees except for 7
Broker transactions	Exempt payees 1 through 4 and 6 through 11 and all C corporations. S corporations must not enter an exempt payee code because they are exempt only for sales of noncovered securities acquired prior to 2012.
Barter exchange transactions and patronage dividends	Exempt payees 1 through 4
Payments over $600 required to be reported and direct sales over $5,000[1]	Generally, exempt payees 1 through 5[2]
Payments made in settlement of payment card or third party network transactions	Exempt payees 1 through 4

[1] See Form 1099-MISC, Miscellaneous Income, and its instructions.

[2] However, the following payments made to a corporation and reportable on Form 1099-MISC are not exempt from backup withholding: medical and health care payments, attorneys' fees, gross proceeds paid to an attorney reportable under section 6045(f), and payments for services paid by a federal executive agency.

Exemption from FATCA reporting code. The following codes identify payees that are exempt from reporting under FATCA. These codes apply to persons submitting this form for accounts maintained outside of the United States by certain foreign financial institutions. Therefore, if you are only submitting this form for an account you hold in the United States, you may leave this field blank. Consult with the person requesting this form if you are uncertain if the financial institution is subject to these requirements. A requester may indicate that a code is not required by providing you with a Form W-9 with "Not Applicable" (or any similar indication) written or printed on the line for a FATCA exemption code.

A—An organization exempt from tax under section 501(a) or any individual retirement plan as defined in section 7701(a)(37)

B—The United States or any of its agencies or instrumentalities

C—A state, the District of Columbia, a U.S. commonwealth or possession, or any of their political subdivisions or instrumentalities

D—A corporation the stock of which is regularly traded on one or more established securities markets, as described in Regulations section 1.1472-1(c)(1)(i)

E—A corporation that is a member of the same expanded affiliated group as a corporation described in Regulations section 1.1472-1(c)(1)(i)

F—A dealer in securities, commodities, or derivative financial instruments (including notional principal contracts, futures, forwards, and options) that is registered as such under the laws of the United States or any state

G—A real estate investment trust

H—A regulated investment company as defined in section 851 or an entity registered at all times during the tax year under the Investment Company Act of 1940

I—A common trust fund as defined in section 584(a)

J—A bank as defined in section 581

K—A broker

L—A trust exempt from tax under section 664 or described in section 4947(a)(1)

M—A tax exempt trust under a section 403(b) plan or section 457(g) plan

Note. You may wish to consult with the financial institution requesting this form to determine whether the FATCA code and/or exempt payee code should be completed.

Line 5

Enter your address (number, street, and apartment or suite number). This is where the requester of this Form W-9 will mail your information returns.

Line 6

Enter your city, state, and ZIP code.

Part I. Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. If you are a resident alien and you do not have and are not eligible to get an SSN, your TIN is your IRS individual taxpayer identification number (ITIN). Enter it in the social security number box. If you do not have an ITIN, see *How to get a TIN* below.

If you are a sole proprietor and you have an EIN, you may enter either your SSN or EIN. However, the IRS prefers that you use your SSN.

If you are a single-member LLC that is disregarded as an entity separate from its owner (see *Limited Liability Company (LLC)* on this page), enter the owner's SSN (or EIN, if the owner has one). Do not enter the disregarded entity's EIN. If the LLC is classified as a corporation or partnership, enter the entity's EIN.

Note. See the chart on page 4 for further clarification of name and TIN combinations.

How to get a TIN. If you do not have a TIN, apply for one immediately. To apply for an SSN, get Form SS-5, Application for a Social Security Card, from your local SSA office or get this form online at *www.ssa.gov*. You may also get this form by calling 1-800-772-1213. Use Form W-7, Application for IRS Individual Taxpayer Identification Number, to apply for an ITIN, or Form SS-4, Application for Employer Identification Number, to apply for an EIN. You can apply for an EIN online by accessing the IRS website at *www.irs.gov/businesses* and clicking on Employer Identification Number (EIN) under Starting a Business. You can get Forms W-7 and SS-4 from the IRS by visiting IRS.gov or by calling 1-800-TAX-FORM (1-800-829-3676).

If you are asked to complete Form W-9 but do not have a TIN, apply for a TIN and write "Applied For" in the space for the TIN, sign and date the form, and give it to the requester. For interest and dividend payments, and certain payments made with respect to readily tradable instruments, generally you will have 60 days to get a TIN and give it to the requester before you are subject to backup withholding on payments. The 60-day rule does not apply to other types of payments. You will be subject to backup withholding on all such payments until you provide your TIN to the requester.

Note. Entering "Applied For" means that you have already applied for a TIN or that you intend to apply for one soon.

Caution: *A disregarded U.S. entity that has a foreign owner must use the appropriate Form W-8.*

Part II. Certification

To establish to the withholding agent that you are a U.S. person, or resident alien, sign Form W-9. You may be requested to sign by the withholding agent even if items 1, 4, or 5 below indicate otherwise.

For a joint account, only the person whose TIN is shown in Part I should sign (when required). In the case of a disregarded entity, the person identified on line 1 must sign. Exempt payees, see *Exempt payee code* earlier.

Signature requirements. Complete the certification as indicated in items 1 through 5 below.

1. Interest, dividend, and barter exchange accounts opened before 1984 and broker accounts considered active during 1983. You must give your correct TIN, but you do not have to sign the certification.

2. Interest, dividend, broker, and barter exchange accounts opened after 1983 and broker accounts considered inactive during 1983. You must sign the certification or backup withholding will apply. If you are subject to backup withholding and you are merely providing your correct TIN to the requester, you must cross out item 2 in the certification before signing the form.

3. Real estate transactions. You must sign the certification. You may cross out item 2 of the certification.

4. Other payments. You must give your correct TIN, but you do not have to sign the certification unless you have been notified that you have previously given an incorrect TIN. "Other payments" include payments made in the course of the requester's trade or business for rents, royalties, goods (other than bills for merchandise), medical and health care services (including payments to corporations), payments to a nonemployee for services, payments made in settlement of payment card and third party network transactions, payments to certain fishing boat crew members and fishermen, and gross proceeds paid to attorneys (including payments to corporations).

5. Mortgage interest paid by you, acquisition or abandonment of secured property, cancellation of debt, qualified tuition program payments (under section 529), IRA, Coverdell ESA, Archer MSA or HSA contributions or distributions, and pension distributions. You must give your correct TIN, but you do not have to sign the certification.

What Name and Number To Give the Requester

For this type of account:	Give name and SSN of:
1. Individual	The individual
2. Two or more individuals (joint account)	The actual owner of the account or, if combined funds, the first individual on the account[1]
3. Custodian account of a minor (Uniform Gift to Minors Act)	The minor[2]
4. a. The usual revocable savings trust (grantor is also trustee) b. So-called trust account that is not a legal or valid trust under state law	The grantor-trustee[1] The actual owner[1]
5. Sole proprietorship or disregarded entity owned by an individual	The owner[3]
6. Grantor trust filing under Optional Form 1099 Filing Method 1 (see Regulations section 1.671-4(b)(2)(i)(A))	The grantor*
For this type of account:	**Give name and EIN of:**
7. Disregarded entity not owned by an individual	The owner
8. A valid trust, estate, or pension trust	Legal entity[4]
9. Corporation or LLC electing corporate status on Form 8832 or Form 2553	The corporation
10. Association, club, religious, charitable, educational, or other tax-exempt organization	The organization
11. Partnership or multi-member LLC	The partnership
12. A broker or registered nominee	The broker or nominee
13. Account with the Department of Agriculture in the name of a public entity (such as a state or local government, school district, or prison) that receives agricultural program payments	The public entity
14. Grantor trust filing under the Form 1041 Filing Method or the Optional Form 1099 Filing Method 2 (see Regulations section 1.671-4(b)(2)(i)(B))	The trust

[1] List first and circle the name of the person whose number you furnish. If only one person on a joint account has an SSN, that person's number must be furnished.

[2] Circle the minor's name and furnish the minor's SSN.

[3] You must show your individual name and you may also enter your business or DBA name on the "Business name/disregarded entity" name line. You may use either your SSN or EIN (if you have one), but the IRS encourages you to use your SSN.

[4] List first and circle the name of the trust, estate, or pension trust. (Do not furnish the TIN of the personal representative or trustee unless the legal entity itself is not designated in the account title.) Also see *Special rules for partnerships* on page 2.

***Note.** Grantor also must provide a Form W-9 to trustee of trust.

Note. If no name is circled when more than one name is listed, the number will be considered to be that of the first name listed.

Secure Your Tax Records from Identity Theft

Identity theft occurs when someone uses your personal information such as your name, SSN, or other identifying information, without your permission, to commit fraud or other crimes. An identity thief may use your SSN to get a job or may file a tax return using your SSN to receive a refund.

To reduce your risk:

- Protect your SSN,
- Ensure your employer is protecting your SSN, and
- Be careful when choosing a tax preparer.

If your tax records are affected by identity theft and you receive a notice from the IRS, respond right away to the name and phone number printed on the IRS notice or letter.

If your tax records are not currently affected by identity theft but you think you are at risk due to a lost or stolen purse or wallet, questionable credit card activity or credit report, contact the IRS Identity Theft Hotline at 1-800-908-4490 or submit Form 14039.

For more information, see Publication 4535, Identity Theft Prevention and Victim Assistance.

Victims of identity theft who are experiencing economic harm or a system problem, or are seeking help in resolving tax problems that have not been resolved through normal channels, may be eligible for Taxpayer Advocate Service (TAS) assistance. You can reach TAS by calling the TAS toll-free case intake line at 1-877-777-4778 or TTY/TDD 1-800-829-4059.

Protect yourself from suspicious emails or phishing schemes. Phishing is the creation and use of email and websites designed to mimic legitimate business emails and websites. The most common act is sending an email to a user falsely claiming to be an established legitimate enterprise in an attempt to scam the user into surrendering private information that will be used for identity theft.

The IRS does not initiate contacts with taxpayers via emails. Also, the IRS does not request personal detailed information through email or ask taxpayers for the PIN numbers, passwords, or similar secret access information for their credit card, bank, or other financial accounts.

If you receive an unsolicited email claiming to be from the IRS, forward this message to *phishing@irs.gov.* You may also report misuse of the IRS name, logo, or other IRS property to the Treasury Inspector General for Tax Administration (TIGTA) at 1-800-366-4484. You can forward suspicious emails to the Federal Trade Commission at: *spam@uce.gov* or contact them at *www.ftc.gov/idtheft* or 1-877-IDTHEFT (1-877-438-4338).

Visit IRS.gov to learn more about identity theft and how to reduce your risk.

Privacy Act Notice

Section 6109 of the Internal Revenue Code requires you to provide your correct TIN to persons (including federal agencies) who are required to file information returns with the IRS to report interest, dividends, or certain other income paid to you; mortgage interest you paid; the acquisition or abandonment of secured property; the cancellation of debt; or contributions you made to an IRA, Archer MSA, or HSA. The person collecting this form uses the information on the form to file information returns with the IRS, reporting the above information. Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation and to cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their laws. The information also may be disclosed to other countries under a treaty, to federal and state agencies to enforce civil and criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism. You must provide your TIN whether or not you are required to file a tax return. Under section 3406, payers must generally withhold a percentage of taxable interest, dividend, and certain other payments to a payee who does not give a TIN to the payer. Certain penalties may also apply for providing false or fraudulent information.