Executive Summary Form

Agenda Number: HLT

Recommendation:
Approve the new Ancillary Services Agreement between Cochise Health & Social Services and Aetna Health, Inc. This Agreement will run for one year and be renewed for subsequent one-year periods.

Background:
CHSS is strategically working to expand our network of insurance company payers, while at the same time, Aetna Health is working to expand their network of providers in Cochise County.

Radi Ann Porter (Director of Nursing) has reviewed and is satisfied with the Agreement from an operational perspective, and Terry Bannon has reviewed and is satisfied from a legal standpoint. After the initial one year term, the Agreement may be terminated by either party with 180 days' written notice.

Fiscal Impact & Funding Sources: Cochise County will benefit by being able to bill Aetna Health for services provided to its members.

Next Steps/Action Items/Follow-up:

Your approval is respectfully requested.

Impact of Not Approving:

Not approving this Agreement will prevent Cochise County from collecting for services provided to Aetna Health members in the county.

ANCILLARY SERVICES AGREEMENT

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ANCILLARY SERVICES AGREEMENT

This Ancillary Services Agreement ("Agreement") is made and entered into as of June 15, 2013 ("Effective Date") by and between Aetna Health Inc., a Pennsylvania corporation, on behalf of itself and its Affiliates (hereinafter "Company") and Cochise County dba Cochise Health and Social Services ("hereinafter Provider"). 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 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) Provider'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 Provider.

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

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

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

1.12 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.

1.13 Party. Company or Provider, as applicable.

1.14 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.

1.15 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.

1.16 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.

1.17 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 Provider and which are furnished or disclosed to Provider by Company.

1.18 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 PROVIDER SERVICES AND OBLIGATIONS

2.1 Provision of Services.
Provider will make available and provide to Members those services and any related facilities, equipment, personnel or other resources necessary to provide the services according to generally accepted standards of Provider's practice ("Provider Services") and accepts the compensation for such Provider Services listed and set forth in the **Services and Compensation Schedule** attached hereto and made a part hereof. Company and Provider may mutually agree in writing at any time, and from time to time, either to increase or decrease the Provider Services made available to Members under this Agreement.

2.1.1 Provider Information. Provider 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. Provider 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. Provider agrees to provide Provider Services to Members with the same degree of care and skill as customarily provided to Provider's patients who are not Members, according to generally accepted standards of Provider's practice. Provider and Company agree that Members and non-Members should be treated equitably. Provider 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 Provider 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 Provider, Provider, 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 Provider Representations.

2.3.1 General Representations. Provider represents, warrants 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, in compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided under this Agreement; (c) it is certified to participate in the Medicare program; (d) it has established an ongoing quality assurance/assessment program which includes, but is not limited to, 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; (e) in no event shall Provider, without Company's prior written approval, perform Covered Services, including, but not limited to performing pre-authorization requests or similar functions related to utilization management, through employees or agents, including a subcontractor, if such employee, agent or subcontractor is physically located outside of the United States of America; (f) all health care personnel employed by, associated or contracted with Provider who treat Members: (g) 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; (h) 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 (i) 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, Provider agrees, on behalf of itself and any subcontractors of Provider acting on behalf of Provider, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Provider acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Provider who provide or may provide Covered Services to Members of Government Programs, and Provider represents and warrants that Provider shall take all steps necessary to cause such employees, independent contractors and subcontractors to comply with the Agreement and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. With respect to Members of Government Programs, Provider acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Provider agrees that all services and other activities performed by Provider under this Agreement will be consistent and comply with Company's obligations under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"), and any applicable state regulatory agency, to offer Medicare Plans. Provider further agrees to allow CMS, any applicable state regulatory agency, and Company to monitor Provider's performance under this Agreement on an ongoing basis in accordance with Medicare laws, rules and regulations. Provider 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 Provider, the activity or responsibility may be revoked if CMS or Company determine that Provider has not performed satisfactorily.

2.4 Provider's Insurance.

During the term of this Agreement, Provider agrees to procure and maintain such policies of general and professional liability and other insurance 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 providers in the state or region in which the Provider operates. Such insurance coverage shall cover the acts and omissions of Provider as well as Provider's agents and employees. Provider will deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Provider 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.

Provider agrees to participate in all benefit products. Company reserves the right to introduce and designate Provider's participation in new Specialty Programs and products during the term of this Agreement and will provide Provider 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 Provider as a preferred participant in any specific Specialty Program or product; provided, however, Provider 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 Provider 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 Provider 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 Provider in each such case. For those programs and products which are not health benefit products, Provider shall have thirty (30) days from receipt of the Company's notice to notify Company in writing if Provider elects not to participate in these product(s).

2.6 Consents to Release Medical Information.

Provider will obtain from Members to whom Provider provides Provider 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, Provider 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 Provider (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 Provider with a means to check Member eligibility. Company shall include Provider in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Provider is a Participating Provider, including when Provider 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 warrants 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; (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 Provider Obligation to Submit Claims. Provider agrees to submit Clean Claims to Company for Provider Services rendered to Members. Provider represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Provider Services to be made directly to Provider. Provider will use best commercial efforts to submit a minimum of 85% of its Member 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"). Provider 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 time frames required under this Agreement or applicable law or regulation. Provider 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) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. This requirement will be waived in the event Provider provides notice to Company, along with appropriate evidence, of extraordinary circumstances outside the control of Provider that resulted in the delayed submission. In addition, unless Provider notifies Company of any payment disputes within one hundred eighty (180) days or such longer time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Provider does not bill Company or Plan Sponsors, or disputes any payment, timely as provided in this Section 4.1.1, Provider's claim for payment will be deemed waived and Provider will not seek payment from Plan Sponsors, Company or Members. Provider shall pay on a timely basis all employees, independent contractors and subcontractors who render Covered Services to Members of Company's Medicare Plans for which Provider is financially responsible pursuant to this Agreement.

Provider 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.

4.1.2 Company Obligation to Pay for Covered Services. Company agrees to: (a) pay Provider for Covered Services rendered to Members of Full Risk Plans, and (b) notify Plan Sponsors to forward payment to Company for payment to Provider for Covered Services rendered to a Plan Sponsor's Members, according to the lesser of (1) Provider'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. Provider 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, Provider 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 Provider 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 or a percentage of charges basis. Provider 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 Provider of overpayments to Provider, and Provider agrees to return any such overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Provider 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 Provider under this Agreement provided Company has delivered to Provider at least ten (10) days prior written notice and Provider has otherwise failed to return such payment to Company. To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Provider acknowledges the financial risks to Provider of this arrangement and has made an independent analysis of the adequacy of this arrangement. Provider, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Provider was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement.

Company acknowledges that Provider may contract with individuals, entities, professionals, or vendors ("Subcontracted Providers") for the purpose of providing ancillary services such as pathology services, laboratory services, anesthesia, and radiology services to Members. For Covered Services provided to Members by Subcontracted Providers for which Provider is compensated by Company under the Agreement, Subcontracted Providers shall seek compensation solely from Provider. Provider agrees to indemnify, defend and hold Company harmless from any claims for payment from Subcontracted Providers for these services. Moreover, Provider will provide Company with a Designation of Payment Schedule from all Subcontracted Providers, which acknowledges that the Subcontracted Provider will look solely to Provider for payment of Covered Services and indemnify and hold harmless Company, Payers, and Members for payment of all compensation owed to Subcontracted Provider under Subcontracted Provider's arrangement with Provider.

4.1.3 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment. To further this end, Provider agrees, consistent with sound medical judgment: (a) to participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members; (b) to comply with Company's precertification and utilization management requirements for those Covered Services requiring such notice; (c) to regularly interact and cooperate with Company's nurse case managers; (d) to utilize Participating Providers, including but not limited to Participating surgery centers and hospitals to the fullest extent possible, consistent with sound medical

judgment; and (e) to abide by all Company's credentialing criteria and procedures, including site visits and medical chart reviews, and to submit to these processes biannually, annually, or otherwise, when applicable.

To obtain advance authorization from Company prior to any non-emergency admission, and in cases where a Member requires an emergency hospital admission, to notify Company, both in accordance with Company's rules, policies and procedures then in effect.

For those Members who require services under a Specialty Program, Provider agrees to work with Company in transferring the Member's care to a Specialty Program Provider.

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, Provider 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. Provider 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 Provider in accordance with applicable Federal law or regulation (e.g., ERISA) provided that Provider has 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, Provider will bill or charge Member contracted rates if the Member has exhausted applicable plan benefits. Provider acknowledges that Company's denial or adjustment of payment to Provider 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. Provider may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Provider 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 Provider 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. Provider 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 Provider 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. Provider acknowledges and agrees that Medicare Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Provider 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. Provider 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, Provider 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.

In the event Government Programs pertains to this Agreement and for purposes of this Section, "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. Company is required to obtain risk adjustment data from Provider for Medicare Members, and Provider agrees to provide complete and accurate risk adjustment data to Company for Medicare Members that conforms to all standards and requirements set forth in applicable laws, rules and regulations and/or CMS instructions that apply to risk adjustment data. Provider certifies, based on best knowledge, information and belief, that any risk adjustment data that Provider submits to Company for Medicare Members is accurate, complete and truthful. Provider agrees to immediately notify Company if any risk adjustment data that was submitted to Company for Medicare Members is erroneous, and follow procedures established by Company to correct erroneous risk adjustment data to ensure Company's compliance with applicable laws, rules and regulations and CMS instructions.

Provider 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 set forth in applicable laws, rules, regulations and/or CMS instructions, and allows 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").

Provider 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"). Provider 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 Provider, Company will submit to Provider a copy of the CMS written notice of such review, along with a written request from Company for Audit Data.

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") or its successor such as ICD-10-CM and ICD-10 PCS, diagnosis submitted by Provider to Company for a Medicare Member ("Diagnosis"), Company may recoup the total 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 Provider a copy of the chart for which the Diagnosis was listed and reviewed by CMS and recoup from Provider the total 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.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies.

Provider agrees to accept and comply with Policies of which Provider 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, Provider agrees to comply with any applicable precertification and/or referral requirements under the Member's Plan prior to the provision of Provider Services. Provider will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, precertification and claim status inquiry transactions. Provider 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, Provider agrees to directly provide testing or accept test results and examinations performed outside Provider 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, Provider 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 Provider to object in writing to any notice of Material Change within thirty (30) days following receipt thereof constitutes Provider's acceptance of such Material Change. In the event that Provider reasonably believes that a Material Change is likely to have a material adverse financial impact upon Provider, Provider 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. Provider 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 Provider Services.

5.2 Notices and Reporting.

To the extent neither prohibited by law nor violative of applicable privilege, Provider 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 Provider 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 Provider 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 Provider 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 Provider or any of its employees, medical staff members or affiliated providers that does or could adversely affect Provider's accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Provider; and (e) any material change in services provided by Provider or licensure status related to such services, including without limitation a significant decrease in medical staff or the closure of a service unit or material decrease in beds. Provider 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 Provider described in this Section 5.2.

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Provider agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive 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; and (c) to maintain such Information and Records for the longer of six (6) years after the last date Provider 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. Provider 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 Provider 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, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Provider 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; and (e) Members shall have 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. Provider 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. Provider agrees to provide Company data necessary for Company to comply with reporting requirements related to the Patient Protection and 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, Provider agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Provider further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. 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.
Provider 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 Federal or state 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 or vendors under contract with Company, and (iii) in the case of Provider'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, Provider is encouraged to discuss Company's provider payment methodology with their patients, including descriptions of the methodology under which the Provider is paid. In addition, Provider 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 one (1) 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 or unless 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 either Party.

6.2 Termination without Cause.
This Agreement may be terminated by either Party with at least one hundred eighty (180) days prior written notice to the other Party; 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 Provider, 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 Provider; (b) the bankruptcy or receivership of Provider, or an assignment by Provider for the benefit of creditors; (c) the loss or material limitation of Provider's insurance under Section 2.4 of this Agreement; (d) a determination by Company that Provider's continued participation in provider networks could result in harm to Members; (e) the debarment or suspension of Provider from participation in any governmental sponsored program, including, but not limited to, Medicare or Medicaid; (f) the indictment or conviction of Provider for any crime; (g) the listing of Provider in the HIPDB; or (h) change of control of Provider to an entity not acceptable to Company. To protect the interests of patients, including Members, Provider 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, Provider 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, Provider agrees to provide Provider Services at Company's discretion: (a) to any Member who is receiving services from Provider as of the effective date of termination until the Member's course of treatment is completed 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 terms of this Agreement, including 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, Provider shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients 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, Provider 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 Provider, 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 Provider will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and its medical staff, and that Policies do not dictate or control Provider's clinical decisions with respect to the care of Members. Provider agrees to indemnify and hold harmless the Company from any and all claims, liabilities and third party causes of action arising out of the Provider's provision of care to Members. Company agrees to indemnify and hold harmless the Provider 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.
Provider consents to the use of Provider'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.
Provider 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 Provider and a Member, or a party designated by a Member, determined by Provider 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.
Provider 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 Provider Dispute Resolution.
Company shall provide an internal mechanism under which Provider may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Provider 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.
Any controversy or claim arising out of or relating to this Agreement including breach, termination, or validity of this Agreement, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration. Upon mutual consent of the parties, the arbitration will be administered by the American Arbitration Association ("AAA") or the Judicial Arbitration and Mediation Services ("JAMS") and conducted by a sole Arbitrator. 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. Depositions for discovery purposes shall not be permitted. The arbitrator may award only monetary damages in accordance with this Agreement.

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 Provider 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. Provider 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 Provider 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 Provider Services by Provider and does not apply to any other organization which succeeds to Provider assets, by merger, acquisition or otherwise, or is an affiliate of Provider. 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 so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Provider.

In the event Provider acquires or takes operational responsibility for another Participating Provider practice, facility or another Participating Provider becomes an employee of Provider (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. Notices shall be sent to the following addresses (which may be changed by giving notice in conformity with this Section 9.7). Provider shall notify Company in writing within seven (7) business days prior to any changes in the information provided by Provider at the address below.

To Provider at:

1415 Melody Lane
Building A
Bisbee, AZ 85603

To Company at:

Aetna
Regional Network Contracting and Operations, F953
2625 Shadelands Drive
Walnut Creek, CA 94598

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 Provider.

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

PROVIDER

By:

Printed Name:

Title:

Date:

FEDERAL TAX I.D. NUMBER: _____86-6000398_____-

COMPANY

By:

Printed Name:

Title:

Date:

Regulatory Addendum – Exhibit A

ARIZONA

1.14 Plan

Section 1.14 Plan shall be deleted and replaced with the following:

"Any health benefit product, plan or program issued, administered or serviced by Company or one of its Affiliates, including, but not limited to, HMO, preferred provider organization, indemnity, and workers' compensation."

2.5 Product Participation

The third paragraph of Section 2.5 Product Participation shall be deleted and replaced with the following:

"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 Provider provides Covered Services, the benefits of this Agreement, including, without limitation, the **Services and Compensation Schedule** attached hereto."

4.1.2 Company Obligation to Pay Covered Services

The first sentence of Section 4.1.2 Company Obligation to Pay Covered Services, shall be deleted and replaced with the following:

"Company agrees to: (a) pay Provider for Covered Services rendered to Members of Full Risk Plans, and (b) notify Plan Sponsors to forward payment to Company for payment to Provider for Covered Services rendered to a Plan Sponsor's Members, according to the lesser of (1) Provider's actual billed charges or (2) the rates set forth in the **Services and Compensation Schedule**, within thirty (30) days or such time as permitted by applicable law or regulation of actual receipt by Company of a Clean Claim."

6.5.2 Upon Insolvency or Cessation of Operations

Section 6.5.2 Upon Insolvency or Cessation of Operations shall be deleted and replaced with the following:

"In the event of insolvency of a Company affiliate that is an HMO, Provider agrees to provide services to HMO Members at the same rates and subject to the same terms and conditions established in the Agreement for the duration of the period after the HMO is declared insolvent, until the earliest of the following: (a) the expiration of the period during which the HMO is required to continue benefits as described in ARS 20-1069, subsection A: the duration of the contract period under the Member's health plan or sixty (60) days from the date insolvency is declared, whichever is longer (for Members confined on the date of insolvency in an inpatient facility this period would last at least until their discharge); (b) a notification from the receiver pursuant to ARS 20-1069, subsection F or a determination by the court that the insolvent HMO cannot provide adequate assurance it will be able to pay contract providers' claims for covered services that were rendered after the HMO is declared insolvent; (c) a determination by the court that the insolvent HMO is unable to pay contract providers' claims for covered services that were rendered after the HMO is declared insolvent; (d) a determination by the court that continuation of the contract would constitute undue hardship to the provider: and (e) a determination by the court that the HMO has satisfied its obligation to all enrollees under its health care plans. This provision shall be construed to be for the benefit of Members. In the event of insolvency of a Company affiliate that is other than an HMO, then in addition to other obligations set forth in this Section 6.5, Provider shall continue to provide Provider Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients on the date of insolvency or other cessation of operations until medically

appropriate discharge. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies."

9.7 Notices

The following address shall be added below the Company address in Section 9.7 Notices:

Cc: Aetna
Attn: Sr. Network Manager
4645 E. Cotton Center Blvd
Building #1
Phoenix, AZ 85040

IMMUNIZATION
SERVICE AND COMPENSATION SCHEDULE

COMPENSATION:

All Other Services - Deny

Payment Details:

Service	Billing Codes	Rates
Im Admin 1st/only Component	**CPT4 Codes:** 90460	100% of Aetna Market Fee Schedule
Im Admin Each Addl Component	**CPT4 Codes:** 90461	100% of Aetna Market Fee Schedule
Immunization Admin, Single	**CPT4 Codes:** 90471	100% of Aetna Market Fee Schedule
Immunization Admin, 2+	**CPT4 Codes:** 90472	100% of Aetna Market Fee Schedule
Immun Admin Oral/nasal	**CPT4 Codes:** 90473	100% of Aetna Market Fee Schedule
Immun Admin Oral/nasal Addl	**CPT4 Codes:** 90474	100% of Aetna Market Fee Schedule
Human Ig, Im	**CPT4 Codes:** 90281	100% of Aetna Market Fee Schedule
Human Ig, Iv	**CPT4 Codes:** 90283	100% of Aetna Market Fee Schedule
Cmv Ig, Iv	**CPT4 Codes:** 90291	100% of Aetna Market Fee Schedule
Hepb Ig, Im	**CPT4 Codes:** 90371	100% of Aetna Market Fee Schedule
Rabies Ig, Im/sc	**CPT4 Codes:** 90375	100% of Aetna Market Fee Schedule
Rabies Ig, Heat Treated	**CPT4 Codes:** 90376	100% of Aetna Market Fee Schedule
Rsv, Mab, Im, 50mg	**CPT4 Codes:** 90378	100% of Aetna Market Fee Schedule
Tetanus Ig, Im	**CPT4 Codes:** 90389	100% of Aetna Market Fee Schedule

Varicella-zoster Ig, Im	**CPT4 Codes:** 90396	100% of Aetna Market Fee Schedule
Anthrax Vaccine Sc Or Im	**CPT4 Codes:** 90581	100% of Aetna Market Fee Schedule
Bcg Vaccine, Percut	**CPT4 Codes:** 90585	100% of Aetna Market Fee Schedule
Hepa Vaccine Adult Im	**CPT4 Codes:** 90632	100% of Aetna Market Fee Schedule
Hepa Vaccine Ped/adol-2 Dose	**CPT4 Codes:** 90633	100% of Aetna Market Fee Schedule
Hepa Vaccine Ped/adol-3 Dose	**CPT4 Codes:** 90634	100% of Aetna Market Fee Schedule
Hepa/hepb Vaccine Adult Im	**CPT4 Codes:** 90636	100% of Aetna Market Fee Schedule
Hib Vaccine, Hboc, Im	**CPT4 Codes:** 90645	100% of Aetna Market Fee Schedule
Hib Vaccine, Prp-d, Im	**CPT4 Codes:** 90646	100% of Aetna Market Fee Schedule
Hib Vaccine, Prp-omp, Im	**CPT4 Codes:** 90647	100% of Aetna Market Fee Schedule
Hib Vaccine, Prp-t, Im	**CPT4 Codes:** 90648	100% of Aetna Market Fee Schedule
Human Papilloma Virus (hpv)	**CPT4 Codes:** 90649	100% of Aetna Market Fee Schedule
Hpv Vaccine 2 Valent Im	**CPT4 Codes:** 90650	100% of Aetna Market Fee Schedule
Flu Vaccine No Preserv, Id	**CPT4 Codes:** 90654	100% of Aetna Market Fee Schedule
Influenza Virus Vaccine	**CPT4 Codes:** 90655	100% of Aetna Market Fee Schedule
Influenza Virus Vaccine	**CPT4 Codes:** 90656	100% of Aetna Market Fee Schedule
Flu Virus Vacc-split 6-35 Mo	**CPT4 Codes:** 90657	100% of Aetna Market Fee Schedule
Flu Virus Vacc-split 3 Yr & Above	**CPT4 Codes:** 90658	100% of Aetna Market Fee Schedule

Flu Vaccine, Nasal	**CPT4 Codes:** 90660	100% of Aetna Market Fee Schedule
Flu Vacc Prsv Free Inc Antig	**CPT4 Codes:** 90662	100% of Aetna Market Fee Schedule
Pneumococcal Vacc, 7 Val Im	**CPT4 Codes:** 90669	100% of Aetna Market Fee Schedule
Pneumococcal Vacc 13 Val Imm	**CPT4 Codes:** 90670	100% of Aetna Market Fee Schedule
Rabies Vaccine, Im	**CPT4 Codes:** 90675	100% of Aetna Market Fee Schedule
Rabies Vaccine, Id	**CPT4 Codes:** 90676	100% of Aetna Market Fee Schedule
Rotovirus Vaccine,pentavalnt	**CPT4 Codes:** 90680	100% of Aetna Market Fee Schedule
Rotavirus Vacc 2 Dose Oral	**CPT4 Codes:** 90681	100% of Aetna Market Fee Schedule
Typhoid Vaccine, Oral	**CPT4 Codes:** 90690	100% of Aetna Market Fee Schedule
Typhoid Vaccine, Im	**CPT4 Codes:** 90691	100% of Aetna Market Fee Schedule
Typhoid Vaccine, H-p, Sc/id	**CPT4 Codes:** 90692	100% of Aetna Market Fee Schedule
Dtap-ipv Vacc 4-6 Yr Im	**CPT4 Codes:** 90696	100% of Aetna Market Fee Schedule
Diphtheria, Tetanus Toxoid	**CPT4 Codes:** 90698	100% of Aetna Market Fee Schedule
Dtap Vaccine, Im	**CPT4 Codes:** 90700	100% of Aetna Market Fee Schedule
Dt Immunization, Im	**CPT4 Codes:** 90702	100% of Aetna Market Fee Schedule
Tetanus Toxoid Absorbed For	**CPT4 Codes:** 90703	100% of Aetna Market Fee Schedule
Mumps Virus Vaccine Live Sub	**CPT4 Codes:** 90704	100% of Aetna Market Fee Schedule
Measles Virus Vaccine Live-s	**CPT4 Codes:** 90705	100% of Aetna Market Fee Schedule

Rubella Virus Vacc Live-subq	**CPT4 Codes:** 90706	100% of Aetna Market Fee Schedule
Measles Mumps&rubella Vac Li	**CPT4 Codes:** 90707	100% of Aetna Market Fee Schedule
Measles&rubella Virus Vac Li	**CPT4 Codes:** 90708	100% of Aetna Market Fee Schedule
Mmrv Vaccine, Sc	**CPT4 Codes:** 90710	100% of Aetna Market Fee Schedule
Oral Poliovirus Vaccine	**CPT4 Codes:** 90712	100% of Aetna Market Fee Schedule
Poliovirus Vaccine, Inactiva	**CPT4 Codes:** 90713	100% of Aetna Market Fee Schedule
Tetanus And Diphtheria	**CPT4 Codes:** 90714	100% of Aetna Market Fee Schedule
Tetanus, Diphtheria Toxoi	**CPT4 Codes:** 90715	100% of Aetna Market Fee Schedule
Chicken Pox Vaccine, Sc	**CPT4 Codes:** 90716	100% of Aetna Market Fee Schedule
Yellow Fever Vaccine, Sc	**CPT4 Codes:** 90717	100% of Aetna Market Fee Schedule
Dtp/hib Vaccine, Im	**CPT4 Codes:** 90720	100% of Aetna Market Fee Schedule
Dtap/hib Vaccine, Im	**CPT4 Codes:** 90721	100% of Aetna Market Fee Schedule
Diphtheria,tetanus Toxoids	**CPT4 Codes:** 90723	100% of Aetna Market Fee Schedule
Cholera Vaccine, Injectable	**CPT4 Codes:** 90725	100% of Aetna Market Fee Schedule
Plague Vaccine Intramuscular	**CPT4 Codes:** 90727	100% of Aetna Market Fee Schedule
Pneumococcal Vaccine	**CPT4 Codes:** 90732	100% of Aetna Market Fee Schedule
Meningococcl Polysacchrid Va	**CPT4 Codes:** 90733	100% of Aetna Market Fee Schedule
Meningococcal Conjugate Vacc	**CPT4 Codes:** 90734	100% of Aetna Market Fee Schedule

Encephalitis Vaccine, Sc	**CPT4 Codes:** 90735	100% of Aetna Market Fee Schedule
Zoster (shingles) Vaccine	**CPT4 Codes:** 90736	100% of Aetna Market Fee Schedule
Inactivated Je Vacc Im	**CPT4 Codes:** 90738	100% of Aetna Market Fee Schedule
Hepatitis B Vaccine,dialysis	**CPT4 Codes:** 90740	100% of Aetna Market Fee Schedule
Hepatitis B Vaccine,adolesce	**CPT4 Codes:** 90743	100% of Aetna Market Fee Schedule
Hepb Vaccine, Ped/adol, Im	**CPT4 Codes:** 90744	100% of Aetna Market Fee Schedule
Hepb Vaccine, Adult, Im	**CPT4 Codes:** 90746	100% of Aetna Market Fee Schedule
Hepb Vaccine, Ill Pat, Im	**CPT4 Codes:** 90747	100% of Aetna Market Fee Schedule
Hepb/hib Vaccine, Im	**CPT4 Codes:** 90748	100% of Aetna Market Fee Schedule
ADMIN INFLUENZA VIRUS VAC	**HCPC Codes:** G0008	100% of Aetna Market Fee Schedule
ADMIN PNEUMOCOCCAL VACCINE	**HCPC Codes:** G0009	100% of Aetna Market Fee Schedule
ADMIN HEPATITIS B VACCINE	**HCPC Codes:** G0010	100% of Aetna Market Fee Schedule
MEDICATION ADMIN VISIT-VACCINATIONS	**HCPC Codes:** T1502	100% of Aetna Market Fee Schedule
All Services not otherwise identified		Not Reimbursed

SERVICES:

The term "Not Reimbursed" as it appears in the above payment details chart "All Services not otherwise identified," means that Aetna shall not provide any payment to Provider or any other person or entity of any kind for any services provided to Members if such services are not expressly set forth below in this Schedule.

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

For services rendered to Members involving vaccinations, Provider agrees to bill Company for only the vaccines and vaccine administration, as appropriate, and for only those vaccines that 1.) are listed on this compensation schedule and 2.) have a corresponding rate of payment. Company agrees to make payment to Provider for such vaccines and vaccine administration, in accordance with this compensation schedule.

COMPENSATION TERMS AND CONDITIONS:

General

a) Provider agrees to accept the above rates as payment in full for all Covered Services provided to Members. Provider must utilize the CPT codes set forth in the compensation section above.

b) All Rates are inclusive of any applicable member copayment, coinsurance, deductible and any applicable tax, including but not limited to sales tax. Company will pay the lesser of the contracted rate or eligible billed charges. Company will pay the lesser of the contracted rate or eligible billed charges.

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, P and, when applicable, use appropriate modifier 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).

ANCILLARY SERVICES PROVIDER ("PROVIDER")
CORE PARTICIPATION CRITERIA SCHEDULE

I. BUSINESS CRITERIA

These criteria shall apply to each Provider 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 Provider must complete a Facility Credentialing Questionnaire and shall periodically supply to Company all requested information.

B. Office Standards (applies to Providers that have an office setting)

Each Provider's office must:

1. Have a visible sign and title identifying the names of all providers practicing in the office.
2. Have all areas physically accessible to all Members, including, but not limited to its entrance, parking and bathroom facilities.
3. Have a clean, properly equipped and accessible patient toilet and hand washing facility.
4. Have a waiting room sufficient to accommodate Members.
5. Have At least two (2) examining rooms which are clean, properly equipped and private.
6. Have an office assistant in office during scheduled hours.
7. Require a medical assistant to attend sensitive (e.g., gynecological) examinations, unless the Member declines such assistant to be present.
8. If vaccines are stored, keep a thermometer in the refrigerator and freezer.
9. Have appropriate protocol 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, office/business must have functional generators to provide emergency power service in the event of a power failure, when appropriate, e.g., offices that perform procedures, store biologics or supplies of vaccines.

C. Business Standards

Each Provider's business must:

1. Be clean, presentable and professional in appearance and prohibit smoking.
2. If providing controlled substances, maintain them in a secure and concealed location.
3. Have a secure and confidential filing system.
4. Have written policies protecting Member confidentiality including medical records and maintain verbal and electronic means for submission of information.

5. Have an established process to ensure that medical records are protected from public access.

6. Have written policies addressing documentation about Advance Directives (whether executed or not) in member's record (except for under age 18).

7. Have written policies addressing office anti-discrimination guidelines.

8. Comply with Company's then current policies and all applicable legal requirements regarding use of allied health professionals.

9. Maintain evidence of current licenses for all Providers practicing, including: state professional license, Federal Drug Enforcement Agency and State Controlled Drug Substance (where applicable).

10. Keep on file and make available to Company any state required practice protocols or supervising agreements for Allied Health Professionals practicing.

11. Designate by age, according to Company guidelines, those Members for whom provider will provide care.

D. Access and Availability of Services

If applicable, each Provider's office/business must:

1. Must offer a reliable mechanism for Members and other health care professionals to be reached twenty-four (24) hours a day, seven (7) days a week.

2. Shall ensure that twenty-four (24) hours a day, seven (7) days a week coverage for Members is rendered by Provider or arranged with another Company Participating Provider.

3. For outpatient services, a covering Provider's office must be geographically accessible and consistent with local community patterns of care to help ensure that a Member is not required to travel more than thirty (30) minutes travel time from the Member's regular Provider's office/business to access the covering Provider's services.

4. For Aetna Workers' Comp Access (AWCA) when applicable, Provider 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.

E. Subcontractors

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

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

2. Company reserves the right to require a Designation of Payment Schedule from all subcontractors in a form approved by the Company. Provider shall indemnify and hold Company and its Members harmless for payment of all compensation owed subcontractor for services provider under the Agreement.

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

F. Copies

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

ADULT IMMUNIZATION PROVIDER
ADDITIONAL PARTICIPATION CRITERIA

A. Provider Requirements

1. Forward a complete report within fourteen (14) days of rendering services to the usual source of medical care for each individual to whom care is delivered.

2. Direct individuals to whom care is delivered to their usual source of medical care or other appropriate source of ongoing medical care for any indicated additional care for the condition for which care was sought.

SERVICE AREA SCHEDULE

Provider's services will be provided in all counties or other applicable service areas listed in the table below.

**Please indicate zip codes for those counties in which only partial coverage is available. In the absence of delineation of non-covered zip codes, it will be determined by Company that the entire county is eligible for service.*

Contracted rates apply to all eligible services rendered to Members in accordance with Company's policies and procedures, regardless of whether the counties or zip codes are listed on the table below.

County	Zip codes covered/included	Zip codes excluded
Cochise County	85603	
Cochise County	85602	
Cochise County	85607	
Cochise County	85635	
Cochise County	85643	

Service and Pay to (Remittance) Location Form

Listed below 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.**

Provider Name: Cochise County dba Cochise Health and Social Services

Service Location Name		Pay to (Remittance) Name	
Main Office		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	1415 Melody Lane	Address	1415 Melody Lane
Suite #	Bldg A	Suite #	Bldg A
City	Bisbee	City	Bisbee
State, Zip	Arizona 85603	State, Zip	Arizona 85603
Phone #	520-432-9400	Phone #	520-432-9400
Fax #	520-432-9480	Fax #	520-432-9480
Email Address		Email Address	
Tax ID #	86-6000398	NPI: 1215968250	NPI Type: 2

Company Use Only: **PIN #**_____ **PVN #**_____

Service Location Name		Pay to (Remittance) Name	
Benson Office		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	126 W. 5th Street	Address	1415 Melody Lane
Suite #		Suite #	Bldg A
City	Benson	City	Bisbee
State, Zip	Arizona, 85602	State, Zip	Arizona 85603
Phone #	520-586-8200	Phone #	520-432-9400
Fax #	520-586-2051	Fax #	520-432-9480
Email Address		Email Address	
Tax ID #	86-6000398	NPI: 1215968250	NPI Type: 2

Company Use Only: **PIN #**_____ **PVN #**_____

Service Location Name		Pay to (Remittance) Name	
Douglas Office		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	1012 N. G. Avenue	Address	1415 Melody Lane
Suite #	101	Suite #	Bldg A
City	Douglas	City	Bisbee
State, Zip	Arizona, 85607	State, Zip	Arizona 85603
Phone #	520-805-5600	Phone #	520-432-9400
Fax #	520-364-5453	Fax #	520-432-9480
Email Address		Email Address	
Tax ID #	86-6000398	NPI: 1215968250	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service Location Name		Pay to (Remittance) Name	
Sierra Vista Office		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	4115 E. Foothills Drive	Address	1415 Melody Lane
Suite #		Suite #	Bldg A
City	Sierra Vista	City	Bisbee
State, Zip	Arizona, 85635	State, Zip	Arizona 85603
Phone #	520-803-3900	Phone #	520-432-9400
Fax #	520-459-8195	Fax #	520-432-9480
Email Address		Email Address	
Tax ID #	86-6000398	NPI: 1215968250	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

Service Location Name		Pay to (Remittance) Name	
Willcox Office		Electronic Pay to (Remittance) Name *(as it appears on the submission)*	
Street	450 S. Haskell Avenue	Address	1415 Melody Lane
Suite #		Suite #	Bldg A
City	Willcox	City	Bisbee
State, Zip	Arizona, 85643	State, Zip	Arizona 85603
Phone #	520-384-7100	Phone #	520-432-9400
Fax #	520-384-0309	Fax #	520-432-9480
Email Address		Email Address	
Tax ID #	86-6000398	NPI: 1215968250	NPI Type: 2

Company Use Only: **PIN #** _____ **PVN #** _____

STANDARD PARTICIPATION AGREEMENT DETERMINATION

Re: Ancillary Services Agreement to expand the Cochise Health & Social Services network of insurance company payers, while at the same time, Aetna Health Inc. is working to expand their network of providers in Cochise County; between the Cochise Health & Social Services and Aetna Health, Inc.

The attached agreement, which is an agreement between public agencies, has been reviewed pursuant to A.R.S. §11-952 on behalf of the Cochise Health & Social Services by the undersigned Deputy County Attorney who has determined that it is in proper form and is within the powers and authority granted under the laws of the State of Arizona.

Approved as to form this 13th day of May, 2013.

EDWARD G. RHEINHEIMER
Cochise County Attorney

By: _____
Terry Bannon
Deputy County Attorney