PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between _____ ("Provider") and Buckeye Community Health Plan ("Health Plan") (each a "Party" and collectively the "Parties"). This Agreement is effective as of the date designated by Health Plan on the signature page of this Agreement ("Effective Date").

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Health Plan desires for Provider to provide such health care services to individuals in such products, and Health Plan desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

NOW, THEREFORE, in consideration of the recitals and mutual promises herein stated, the Parties hereby agree to the provisions set forth below.

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with Health Plan.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.7, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means, as appropriate in the context, Health Plan and/or one or more of its Affiliates, except those specifically excluded by Health Plan.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Health Plan to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Health Plan (e.g., Health Plan Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Participating Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as Schedule C is the initial list of the Contracted Providers as of the Effective Date. Provider shall provide Health Plan, from time to time or on a periodic basis as requested by Health Plan, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Health Plan with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Health Plan of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within thirty (30) days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing

criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Health Plan shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means. Upon Provider's reasonable request, Health Plan shall provide Provider with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Health Plan will use reasonable efforts to notify Provider in advance of such change. Such notice may be given by Health Plan through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment.

2.8. Treatment Decisions. No Company or Payor is liable for, nor will it exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company shall not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of either Health Plan, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Provider or Contracted Provider, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Health Plan of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any settlements or judgments in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Health Plan or Payor in writing within ten (10) days, and in any instance described in subsection (iv) above, Provider must notify Health Plan or Payor in writing within thirty (30) days, from the date it first obtains knowledge of the pending of the same.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Health Plan complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain statistical and descriptive medical and patient data and identifying information, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement.

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider.

ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Health Plan, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) in the aggregate unless a lesser amount is accepted by Health Plan or where State law mandates otherwise. Provider and each Contracted Provider will provide Health Plan with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Health Plan's request, Provider and each Contracted Provider will furnish Health Plan with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Health Plan. Health Plan agrees to indemnify and hold harmless (and at Provider's request defend) Provider, Contracted Providers, and their officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and Health Plan and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the matter is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the matter has not been resolved within sixty (60) days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Health Plan Effective Date, and will remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred eighty (180) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred eighty (180) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least one hundred eighty (180) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least ninety (90) days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the sixty (60) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Health Plan has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Health Plan determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Health Plan, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.3. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Health Plan giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.4. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted

Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.5. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 6.2, 7.3, and 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among Health Plan, Company, Provider, and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any Company under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without Health Plan's prior written consent. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of Health Plan, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. Health Plan may amend this Agreement by giving Provider written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Provider upon the giving of such notice.

8.7.2. Health Plan may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. Unless Provider notifies Health Plan in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Health Plan, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being

Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product).

8.8. Entire Agreement. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Health Plan and Provider relating to a subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. The waiver by either Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To Health Plan at:	To Provider at:
Attn: President	Attn: _____
Buckeye Community Health Plan	_____
4349 Easton Way, Suite 200	_____
Columbus, OH 43219	_____, _____ _____
	_____

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Health Plan may provide notices by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. Neither Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information and Provider shall not disclose such information to any person or entity without Health Plan's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of the Agreement with Health Plan.

* * * * *

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

HEALTH PLAN:	**PROVIDER:**
Buckeye Community Health Plan	_____ (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name: Natalie A. Lukaszewicz	Print Name:
Title: Vice President, Network Development & Contracting	Title:
Signature Date:	Signature Date:
ECM #:	Tax Identification Number: _____
To be completed by Health Plan only:	State Medicaid Number: _____
Effective Date:	National Provider Identifier: _____

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1 Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Hospital agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Hospital's performance data.

2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying

that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each Practitioner agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Practitioner's performance data.

3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each ancillary provider agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use ancillary provider's performance data.

4 FQHC. If Provider or a Contracted Provider is a federally qualified health center ("FQHC"), the following provisions apply.

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Health Plan has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Health Plan at any time upon request. FQHC shall promptly notify Health Plan if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

4.2 FQHC Indemnification. To the extent FQHC is prohibited by law cannot agree to mutual indemnification terms specifying that one entity shall not be liable for actions/events in the other entity, Section 5.1 and Section 5.2 of this Agreement will not apply and each Party agrees to accept and is responsible for its own acts and omissions in providing services pursuant to this Agreement as well as those acts or omissions of its employees and nothing in this Agreement shall be construed to place any responsibility for such acts or omissions onto the other Party.

4.3 FQHC Compliance with Regulatory Requirements; Imposed Sanctions and Penalties. To the extent FQHC is prohibited by law cannot agree to sanctions or penalties due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, the following sentence in Section 2.14 of this Agreement will not apply: "If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

5 Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Health Plans Standards. Each facility agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use facility's performance data.

6 Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Health Plan. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Health Plan, via written notice or via telephone contact at a number to be provided by Health Plan, within the following time frames:

6.5.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to urgent care or the emergency department of any hospital, or of a Covered Person's hospitalization, within 24 hours of becoming aware of such visit or hospitalization.

6.5.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

6.5.4 Provider or the applicable Contracted Provider shall notify Health Plan of any change in a Covered Person's medical or behavioral health condition, within 24 hours of becoming aware of such change. (Examples of changes in condition are set forth in the Provider Manual.)

6.5.5 Provider or the applicable Contracted Provider shall notify Health Plan of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Health Plan or its designee the Minimum Data Set as defined by CMS and required under federal law and Health Plan policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Health Plan.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Health Plan's LTSS quality improvement plan. Each Contracted Provider shall permit Health Plan to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification ("EVV"). If Contracted Provider provides in-home services, Contracted Provider shall comply with ODM's and Health Plan's electronic visit verification system requirements where applicable.. Further instructions regarding EVV are set forth in the Medicaid Product Attachment attached and incorporated into this Agreement.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Health Plan thereafter. Provider shall provide the results of such background checks to Health Plan and member, if self-directed, upon request. Provider agrees to immediately notify Health Plan of any criminal convictions of any Contracted or sub-contracted Provider. Provider shall pay any costs associated with such criminal background checks.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid
Attachment B: Medicare
Attachment C: Individual

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
CONTRACTED PROVIDERS

ENTITY/GROUP/CLINIC/FACILITY NAME	TAX ID #	NPI #

NOTE: This Schedule is intended to capture all groups, clinics and facilities participating under the Agreement (i.e., are Contracted Providers under this Agreement) as of the Effective Date.

Attachment A: Medicaid

SCHEDULE A-1
OHIO STATE MANDATED PROVISIONS AND PRODUCT ATTACHMENT

The Ohio State Mandated Provisions and Product Attachment and the Buckeye Community Health Plan Medicaid Addendum are incorporated into the Agreement entered into by and between Health Plan and Provider. To the extent that any terms set forth in the Ohio Product Attachment conflict with provisions in the Agreement, the terms of the Ohio Product Attachment shall control. The terms and conditions of the Medicaid Addendum, attached hereto and made a part hereof, supersede any provisions in the Ohio Product Attachment or the Agreement.

I DEFINITIONS

A. **Emergency Care.** Emergency Care means 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 any of the following: placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

B. **Health Plan Coverage Plan.** Health Plan Coverage Plan means the Ohio Department of Medicaid ("ODM") Managed Care Plan ("MCP") Provider Agreement, which describes the Covered Services that Health Plan has agreed to arrange to provide to Covered Persons. Plan may be amended, modified, replaced, or supplemented from time to time by ODM.

C. **Medically Necessary.** Medically Necessary means, unless otherwise defined in the applicable Health Plan Coverage Plan, any health services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the Covered Person can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. A Medically Necessary service must (1) meet generally accepted standards of medical practice; (2) be appropriate to the illness or injury for which it is performed as to type of service and expected outcome; (3) be appropriate to the intensity of service and level of setting; (4) Provide unique, essential, and appropriate information when used for diagnostic purposes; (5) be the lowest cost alternative that effectively addresses and treats the medical problem.

D. **State.** As used in this Agreement, the term "State" refers to the State of Ohio.

II PROVISIONS MANDATED BY LAW

A. **Hold Harmless**. Provider agrees that in no event, including, but not limited to, nonpayment by the Health Insuring Corporation, insolvency of the Health Insuring Corporation, or breach of this agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the covered enrollee, for health care services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the Health Insuring Corporation or its successor.

This section shall survive the termination of the Agreement with respect to services covered and provided under the Agreement during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of the Health Insuring Corporation.

B. **Continued Service**. Provider shall continue to provide covered health care services to enrollees in the event of the Health Insuring Corporation's insolvency or discontinuance of operations, and shall continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the Health Insuring Corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, the Provider may limit the required provision of covered health care services relating to that inpatient care in accordance with division (D)(3) of Section 1751.11 of the Ohio Revised Code, and may also limit such required provision of covered health care services to the period ending thirty days after the Health Insuring Corporation's insolvency or discontinuance of operations.

   The provisions required by this section shall not require Provider to continue to provide any covered health care service after the occurrence of any of the following:

   1. The end of the thirty-day period following the entry of a liquidation order under Chapter 3903 of the Revised Code;

   2. The end of the enrollee's period of coverage for a contractual prepayment or premium;

   3. The enrollee obtains equivalent coverage with another Health Insuring Corporation or insurer, or the enrollee's employer obtains such coverage for the enrollee;

   4. The enrollee or the enrollee's employer terminates coverage under the contract; or

   5. A liquidator effects a transfer of the Health Insuring Corporation's obligations under the contract under division (A)(8) of section 3903.21 of the Ohio Revised Code

C. **Certain Terms**. Those terms that are used in this Agreement and that are defined by Chapter 1751 of the Ohio Revised Code shall be interpreted in a manner consistent with the definitions provided therein. This Section does not apply to the coverage of beneficiaries enrolled in Title XVIII of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, pursuant to a Medicare risk contract or Medicare cost contract, or to the coverage of beneficiaries enrolled in the federal employee health benefits program pursuant to 5 U.S.C.A. 8905, or to the coverage of beneficiaries enrolled in Title XIX of the "Social Security Act," 49 Stat. 620 (1935), 42 U.S.C.A. 301, as amended, known as the medical assistance program or Medicaid, provided by the Department of Job and Family Services under Chapter 5111 of the Revised Code, or to the coverage of beneficiaries under any federal health care program regulated by a federal regulatory body, or to the coverage of beneficiaries under any contract covering officers or employees of the state that has been entered into by the Department of Administrative Services.

D. **Interpretation**. Notwithstanding anything in the Agreement or this Exhibit, none of the terms of the Agreement or Exhibit shall be construed:

   1. As an inducement to the Provider to reduce or limit medically necessary health care services to a covered enrollee;

   2. As a penalty to the Provider that assists an enrollee to seek a reconsideration of the Health Insuring Corporation's decision to deny or limit benefits to the enrollee;

   3. As a limit or other restriction on the Provider's ethical and legal responsibility to fully advise enrollees about their medical condition and about medically appropriate treatment options;

   4. As a penalty to the Provider for principally advocating for medically necessary health care services;

5. As a penalty to the Provider for providing information or testimony to a legislative or regulatory body or agency. This shall not be construed to prohibit the Health Insuring Corporation from penalizing a Provider that provides information or testimony that is libelous or slanderous or that discloses trade secrets that the Provider has no privilege or permission to disclose.

6. Nothing in this Section shall be construed to prohibit the Health Insuring Corporation from doing either of the following:

    a. Taking a determination not to reimburse or pay for a particular medical treatment or other health care service;

    b. Enforcing reasonable peer review or utilization review protocols, or determining whether a particular provider has complied with these protocols.

E. **Responsibility**. The Health Insuring Corporation acknowledges its statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees as provided under the laws of the State of Ohio.

F. **Ohio Department of Medicaid Requirements**. As required by the Ohio Department of Medicaid, the following provisions shall also apply to the Agreement:

1. **Credentialing**. If the Health Insuring Corporation has delegated its credentialing to Hospital, the Health Insuring Corporation, at its discretion, retains the right to approve, suspend, or terminate any provider, hospital, or other health care provider, including institutional providers and ancillary services providers, that has contracted with, or on whose behalf a contract has been entered into with, Hospital to participate in one or more of Health Insuring Corporation's plans.

2. **Revocation of Delegation**. If Health Insuring Corporation has delegated any functions to Provider, and Health Insuring Corporation or any governmental department, agency, or other subdivision of the state of Ohio (the "Agency") determines delegation is not in the best interest of the person entitled to coverage, and the Provider is performing inadequately, or the Provider has disclosed protected health information ("PHI") or used PHI in an unauthorized manner, as defined in the Agreement, Health Insuring Corporation may require Provider to develop a corrective action plan to address the deficiencies or areas of improvement identified by the Agency or Health Insuring Corporation. The Health Insuring Corporation may also revoke any or all of the delegated functions.

3. **Sanctions**. In addition to the provisions required by the Ohio Department of Medicaid as noted in i) and ii) above, the Health Insuring Corporation and Provider agree that in the event the Agency imposes sanctions against the Health Insuring Corporation for Provider's inadequate performance, Provider shall hold Health Insurance Corporation harmless, including repayment of such sanctions and related legal fees or other associated costs.

HEALTH PLAN:	**PROVIDER:**
Buckeye Community Health Plan	
By:	By:
Printed Name: Natalie A. Lukaszewicz	Printed Name:
Title: Vice President, Network Development & Contracting	Title:
Date:	Date:

Attachment A: Medicaid

SCHEDULE A-2
Medicaid Addendum

This Addendum supplements the Base Contract or Agreement between **Buckeye Community Health Plan** and _____, effective _____, 20__, and runs concurrently with the terms of the Base Contract or Agreement. This Addendum is limited to the terms and conditions governing the provision of and payment for health services provided to Medicaid Member(s).

The provider will provide services to the following eligible Medicaid consumer populations as specified in the Ohio Department of Medicaid Provider Agreement (select all that apply):

☐ All Medicaid Managed Care members (non-duals)
☐ All MyCare Ohio members (dual eligible)
☐ Medicaid Managed Care Single Case Agreement
☐ MyCare Ohio Single Case Agreement

The provider agrees to provide services to the Managed Care Organization's (MCO's) member(s) within the MCO's designated service area(s) as specified below (select all that apply):

Medicaid Managed Care Service Areas	**MyCare Ohio Service Areas**		
☐ Central/Southeast Region	☐ Central	☐ West Central	☐ Southwest
☐ Northeast Region	☐ Northwest	☐ Northeast	☐ Northeast Central
☐ West Region	☐ East Central		

☐ *Not applicable (out-of-state provider)*

With the exception of single case agreements, the provider must either be currently enrolled as a Medicaid provider and meet the qualifications specified in OAC rule 5160-26-05(C) or be in the process of enrolling as an ODM provider. A MyCare Ohio waiver provider must be currently enrolled as an ODM provider with an active status in accordance with OAC rule 5160-58-04.

ADDENDUM SECTIONS

Section A	Provisions applicable to contracted network providers and single case agreements
Section B	Provisions only applicable to contracted network providers
Section C	Provisions applicable to contracted network providers and single case agreements depending on the service being provided
Section D	Provisions applicable to managed care organizations

ADDENDUM DEFINITIONS

Agreement/Base Contract	The contract or single case agreement between the managed care organization and the provider (hereinafter referred to as Base Contract).
Managed Care Organization (MCO)	A health insuring corporation (HIC) licensed in the state of Ohio that enters into a managed care provider agreement with ODM. For the purposes of this Addendum, references to an MCO include MyCare Ohio plans.
Medicaid	The program of medical assistance established by Title XIX of the "Social Security Act," 42 U.S.C. 1396 et seq., including any medical assistance provided under the Medicaid state plan or a federal Medicaid waiver granted by the United States secretary of health and human services
Member	A Medicaid recipient who has selected MCO membership or has been assigned to an MCO for the purpose of receiving health care services.

OAC	Ohio Administrative Code.
ORC	Ohio Revised Code.
Provider	A hospital, health care facility, physician, dentist, pharmacy, or otherwise licensed, certified, appropriate individual or entity, which is authorized to or may be entitled to reimbursement for health care services rendered to an MCO's member.

ADDENDUM PROVISIONS

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

A. All providers providing health care services to Buckeye Community Health Plan's Medicaid managed care and/or MyCare Ohio members, including providers operating under a single case agreement, agree to abide by all of the following specific terms:

1. The provider, acting within their scope of practice, will provide services as enumerated in Attachment D of this Addendum. For single case agreements, Attachment D only needs to be completed if the Base Contract does not specify the service being provided. Any amendment to Attachment D must be agreed to by both parties.

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

3. The Base Contract and Addendum are governed by, and are construed in accordance with all applicable laws, regulations, and contractual obligations of the MCO.

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

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

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

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

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

6. The provider shall be compensated pursuant to the method and in the amounts specified in the Base Contract. Any amendment to the method or compensated amount in the Base Contract must be agreed to by both parties.

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

8. The provider, in performance of the subcontract or in the hiring of any employees for the performance of services under the contract, shall not by reason of race, color, religion, gender, sexual orientation, age disability, national origin, military status, genetic information, health status or ancestry, discriminate against

any citizen of Ohio in the employment of a person qualified and available to perform the services to which the subcontract relates.

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

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

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

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

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

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

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

    1. FQHCs and RHCs may be reimbursed by ODM in the event of MCO insolvency pursuant to Section 1902(bb) of the Social Security Act.

    2. The provider may bill the member when the MCO denied prior authorization or referral for the services and the following conditions are met:

        i. The provider notified the member of the financial liability in advance of service delivery;

        ii. The notification, by the provider, was in writing, specific to the service being rendered, and clearly states that the member is financially responsible for the specific service. A general patient liability statement signed by all patients is not sufficient for this purpose; and

        iii. The notification is dated and signed by the member.

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

15. In accordance with OAC rule 5160-26-05, the provider agrees to identify, and where indicated arrange, for the following at no cost to the member:

    1. Sign language services; and

    2. Oral interpretation and oral translation services.

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

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

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

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

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

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

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

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

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

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

B. All participating providers providing health care services to Buckeye Community Health Plan's Medicaid managed care and/or MyCare Ohio members, not including providers operating under a single case agreement, agree to abide by all of the following specific terms:

    1. Notwithstanding item A.2 of this Addendum, the provider may non-renew or terminate the Base Contract if one of the following occurs:

        a. The provider gives the MCO at least 60 days prior notice in writing for the nonrenewal or termination of the Base Contract, or the termination of any services for which the provider is contracted. The effective date for the nonrenewal or termination of the Base Contract or any contracted services must be the last day of the month; or

        b. ODM proposed action in accordance with OAC Chapter 5160, including rule 5160-26-10(G), regardless whether the action is appealed. The provider's nonrenewal or termination written notice must be received by the MCO within 15 working days prior to the end of the month in which the provider is proposing nonrenewal or termination. If the notice is not received by this date, the provider must extend the nonrenewal or termination date to the last day of the subsequent month.

2. The provider will cooperate with the MCO's quality assessment and performance improvement (QAPI) program in all the MCO's provider subcontracts and employment agreements for physician and non-physician providers.

3. The provider will cooperate with the ODM external quality review as required by 42 C.F.R. 438.358, and on-site audits, as deemed necessary based on ODM's periodic analysis of financial, utilization, provider panel, and other information in OAC Chapter 5160, including rule 5160-26-07.

C. If applicable based on the service(s) being provided to the Medicaid managed care and/or MyCare Ohio member, the provider agrees to abide by the following specific terms:

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

2. If the provider is a hospital or hospital system, Attachment C (ODM Hospital Services Form) must be completed and included with this Addendum, which specifies which services of the hospital are included in the Base Contract.

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

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

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

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

D. The MCO agrees to abide by the following specific terms:

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

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

3. The MCO will not prohibit, or otherwise restrict a provider, acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient, for the following:
   i. The member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.

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

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

iv. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

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

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

[Signature Block Follows]

Signatures	
MCO Name: **Buckeye Community Health Plan**	Provider Name:
Signature:	Signature:
Printed Name: Natalie A. Lukaszewicz	Printed Name:
Title: Vice President, Network Development & Contracting	Title:
Date:	Date:

Attachment A: Medicaid

SCHEDULE A-3
ADDENDUM PROVISIONS

Attachment A: Primary Care Provider Attestation

Provider Group Name: _____ Health Plan Name: Buckeye Community Health Plan

Group Tax ID Number: _____ Group NPI: _____

(Groups should provide Group name, NPI and Tax ID Number above, and individual NPI under "Provider NPI" below)

Last	First	MI	Deg	Spec	Service Location Name	Address	City	St	Zip	Provider NPI	Capacity

Health Plan acknowledges changes on the date received. Effective Date will be determined by the Health Plan. "Capacity" represents the maximum number of the Health Plan's Medicaid members the primary care provider (PCP) agrees to serve. Each PCP's name must be listed. PCPs, whether individually or as part of a group, must serve a minimum of 50 of the Health Plan's Medicaid members at each practice location in order to be listed in Health Plan's provider directory. Please indicate a numeric capacity value instead of "unlimited" or similar response. For any given PCP, total capacity must not exceed 2,000 across all locations. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3).

Attachment A: Medicaid

SCHEDULE A-3
ADDENDUM PROVISIONS

Attachment B: Non-Primary Care Providers Only

Provider Group Name: _____ Health Plan Name: Buckeye Community Health Plan

Group Tax ID Number: _____ Group NPI: _____

(Groups should provide Group name, NPI and Tax ID Number above, and individual NPI under "Provider NPI" below)

Last	First	MI	Deg	Spec	Service Location Name	Address	City	St	Zip	Provider NPI
Health Plan acknowledges changes on the date received. Effective Date will be determined by the Health Plan. Each provider's name must be listed. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3).										

Attachment A: Medicaid

SCHEDULE A-3
ADDENDUM PROVISIONS

Attachment C: Hospital Services Form

Health Plan Name: Buckeye Community Health Plan

The provider must complete a copy of this form for each hospital covered by the terms and conditions of this addendum. If multiple pages are used, the pages must be numbered sequentially on every page (e.g., 1 of 3, 2 of 3, and 3 of 3) and the signature block must be included on the each page. Health Plan acknowledges changes on the date received. Effective Date will be determined by the Health Plan.

1) **Hospital Information**:

Hospital Name:	
Address: (including county):	
Tax ID Number:	NPI:

2) **Hospital Services Categories**

Please check the applicable line for each category of service the above-named hospital covers.

□ Adult General Medical/Surgical Services	□ Midwife Services
□ Pediatric General Medical/Surgical Services	□ Outpatient Surgery
□ Obstetrical Services	□ Pediatric Intensive Care
□ Nursery Services	□Special Care
□ Nursery Services Level 1 & 2	□ Psychiatric Services
□ Neonatal Intensive Care Level 3	□ Practitioner Services
□ Adult Intensive Care	□ Inpatient Psychiatric Care/Institution for Mental Disease
□ Other – please specify:	

3) **Hospital does not provide the following hospital service(s) because of an objection on moral or religious grounds.** List Services:

_____

_____

_____

_____

Attachment A: Medicaid

SCHEDULE A-3
ADDENDUM PROVISIONS

Attachment D: Services Provided

Provider Group Name: _____ Health Plan Name: Buckeye Community Health Plan

Group Tax ID Number: _____

Service Site NPI: _____

(Individuals should provide individual name, Tax ID Number and NPI above)

Provider agrees to provide services as enumerated below (specify below):

□ Ambulance transportation	□ Mental health and/or substance abuse services
□ Ambulette transportation	□ Nursing facility services
□ Ambulatory Surgery Center	□ Obstetrical and/or gynecological services
□ Advanced practice nurse services specify: _____	□ Ophthalmology services
□ Chiropractic services	□ Outpatient hospital services
□ Dental services	□ Physical and occupational therapy
□ Durable medical equipment (DME)	□ Podiatry services
□ Emergency Services	□ Pharmacy
□ Family planning services and supplies	□ Physician services
□ Federally Qualified Health Center services	□ Primary care provider services
□ Home health services/Private Duty Nursing	□ Renal dialysis
□ Hospice care	□ Rural Health Clinic services
□ Medical Imaging	□ Specialty physician services, Specify (e.g., cardiology, allergy, etc): _____
□ Inpatient hospital services	□ Speech and hearing services
□ Laboratory services	□ Vision (optical) services, including eyeglasses
□ Other – please specify:	

Behavioral Health Services

BH Provider Type:	□ Community Mental Health Center / Type 84
	□ Substance Use Disorder / Type 95
	□ Non-Type 84/95 BH Provider
Services	
□ Pharmacological Management	□ Ambulatory Detox
□ Behavioral Health Assessment	□ Targeted Case Management for AOD
□ Behavioral Health Counseling and Therapy	□ Intensive Outpatient
□ Crisis Intervention	□ Laboratory urinalysis
□ Partial Hospitalization	□ Med –Somatic
□ Community Psychiatric Support Treatment	□ Methadone Administration
□ Opioid Treatment Provider	□ Behavioral Health Respite

□ Individual Placement & Support / Supported Employment (IPS/SE)	□ Peer Recovery Support
□ Assertive Community Treatment (ACT)	□ Intensive Home Based Treatment (IHBT)
□ Substance Use Disorder Residential	□ Mental Health Group Day Treatment
□ Other – please specify:	

Home and Community Based Services (included only in the MyCare Ohio benefit package)

□ Out of Home Respite Services	□ Waiver Nursing Services
□ Adult Day Health Services	□ Home Delivered Meals*
□ Waiver Transportation*	□ Assisted Living Services
□ Chore Services*	□ Home Care Attendant
□ Social Work Counseling	□ Choices Home Care Attendant
□ Emergency Response Services*	□ Enhanced Community Living Services
□ Home Modification Maintenance and Repair*	□ Nutritional Consultation
□ Personal Care Services	□ Independent Living Assistance
□ Homemaker Services	□ Community Transition Services
□ Pest Control*	□ Alternative Meals Service
□ Home Care Attendant Nursing	
□ Home Medical Equipment and Supplemental Adaptive and Assistive Device Services*	

**Indicates service provider types which may be counted in more than 1 county or region. All others may only count in the county where the provider is physically located.*

Effective Date of changes will be determined by the Health Plan.

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
ANCILLARY SERVICES

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ancillary Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ancillary Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the Payor's Medicaid fee schedule.

Additional Provisions:

1. Code Editing Software. As applicable, Health Plan will process claims utilizing the most current version of a code editing software product by McKesson Corporation called ClaimsXten®. Health Plan reserves the right to change or utilize other code editing software, at its discretion, and will notify Contracted Provider of any such change.

2. State Medicaid Fee Schedule. The State Medicaid fee schedule can be located on the Ohio Department of Medicaid website at http://jfs.ohio.gov/OHP.

3. Claims Payment Appeals. Health Plan shall request any appeal of claims payments in accordance with and as outlined in the Provider Manual, which is located at www.bchpohio.com.

4. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates (ii) the effective date of such code updates, as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

5. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; (ii) the effective date of such fee schedule updates, as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the first day of the month following thirty (30) days after

publication by the entity responsible for such Fee Change Update. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

6. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.

7. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple dates of service.

8. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment A: Medicaid

EXHIBIT 2
COMPENSATION SCHEDULE
ANCILLARY SERVICES
AMBULANCE

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulance Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the Payor's Medicaid fee schedule.

Additional Provisions:

1. Code Editing Software. As applicable, Health Plan will process claims utilizing the most current version of a code editing software product by McKesson Corporation called ClaimsXten®. Health Plan reserves the right to change or utilize other code editing software, at its discretion, and will notify Contracted Provider of any such change.

2. State Medicaid Fee Schedule. The State Medicaid fee schedule can be located on the Ohio Department of Medicaid website at http://jfs.ohio.gov/OHP.

3. Claims Payment Appeals. Health Plan shall request any appeal of claims payments in accordance with and as outlined in the Provider Manual, which is located at www.bchpohio.com.

4. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates (ii) the effective date of such code updates, as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

5. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) the first day of the month following thirty (30) days after publication by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; (ii) the effective date of such fee schedule updates, as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product

is not regulated by such governmental agency, the first day of the month following thirty (30) days after publication by the entity responsible for such Fee Change Update. Claims processed prior to the Fee Change Effective Date shall not be reprocessed to reflect any updates to such fee schedule.

6. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.

7. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple dates of service.

8. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

EXHIBIT 3
COMPENSATION SCHEDULE
ANCILLARY SERVICES
AMBULATORY SURGERY CENTER ("ASC")

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulatory surgery center Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulatory surgery center Covered Services is the lesser of: (i) Allowable Charges; or (ii) one hundred percent (100%) of the Payor's Medicaid fee schedule.

Additional Provisions:

1. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

2. Payment for Multiple Procedures. Where multiple outpatient surgical or scope procedures performed on a Covered Person during a single occasion of surgery, reimbursement will be as follows: i) the procedure for which the Allowed Amount under this Compensation Schedule is greatest will be reimbursed at one hundred percent (100%) of such Allowed Amount; ii) the procedures with second and third greatest Allowed Amounts under this Compensation Schedule will each be reimbursed at fifty percent (50%) of such Allowed Amounts; iii) any additional procedures will not be eligible for reimbursement.

3. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code or services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.

4. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple date of service.

5. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to

billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

6. Fee Change Updates. Updates to such fee schedule shall become effective on the date ("Fee Change Effective Date") that is the later of: (i) within 20 calendar days of being notified by the governmental agency having authority over the applicable product of such governmental agency's acceptance of such fee schedule updates; (ii) the effective date of such fee schedule updates, as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the first day of the month following thirty (30) days after publication by the entity responsible for such Fee Change Update. Claims processed prior to the Fee Change Effective Date shall be reprocessed to reflect any updates to such fee schedule.

7. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.