FACILITY SERVICES AGREEMENT

TABLE OF CONTENTS

FACILITY SERVICES AGREEMENT

This Facility Services Agreement ("Agreement") is made and entered into as of April 1, 2014 ("Effective Date") by and between Aetna Health Management, LLC, a Delaware limited liability company, on behalf of itself and its Affiliates (hereinafter "Company") and Western Rehabilitation Health Network, LC, on behalf of itself and the facilities and clinics it contract for (hereinafter "Facility"). The Regulatory Compliance Addendum attached to this Agreement as Exhibit A, is expressly incorporated into this Agreement and is binding upon the parties to this Agreement. In the event of any inconsistent or contrary language between the Regulatory Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the parties agree that the provisions of the Regulatory Compliance Addendum shall prevail, but, if applicable, only with respect to a particular line of business (e.g., fully-insured HMO) and/or product.

WHEREAS, Company contracts with certain health care providers and facilities to provide health care services to Members and in return for the provision of health care services by providers and facilities, Company will pay or arrange for the payment of claims for Covered Services under the terms of this Agreement.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings in this Agreement, the sufficiency of which is hereby acknowledged, and intending to be legally bound, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

1.1 Affiliate. Any corporation, partnership or other legal entity directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

1.2 Clean Claim. Unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-10 or its successor standard, HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS 1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits and (d) has no defect or error (including any new procedures with no CPT code, experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

1.3 Coinsurance. The percentage of the lesser of: (a) the rates established under this Agreement; or (b) Facility's usual, customary and reasonable billed charges, which a Member is required to pay for Covered Services under a Plan.

1.4 Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information", as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

1.5 Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Facility.

1.6 Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan.

1.7 Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

1.8 Emergency Services. Those services necessary to treat 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: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

1.9 Final Contract Period. The final term of any contract between the Centers for Medicare and Medicaid Services ("CMS") and Company to offer one or more Medicare Plans.

1.10 Full Risk Plan. A Plan where Company is the underwriter, in full, of the Plan (i.e. fully-insured Plans).

1.11 Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Facility's reimbursement for Facility Services or (ii) Facility administration.

1.12 Medically Necessary or Medical Necessity. Health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community or otherwise consistent with the standards set forth in (b) above.

1.13 Medicare Plan. A Medicare Advantage plan offered by Company to Medicare beneficiaries under a contract with CMS pursuant to Part C of Title XVIII of the Social Security Act.

1.14 Member. An individual covered by or enrolled in a Plan.

1.15 Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed according to Company's policies by Company or its designee.

1.16 Party. Company or Facility, as applicable.

1.17 Plan. A Member's health care benefits as set forth in the Member's Summary Plan Description, Certificate of Coverage or other applicable coverage document, including, but not limited to, a Medicare Plan.

1.18 Plan Sponsor. An employer, insurer, third party administrator, labor union, organization or other person or entity which has contracted with Company to offer, issue and/or administer a Plan that is not a Full Risk Plan and has agreed to be responsible for funding benefit payments for Covered Services provided to Members under the terms of a Plan.

1.19 Policies. The policies and procedures promulgated by Company which relate to this Agreement. Policies include, but are not limited to, those policies and procedures set forth in Company's manuals, Health Care Professional toolkit or their successors, Clinical Policy Bulletins and other policies and procedures (as modified from time to time) and made available via Company's internet website, letter, newsletter, electronic mail or other media.

1.20 Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement or any future agreement between the Parties whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Facility and which are furnished or disclosed to Facility by Company.

1.21 Specialty Program. A Company established program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors (e.g., organ transplants, women's health, other disease management programs, etc).

2.0 FACILITY SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Facility will make available and provide to Members, Facility services and any related facilities, equipment, personnel or other resources necessary to provide the services according to generally accepted standards of Facility's practice ("Facility Services") and accepts the compensation for such Facility Services listed and set forth in the **Services and Compensation Schedule** attached hereto and made a part hereof. Company and Facility may mutually agree in writing at any time, and from time to time, either to increase or decrease the Facility Services made available to Members under this Agreement. Upon written notice from Facility, Company may agree to add new or relocating facilities and locations to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Facility.

2.1.1 Facility Information.
Facility shall provide to Company a complete list of office and/or service addresses, e-mail addresses, telephone and facsimile numbers, and area of practice or specialty. Facility shall notify Company in writing within seven (7) business days of its acquiring knowledge of any change in this information.

2.2 Non-Discrimination.

2.2.1 Equitable Treatment of Members. Facility agrees to provide Facility Services to Members with the same degree of care and skill as customarily provided to Facility's patients who are not Members, according to generally accepted standards of Facility's practice. Facility and Company agree that Members and non-Members should be treated equitably. Facility agrees not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Facility Services required, or any other grounds prohibited by law or this Agreement.

2.2.2 Affirmative Action. Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Facility, Facility, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal

criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.3 Facility Representations.

2.3.1 General Representations. Facility represents and covenants, as applicable, that: (a) it has and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies; (b) it is, and will remain throughout the term of this Agreement, accredited by The Joint Commission ("TJC"), Committee on Accreditation of Rehabilitation Facilities ("CARF"), American Association for Accreditation of Ambulatory Surgery Facilities ("AAAASF"); American Osteopathic Association's Healthcare Facilities Accreditation Program ("HFAP"); or another applicable accrediting agency recognized by Company; (c) that neither Facility nor any Provider Related Parties (as defined in Section 2.3.2) has (i) been excluded from participation in any federal or state-funded health program; or (ii) been listed in the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the Exclusion Lists (as defined in Section 2.3.2.1 (d)) (each a "Data Source"); (d) it is, and will remain throughout the term of this Agreement, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided under this Agreement; (e) it is certified to participate in the Medicare program; (f) it has established an ongoing quality assurance/assessment program which includes, but is not limited to, appropriate credentialing of employees and subcontractors and shall supply to Company the relevant documentation, including, but not limited to, internal quality assurance/assessment protocols, state licenses and certifications, Federal agency certifications and/or registrations upon request; (g) does not use any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor, agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity and Facility and such Offshore Entity consent to Company's right to audit prior to the provision of services for Plans; (h) all Facility-Based providers and ancillary health care personnel employed by, associated or contracted with Facility who treat Members ("Ancillary Personnel") are, where applicable, properly credentialed, privileged, and re-appointed within the scope of their specialty and: (i) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised, and qualified by education, training and experience to perform their professional duties; and (ii) will act within the scope of their licensure or certification, as the case may be; (i) its credentialing, privileging, and re-appointment procedures are in accordance with its medical staffs by-laws, regulations, and policies, comply with TJC standards, meet the querying and reporting requirements of the National Practitioner Data Bank ("NPDB") and Healthcare Integrity and Protection Data Bank ("HIPDB"), and fulfill all applicable state and Federal standards; and (j) this Agreement has been executed by its duly authorized representative.

2.3.2 Government Program Representations. Company has or may seek a contract to serve Medicare beneficiaries ("Government Programs"). To the extent Company participates in such Government Programs, Facility agrees, on behalf of itself and any subcontractors of Facility acting on behalf of Facility, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Facility acknowledges and agrees that all provisions of this Agreement shall apply equally to any permanent and temporary employees and Downstream Entities, as defined in 42 C.F.R. § 422.2 (collectively, "Provider Related Parties") of Facility who provide or may provide Covered Services to Members of Government Programs, and Facility represents and warrants that Facility shall take all steps necessary to cause Provider Related Parties to comply with the Agreement and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. In the event Facility or any Provider Related Parties are listed in a Data Source after the Effective Date of this Agreement, Company shall have the right, in its sole discretion and judgment, to terminate any schedule or attachment to the Agreement relating to the performance of Facility Services

for Medicare Plans by Provider in accordance with the applicable provisions of the Agreement or to disqualify the listed person(s) from providing any part of the Facility Services.

Facility agrees that all services and other activities performed by Facility under this Agreement will be consistent and comply with Company's obligations under its contract(s) with CMS, and any applicable state regulatory agency, to offer Medicare Plans. Facility further agrees to allow CMS, any applicable state regulatory agency, and Company to monitor Facility's performance under this Agreement on an ongoing basis in accordance with Medicare laws, rules and regulations. Upon request, Facility shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Facility generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Facility certifies, to the best of their knowledge and belief, that such data is accurate, complete and truthful. Facility acknowledges and agrees that Company may only delegate its activities and responsibilities under its contract(s) with CMS and any applicable regulatory agency, to offer Medicare Plans in a manner consistent with Medicare laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Facility, the activity or responsibility may be revoked if CMS or Company determine that Facility has not performed satisfactorily.

2.3.2.1 Medicare Compliance Program Requirements.

(a) Facility agrees to comply with all applicable requirements set forth in the CMS Compliance Program Guidelines ("Compliance Program Guidelines") that apply to "first tier entities" and/or "downstream entities," as those terms are defined by CMS. In accordance with the Compliance Program Guidelines, Company will provide to Facility general compliance information through distribution of Company's standards of conduct and/or compliance policies and procedures ("Company Standards of Conduct").

(b) Consistent with the Compliance Program Guidelines, Facility agrees to either: (1) distribute Company Standards of Conduct to Provider Related Parties, or (2) adopt standards of conduct and prepare compliance policies and procedures that are detailed and specific and describe the operation of Facility's compliance program ("Provider Standards of Conduct"), and distribute such Provider Standards of Conduct to Provider Related Parties.

Facility agrees that distribution of Company or Provider Standards of Conduct shall occur within ninety (90) days of hire or contracting, when there are updates to such Standards of Conduct, and annually thereafter. Further, Facility must maintain documentation necessary to demonstrate to Company and CMS that Company or Provider Standards of Conduct was distributed to Provider Related Parties as required in the Compliance Program Guidelines ("Standard of Conduct Documentation"). Facility agrees that Standard of Conduct Documentation is "Information and Records," as defined in Section 5.3.2 of this Agreement, and will maintain and provide access to all Standard of Conduct Documentation as described in Section 5.3.2 of this Agreement.

(c) In accordance with the Compliance Program Guidelines, Facility shall ensure that all of Provider's Related Parties complete a Medicare fraud, waste and abuse training course ("Medicare Compliance Training"). Provider Related Parties may complete Medicare Compliance Training by completing: (1) the CMS "Medicare Parts C&D Fraud, Waste and Abuse" course ("CMS Module"), which is available on CMS' website, or (2) a course provided by Facility. Provider Related Parties meeting the CMS Medicare Compliance Training requirements through enrollment in the fee-for-service Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provider are deemed by CMS rules to have met the Medicare Compliance Training requirement in this Section. Facility agrees that new Provider Related Parties will complete Medicare Compliance Training within ninety (90) days of

initial hire or the effective date of contracting with Facility, and at least annually thereafter.

If Facility chooses to provide its own Medicare Compliance Training rather than use the CMS Module, Facility shall ensure that Medicare Compliance Training complies with all laws, rules and regulations that apply to Medicare Compliance Training, including, without limitation, the requirements set forth in the Medicare Compliance Guidelines. In addition, Facility shall: (i) maintain and provide to Company, upon request, a copy of the Medicare Compliance Training provided to Provider Related Parties and all information and documentation demonstrating that Provider Related Parties completed Medicare Compliance Training on an annual basis (collectively, "FWA Documentation"), including proof of training (i.e., copies of sign-in sheets, Provider Related Parties attestations, and/or electronic certifications) from Provider Related Parties completing the Medicare Compliance Training, and (ii) agree to sign and submit to Company on an annual basis a written attestation (in a form and manner determined by Company), attesting to Facility's and each Provider Related Party's completion of Medicare Compliance Training. Facility agrees that FWA Documentation is "Information and Records", as defined in Section 5.3.2 of this Agreement, and will maintain and provide access to all FWA Documentation as described in Section 5.3.2 of this Agreement.

(d) In accordance with applicable laws, rules and regulations and the Compliance Program Guidelines, Facility agrees to review the Department of Health and Human Services ("HHS") Office of Inspector General List of Excluded Individuals and Entities and the General Service Administrative Excluded Parties Lists System (collectively, "Exclusion Lists") to ensure that Provider Related Parties are not included on such Exclusion Lists. Provider agrees to review the Exclusion Lists prior to initially hiring, appointing or contracting with any new Provider Related Party and at least once per month thereafter to confirm that Provider Related Parties are not included on such Exclusion Lists. Facility agrees that if a Provider Related Party appears on an Exclusion List and/or is excluded from participation in any federally-funded health program, Facility will immediately remove the Provider Related Party from any work related directly or indirectly to Company's Medicare Plans, and take all corrective actions required under applicable laws, rules or regulations.

2.3.2.2 Monitoring and Oversight. Facility acknowledges and agrees to allow Company and CMS to monitor Facility's performance of Facility Services on an ongoing basis. If Company has reason to believe that Facility has failed to carry out the Facility Services in accordance with the terms of the Agreement or any attachments or schedule thereto, Company may take such steps, as it deems necessary, including but not limited to the following:

(i) Audit Facility's performance of the Facility Services.
(ii) Require Facility to submit, within a reasonable time frame specified by Company, a corrective action plan to address any compliance or other failure to carry out the Facility Services identified by Company.
(iii) Require Facility to implement, within ten (10) calendar days of notice, a corrective action plan approved by Company and permit increased audits of Facility's performance of Facility Services to ensure compliance with such plan.
(iv) Suspend Facility's performance of Facility Services pending the submission of a corrective action plan acceptable to Company and successful implementation of such plan as determined by Company.

Facility agrees that it shall be a considered a material breach of the Agreement if a corrective action plan acceptable to Company cannot be developed and fully implemented within ten (10) calendar days or, in Company's sole discretion, at such other timeframe determined by Company. If such compliance or other failure to carry out the Facility Services cannot be corrected within such time

period, Company may, in Company's sole discretion, either revoke delegation of services under the Agreement or terminate any schedule to the Agreement for Facility Services upon notice to Facility.

2.4 Facility's Insurance.
During the term of this Agreement, Facility agrees to procure and maintain such policies of general and professional liability and other insurance at or a comparable program of self-insurance at minimum levels as required by state law, or in the absence of a state law specifying a minimum limit, an amount customarily maintained by facilities in the state or region in which the Facility operates. Such insurance coverage shall cover the acts and omissions of Facility as well as those of Facility's agents and employees. Facility agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Facility agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of these policies.

2.5 Product Participation.
Facility agrees to participate in the benefit products listed on the **Product Participation Schedule**. Company reserves the right to introduce and designate Facility's participation in new Specialty Programs and products during the term of this Agreement and will provide Facility with written notice of such new Specialty Programs and products and the associated compensation.

Nothing in this Agreement shall require that Company identify, designate or include Facility as a preferred participant in any specific Specialty Program or product; provided, however, Facility shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Specialty Program or product in which Facility has agreed to participate in this Agreement.

Company may sell, lease, transfer or otherwise convey to payers (other than Plan Sponsors) which do not compete with Company's product offerings in the geographic area where Facility provides Covered Services, the benefits of this Agreement, including, without limitation, the **Services and Compensation Schedule** attached hereto, under terms and conditions which will be communicated to Facility in each such case. For those programs and products which are not health benefit products, Facility shall have thirty (30) days from receipt of the Company's notice to notify Company in writing if Facility elects not to participate in these product(s).

2.6 Consents to Release Medical Information.
Facility will obtain from Members to whom Facility provides Facility Services, any necessary consents or authorizations to the release of Information and Records to Company, Plan Sponsors, their agents and representatives. In performing this covenant, Facility shall comply with any applicable Federal and state law or regulation.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Plan Sponsors shall provide Members with a means to identify themselves to Facility (e.g., identification cards), an explanation of provider payments, a general description of products (e.g. Quick Reference Card), a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Facility with a means to check Member eligibility. Company shall include Facility in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Facility is a Participating Provider, including when Facility is designated as preferred participant, and shall make these directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and covenants that: (a) it, where applicable, is licensed to offer, issue and administer Plans in the service areas covered by this Agreement by the applicable regulatory authority ("License"); (b) it will not lose such License involuntarily during the course of this Agreement; and (c) it is, and will remain throughout the term of this Agreement, substantially in compliance with all applicable Federal and state laws

and regulations related to this Agreement and the services to be provided in this Agreement; including without limitation, any applicable prompt payment statutes and regulations.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Facility Obligation to Submit Claims. Facility clinics/providers agrees to submit Clean Claims to Company for Facility Services rendered to Members. Facility represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Facility Services to be made directly to Facility clinics/providers. Facility clinics/providers will submit all claims electronically to Company using the HIPAA required ASC X12N 837—Health Care Claim: Professional for professional claims and the ASC X12N 837—Health Care Claim: Institutional for institutional claims or an industry standard successor format ("Electronic Claim"). Facility clinics/providers shall not submit a claim to Company in paper form unless Company fails to pay or otherwise respond to electronic claims submission in accordance with the timeframes required under this Agreement or applicable law or regulation. Facility agrees that Company, or the applicable Plan Sponsor, will not be obligated to make payments for billing received more than one hundred and twenty (120) days from (a) the date of service or, (b) from the date of receipt of the primary payer's explanation of benefits when Company is the secondary payer. This requirement will be waived in the event Facility provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside the control of Facility that resulted in the delayed submission. In addition, unless Facility notifies Company of any payment disputes or dispute regarding claim denial within one hundred eighty (180) days, or such longer time as required by applicable state law or regulation, of receipt of payment or claim denial from Company, such payment or claim denial will be considered full and final payment or determination for the related claims. If Facility clinics/providers do not bill Company or Plan Sponsors, or disputes any payment, timely as provided in this Section 4.1.1, Facility clinic's/provider's claim for payment will be deemed waived and Facility clinics/providers will not seek payment from Plan Sponsors, Company or Members. Facility clinics/providers shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Members for which Facility is financially responsible pursuant to this Agreement.

Facility agrees to permit rebundling to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and to allow Company to make other adjustments for inappropriate billing or coding (e.g., duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). In performing rebundling and making adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Medicare and other industry standards in the development of its rebundling logic.

In circumstances where the compensation under this Agreement includes payment for the services of facility-based providers, including, but not limited to pathologists, radiologists, anesthesiologists, psychiatry, clinical social worker, clinical psychologist, licensed professional counselor and marriage/family therapist ("Facility-based Providers"), Facility shall be financially and administratively responsible for payment to all Facility-based Providers who render Covered Services to Members at Facility and Facility-based Providers shall look solely to Facility for payment. Notwithstanding the previous sentence, Company reserves the right to pay, or to instruct Payers to pay, any Facility-based Provider for Covered Services for which Facility is financially responsible and for

which a valid, undisputed invoice, or portion thereof, is outstanding for more than fourteen (14) days beyond its due date, except that Company need not wait fourteen (14) days if Facility has engaged in a pattern of late payments. If Facility cannot resolve the claims submitted by the Facility-based Providers, Company has the right to offset other amounts owed to Facility in order to recover from Facility any money that Company has paid to the Facility-based Providers. Facility agrees to indemnify, defend, and hold Company harmless from any claims for payment from Facility-based Providers for these services and holds Payers and Members harmless for payment of any compensation owed by Facility to Facility-based Providers under Facility-based Providers' arrangement with Facility.

4.1.2 Company Obligation to Pay for Covered Services. Company agrees to: (a) pay Facility clinics/providers for Covered Services rendered to Members of Full Risk Plans, and (b) notify Plan Sponsors to forward payment to Company for payment to Facility clinics/providers for Covered Services rendered to a Plan Sponsor's Members, according to the lesser of (1) Facility's actual billed charges or (2) the rates set forth in the **Services and Compensation Schedule**, within forty-five (45) days (or such time as permitted by applicable law or regulation) of actual receipt by Company of a Clean Claim. Facility clinics/providers will utilize online explanation of benefits, electronic remittance of advice and electronic funds transfer in lieu of receiving paper equivalents. While Company may pay claims on behalf of Plan Sponsors, Facility and Company acknowledge that Company has no legal responsibility for the payment of such claims for Covered Services rendered to a Plan Sponsor's Members; provided, however, that Company agrees to reasonably assist Facility clinics/providers as appropriate in collecting any such payments.

Company may authorize a designee to perform pre-payment reviews of certain claims. This review may include, but not be limited to, a request for itemized bills or more specific detail with respect to claims contracted on a percentage of charges basis. Facility acknowledges that Company may, as a result of the review, deny payment for, among other things, duplicate charges, errors in billing or categorization of capital equipment. Company and/or its designee may, from time to time, notify Facility of overpayments to Facility clinics/providers or Ancillary Personnel for whom Facility clinics/providers bill and Facility clinics/providers agree to return any such overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Facility clinics/providers to a patient who was not a Member) within a reasonable period of time. In the event Company is unable to secure the return of any such payment within such reasonable time, Company reserves the right to offset such payment against any other monies due to Facility clinics/providers under this Agreement provided Company has delivered to Facility clinics/providers at least ten (10) days prior written notice and Facility clinics/providers have otherwise failed to return such payment to Company. .

4.1.3 Utilization Management. The Parties agree that Company, on its behalf and on behalf of Plan Sponsors, reserves the right to perform utilization management (including retrospective review) and to adjust or deny payment for the inefficient delivery of Facility Services related to admissions, or length of stay. To facilitate timely and accurate concurrent utilization management, Facility and Company will cooperate as necessary to facilitate on-site and/or concurrent telephonic utilization management at Facility. Company agrees that it will not conduct retrospective review so long as Company has been provided a reasonable opportunity to conduct full and complete concurrent utilization management review in accordance with Policies while the Member was in the Facility, except where (1) Facility, a Participating Provider or any other provider rendering care at or on behalf of Facility, has provided inaccurate or incomplete information to Company or (2) the patient was not a known Member as of the time of the provision of care.

4.2 Coordination of Benefits.

Company will coordinate benefits as allowed by state or federal law, or, in the absence of any applicable law, in accordance with plan requirements. If Medicare is the primary payer under coordination of benefit principles, Facility may not collect more than Medicare allows. In no event will Company pay more than the compensation due under this Agreement.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Facility clinics/providers may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles not collected at the time that Covered Services are rendered; (b) a Plan Sponsor becomes insolvent or otherwise fails to pay Facility clinics/providers in accordance with applicable Federal law or regulation (e.g., ERISA) provided that Facility clinics/providers have first exhausted all reasonable efforts to obtain payment from the Plan Sponsor; and (c) services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Notwithstanding the foregoing, Facility clinics/providers will bill or charge Member contracted rates if the Member has exhausted applicable plan benefits. Facility acknowledges that Company's denial or adjustment of payment to Facility clinics/providers based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Facility clinics/providers may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Facility hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Facility clinics/providers bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other asset controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles or other supplemental charges made in accordance with the terms of the applicable Plan. Facility further agrees that Medicare Members will not be held liable for payment of any fees that are the legal obligation of Company. Facility further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Facility and Members or persons acting on their behalf. Where required by applicable law no modification of this provision shall be effective without the prior written approval of such applicable regulatory agency.

4.3.3 Cost Sharing Protections for Dual Eligible Members. Facility acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Facility any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Facility further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or bill the applicable State Medicaid plan for the appropriate Cost Sharing Amounts owed by the State Medicaid plan.

To protect Members, Facility agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

4.4 Risk Adjustment Data Validation.

This Section applies in the event that Facility participates in Government Programs. For purposes of this Section: (1) "risk adjustment data" shall have the meaning set forth in 42 C.F.R. Section 422.310(a), as may be amended from time to time, and (2) "Diagnosis" shall mean an International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM") diagnosis code, or its successor (such as ICD-10-CM or ICD-10-PCS), that Provider submits to Company for a Medicare Member. In accordance with 42 C.F.R. § 422.310, Company is required to obtain risk adjustment data from Facility for Medicare Members, and Facility agrees to provide complete and accurate risk adjustment data to Company for Medicare Members that conforms to the requirements of this section and all standards and requirements including, but not limited to, CMS regulations and instructions that apply to risk adjustment data. In accordance with 42 C.F.R. § 422.504(l)(3), Facility certifies, based on best knowledge, information and belief, that any risk adjustment

data that Facility submits to Company for Medicare Members is accurate, complete and truthful. Facility acknowledges and agrees that risk adjustment data is used to determine CMS payments to Company and, as a result, Facility agrees to immediately notify Company if any risk adjustment data that was submitted, directly or indirectly, to Company for Medicare Members is inaccurate, incomplete or erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable standards and requirements.

Facility further agrees to maintain accurate, legible and complete medical record documentation for all risk adjustment data submitted to Company for Medicare Members in a format that meets all standards and requirements including, but not limited to, CMS regulations and instructions, and allow any federal governmental authorities with jurisdiction or their designees ("Government Officials") to: (1) confirm that the appropriate diagnoses codes and level of specificity are documented; (2) verify the date of service is documented and within the risk adjustment data collection period; and (3) confirm that the appropriate provider's signature and credentials are present ("Medical Records").

In accordance with 42 C.F.R. § 422.310 and 422.504(i)(2), Facility agrees to provide Company and Government Officials, or their designees, with medical records and any other information or documentation required by Government Officials for the validation of risk adjustment data ("Audit Data"). Facility agrees to provide Company with Audit Data within the timeframe established by Company to ensure Company's compliance with deadlines imposed by Government Officials for the submission of Audit Data. In the event that CMS conducts a review that includes the validation of risk adjustment data submitted by Facility, Company will submit to Facility a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

If Facility is compensated on a fee for service basis and a Government Official imposes a financial adjustment or penalty on Company based on a finding that there is insufficient information or documentation to support a Diagnosis ("Audit Finding"), Company may recoup the total amount that Company paid to Facility for the Current Procedural Terminology (CPT), Diagnostic Related Groupings (DRG) codes, or other nationally recognized medical codes used to bill Company for inpatient and/or outpatient Covered Services rendered to treat such Diagnosis ("Billing Codes"). Company shall only recoup payments made to Facility for Billing Codes associated with dates of service that are within the calendar year(s) that is described in the Audit Finding. Prior to recouping any payments made to Facility for a Diagnosis for which an Audit Finding was issued, Company will provide Facility with copies of: (1) the pertinent portion(s) of the final written audit report prepared by a Government Official demonstrating that an Audit Finding was issued relating to the Diagnosis, and (2) a copy of the Medical Records submitted by Company to the Government Official for the Diagnosis.

4.5 Medicare Payment Adjustment.

The Parties acknowledge and agree that payments under the Medicare program to providers, suppliers, and Medicare Advantage organizations may be adjusted as the result of legislation, regulation, executive order or other federal mandate ("Medicare Payment Adjustment"). Furthermore, any such Medicare Payment Adjustment could result in an increase or decrease in Medicare payments. In accordance with the terms of this Agreement, the Parties agree that, in the event of a Medicare Payment Adjustment, Company's payment to Facility will be adjusted in accordance with the Medicare Payment Adjustment. Company shall adjust payments under this Agreement for Covered Services rendered by Facility on and after the effective date of the Medicare Payment Adjustment, and shall continue to adjustment payments to Facility for until the earlier of (i) the Medicare Payment Adjustment is discontinued or (ii) is replaced by a subsequent Medicare Payment Adjustment.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Facility agrees to accept and comply with Policies of which Facility knows or reasonably should have known (e.g., Clinical Policy Bulletins or other Policies made available to Participating Providers). Except when a Member requires Emergency Services, Facility agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Facility Services. Facility will utilize

the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Facility agrees to notify Company of all admissions of Members, and of all services for which Company requires notice, upon admission or prior to the provision of such services. For the purpose of pre-admission testing, Facility agrees to directly provide testing or accept test results and examinations performed outside Facility provided such tests and examinations are: (a) performed by a state licensed laboratory for laboratory tests, and a licensed physician for such other tests and examinations; and (b) performed within a time reasonably proximate to the admission. For those Members who require services under a Specialty Program, Facility agrees to work with Company in transferring the Member's care to a Specialty Program Provider, as the case may be. Company may at any time modify Policies. Company will provide ninety (90) days prior notice by letter, newsletter, electronic mail or other media, of Material Changes. Failure by Facility to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Facility's acceptance of such Material Change. In the event that Facility reasonably believes that a Material Change is likely to have a material adverse financial impact upon Facility, Facility agrees to notify Company, specifying the specific bases demonstrating a likely material adverse financial impact, and the Parties will negotiate in good faith an appropriate amendment, if any, to this Agreement. Facility agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Plan Sponsors and Members from any financial liability for the applicable portion of the Facility Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Facility agrees to provide notice to Company, and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition, of: (a) any action taken by Facility adversely affecting medical staff membership of Participating Physicians and other Participating Providers, whether or not such actions are reportable to NPDB or HIPDB; (b) any litigation brought against Facility or any of its employees, medical staff members or affiliated providers which is related to the provision of health care services and could have a material impact on the Facility Services provided to Members; (c) any investigation initiated by TJC, another accrediting agency recognized by Company or any government agency or program against or involving Facility or any of its employees, medical staff members or affiliated providers that does or could adversely affect Facility's accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Facility; and (e) any material change in services provided by Facility or licensure status related to these services, including without limitation a significant decrease in medical staff or the closure of a service unit or material decrease in beds. Facility agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of, any actions taken by Facility described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Facility agrees: (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive, accurate and timely manner and in accordance with customary medical practice, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws, including but not limited to, the requirements set forth in 42 C.F.R. §§ 422.136; and (c) to maintain such Information and Records for the longer of six (6) years after the last date Facility Services were provided to Member, or the period required by applicable law. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Facility agrees that (a) Company (including Company's authorized designee) and Plan Sponsors shall have access to all data and information obtained, created or collected by Facility related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Plan Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, medical and financial records, contracts and computer or other electronic systems) and information relating to this Agreement and to those services rendered by Facility to Members

("Records"); (c) consistent with the consents and authorizations required by Section 2.6 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, including pre-payment review, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; (e) medical information relating to Members is released only in accordance with applicable federal or state law, or pursuant to court orders or subpoenas; and (f) Members shall have timely access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Facility agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event later than the date required by any applicable law or regulatory authority. Except as required by applicable state or federal law, Facility agrees that Company (including Company's authorized designee), Plan Sponsors and Members shall not be required to reimburse Facility for expenses related to providing copies of patient records or documents to any local, State or Federal agency: (i) pursuant to a request from any law or regulatory agency; (ii) pursuant to administration of Company's utilization management; or (iii) in order to assist Company in making a determination regarding whether a service is a Covered Service for which payment is due; or (iv) for any other purpose. Facility agrees to provide Company data necessary for Company to 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. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members. In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Facility, on behalf of itself and any Provider Related Parties, agrees to provide Company and HHS, the Comptroller General or their designees (collectively, "Permitted Parties") access to all Information and Records (as defined in Section 5.3.2), and that this right of inspection, evaluation and audit will continue for the longer of: (i) a period of ten (10) years from the final date of the Final Contract Period of any contract between Company and CMS to offer Medicare Plans, or (ii) the completion of any audit. Facility also agrees to maintain Information and Records for the longer of: (i) ten (10) years from the final date of the Final Contract Period of any contract between Company and CMS to offer Medicare Plans, or (ii) the completion of any audit.

In addition, to the extent applicable to Facility, Facility, on behalf of itself and any Provider Related Parties, agrees to comply with 42 C.F.R. § 422.2480(c) and to maintain all Information and Records containing data used by Company to calculate Medicare Medical Loss Ratios ("MLRs") for Company's Medicare Plans and/or evidence needed by Company and/or federal governmental authorities with jurisdiction to validate MLRs (collectively, "MLR Information and Documentation") for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS. Facility further agrees that, with respect to Medicare Plans, Company, federal governmental authorities having jurisdiction, and their designees, upon request, shall have access to all MLR Information and Records, and that this right of inspection, evaluation and audit of MLR Information and Records shall continue for a minimum of ten (10) years from the date such MLRs were reported by Company to CMS.

This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Facility agrees to cooperate with any Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance ("NCQA") or a state or Federal agency with authority over Company and/or the Plan, as applicable.

5.5 Proprietary Information.

Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the Proprietary Information. Unless such Proprietary Information is otherwise publicly available, each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Plan Sponsors, consultants and vendors under contract with Company, and (iii) in the case of Facility's disclosure to Members for the purposes of advising Members of potential treatment options and costs. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party to this Agreement, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Facility through its staff is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Facility is paid. In addition, Facility through its staff may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of three (3) year(s) from the Effective Date, and thereafter shall automatically continue for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated or non-renewed as of the anniversary date of the Effective Date by either Party with at least one hundred eighty (180) days prior written notice to the other Party prior to such anniversary date of the Effective Date; provided, however, that no termination of this Agreement pursuant to this Section 6.2 shall be effective during the Initial Term hereof.

6.3 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 material default or substantial breach by the other Party of one or more of its obligations under this Agreement, unless such material default or substantial breach is cured within sixty (60) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such sixty (60) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such sixty (60) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 of this Agreement.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Facility, at Company's discretion at any time: (a) the withdrawal, expiration or non-renewal of any Federal, state or local license, certificate, approval or authorization of Facility; (b) the bankruptcy or receivership of Facility, or an assignment by Facility for the benefit of creditors; (c) the loss or material limitation of Facility's insurance under Section 2.4 of this Agreement; (d) a determination by Company that Facility's continued participation in provider networks could result in harm to Members; (e) the debarment or suspension of Facility from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (f) the indictment or conviction of Facility for any crime; (g) the revocation or suspension of Facility's accreditation by TJC or any other applicable accrediting agency recognized by Company; (h) the listing of Facility in the HIPDB; or (i) change of control of Facility to an entity not acceptable to Company. To protect the interests of patients, including Members, Facility will provide immediate notice to Company of any of the events described in this Section 6.4, including notification of impending bankruptcy.

6.5 Obligations Following Termination.

Following the effective date of any expiration or termination of this Agreement or any Plan, Facility and Company will cooperate as provided in this Section 6.5. This Section 6.5 shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above, Facility agrees to provide Facility Services at Company's discretion: (a) to any Member who is an inpatient at Facility as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider; and (b) to any Member for up to one (1) calendar year. The **Services and Compensation Schedule** shall apply to all services under this Section 6.5.1.

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, then in addition to other obligations set forth in this Section 6.5, Facility shall continue to provide Facility Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients in Facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Facility shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

6.6 Obligations During Dispute Resolution Proceedings.
In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 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.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.
The relationship between Company and Facility, as well as their respective employees and other agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Facility will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Facility will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Facility acknowledges that all Member care and related decisions are the responsibility of Facility and its medical staff, and that Policies do not dictate or control Facility's clinical decisions with respect to the care of Members. Facility agrees to indemnify and hold harmless the Company from any and all claims, liabilities and third party causes of action arising out of the Facility's provision of care to Members. Company agrees to indemnify and hold harmless the Facility from any and all claims, liabilities and third party causes of action arising out of the Company's administration of Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.
Facility consents to the use of Facility's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media.

7.3 Interference with Contractual Relations.
Facility shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Plan Sponsors or other entities currently under contract with Company to cancel, or not renew their contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or

disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Nothing in this Section 7.3 is intended or shall be deemed to restrict (i) any communication between Facility and a Member, or a party designated by a Member, determined by Facility to be necessary or appropriate for the diagnosis and care of the Member and otherwise in accordance with Section 5.5; or (ii) notification of participation status with other HMOs or insurers. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Facility agrees to: (a) cooperate with, participate in and abide by decisions of Company's applicable medical necessity appeal, grievance and external review procedures for Members (including, but not limited to, Medicare appeals and expedited appeals procedures); and (b) provide Company with the information necessary to resolve same.

8.2 Facility Dispute Resolution.
Company shall provide an internal mechanism under which Facility may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Facility shall exhaust this internal mechanism for any contractual disputes prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any discussions and negotiations held pursuant to this Section 8.2 shall not be admitted into evidence in any court proceeding.

8.3 Arbitration.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. The parties agree that the AAA Optional Rules for Emergency Measures of Protection shall not apply to the proceedings. Before any contractual or claim payment dispute proceeds to arbitration, Facility must have fully exhausted Company's internal provider dispute resolution processes. Upon mutual consent of the parties, the arbitration will be administered by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor-Provider Arbitration Rules, except to the extent modified by these arbitration provisions. The arbitrator shall be, to the extent available, either a retired judge or selected from a panel of persons trained and expert in the area of health care law. The governing law provision of this Agreement shall apply to the arbitration proceeding, except to the extent Federal substantive law would apply to any claim. Either party may file a summary disposition motion of any kind with the arbitrator. The arbitrator shall prepare in writing and provide to the parties an award including factual findings and the reasons on which their decision is based. If a party believes that the arbitrator has committed an error of law or legal reasoning, the party can appeal to a court of competent jurisdiction to correct any such error of law or legal reasoning. There is no right to de novo review of the arbitration decision. The decision of the arbitrator may be entered and enforced as a final judgment in any court of competent jurisdiction. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000.00.

8.3.2 Confidentiality. 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 a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.2, including the imposition of sanctions.

8.3.3 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing and the identities of all individuals with knowledge about the dispute or claim Discovery shall be limited in accordance to the "Regular Track," as defined by the AAA Healthcare Payor-Provider Arbitration Rules. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

8.3.4 Arbitration Award. The arbitrator may award only monetary relief for breach of contract, but is not empowered to award punitive, exemplary, extra-contractual damages or equitable remedies, including but not limited to lost profits or opportunities, attorney's fees or interest. The award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.5 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed and agreed to by duly authorized representatives of both Parties, except as expressly provided herein. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement upon written notice, by letter, newsletter, electronic mail or other media, to Facility to comply with applicable law or regulation, or any order or directive of any governmental agency. This Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority of this Agreement.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach of this Agreement. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Facility waives any claims or cause of action for fraud in the inducement or execution related to these waivers.

9.3 Governing Law.
This Agreement shall be governed in all respects by the laws of the State where Facility is located.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application of it is invalid, illegal or unenforceable in any respect in any instance shall 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.

9.6 Successors; Assignment.
This Agreement relates solely to the provision of Facility Services by Facility and does not apply to any other organization which succeeds to Facility assets, by merger, acquisition or otherwise, or is an affiliate of Facility. Neither Party may assign its rights or delegate its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld. Company may assign its rights or delegate its duties and obligations to an Affiliate or successor in interest.

In the event that Facility acquires or takes operational responsibility for another Participating Provider practice, facility or another Participating Provider becomes an employee of Facility (in a same or similar capacity as the provider had before the employment or acquisition) then the then current agreement between Company and such Participating Provider will remain in place and apply to Covered Services provided by such Participating Provider until the expiration of the then current term of such participation agreement.

9.7 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. For any notices not subject to the previous sentence and sent by regular mail or email, such notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this Section 9.7). Facility shall notify Company in writing at least seven (7) business days prior to any changes in the address information below.

To Facility contract notice address at:
Western Rehabilitation Health Network, LC
1755 S. 4490 W., Ste. C
Salt Lake City, UT 84104

To Facility at contract notice email address at:

To Company at:
Aetna
Regional Network Contracting and Operations, F953
2850 Shadelands Drive, Suite 200
Walnut Creek, CA 94598

With respect to Behavioral Health:

Aetna Behavioral Health
1425 Union Meeting Road
PO Box 5
Blue Bell PA 19422

9.8 Non-Exclusivity. This Agreement is not exclusive, and does not preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Facility.

9.9 Survival. In addition to those provisions which by their terms survive expiration or termination of this Agreement (e.g. 4.3.2 and 5.3.1), Sections 5.5, 6.5 and 7.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise to expiration or termination of this Agreement.

9.10 Entire Agreement.
This Agreement including the Product Participation Schedule, Participation Criteria Schedules, Services and Compensation Schedules, if applicable and any additional attached schedules constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. In addition to this Agreement, the Parties or their Affiliates may have previously entered into one or more pre-existing provider agreements. These agreements will continue in force without change until any such agreement is terminated in accordance with its terms.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

FACILITY

By: Rhonda Noble
Rhonda Noble (Feb 12, 2014)
Printed Name: Rhonda Noble

Title: Manager

Date: Feb 12, 2014

FEDERAL TAX I.D. NUMBER: 522229954

COMPANY

By: Heather Jiannalone
Printed Name: Heather Jiannalone

Title: Director, Network Management

Date: Mar 11, 2014

Regulatory Addendum – Exhibit A

IDAHO

6.2 Termination without Cause

Section 6.2 Termination without Cause, shall be deleted and replaced with the following:

"This Agreement may not be terminated by either Party without cause."

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY
SERVICES AND COMPENSATION SCHEDULE

COMPENSATION:

Payment Details:

Service	Billing Codes	Rates
Pt Evaluation	**CPT4 Codes:** 97001	$72.00 Per Unit
Mechanical Traction Therapy	**CPT4 Codes:** 97012	$12.98 Per Unit
Electric Stimulation Therapy	**CPT4 Codes:** 97014	$12.52 Per Unit
Ultrasound Therapy	**CPT4 Codes:** 97035	$12.76 Per Unit
Therapeutic Exercises	**CPT4 Codes:** 97110	$27.00 Per Unit
Neuromuscular Reeducation	**CPT4 Codes:** 97112	$28.00 Per Unit
Manual Therapy	**CPT4 Codes:** 97140	$23.56 Per Unit
Therapeutic Activities	**CPT4 Codes:** 97530	$27.30 Per Unit
Rmvl Devital Tis 20 Cm/<	**CPT4 Codes:** 97597	$82.17 Per Unit
Rmvl Devital Tis Addl 20 Cm<	**CPT4 Codes:** 97598	$27.71 Per Unit
Wound(s) Care Non-select	**CPT4 Codes:** 97602	$39.73 Per Unit
Negative Pressure Wound Ther	**CPT4 Codes:** 97605	$45.70 Per Unit
Negative Pressure Wound	**CPT4 Codes:** 97606	$48.93 Per Unit
Checkout For Orthotic/prosth	**CPT4 Codes:** 97762	$42.47 Per Unit
Med Nutrition, Indiv, Init	**CPT4 Codes:** 97802	$37.04 Per Unit

Med Nutrition, Indiv, Subseq	**CPT4 Codes:** 97803	$32.31 Per Unit
Medical Nutrition, Group	**CPT4 Codes:** 97804	$16.18 Per Unit
All Services not otherwise identified		100% of Aetna Market Fee Schedule

SERVICES:

Provider will provide services that are within the scope of and appropriate to the Provider's license and certification to practice.

COMPENSATION TERMS AND CONDITIONS:

Definitions

"Aetna Market Fee Schedule" (AMFS) – A fee schedule that is based upon the contracted location where service is performed.

"Service Groupings" – A grouping of codes (e.g., HCPCS, CPT4, ICD-9 (ICD-10 or successor standard)) that are considered similar services and are contracted at one rate under the Services and Compensation Schedule.

General

a) Rates are inclusive of any applicable Member Copayment, Coinsurance, Deductible and any applicable tax including but not limited to sales tax. For procedures and/or services not specifically listed above, Provider agrees to accept then current AMFS as payment in full.

Company will pay the lesser of the contracted rate or eligible billed charges.

b) CPT-4 codes included in the Professional Component of this Agreement apply to the services rendered and are not limited to the specialty of the performing provider.

c) Except where prohibited by applicable law of the Agreement, Company may, at its sole discretion, upon thirty (30) days prior written notice to Provider reduce the rates for Covered Services by ten percent (10%) for a three (3) month period should Provider fail to provide timely notice of change in information to Company as set forth in the Agreement.

Billing

d) Provider must designate the codes set forth in this Compensation Schedule when billing.

e) When Provider is compensated on a fee for services basis and if a Government Official imposes a financial adjustment or penalty on Company based on a determination that there is insufficient information or documentation to support an International Classification of Diseases, 9th Revision, Clinical Modification ("ICD-9-CM" (ICD-10 or successor standard)) diagnosis submitted by Provider to Company for a Medicare Member ("Diagnosis"), Company may recoup an amount that Company paid to Provider for the nationally recognized codes associated with the Diagnosis for the dates of service in question, for which that Diagnosis

was listed. Company will notify Provider upon Company's receipt of a final written audit report from CMS reflecting a CMS finding that there was insufficient documentation to support a Diagnosis submitted by Provider to Company ("CMS Finding"). Company will provide a copy of the chart for which the Diagnosis was listed and reviewed by CMS and recoup from Provider an amount that Company paid to Provider for the nationally recognized codes associated with the Diagnosis for the dates of service in question, for which that Diagnosis was listed.

Coding

f) Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (ICD-10 or successor standard) Diagnosis and Procedure codes, National Drug Codes (NDC) and the American Society of Anesthesiologists (ASA) relative values for the basic coding, and description for the services provided. As changes are made to nationally recognized codes, Company will update internal systems to accommodate new codes. Such updates may include changes to Service Groupings. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

FACILITY CORE PARTICIPATION CRITERIA SCHEDULE

I. BUSINESS CRITERIA

These criteria shall apply to each Facility applicant for the duration of the Agreement and shall be enforced at the sole discretion of Company. Any exceptions to the Business Criteria must be approved in advance by the Company.

A. Applicability

1. If applicable, each applicant must complete a Facility Credentialing Questionnaire and shall periodically supply to Company all requested information.

2. All providers rendering services to Members at Facility must be Participating Providers. Facility shall notify Company in writing within ten (10) days of acquiring knowledge of additions or changes in providers' status.

3. If applicable, Facility must have an agreement with a participating hospital and medical transportation provider in place for the immediate transfer of patients.

B. Facility Standards

Each Facility must:

1. Have a visible sign containing the name of the entity.

2. Have all areas physically accessible to all Members, including, but not limited to, its entrance, parking and bathroom facilities.

3. Be clean, presentable and professional in appearance and prohibit smoking.

4. Have a clean, properly equipped and accessible patient toilet and hand washing facility.

5. Have a waiting room sufficient to accommodate Members.

6. Have an established process to ensure that medication room(s) and medical records are protected from public access.

7. Have a secure and confidential filing system.

8. Have written policies protecting Member confidentiality including medical records, and maintain verbal and electronic means for submission of information.

9. Require a medical assistant to attend sensitive (e.g. gynecological or adolescent) examinations, unless the Member declines such assistant to be present.

10. Produce upon request evidence of current licenses for all physicians/providers/allied health professionals practicing in the Facility, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).

11. Keep on file and make available to Company any state required practice protocols or supervising agreements for allied health professionals practicing in Facility, including a requirement for notifying Members if an allied health professional (e.g., physician's assistant, advanced practice nurse, nurse practitioner, nurse midwife) may provide care.

13. Have appropriate equipment immediately available for the treatment of medical emergencies and must have documented medical emergencies procedures addressing treatment, transportation and disaster evacuation plans to provide for the safety of Members. Additionally, facility must have functional generators to provide emergency power service in the event of a power failure.

14. Ensure equipment has current certifications, indicating proper maintenance and calibration at regularly scheduled intervals to ensure the equipments' operational safety, and comply with any and all applicable standards, including OSHA standards and federal, state and local laws and regulations.

15. Have an advance directive policy if applicable.

16. Shall furnish Company upon request any and all studies and reports, either copies or originals as specified by Company, for any and all examinations being conducted by Company.

17. Have a mechanism in place to ensure that all contracted technical and professional services related to the services offered by Facility are available.

18. Have a quality assurance program, and shall provide upon request documentation of such program (e.g. development of outpatient clinical pathways; monitoring of radiologic interpretation; and monitoring of acute patient transport to the hospital).

19. Have a quality improvement program and must track outcomes or trends to be used as a tool for quality improvement.

20. Ensure that all agency staff shall have been trained to the Facility's applicable policies and procedures to perform the duties of their position, received appropriate health screening as required by the department of public health and have participated in continuing education and/or in-service in accordance with state or federal standards.

21. Have emergency equipment (Advanced Cardiac Life Support [ACLS] resuscitation equipment including defibrillator and materials necessary to perform endotracheal intubation and emergency ventilation), oxygen, cardiac monitoring capability, defibrillator, nebulizer, equipment for airway maintenance, and the capability to administer non-narcotic medical therapy for the treatment of headaches if Facility provides inpatient, urgent care, or surgical care.

22. Have one Basic Life Support-trained (BLS) and one ACLS health care practitioner on site during the hours of operation and until any Member operated on that day is discharged if Facility provides emergency inpatient, urgent care or surgical care.

23. Maintain appropriate Clinical Laboratory Improvement Amendments (CLIA) certification for lab equipment where applicable.

B. Access and Availability of Services

1. Inpatient Facility hours of operations are twenty-four hours, seven days per week (24/7).

2. Outpatient Facility hours of operations must be sufficient to meet the appointment access standards including evenings and weekends.

    a. Urgent tests - same day.
    b. Diagnostic tests – within seven (7) business days or within a timeframe agreeable by a referring physician.
    c. Screening tests – within thirty (30) business days or within a timeframe agreeable by a referring physician.

d. Initiate treatment within a timeframe agreeable by the referring physician. Facility must return treatment reports to referring physicians in a timely fashion.
e. May be modified from time to time at the sole discretion of Company.

3. Where applicable to Facility, appropriate medical staff shall be on site at all times when patients are being treated. "On-site" is defined as attached to or on the grounds of the Facility.

4. Facility shall arrange for physician on-call, emergency services and appropriate oversight of Facility operations.

5. In the event that the Facility requires the services of a physician/specialist, if specific laboratory, radiologic services and/or other ancillary services cannot be performed by the Facility, the Facility shall rely upon the services of Company participating physician/specialist, laboratory and/or radiologic providers, unless not feasible in an emergency situation.

6. Facility physicians, nurse practitioners and/or physician's assistants with prescriptive authority shall when possible, prescribe medication in accordance with the Company formulary.

7. For Aetna Workers' Comp Access (AWCA) when applicable, Facility shall schedule an initial visit and provide services within a reasonable period of time or, where applicable, within that period of time as required by workers compensation law.

8. Facility shall have provisions in place to address patient overflow.

C. Subcontractors

To the extent Facility intends to subcontract some of its services under the Agreement, Facility will provide Company with a list of all subcontractors intended to be used to provide Facility services to Members. In all circumstances, where Facility subcontracts for any services under the Agreement:

1. Facility represents and warrants that subcontractor(s) will abide by the provisions set forth in the Agreement;

2. Company reserves the right to require a Designation of Payment Schedule from all subcontractors in a form approved by the Company. Facility indemnifies and holds Company and its Members harmless for payment of all compensation owed subcontractor(s) for services provided under the Agreement; and

3. Company's prior written approval is required, if Facility intends to perform covered services through employees or agents, including a subcontractor, physically located outside of the United States of America.

D. Copies

Unless allowed by state law or regulatory requirement, Facility agrees not to charge Members for copies of medical records/reports or require deposits for the release of these copies to Members.

PHYSICAL THERAPY (PT) / OCCUPATIONAL THERAPY (OT) / SPEECH PATHOLOGY (SP) AND SPEECH THERAPY (ST)
ADDITIONAL PARTICIPATION CRITERIA

A. Facility/Provider Standards

1. Must have dedicated space for physical therapy and rehabilitation services.

B. Facility/Provider Requirements

1. Must possess equipment adequate for the provision and administration of all therapy treatment in accordance with professional standards (e.g., modality treatments, resistive exercises, and objective strength testing of trunk and/or lower extremities).

2. Unless state law or regulation allows for a greater ratio, the therapist to assistant staff ratio must not exceed 1:2.

3. Must provide an initial report and a multidisciplinary care plan to the referring Provider and/or Primary Care Physician within seven (7) days of Member initiating treatment at Facility, and must continue to update those reports at appropriate intervals.

C. Access and Availability of Services

1. Shall provide a minimum of twenty (20) office hours per week.

PRODUCT PARTICIPATION SCHEDULE

Participation under this Facility Agreement will include the Aetna Products indicated below. Compensation for these products will be according to the Services and Compensation Schedule attached to this Agreement.

- Gated Health Benefit Product – Commercial health benefit plan which contains a Primary Care Physician as a component of the Plan design regardless of whether (i) selection of a Primary Care Physician is mandatory or voluntary under the terms of the Plan; or, (ii) an individual Member has selected a Primary Care Physician. Gated Health Benefit Products include but are not limited to: *HMO, QPOS, Elect Choice, Managed Choice POS, Aetna Choice POS II, and Aetna Select.*

- Non-Gated Health Benefit Product – Commercial health benefit plan which does not allow for the designation and/or use of a Primary Care Physician in the administration of the benefit Plan. Non-Gated Health Benefit Products include but are not limited to: *Open Choice PPO and National Advantage.*

  Many member ID cards include the National Advantage logo (NAP) in conjunction with Gated and non-Gated Health Benefit Products. In those circumstances the rate applicable to other product (not NAP) on the ID card will apply.

- Government Programs – All plans offered by Company under any government contract serving Medicare beneficiaries. Government Programs include, but are not limited to: all Aetna Medicare Advantage HMO, PPO, and POS.

  Government Programs excludes Medicaid program offered by Company.

  Compensation for Government Programs may vary based upon the applicable products as specified in the Service and Compensation Schedule.

- Non-Health Benefit Products – Including but not limited to: *Aetna Workers' Comp Access*.

Service and Pay to (Remittance) Location Form

Attached is each participating provider* with the corresponding physical service location, pay to (remittance) address and telephone numbers:

***Upon written notice from Provider, Company may agree to add new or relocating facilities, locations or providers to existing Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company**. **Other demographic information may be revised upon written notice from Provider.**