ANCILLARY PARTICIPATION AGREEMENT

STATE: OKLAHOMA

COVER SHEET

Creation Date:	
Icertis Contract Number:	**Merlin ID:**
Provider Name: **Legal Name:** **DBA Name:**	

Federal Tax ID: **EIN: ICM Tax ID**

Optional Information: **NPI:**

Contract Contact Information: **Name:**

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

Address for Notice: **Name:**

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

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

ANCILLARY PROVIDER PARTICIPATION AGREEMENT

This Ancillary Provider Participation Agreement ("**Agreement**") is made and entered into by and between [insert name of provider entity] (hereinafter referred to as "**Provider**") and Humana Health Plan, Inc. and Humana Insurance Company and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**").

RELATIONSHIP OF THE PARTIES

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

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

SERVICES TO MEMBERS

2.1 Subject at all times to the terms of this Agreement, **Provider** agrees to provide or arrange for professional medical service and/or related health care services to individuals designated by **Humana** (herein referred to as "**Members**") with an identification card.

2.2 Deleted in its entirety

2.3 Deleted in its entirety

THIRD PARTY BENEFICIARIES

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

SCOPE OF AGREEMENT

4.1 This Agreement sets forth the rights, responsibilities, terms and conditions governing: (i) the status of **Provider** and **Provider's** employees, subcontractors and independent contractors as health care providers (hereinafter referred to as "**Participating Providers**") provision of those health care services for which benefits are payable under a Member's health benefits contract (hereinafter referred to as "**Covered Services**") provided to Member in accordance with the reimbursement terms in the Payment Attachment. 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** represents and warrants that it is authorized to negotiate terms and conditions of provider agreements, including this Agreement, and further to execute such agreements for and on behalf of itself and its **Participating Providers**. **Provider** further represents and warrants that

Participating Providers will abide by the terms and conditions of this Agreement, including each of **Providers** employed, subcontracted or independently contracted providers. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between **Provider** and Members regarding the Members' medical conditions or treatment options, and **Provider** acknowledges that all patient care and related decisions are the sole responsibility of **Provider** and **Humana** does not dictate or control clinical decisions with respect to the medical care or treatment of Members.

4.3 Notwithstanding anything to the contrary in this Agreement, it is understood that hospital-based physician services, or other physician services, including but not limited to, services provided by pathologists, emergency room physicians, anesthesiologists and radiologists, are not covered under this Agreement. In addition, **Provider** acknowledges that it maintains separate contractual arrangements with such hospital-based physicians. Upon request, **Provider** agrees to assist **Humana** in negotiations with hospital-based physicians rendering services at **Provider**. The parties acknowledge and agree that in the event **Humana** is unable to negotiate a mutually agreeable provider participation agreement with the hospital-based physicians providing services at **Provider**, **Humana** may terminate this Agreement without cause upon sixty (60) days prior written notice to **Provider**.

4.4 Deleted in its entirety

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 ambulatory surgery center, (iii) radiology center, (iv) sleep center; or (v) physician, physician group, Independent Practice Association or Physician Hospital Organization (collectively, "**Entity**"). In the event of **Provider's** Acquisition of an Entity and such Entity has an agreement in effect with **Humana** for the provision of **Covered Services**, then such Entity shall not become a participating provider with **Humana** under this Agreement but, rather, the existing separate agreement between **Humana** and such Entity will control for its duration. Furthermore, **Provider** shall not exercise any termination or nonrenewal right which may exist in the agreement between **Humana** and such Entity for a period of twelve (12) months subsequent to the effective date **Provider** acquires its ownership interest in such Entity.

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

TERM AND TERMINATION

6.1 This term of this Agreement shall commence on the date **Humana** inserts in this Agreement (the "**Effective Date**"). **Humana** has full authority to determine the Effective Date according to **Humana's** processing and/or credentialing requirements. The Initial Term of this Agreement shall be for three (3) years ("Initial Term"). After the Initial Term, this Agreement shall automatically renew for subsequent one (1) year terms unless either party provides written notice of non-renewal to the other party at least ninety (90) days prior to the end of the initial term or any subsequent renewal terms.

6.2 Notwithstanding anything to the contrary herein, after the Initial Term, either party may terminate this Agreement without cause by providing to the other party one hundred twenty (120) days prior written notice of termination.

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

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

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

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

POLICIES AND PROCEDURES

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

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

7.3 Notwithstanding anything to the contrary in this Agreement or in the Member's health benefits contract, **Provider** shall obtain authorization from **Humana** prior to the provision of those services for which **Humana** requires prior authorization. Prior to rendering any non-emergent service, **Provider** is responsible for determining if such service requires prior authorization by reviewing **Humana's** prior authorization requirements posted on http://www.humana.com/providers/ (or any subsequent location as may be specified in the Manual or otherwise by written notice) or by contacting **Humana's** customer service phone number, as indicated on Member's identification

card. **Provider** shall not under any circumstance bill, charge, seek, receive and/or retain payment from Member.

CREDENTIALING AND PROFESSIONAL LIABILITY INSURANCE

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

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

PROVISION OF MEDICAL SERVICES

9.1 **Provider** shall provide Members all available **Covered Services** within the normal scope of and in accordance with **Provider's** licenses, certifications and privileges to provide certain **Covered Services** based upon **Provider's** qualifications as determined by Humana. **Provider** agrees to comply with all requests for information related to **Provider's** qualifications in connection with **Humana's** determination whether to extend privileges to provide certain services and/or procedures to Members. **Provider** or any **Participating Provider** shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts related to the provision of **Covered Services** for which **Humana** has notified **Provider** or any **Participating Provider** that privileges to perform such services have not been extended.

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

9.3 Deleted in its entirety.

9.4 **Humana** prohibits pass-through billing. Pass through billing occurs when the ordering physician requests and bills for a service, but the service is not performed by the ordering physician or those under their direct employ. **Provider** agrees that services related to pass-through billing will not be eligible for reimbursement from **Provider** and **Provider** shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts related to the provision of pass-through billing.

STANDARDS OF PROFESSIONAL PRACTICE

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

QUALITY AND UTILIZATION REVIEW DATA REQUESTED BY HUMANA

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

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

MEDICAL RECORDS

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

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

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

GRIEVANCE AND APPEALS PROCESS/BINDING ARBITRATION

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

13.2 **Agreement to Arbitrate**. The parties agree that any dispute arising out of their business relationship which cannot be settled by mutual agreement shall be submitted to final and binding arbitration under the Healthcare Payor Provider Arbitration Rules of the American Arbitration

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

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

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

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

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

USE OF PROVIDER'S NAME

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

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

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

PAYMENT

15.1 **Provider** shall accept payment from **Humana** for **Covered Services** provided to Member in accordance with the reimbursement terms in the Payment Attachment. **Provider** shall collect directly from Member any co-payment, coinsurance, or other Member cost share amounts (hereinafter referred to as "**Copayments**") applicable to the Covered Services provided and shall not waive, discount or rebate any such Copayments. Payments made in accordance with the Payment Attachment less the Copayments owed by Members pursuant to their health benefits contracts shall be accepted by **Provider** as payment in full from **Humana** for all Covered Services. This provision shall not prohibit collection by **Provider** from Member for any services not covered under the terms of the applicable Member health benefits contract. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

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

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

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

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

15.6 Notwithstanding any other reimbursement terms specified in this Agreement, for all Covered Services rendered to Medicare Advantage Members (including but not limited to Members enrolled in Medicare-Medicaid alignment plans or their equivalent) the reimbursement for which under this Agreement is determined in whole or in part by a Medicare reimbursement methodology, the final payment amount to **Provider** as determined under this Agreement shall be reduced in the same manner as the reduction in the final payment amount that CMS is applying to provider payments in Medicare Parts A and/or B pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Control Act of 2011, or any successor legislation ("**Sequestration**"). This provision is effective April 1, 2013 and shall apply for the duration of the time in which Sequestration reductions apply to provider payments under Medicare Parts A and/or B.

SUBMISSION OF CLAIMS

16.1 **Provider** shall submit all claims and encounters to **Humana** or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") compliant 837 electronic format, or a UB-04 and/or a CMS 1500 paper format (in accordance with industry standard), or their successors. Claims and encounters will utilize HIPAA compliant Code Sets for all coded values. Claims shall include the **Provider's** NPI and the valid taxonomy code that most accurately describes the health care services reported on the claim. Claims shall be submitted within one hundred eighty (180) days from the date of service. **Hospital** must resubmit any denied or corrected claims within an additional one hundred (180) days from date of service, except for reasons related to (i) administrative correction or action by Humana taken to resolve a dispute; (ii) reversal of eligibility determination; (iii) investigation for fraud or abuse of Hospital; or (iv) court order or hearing decision. **Humana** may, in its sole discretion, deny payment for any claim(s) received by **Humana** after one hundred eighty (180) days from the date of service, or the time specified above or as required by applicable state law. **Provider** acknowledges and agrees that at no time shall Members be responsible for any payments to **Provider** except for applicable Copayments and non-covered services provided to such Members.

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

16.3 Unless applicable law mandates submission may be in paper format, **Provider** shall submit all claims, encounters, and clinical data to **Humana** by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by **Humana**. **Provider** acknowledges that **Humana** may market certain products that will require electronic submission of claims and clinical data in order for **Provider** to participate. **Provider** shall notify **Humana** when they have completed their transition to Electronic Medical Records and agrees to provide information on the status to **Humana** upon request. Unless applicable law mandates submission may be in paper format, **Provider** shall submit to **Humana** all

Humana required clinical data (including, but not limited to, laboratory data) by available electronic means within thirty (30) days of the date of service or within the time specified by applicable law.

COORDINATION OF BENEFITS

17.1 When a Member has coverage, other than with **Humana**, which requires or permits coordination of benefits from a third party payor in addition to **Humana**, **Humana** will coordinate its benefits with such other payor(s). In all cases, **Humana** will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, **Humana** will pay the lesser of: (i) the amount due under this Agreement; (ii) the amount due under this Agreement less the amount payable or to be paid by the other payor(s); or (iii) the difference between the primary Payor's allowed amount and the amount paid by the other payor(s). In no event, however, will **Humana**, when its plan is a secondary payor, pay an amount, which, when combined with payments from the other payor(s), exceeds the rates set out in this Agreement; provided, however, if Medicare is the primary payer, **Humana** will, to the extent required by applicable law, regulation or Centers for Medicare and Medicaid Services ("**CMS**") Office of Inspector General ("**OIG**") guidance, pay **Provider** an amount up to the amount **Humana** would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

NO LIABILITY TO MEMBER FOR PAYMENT

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

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

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

ACCESS TO INFORMATION

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

NEW PRODUCT INTRODUCTION AND NETWORK SELECTION

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

to reach agreement on the terms of **Provider's** participation. If agreement on such new product cannot be reached, such new product shall not apply to this Agreement.

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

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 **Humana**. As used in this paragraph, the term "assignment" shall also include a change of control in **Provider** by merger, consolidation, transfer, or the sale of thirty-three percent (33%) or more stock or other ownership interest in **Provider**. Any attempt by **Provider** to assign this Agreement or any interest hereunder without complying with the terms of this paragraph shall be void and of no effect, and **Humana**, at its option, may elect to terminate this Agreement upon thirty (30) days written notice to **Provider**, without any further liability or obligation to **Provider**. **Humana** may assign this Agreement in whole or in part to any purchaser of or successor to the assets or operations of **Humana**, or to any affiliate of **Humana**, provided that the assignee agrees to assume **Humana's** obligations under this Agreement. Upon notice of an assignment by **Humana**, **Provider** may terminate this Agreement upon thirty (30) days written notice to **Humana**.

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 24.10**, of this Agreement.

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

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

DISPUTE RESOLUTION/LIMITATIONS ON PROCEEDINGS

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

23.2 **Provider** may contest the amount of the payment, denial or nonpayment of a claim only within a period of eighteen (18) months following the date such claim was paid, denied or not paid by the

required date by **Humana**. In order to contest such payments, **Provider** shall provide to **Humana**, at a minimum, in a clear and acceptable written format, the following information: Member name and identification number, date of service, relationship of the Member to the patient, claim number, name of the provider of the services, charge amount, payment amount, the allegedly correct payment amount, difference between the amount paid and the allegedly correct payment amount, and a brief explanation of the basis for the contestation. **Humana** will review such contestation(s) and respond to **Provider** within sixty (60) days of the date of receipt by **Humana** of such contestation.

MISCELLANEOUS PROVISIONS

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

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

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

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

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

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

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

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

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

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

.

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

PROVIDER/AUTHORIZED SIGNATORY

Legal Entity: _____

Provider DBA Name: _____

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Tax ID: _____

HUMANA

Signature: _____

Printed Name: _____

Title: _____

Date: _____

Address For Notice:

PROVIDER:

HUMANA:

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

PRODUCT PARTICIPATION LIST
ATTACHMENT

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

Health Benefits Plan	**(Check only those which apply)**
Oklahoma Medicaid Plan(s)	X

PROVIDER LOCATIONS
ATTACHMENT

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

The following is a list of **Provider's** locations, including address, telephone and fax numbers, tax identification number, National Provider Identifier ("**NPI**"), contact person, office hours, specialty services available for each service location included in this Agreement and other **Provider** personnel who will be providing services to **Humana** Members under this Agreement. **Provider** shall provide **Humana** with no less than sixty (60) days prior written notice of any addition, change or closing of a location. **Provider** will provide updates of this listing to **Humana** on a quarterly.

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 **Provider**.) Attach additional sheets if necessary.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

HUMANA'S UTILIZATION REVIEW PROGRAM ATTACHMENT

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

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

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

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

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

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

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

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

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

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

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

OKLAHOMA MEDICAID PROVIDER REGULATORY ATTACHMENT

The following additional provisions apply specifically to **Humana's** 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 agreements between **Humana** and **Provider**. In the event of a conflict between the terms and conditions of the Agreement and this Attachment, the terms and conditions of this Attachment shall control as they apply to **Humana's** Oklahoma Medicaid products and plans.

1. DEFINITIONS FOR THIS ATTACHMENT:

1.1 Member: A person enrolled in a **Humana** Oklahoma Medicaid managed care plan. Member may be referred to as patient, enrollee, client, customer, or beneficiary of Oklahoma's Medicaid products.

1.2 Provider Agreement: The provider participation agreement between **Humana** and **Provider** to serve **Humana's** Members. This Attachment is attached to the Agreement. For purposes of this Attachment, "affiliate" means, when used with reference to a specific Humana Inc. organization, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with Humana Inc. Under this Agreement, Humana Wisconsin Health Organization Insurance Corporation is an affiliate and licensee of the Oklahoma Insurance Department authorized to transact business within the State of Oklahoma.

1.3 Contract: The agreement between **Humana** and Oklahoma Health Care Authority ("OHCA") for the provision of benefits to Members.

1.4 Covered Services: Medically necessary services for which benefits are payable under a Oklahoma Health Care Authority Medicaid managed care plan and pursuant to the Contract.

1.5 State: The State of Oklahoma or any other State of Oklahoma regulator authorized to oversee Sooner Select.

1.6 Sooner Select: The Oklahoma Medicaid medical assistance and benefit program under the Ensuring Access to Medicaid Act (56 O.S. 2021, Section 4002.1 et al.), as amended, Oklahoma Statute Title 56 et al., as amended, applicable Oklahoma Statutes and Oklahoma Administrative Code, and federal laws and regulations.

1.7 Regulatory Rules: All applicable statutes, codes, regulations, including, but not limited to, 42 C.F.R. 422; 438 et al.; Oklahoma Statute Title 56 et al., including but not limited to 56 O.S. 2021, Section 4002.1 et al.; Oklahoma Administrative Code, including but not limited to Title 317 et al.; OHCA policy, guidance, and program requirements issued by the State including without limitation the Request for Proposals Solicitation Number 8070000052 and OHCA Sooner Select policies and program manuals and guides.

2. GENERAL:

2.1 Humana shall be responsible for maintaining the Agreement in accordance with 42.C.F.R. *§* 438.214.

2.2 Notwithstanding anything to the contrary in the Provider Agreement, **Humana** 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. **Humana** will secure OHCA's approval prior to any such updates becoming effective. A current version of this Attachment is available in the online **Humana** Oklahoma Medicaid Provider Manual.

2.3 Incorporation of Contract. All applicable provisions of the Contract and other requirements imposed by the OHCA on SoonerSelect or similar Medicaid benefit offered in Oklahoma and administered by Humana are incorporated herein and shall at all times be administered in accordance

and consistent with the Contract. Contract requirements that are not set forth in this underlying Agreement are included in Exhibits, Schedules, Attachments, and Addendums to this Agreement and include the applicable Contract requirements attached hereto. Notwithstanding the foregoing, any Contract requirements applicable to the performance of this Agreement by Humana or Provider (or its delegate or subcontractor) shall bind Humana and Provider whether or not expressly set forth herein. **Provider** agrees to comply with all applicable terms and conditions of the Contract as well as all Regulatory Rules and applicable OHCA and federal statutes, regulations, policies, procedures and rules.

2.4 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.

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

2.6 Notwithstanding anything to the contrary in the Agreement, parties represent, independently and not on behalf of the other, each respectively: (i) is properly licensed and insured per State limits, (ii) is legally organized and validly existing under Regulatory Rules, (iii) is in good standing with the State, and (iv) intends to transact intrastate business within the State of Oklahoma.

3. PROVDER REQUIRED PROVISIONS:

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

3.2 If the OHCA determines that any provision in the Agreement conflicts with the Contract, such provision shall be null and void and all other provisions shall remain in full force and effect.

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

3.4 Provider shall maintain through the terms of the Agreement and at its own expense professional and comprehensive general liability and medical malpractice insurance at no less than OHCA minimums, as directed.

3.5 Provider agrees to adhere to all Payor and/or Humana credentialing and recredentialing and State enrollment requirements under the Agreement and Regulatory Rules, without limitation Payor and/or Humana Manual and State Manuals.

4. MARKETING:

4.1 The **Provider** shall adhere to the Regulatory Rules marketing restrictions as applicable and requirements described in the Contract.

4.2 In accordance with § 1932 (b)(3)(A) of the Social Security Act, **Humana** 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.

5. PROVISION OF SERVICES:

5.1 Provider shall provide Members all Covered Services that are within the normal scope of and in accordance with **Provider's** licenses and/or certifications, and Members access to those Covered Services through making appointments or otherwise making contact with the **Provider**.

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

5.3 Provider shall meet applicable appointment waiting time standards set forth in the Contract and Regulatory Rules which include:

a. For Adult and Pediatric Primary Care Providers ("PCP's):
   i. Not to exceed thirty (30) days from the date of request for routine appointments;
   ii. Within seventy-two (72) hours for non-urgent sick visits;
   iii. Within twenty-four (24) hours for urgent care.
   iv. Each PCP shall allow for at least some same-day appointments to meet acute care needs.

b. For OB/GYN Providers:
   i. Not to exceed thirty (30) days from the date of request for routine appointments;
   ii. Within seventy-two (72) hours for non-urgent sick visits;
   iii. Within twenty-four (24) hours for urgent care.

   For maternity care:
   i. First Trimester – Not to exceed fourteen (14) calendar days;
   ii. Second Trimester – Not to exceed seven (7) calendar days;
   jjj, Third Trimester – Not to exceed three (3) calendar days.

c. For Adult and Pediatric Specialty Providers:
   i. Not to exceed sixty (60) days from the date of request for routine appointments;
   ii. Within twenty-four (24) hours for urgent care.

d. For Adult and Pediatric Mental Health and Substance Use Providers:
   i. Not to exceed thirty (30) days from the date of request for routine appointments;
   ii. Within seven (7) days for residential care and hospitalization;
   iii. Within twenty-four (24) hours for urgent care.

6. TERMINATION:

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

6.2 Humana and **Provider** shall have the right to terminate the Provider Agreement . Either party may terminate the Provider Agreement for cause with thirty (30) Days advance written notice to the other party and without cause with sixty (60) Days advance written notice to the other party.

6.3 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.

6.4 OHCA shall have the right to direct **Humana** to terminate any Provider Agreement if OHCA determines that termination is in the best interest of the State of Oklahoma.

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

7. MEMBER SERVICES:

7.1 Providers shall abide by Member rights and responsibilities denoted in the **Contract**. A listing of Member rights and responsibilities may be found within the Humana Healthy Horizons in Oklahoma Provider Policies and Procedures Manual available on Humana's website https://www.Humana.com/provider/news/publications

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

7.3 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).

7.4 Providers shall accommodate the presence of interpreters in accordance with SoonerSelect.

7.5 Provider in accordance with § 1932(b)(6) of The Act and 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2), shall hold Member harmless for the costs of covered services except for any applicable Co-payment amount allowed by OHCA.

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

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

7.8 Provider agrees to comply with necessary and authorized Member communications, movement, and/or re-assignment, as required or compelled by the State or authorized enforcement body under the Regulatory Rules.

7.9 Tobacco Free Requirements: Provider shall be required to implement and provide a tobacco-free campus in accordance with the standards of the Tobacco Free policy of the State of Oklahoma 63 O. S. § 1-1523 and Executive Order 2013-43.

8. RECORDS MAINTENCE AND AUDIT REQUIREMNTS:

8.1 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.

8.2 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 **Humana**, OHCA or its designated agent(s) during and after the term of the Provider Agreement.

8.3 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.

8.4 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.

8.5 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.

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

8.7 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.

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

8.9 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.

9. QUALITY AND UTILZATION MANGEMENT:

9.1 Humana 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 **Humana** and shall participate in any corrective action processes that will be taken where necessary to improve quality of care.

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

9.3 Provider shall participate and cooperate in internal and external quality management or quality improvement activities, such as, monitoring, utilization review, peer review and/or appeal procedures established by Payor and/or Humana and/or OCHA.

9.4 Provider shall follow the standards for medical necessity as required under the Contract and the Regulatory Rules.

9.5 Provider and Humana agree to participate in **Humana** and OHCA directed and facilitated advisory board.

10. PROGRAM INTEGRITY:

10.1 As a condition of receiving any amount of payment, **Provider** shall comply with program integrity requirements of the Contract and the Regulatory Rules, as applicable.

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

10.3 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.

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

10.5 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.

10.6 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 "**Error! Reference source not found.**" of the Contract.

10.7 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 **Humana** any exclusion information discovered.

11. PROVIDER COMPLIANCE PROGRAM:

11.1 Provider agrees to maintain and update, as required, its compliance program with no less than written policies and procedures of its business model, roles and responsibilities of its treating and member-facing personnel, organizational chart, succession planning, ownership, background checks for all personnel, fraud, waste, and abuse reporting protocols, and a plan for fraud, waste, and abuse employee training as required.

12. CLAIMS AND PAYMENT:

12.1 Provider shall promptly submit all information needed for **Humana** to make payment for authorized items, services, or procedures under Member's Oklahoma health benefit plan.

12.2 Provider shall submit timely, complete, and accurate encounter claims in accordance with the Contract and Regulatory Rules.

12.3 Provider shall submit all claims that do not involved a third-party payer for services rendered to **Humana's** Members within one hundred and eighty (180) days or less from the date of service. Resubmitted claims, when applicable, shall be submitted within an additional one hundred and eighty (180) days from the date of service.

12.4 Humana shall make timely payment to the **Provider** for Covered Services upon approval of a clean claim properly submitted by the **Provider** within the required timeframes. **Humana** shall only accept uniform claim forms submitted by **Provider** that have been approved by the Administration and completed according to Administration guidelines.

12.5 Provider shall accept payment from **Humana** as payment for services performed and cannot request payment from the Administration or the Member, unless the Member is required to pay a Copayment for the service rendered.

12.6 Humana will provide at least thirty (30) days written notice to **Provider** prior to any change in payment structure or reimbursement amount, unless mandated otherwise by OHCA upon which **Humana** will notify **Provider** of the effective date of change. The written notice will contain clear and detailed information about the change and will not be retroactive, unless mandated by Administration.

12.7 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 **Humana**, 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 **Humana** 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.

12.8 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 **Humana** by making all reasonable attempts, but no less than three good faith, documented attempts to pursue Third Party Liability of Members.

13. GRIEVANCES AND APPEALS:

13.1 In accordance with the Agreement and Regulatory Rules, including but not limited to 42 C.F.R. §§ 438.414 and 438.10(g)(2)(xi), the **Provider** has the right to file an internal appeal with Payor and/or Humana regarding denial of the following:

a. A health care service;
b. Timely submitted claim for reimbursement;
c. Payment to Provider on Provider's clean claim.

Members may file a grievance at any time, but an appeal must be filed within sixty (60) days of notice of the adverse determination which the Member wishes to appeal. Assistance from Humana is available to Members for filing grievance and appeals. Members have a right to request a State Fair Hearing after Humana has made an adverse determination on the Member's appeal. Members have a right to request continuation of the benefits subject to the appeal or State filing, subject to timing

requirements of the filing; and Members may be liable for the cost of any continued benefits while the appeal or State filing is pending if the final decision upholds Payor's adverse determination.

13.2 Humana shall take no punitive action against a **Provider** who either requests an expedited resolution or supports a Member's grievance or appeal. Additional details on grievance and appeals process may be found within Payor's Oklahoma Provider Manual available on Humana's website (https://www.humana.com/provdier/news/publications).

14. PROVISIONS APPLICABLE TO PRIMARY CARE PROVIDERS:

14.1 If **Provider** is considered a Primary Care Provider ("PCP"), **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. Screen Members for behavioral health disorders and conditions;
d. Make referrals for specialty care and other Covered Services and, when applicable, work with **Humana** to allow Members to directly access a specialist as appropriate for a Member's condition and identified needs;
e. Maintain a current medical record for the Member;
f. Use health information technology to support care delivery;
g. Provide care coordination in accordance with the Member's care plan, as applicable based on **Humana's** Risk Stratification Level Framework, and in cooperation with Member's care manager;
h. Ensure coordination and continuity of care with **Providers**, including but not limited to specialists and behavioral health **Providers**;
i. 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;
j. 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;
k. 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
l. Participate in continuous quality improvement and voluntary performance measures established by **Humana** and/or OHCA.

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

15. MENTAL HEALTH PARITY:

15.1 Humana and **Provider** must comply with applicable requirements of the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K, including the requirements that treatment limitations applicable to mental health or substance abuse disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by **Humana** and there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

16. PROVISIONS APPLICABLE TO BEHAVIORAL HEALTH SERVICE PROVIDERS:

16.1 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.

16.2 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.

16.3 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.

16.4 Humana 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 **Humana** policy and procedures.

17. PROVISIONS APPLICABLE TO PROVIDERS WITH LABORATORY SERVICES:

17.1 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. Humana shall be responsible for maintaining a comprehensive network of independent and other laboratories that ensures laboratories are accessible to all Members.

18. NON-ALLOWABLE PROVISIONS:

18.1 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 **Humana** shall not apply to the Oklahoma Medicaid line of business.

18.2 The parties acknowledge and agree that nothing contained in this Agreement is intended to disrupt the **Provider** and **Member** relationship, and **Provider** acknowledges that all patient care and related decisions are the responsibility of the **Provider** and attending physicians, and that Humana does not dictate or control clinical decisions with respect to the behavioral health care or treatment of Members.

PAYMENT ATTACHMENT – OKLAHOMA MEDICAID

[INTENTIONALLY LEFT BLANK.]