OhioHealth Group

OHIOHEALTH GROUP, LTD.
PARTICIPATING PROVIDER AGREEMENT
(Individual Practitioner)

This Participating Provider Agreement (this "Agreement") is made effective as of the Effective Date, by and between OhioHealth Group, Ltd. ("OHG"), and _____ ("Practitioner") on the signature page of this Agreement.

BACKGROUND INFORMATION

A. OHG attempts to contract directly or indirectly with Payors to arrange for such Payors to utilize Participating Hospitals, Participating Practitioners, and Participating Providers to provide, arrange for and/or administer, at predetermined rates, the provision of Health Care Services;

B. OHG also contracts with Participating Hospitals, Participating Practitioners, and Participating Providers to provide Health Care Services at predetermined rates; and

C. OHG desires to engage Practitioner to provide Health Care Services to Beneficiaries for those Programs for which both OHG and Practitioner have executed Program Attachments and Practitioner desires to be so engaged pursuant to the terms of this Agreement and the executed Program Attachments.

AGREEMENT

The parties hereby acknowledge the accuracy of the foregoing Background Information and hereby agree as follows:

I. DEFINITIONS

For purposes of this Agreement and the Program Attachments, the following capitalized terms shall have the following meanings:

Beneficiary means any person whether referred to as "Insured," "Member," "Subscriber," "Participant," "Enrollee," "Dependent," or otherwise who is eligible to receive Covered Services under a Service Agreement paid for by a Payor or whom a Payor is legally obligated to indemnify for the cost of such Covered Services, and who has enrolled in a Plan provided by a Payor.

Beneficiary Services Program means the program developed and implemented by OHG or a Payor designed to process and consider questions, complaints, and other appropriate matters raised with respect to the Covered Services provided to Beneficiaries under a Plan.

Complete Claim means, unless otherwise defined by applicable law, a properly completed claim for payment for Covered Services received by Payor or Payor's designee, meeting OHG's billing standards, that requires no further information, documentation, adjustment, or alteration by Participating Provider in order to be processed or paid. In order to constitute a Complete Claim, claim must be submitted on UB-92 or CMS-1500 form, as applicable, or successor forms, using standard code sets and methodology, such as CPT, ICD-9 and HCPCS. For a complete description of the information that must be included in a complete claim, refer to the applicable Program Manual.

Coinsurance means a payment that a Beneficiary is required to make to a Participating Practitioner or Participating Provider for Covered Services under a Plan, which is calculated as a percentage of the contracted reimbursement rate of such services.

Copayment or Deductible means a payment that a Beneficiary is required to make to a Participating Practitioner or Participating Provider under a Plan, which is calculated as a fixed dollar payment.

Covered Services means those Medically Necessary Health Care Services to which a Beneficiary is entitled under a Plan.

Designated Hospital means the acute care hospital designated by Practitioner as his or her primary admitting institution, if applicable.

Effective Date means the date set forth on the signature page of this Agreement.

Emergency Medical Condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (a) 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; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Emergency Services mean medical, surgical, hospital, and related health care services and testing, including ambulance services, required to treat an Emergency Medical Condition in accordance with the applicable provisions of the Ohio Revised Code.

Experimental or Investigational means Health Care Services that either:

(A) are not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or use in testing or other studies; or

(B) requires approval by a federal or state governmental authority or agency and such approval has not been granted prior to the services being performed.

Health Care Services means those services including diagnostic, therapeutic, evaluative~~,~~ and preventive services that are generally and customarily provided to patients by acute general hospitals, outpatient facilities or by physicians, surgeons, dentists and other medical personnel, wherever performed.

Medically Necessary means Health Care Services that:

(A) are appropriate and consistent with the Beneficiary's diagnosis in accord with generally accepted standards of medical practice as determined OHG or MGO;

(B) are not considered Experimental or Investigational;

(C) could not have been omitted without adversely affecting the Beneficiary's condition or quality of care; and

(D) are the most appropriate supply or level of service that can be provided on a cost-effective basis.

Non-Covered Services means Health Care Services that are not designated as Covered Services under a Payor's Plan and are not designated as benefits to Beneficiaries under such Plan and/or are determined to be medically inappropriate or unnecessary under the Utilization Management criteria applicable to the Plan, or are determined to be medically inappropriate or unnecessary under medical review criteria or protocols adopted by OHG to implement the Program.

Participating Hospital means a hospital that has a direct or indirect contractual agreement with OHG with respect to the particular Program under which the Beneficiary is covered and to which a Participating Practitioner may admit Beneficiaries for care and treatment in accordance with Program Requirements.

Participating Practitioner means an individual health care practitioner who is licensed under the laws of the State in which the individual is providing Health Care Services and has a direct or indirect contractual arrangement with OHG to provide Covered Services to Beneficiaries.

Participating Provider means a hospital, ambulatory care facility, home health care agency or any other organization, including a group or network of Participating Practitioners that provides Health Care Services and has a direct or indirect contractual arrangement with OHG to provide Covered Services to Beneficiaries.

Payor means any employer, trust, insurance company, union health and welfare fund, preferred provider organization, health maintenance organization, health insuring corporation, intermediary organization, or any other person or entity that has entered into a Service Agreement with OHG.

Performance Improvement Plan means the plan developed in conjunction with a Participating Provider or Participating Practitioner prior to termination of the Participating Provider or Participating Practitioner for failure to meet OHG's Quality Management and/or Utilization Management standards.

Program means a Preferred Provider Organization (PPO) or other type of health care or administrative services which are provided by or arranged by OHG, or another entity under contract with OHG to access OHG's Participating Practitioner and Participating Provider Network and which are specifically described in applicable Program Attachments, Program Requirements and Program Manuals.

Program Attachment means a document signed by the parties and attached to this Agreement for each Program in which Practitioner shall be participating, that sets forth certain terms and conditions applicable to such Program.

Program Manual means a manual developed by OHG or another Payor for Providers and Practitioners that sets forth operational policies, procedures and requirements governing a particular Program.

Program Requirements means the rules and procedures that establish conditions to be followed by Participating Practitioners and Providers with respect to Programs. Any reference to Program Requirements includes the information in this Agreement, the Program Attachments, and the Program Manuals distributed by OHG.

Quality Management means the processes established and operated by OHG or its designee relating to the quality of Covered Services provided to Beneficiaries.

Service Agreement means an agreement between OHG and a Payor to implement a Program that specifies the Covered Services to be provided to or for the benefit of, or arranged for, or reimbursed to, Beneficiaries, the terms and conditions under which those Covered Services are to be provided and reimbursed, and is consistent with applicable Program Requirements.

Utilization Management means the processes to review and determine whether certain Health Care Services provided or to be provided to Beneficiaries are in accordance with Program Requirements.

II. OBLIGATIONS OF PRACTITIONER

A. Provision of Services

1. Practitioner shall only participate in and provide Covered Services for those Programs set forth in the Program Attachments that OHG and Practitioner have each executed ("Participating Programs").

2. Practitioner shall provide to each Beneficiary those Covered Services which the Practitioner is qualified by law to provide and which Practitioner customarily provides in a manner consistent with the norms of practice, the Practitioner's professional and ethical obligations, and all terms, conditions, standards and requirements of this Agreement and the Program or Programs in which Practitioner is participating. Practitioner shall not, distinguish between Beneficiaries and other patients in the quality of the Covered Services provided. Practitioner shall observe, protect, and promote the rights of Beneficiaries as patients. Practitioners shall not discriminate against any Beneficiary on the basis of sex, marital status, age, race, ethnicity, sexual preference, disability, color, religion, national origin, health status, handicap or source of payment.

3. Practitioner shall provide Covered Services at locations approved by OHG. Provider shall not eliminate or change such locations without first providing OHG with sixty (60) days' prior written notice.

4. Practitioner shall admit Beneficiaries only to Participating Hospitals except in the case of an Emergency Medical Condition or as otherwise described in applicable Program Requirements or as otherwise required by law. Subject to the foregoing, Practitioner shall designate one or more Participating Hospitals where Practitioner will admit Beneficiaries under his or her care unless admission to another hospital is otherwise approved in writing in advance by OHG or its designee.

5. Practitioner shall refer Beneficiaries to and/or use Participating Practitioners and Participating Providers for the provision of Covered Services except in the case of an Emergency Medical Condition, or as otherwise described in applicable Program Requirements or as otherwise required by law.

6. If Practitioner is designated as a primary care physician under a Program, Practitioner shall arrange for on-call coverage to assure that appropriate care will be available to Beneficiaries as provided in the Service Agreement for the Program.

B. Compliance and Participation

1. Practitioner shall be bound by and comply with the provisions of applicable state and federal laws and regulations.

2. Upon request, Practitioner shall participate in, and cooperate with OHG's credentialing and recredentialing requirements and such other activities as OHG or its designee deems reasonably necessary in connection with its efforts to obtain and maintain NCQA, JCAHO, and/or appropriate accreditation, including without limitation, periodic site reviews of offices, records, premises and operations of Practitioner.

3. Practitioner shall comply with the requirements of, and shall participate in, such Quality Management and Utilization Management programs developed or implemented by OHG or a Payor (as agreed to by OHG), as such programs may be clarified, amended or supplemented from time to time, and the decisions, rules and regulations established under such programs, including without limitation, precertification of elective admissions and procedures, referral processes and reporting of clinical encounter data.

4. Practitioner shall comply with the requirements of, and shall participate in a Performance Improvement Plan developed or implemented by OHG or a Payor's designee (as agreed to by OHG), following written notice to Practitioner of a failure to meet OHG's or Payor's standards for quality or utilization in the delivery of Covered Services as described in the applicable sections of the Ohio Revised Code.

5. Practitioner shall accept those compensation arrangements and rates set forth in this Agreement and/or the Program Attachment (or Payor or OHG supplied supplemental materials) as payment in full for those Covered Services rendered by Practitioner to Beneficiaries for those Programs in which Practitioner is a Participating Practitioner. OHG shall not be liable to Practitioner for any amounts a Payor fails to pay to Practitioner for Covered Services rendered by Practitioner. Practitioner shall hold harmless OHG against any claims for non-payment or under payment.

C. Books and Records

1. Provider shall create and maintain adequate medical records regarding Covered Services provided to Beneficiaries in accordance with accepted medical records documentation and storage procedures and applicable laws, regulations and Program Requirements and maintain the

confidentiality of such records in accordance with applicable federal and state laws. All such records shall be maintained for the period of time required by applicable law. Upon prior written request, and to the extent permitted by law, Provider shall provide to OHG, to a Payor, to their designees, to appropriate state and federal authorities and their agents (involved in assessing the quality of care or investigating grievance or complaints from Beneficiaries) and to Beneficiaries, copies of medical records and information relating to the treatment and Covered Services Provider provided to Beneficiaries. Provider may charge a fee of twenty-five cents ($0.25) per page, not to exceed twenty-five dollars ($25.00) per medical record unless prohibited by the terms and conditions of the applicable Program Requirements and applicable state and federal law. Medical records and information provided pursuant to this paragraph 1 shall be kept confidential by the recipient and disclosed only as permitted under pertinent state and federal law. The provisions of this paragraph 1 shall survive termination of this Agreement and/or any Program Attachment.

2. Practitioner shall cooperate with OHG, or its designee, to facilitate the information and record exchanges necessary for Quality Management, Utilization Management, or other programs required for OHG's operations and/or by the Program Requirements as any and all may change from time to time. Practitioner shall also cooperate with OHG, or its designee, in the development and maintenance of statistical data, records and procedures in support of Quality Management, Utilization Management and other applicable Program Requirements, as they may change from time to time.

3. Practitioner shall cooperate in connection with any transfers of Beneficiaries' medical records required when Practitioner ceases rendering services to a Beneficiary whether during the term of this Agreement or after termination of this Agreement or a Program Attachment. Practitioner agrees to provide first copies of such records at no charge. If any additional copies are needed, Practitioner can bill for such copies according to Section II.C.1 or applicable state or federal law.

III. OBLIGATIONS OF OHG

A. Payor Contracting

1. OHG shall attempt to contract, directly or indirectly, with Payors who agree to pay in accordance with this Agreement and or the applicable Program Attachment for Covered Services rendered by Practitioner and other Participating Providers and Participating Practitioners. Practitioner acknowledges and agrees that Practitioner shall only have the right to participate in those Programs for which Program Attachments have been signed by both of the parties and attached hereto and that OHG is under no obligation to include Practitioner in any Programs provided or arranged for by OHG or OHG affiliates. There are no assurances that OHG will be able to contract with a Payor and OHG shall not be liable to Practitioner if OHG cannot contract with a Payor.

2. OHG shall, upon specific request by Practitioner, identify to Practitioner the Payor responsible for payment of Covered Services rendered by Practitioner under a Program in which Practitioner is participating.

B. Procedures, Communications and Other Administrative Duties

1. OHG shall require Payor to establish a system of Beneficiary identification and procedures for verification by Practitioner (through written or telephone request) of Beneficiary eligibility to receive Covered Services and whether certain services to be rendered to a Beneficiary are Covered Services, which system and procedures shall be communicated to Practitioner. Beneficiary identification cards and such other mechanisms or procedures instituted by OHG or a Payor do not guarantee eligibility and Beneficiary eligibility determinations are not a guarantee of participation or coverage or payment, both participation and coverage must be determined in accordance with the terms of applicable Program Requirements.

2. OHG shall from time to time communicate to Practitioner the current Program Requirements of the Programs in which Practitioner is participating, which shall include, without limitation, specific information regarding Covered Services and applicable Coinsurance, Copayments and Deductibles.

3. OHG shall provide Payors with information identifying Practitioner as a Participating Practitioner and explaining, with particularity, the availability of Health Care Services from Practitioner and the economic benefits of the use by Beneficiaries of Participating Practitioners and Providers. However, OHG cannot guarantee that any Payor will, in turn, provide such information to Beneficiaries.

4. OHG shall list the name, address, telephone number and specialty(ies) of Practitioner in a directory or listing of Participating Practitioners and Participating Providers which shall be kept reasonably updated and may be furnished to Payors and Beneficiaries from time to time. OHG may also list the name, address, telephone number and specialty(ies) of Practitioner in other materials or publications deemed by OHG, in its sole discretion, to be reasonably necessary or desirable for the conduct of OHG's business. Practitioner authorizes OHG and other Payors to utilize the directory or listing information in any marketing activities undertaken by OHG or applicable Payors. Upon termination of this Agreement, Practitioner shall not engage in any activity that implies a continuing relationship with OHG or any of the Programs; and Practitioner acknowledges and agrees that to do so would cause OHG irreparable harm.

C. Beneficiary Services Program

1. OHG shall require Payors to develop and implement a Beneficiary Services Program for each Program, designed to process and consider questions, complaints and other matters raised by Beneficiaries with respect to Covered Services rendered. In the event an issue involving Practitioner arises under a Beneficiary Services Program, Practitioner will participate in and cooperate with the procedures of the Beneficiary Services Program and shall comply with all final determinations made by the applicable Payor(s) pursuant thereto.

D. Performance Feedback

1. OHG may, but shall not be obligated to, provide feedback for Practitioner's own use in assessing and enhancing performance with regard to quality of care, patient satisfaction and efficient practice. In doing so, OHG may perform surveys and analyze costs in comparison with regional and national peers and benchmarks. OHG may also from time to time inspect Practitioner’s office and procedures, and review a sample of Practitioner’s medical records for Beneficiaries and provide performance feedback on past treatment.

IV. COMPENSATION AND BILLING

A. Payment to Practitioner

1. As set forth in this Agreement and applicable Program Attachments, as amended, Practitioner shall accept those compensation arrangements and rates set forth in this Agreement and/or the Program Attachment, as amended (or Payor or OHG supplied supplemental materials) as payment in full for those Covered Services rendered by Practitioner to Beneficiaries for those Programs in which Practitioner is a Participating Practitioner. Compensation arrangements and rates for Covered Services are set forth in applicable Program Attachments, as amended. Such compensation arrangements and rates shall constitute payment in full from the applicable Payor. OHG and/or Beneficiary shall not be liable to Practitioner for any amounts a Payor fails to pay to Practitioner for Covered Services rendered by Practitioner. Practitioner shall hold harmless OHG and Beneficiary against any claims for non-payment or under payment. Practitioner shall receive payment from the applicable Payor for Covered Services rendered by Participant to Beneficiaries of such Payor.

B. Billing

1. For any Covered Service, Practitioner shall bill for Covered Services according to the following:

   a. Practitioner shall submit claims on the appropriate claim form as determined by OHG for all Covered Services within three hundred sixty five (365) days of the date those services are rendered. Claims received after this three hundred sixty five (365) day period may be denied for payment and Practitioner shall hold OHG, the applicable Beneficiary, and the Payor financially harmless for the payment of such claims. Practitioner shall submit claims to the location designated on the Beneficiary's identification card or designated on the applicable Program Attachments.

   b. Any amount owing to Practitioner from Payor under this Agreement after Payor receives a Complete Claim from Practitioner shall be paid within the time period set forth in the applicable Program Attachment of which Participant and OHG are signatories, taking into consideration any requests from OHG, the applicable Payor, or their designees for additional information and whether or not the claim involves coordination of benefits. For a complete description of all the information that must be included in a Complete Claim refer to the applicable Program Manual.

2. Practitioner may bill an individual directly for any services provided following the date the individual ceases to be a Beneficiary. Neither OHG nor any other Payor has any obligation under this Agreement to pay for services rendered to individuals who are not Beneficiaries.

3. Unless prohibited by applicable Program Requirements, if a Practitioner provides to a Beneficiary Health Care Services that are not Covered Services under the Program in which the Beneficiary is enrolled and benefits are not available under the Program, Practitioner may bill the Beneficiary the Practitioner's usual and customary fee for the Health Care Services, if the Practitioner notifies the Beneficiary in advance of his or her personal obligation for payment for Health Care Services that are not Covered Services under the Program. However, if a Health Care Service has been determined to not be Medically Appropriate under the Utilization Management criteria or other Program Requirements applicable to the Program under which Beneficiary seeks treatment, the Practitioner may, unless otherwise prohibited by applicable Program Requirements, bill the Beneficiary for the Health Care Services provider to Beneficiary by Practitioner only if, in advance of the Health Care Services being performed: (i) the Beneficiary has been informed that the Health Care Service(s) has been determined under the Program to not be Medically Appropriate or not Medically Necessary; and (ii) Beneficiary agrees in writing to be financially

responsible for the cost of the Health Care Service.

4. Practitioner shall submit any incorrectly paid claims to Payor for correction within 12 months of the original date of payment.

C. Resolution of Disputes

1. For each Program, OHG shall require Payor to develop a procedure for resolving disputes between Practitioner and Payor arising out of Health Care Services provided to a Participant under the Payor's Program, including but not limited to fees for Covered Services. In the event of a dispute, OHG shall require Payor to notify Practitioner of the applicable procedure and Practitioner agrees to participate in and cooperate with the procedure established by the Program Requirements.

D. Coordination of Benefits

1. OHG shall require Payor and Practitioner to agree to cooperatively exchange information relating to coordination of benefits with regard to any Beneficiary for whom Practitioner is providing services. In all instances, Coordination of Benefits will be administrated in accordance with O.R.C. Section 3902, 11-14, as may be amended from time to time.

2. With respect to those Health Care Services reimbursed on a fee-for-service basis:

   a. Certain claims for services rendered to Beneficiaries are claims for which another Payor may be primarily responsible under coordination of benefits rules. Practitioner may pursue and process any such coordination of benefits claims and, in so doing, shall comply with the primary Payor's billing rules, including, but not limited to, any of the primary Payor's limitations on billing Beneficiaries.

   b. When a Payor is other than primary under applicable coordination of benefits rules, Payor will pay no greater amount than that which, when added to amounts payable to Practitioner from other sources under the applicable coordination of benefit rules, equals one hundred percent of the Practitioner's reimbursement for Covered Services pursuant to this Agreement.

   c. When Payor is primary under applicable coordination of benefit rules, (defined by O.R.C. 3901.38, 11-14), Payor will pay amounts due pursuant to this Agreement without regard for the obligations of any secondary Payors.

E. Review of Records

1. Upon reasonable notice and during regular business hours, Payor or its designee shall have the right to inspect, review and make copies at Payor’s expense of all medical and billing records maintained by Practitioner with respect to all payments received by Practitioner from all sources for Covered Services rendered by Practitioner to Beneficiaries during the term of this Agreement. Payor or its designee shall have the right to conduct periodic audits of such records and may audit its own records to determine if amounts have been properly paid under this Agreement, provided that advance notice of any audit is provided to Practitioner and the audit is conducted during normal business hours of the Practitioner. Payor or its designee shall conduct any audits within 12 months of the original date of payment. Payor or its designee shall provide Practitioner with the results of any such audits and any amounts determined to be due and owing as a result of such

audits shall be promptly paid or, at the option of the party to whom such amounts are owed, offset against amounts due and owing by such party hereunder. The audits conducted by Payor or its designee pursuant to this paragraph may include the use of statistical sampling techniques. This provision shall survive the termination of this Agreement or any Program Attachment.

F. Prompt Pay

1. Payors who have contracted with OHG to access Participating Practitioners shall use good faith efforts to make or arrange for payment for all Complete Claims for Covered Services submitted by Participating Practitioners in accordance with the compensation rates set forth in the applicable Program Attachment. This Agreement is subject to the requirements of O.R.C. Section 3901.381 – 3901.3814 or any successor statute that may hereinafter be enacted, which the parties acknowledge shall apply to Participating Practitioners' Claims for Covered Services. If Payor fails to pay claims for Covered Services rendered by Participating Providers within the time requirements and parameters specified within said O.R.C. Section 3901.381 – 3901.3814 or successor statue that may hereinafter be enacted shall not prejudice any other rights or remedies available to Participating Practitioners at law or in equity on account of a Payor's failure to comply with such requirements or parameters. Further, if Participating Practitioners do not receive payment under this Agreement for Covered Services rendered within 30 calendar days after Payor's receipt of a Complete Claim, the Participating Practitioners may impose interest on the unpaid amount based upon 18% APR unless prohibits under Payor payment rules. The obligation for payment under this Agreement for Health Services rendered to a Beneficiary is solely that of the Payor. This excludes claims that have been suspended due to the need to determine Medical Necessity, or the extent of Payor's payment liability, if any, because of issues such as coordination of benefits, subrogation, or verification of coverage.

V. CREDENTIALING

A. OHG or a designee shall be responsible for the credentialing and recredentialing of Practitioner in accordance with the criteria set forth in the Program Manuals, as amended.

B. Practitioner shall promptly notify OHG of any situation of which he or she is aware that may affect Practitioner's ability to practice, including, but not limited to, license suspension; restriction or revocation; any disciplinary action, investigation, or censure by the DEA, Medicare or Medicaid, state licensing board, professional society, specialty board, professional organization or similar entity; an investigation, indictment or conviction for any felony criminal offense; hospital privileges limited, restricted, suspended or terminated, or any other adverse action taken by a hospital or a medical staff; any confirmed substantive negative quality issues; or an unfavorable malpractice judgment.

C. OHG agrees to provide Practitioner with prompt written notice of any adverse credentialing action.

D. Practitioner shall complete and submit to OHG a Practitioner application, in the form provided by OHG, and Practitioner shall inform OHG in a timely manner of any changes to any Practitioner's information set forth in Practitioner's application submitted to OHG.

VI. ADDITIONAL RIGHTS AND OBLIGATIONS OF THE PARTIES

A. Insurance, Indemnification and Liability

1. Throughout the term of this Agreement, Practitioner shall maintain, at his or her expense, general and professional liability coverage in a form and amount acceptable to OHG. Unless otherwise determined by OHG, the minimum limits for both coverages shall be $1 million per occurrence /$3 million in the aggregate. Upon OHG's request, Practitioner shall provide OHG with certificates evidencing such coverage. In the event Practitioner has a "claims made" policy, and changes professional liability insurance carriers during the term of this Agreement, such party shall either acquire appropriate "tail" insurance from the prior carrier or "prior acts" coverage from the new carrier, and shall provide OHG with a certificate or other appropriate evidence of such continuous coverage, upon request.

2. Each party agrees to indemnify and hold harmless the other party and its directors, managers, officers, employees and agents from any and all actions, causes of actions, claims, damages or losses of any kind, including reasonable attorney's fees, incurred by such other party to the extent resulting from the intentional, reckless, or negligent acts or omissions of the indemnifying party and its employees and agents. For purposes of this paragraph 2, a party, its employees, and agents shall not be considered agents of the other party.

3. OHG, and affiliate of OHG, and a manager, officer, committee member, employee, or agent of OHG, or an OHG affiliate (collectively, “OHG Persons”) shall not be liable to Practitioner for damages resulting from any action taken or recommendation made by any of the OHG Persons within the scope of the functions of such OHG Person’s position with OHG or an OHG affiliate, if such OHG Person acts without malice, and in the belief that such action or recommendation is warranted by the facts known to such OHG Person.

B. Confidentiality

1. OHG and Payor shall maintain the confidentiality and privacy of information contained in the medical records of Beneficiary and shall require Practitioner to do so as a material condition of this Agreement. Practitioner shall not disclose such information to any third party without the prior written consent of the Beneficiary, except for dissemination of such information as required (a) by applicable state and/or federal law or court order, or (b) by OHG or Payor and its Quality Management and Utilization Management programs. These confidentiality obligations shall not terminate with the expiration or termination of this Agreement and/or any Program Attachments.

2. The parties acknowledge that, as a result of this Agreement, each may have access to certain trade secrets and other confidential and proprietary information of the other. Each party shall hold, and cause its employees and agents to hold, such trade secrets and other confidential and proprietary information, including the terms and conditions of this Agreement, in confidence and shall not disclose such information, and shall take precautions to ensure that its employees and agents do not disclose such information, either by publication or otherwise, to any person without the prior written consent of the other party except as may be required by law and except as may be required to fulfill the rights and obligations set forth in this Agreement. Such confidential and proprietary information shall include, without limitation, the Program Attachments and Program Requirements. The provisions of this paragraph shall survive the termination of this Agreement and any Program Attachments.

3. Nothing in paragraphs 1 and 2 above shall be construed to prohibit:

   a. communications necessary or appropriate for the delivery of Health Care Services;

   b. communications to a Beneficiary regarding available treatment alternatives regardless of the provisions or limitations of such Beneficiary's coverage;

c. communications to Beneficiaries regarding applicable rights to appeal coverage determinations; or

d. communications to Beneficiaries identifying the type of reimbursement arrangement under which Practitioner is compensated for Covered Services under this Agreement (i.e. fee-for-service, capitation, etc.), excluding any communications with regard to the applicable rates of reimbursement.

C. Representations and Warranties of the Parties

1. Practitioner represents and warrants to OHG as follows:

a. that the information set forth in the Practitioner Application submitted to OHG is true and correct. Practitioner shall promptly notify OHG of any changes in the information contained in any such Application within thirty (30) days of such change;

b. that under this Agreement with Practitioner, only Practitioner will be allowed to provide Covered Services to Beneficiaries;

c. that Practitioner shall during the term of this Agreement: (i) be duly licensed to provide Health Care Services, under the laws of the state in which the Practitioner is providing Covered Services; (ii) have a current and valid DEA license, if applicable; (iii) be a member in good standing, with appropriate clinical privileges, on the medical staff of the Practitioner's Designated Hospital, if applicable; and (iv) regularly provide OHG evidence of renewals of, and current information regarding, the foregoing matters;

d. that Practitioner currently maintains general and professional liability insurance coverage in the minimum amounts required by this Agreement, and will promptly notify OHG of any material modification, cancellation or restriction of such coverage;

e. that Practitioner will provide written notice to OHG within ten (10) days after Practitioner learns of any report that is filed with the National Practitioner Data Bank regarding Practitioner;

f. that Practitioner shall immediately give OHG written notice of any written claim or lawsuit against Practitioner arising out of any act or omission of Practitioner or any employee, agent or contractor of Practitioner, relative to the rendering of Covered Services to a Beneficiary;

g. that Practitioner's decisions regarding the delivery of Health Care Services to Beneficiaries shall be based only on appropriateness of care and service; and

h. that Practitioner is not compensated by OHG for utilization review denials of coverage or service and does not receive financial incentives for denials of coverage or service.

2. OHG represents and warrants to Practitioner as follows:

a. that OHG is a duly organized limited liability company in good standing under the law of the State of Ohio, and is empowered and duly authorized to enter into this Agreement;

b. that OHG is currently, and for the duration of this Agreement shall remain, in compliance with any and all applicable laws and regulations of the federal government and of the State of Ohio;

c. that Utilization Management and Quality Management decision making is based only on

appropriateness of care and service; and

d. that Practitioners or other individuals conducting Utilization Management review are not compensated for denials of coverage or service.

3. OHG makes no representations or guarantees concerning the number of Beneficiaries that will become patients of Practitioner.

D. Operational Policies and Procedures

In addition to the Program Manuals, OHG or its designee may issue and deliver to Practitioner, additional operational policies or procedures for the purpose of implementing or clarifying this Agreement or Program Attachment, and may supplement or withdraw such policies or procedures as needed. Ninety (90) days after the delivery to Practitioner of any such policies, procedures or supplement thereto which materially modify existing policies or procedures in Program Manuals or otherwise ("Implementation Date"), the provisions thereof shall become fully binding on Practitioner as if expressly set forth in this Agreement. If such policies, procedures or supplements thereto are not acceptable to Practitioner, Practitioner may give written notice of termination of this Agreement or the affected Program Attachment to OHG no later than thirty (30) days after receipt of such policies, procedures or supplements thereto, in which case this Agreement or the affected Program Attachment shall terminate effective as of the Implementation Date, unless OHG otherwise agrees to continue this Agreement or the affected Program Attachment with Practitioner without the proposed policies, procedures or supplements thereto. Failure of Practitioner to provide to OHG notice of non-acceptance within said thirty (30) day period shall be deemed to be acceptance of the proposed policies, procedures or supplements. In the event the provisions of any such policies, procedures or supplements are inconsistent with the terms of this Agreement or a Program Attachment, the terms of this Agreement or the applicable Program Attachment shall prevail.

VII. TERM AND TERMINATION

A. Term of Agreement

This Agreement shall begin on the Effective Date and shall continue for a period of one year. Thereafter, this Agreement shall automatically renew for successive one year periods, unless terminated as set forth below.

B. Termination

1. For Cause. Practitioner or OHG may each terminate this Agreement and all Program Attachments hereto at any time for cause. Cause for termination includes, but is not limited to, the following:

a. Failure of Practitioner to comply or cooperate with OHG's Credentialing, Quality Improvement, Quality Management, Utilization Management programs and/or a Performance Improvement Plan developed for Practitioner. In the event the termination decision is based upon the failure of the Practitioner to meet OHG's standards for quality or utilization in the delivery of Health Care Services, OHG will notify Practitioner of the termination decision, the reasons for the decision and of the opportunity to participate in a Performance Improvement Plan. Practitioner agrees to assist OHG in developing and implementing a suitable Performance Improvement Plan. If Practitioner fails to comply with the Performance Improvement Plan, OHG may promptly terminate Practitioner, subject to any appeal rights set forth in the Program Requirements.

b. Other material breach of this Agreement by either party.

c. Any material addition or alteration by OHG of policies and procedures governing the provision of Covered Services to Beneficiaries (in accordance with Section VI.D) or

amendment by OHG of this Agreement (in accordance with Section VIII.D) if such action is unacceptable to Practitioner; provided that Practitioner gives OHG notice of rejection of such action within thirty (30) days after the date of receipt by Practitioner of OHG's notice concerning the addition, alteration or amendment and provided that OHG does not elect to continue this Agreement without such addition, alteration or amendment, as set forth in Section VI.D or Section VIII.D hereof.

d. Insolvency of either party.

e. Failure by Practitioner to maintain licenses, certifications, permits or approvals required to perform Practitioner's duties under this Agreement or to comply with applicable laws, regulations or Program Requirements.

f. Failure by OHG to maintain licenses, certifications, permits or approvals required to perform OHG's duties under this Agreement or to comply with applicable laws or regulations.

g. Commission or omission of any act or any conduct or allegation of conduct for which OHG's or Practitioner's license or certification may be subject to revocation or suspension, whether or not actually revoked or suspended, or if OHG or Practitioner is otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction over such party, or for any action set forth in section V. B. that is described as requiring disclosure.

h. Any material misrepresentation or falsification of any information submitted by Practitioner to OHG.

i. Failure of Practitioner to maintain required liability coverage protection.

j. Commission or omission of any act or conduct by Practitioner which is detrimental to a Beneficiary's health or safety.

Unless otherwise provided in applicable Program Attachments to this Agreement, termination for any other reason set forth above shall be upon thirty (30) days' prior written notice to the other party by the terminating party unless said reason for termination is cured to the satisfaction of the terminating party within said thirty (30) day period, in which case this Agreement shall not terminate. Notwithstanding the foregoing, OHG shall have the right to immediately terminate this Agreement for cause, upon written notice thereof to Practitioner if OHG in good faith determines that such immediate termination is necessary to avoid imminent risk of harm to a Beneficiary or Beneficiaries.

2. Without Cause. This Agreement or any individual Program Attachment to this Agreement (unless otherwise provided in the Program Attachment) may be terminated at any time without cause or prejudice upon ninety (90) days' prior written notice by either party. Termination of any individual Program Attachment will not have the effect of terminating the entire Agreement and all remaining provisions of this Agreement and remaining Program Attachments to this Agreement will remain in full force and effect. In the event only a Program Attachment is terminated, then the termination notice shall expressly state the identity of the terminating Program Attachment.

C. Rights and Obligations Upon Termination

Upon termination of this Agreement for any reason, the rights of each party hereunder shall terminate, except as provided in this Agreement and any Program Attachments to this Agreement. Any such termination shall not release Practitioner or OHG from obligations under this Agreement or any Program Attachment occurring prior to the effective date of termination. Practitioner shall accept compensation

and rates outlined in Section IV.A.1 and applicable Program Attachments for services rendered to a Beneficiary prior to the effective date of termination as payment in full.

VIII. MISCELLANEOUS

A. Independent Contractor Relationship

1. This Agreement is not intended to create nor shall it be construed to create any relationship between OHG and Practitioner other than that of independent entities contracting for the purpose of effecting provisions of this Agreement. Neither party nor any of their agents, employees or representatives shall be construed to be the partner, agent, employer, employee or representative of the other.

2. Nothing in this Agreement, including Practitioner's participation in the Quality Management and Utilization Management process, shall be construed to interfere with or in any way affect Practitioner's obligation to exercise independent professional judgment in rendering Health Care Services to Beneficiaries.

B. Assignment and Delegation of Duties

Neither OHG nor Practitioner may assign duties, rights or interests under this Agreement or any Program Attachment unless the other party shall so approve by prior written consent, provided, however, that any reference to OHG herein shall include any successor in interest and OHG may assign its duties, rights and interests under this Agreement or any Program Attachment in whole or in part to an OHG affiliate or may delegate any and all of its duties in the ordinary course of business.

C. Interpretation

The validity, enforceability and interpretation of this Agreement shall be governed by applicable federal law and by applicable laws of the State of Ohio.

D. Amendment

1. This Agreement or a Program Attachment (unless otherwise provided for in the Program Attachment) may be materially amended by OHG by giving ninety (90) days prior written notice to Practitioner of the proposed amendment. If an amendment is not acceptable to Practitioner, Practitioner shall give written notice of termination of this Agreement or the applicable Program Attachment to OHG no later than thirty (30) days after receipt of the written notice of amendment, in which case this Agreement or the applicable Program Attachment(s) shall terminate effective as of the effective date of the proposed amendment, unless OHG otherwise agrees in writing to continue this Agreement or the applicable Program Attachment without the proposed amendment. Failure of Practitioner to provide such notice within said thirty (30) day period shall be deemed to be acceptance of the amendment.

2. Non-material amendments to this Agreement or a Program Attachment may be made by OHG giving 15 days prior written notice to the Practitioner of the proposed amendment.

3. Notwithstanding the foregoing provisions of this Section VIII.D, in the event that state or federal law or regulation should change, alter or modify the present services, levels of payments to Practitioner or OHG, standards of eligibility of Beneficiaries, or any operations of OHG, such that the terms, benefits and conditions of this Agreement or a Program Attachment must be changed accordingly, then upon notice from OHG, Practitioner shall continue to perform services under this Agreement or the Program Attachment as modified.

4. OHG may, from time to time, invite Practitioner to participate in future Programs. Practitioner may agree to participate in future Programs by executing a new Program Attachment. If Practitioner refuses any future Program that OHG offers, OHG may terminate this Agreement and all then current Program Attachments in which Practitioner is participating based on Practitioner's refusal upon written notice to the Practitioner no sooner than 180 days after the refusal.

5. Except as provided above, amendments to this Agreement must be agreed to in advance in writing by OHG and Practitioner.

E. Program Attachments

The Program Attachments hereto are a part of this Agreement and their terms shall supersede those of other parts of this Agreement in the event of a conflict.

F. Third Party Beneficiaries

Except to the extent otherwise specifically provided in this Agreement or a Program Attachment to this Agreement, nothing herein contained is intended to confer upon any person, other than the parties hereto, any rights, remedies, obligations or liabilities under or by reason of this Agreement.

G. Entire Contract

This Agreement together with all Program Attachments and documents referred to herein contains all of the terms and conditions agreed upon by the parties, and supersedes all other documents and/or agreements, express or implied, regarding the subject matter of this Agreement and the Program Attachments.

H. Notice

Any notice required hereunder shall be in writing and shall be deemed to have been delivered three (3) days after the noticing party deposits it in the United States mail, postage prepaid, to the other party at their respective addresses set forth below each party's signature or to such other address as shall have been given in writing by the non-noticing party to the other.

I. Enforceability and Waiver

The invalidity and unenforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

J. Regulatory Approval

In the event that OHG has not been licensed or has not received any necessary regulatory approval for use of this Agreement or a Program Attachment prior to the execution of this Agreement or the Program Attachment, this Agreement and/or the Program Attachment, as the case may be, shall be deemed to be a binding letter of intent. In such event, this Agreement and/or the Program Attachment, as the case may be, shall become effective on the date that such regulatory approval is obtained. If OHG is unable to obtain such regulatory approval for this Agreement after a good faith attempt, OHG shall notify Practitioner and both parties shall be released from any liability under this Agreement and any Program Attachment, as the case may be, and this Agreement and all Program Attachment(s) shall be deemed terminated. If this Agreement meets all regulatory requirements and only a Program Attachment lacks the necessary regulatory approval, and OHG is unable to obtain such regulatory approval for the Program Attachment after a good faith attempt, OHG shall notify Practitioner and both parties shall be released from any liability under such Program Attachment and the Program Attachment shall be deemed terminated.

K. Ohio Mandated Insurance Fraud Warning

The State of Ohio Department of Insurance requires the following provisions in this provider contract:

> Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

L. Survivability

The following sections shall survive termination of this Agreement: II.B, II.C, IV, VI, VII,and VIII.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the effective date.

Provider:

By: _____

Printed Name: _____

Title:_____

Date: _____

Address:_____

Phone: _____

County: _____

NPI: _____

Federal Tax ID No.:_____

Provider Email Address:

_____

EFFECTIVE DATE:

PPO:_____

OTHER:_____

OhioHealth Group, Ltd.

By: _____
Kathryn Savenko
Vice President, Business Operations

Date: _____

Address: 155 E Broad St, Suite 1700
Columbus, Ohio 43215

OhioHealth Group

OHIOHEALTH GROUP, LTD.
OHIOHEALTH GROUP PPO PROGRAM ATTACHMENT
TO
PARTICIPATING PROVIDER AGREEMENT
(Individual Practitioner)

The provisions of this OhioHealth Group PPO Program Attachment (this "Attachment") to Participating Provider Agreement, including the payment terms set forth therein, are subject to the terms set forth in the Participating Provider Agreement by and between OhioHealth Group, Ltd. ("OHG") (the "Agreement") which by this reference is hereby incorporated herein.

PURPOSE

This Attachment is by and between OHG and _____ ("Practitioner"). This Attachment is for the OHG PPO Program entitled **"HealthReach"** and once executed by both Practitioner and OHG authorizes Practitioner to participate in the Program and provide Covered Services to Beneficiaries of Payors participating in the Program. The terms and provisions of this Attachment and the Agreement are applicable to Covered Services rendered by Practitioner to Beneficiaries of Payors participating in the Program set forth in this Attachment. All of the Program's policies, procedures and requirements in the applicable Program Manual, as revised and amended, (including the applicable Payor's Program Manual) are hereby made a part of this Attachment.

I. PARTIES' OBLIGATIONS

A. Compensation and Billing

1. Practitioner's reimbursement for Covered Services provided to Beneficiaries of Payors participating in this Program shall be the rates set forth and attached hereto in Exhibit A to this Attachment, less applicable Copayments, Deductibles, Coinsurance, and any applicable PPO administrative fees, which shall not exceed 4%. The rates set forth in Exhibit A to this Attachment shall apply to all Health Care Services rendered to Beneficiaries in the PPO Program.

2. Practitioner will look solely to Payor for compensation for Covered Services except for Copayments, Deductibles or Coinsurance. Practitioner agrees, that whether or not there is any unresolved dispute for payment, that under no circumstances will Practitioner directly or indirectly make any charges or claims for Covered Services, other than for Copayments, Deductibles or Coinsurance, against any Beneficiaries or their representatives and that this provision survives termination of this Attachment for services rendered prior to such termination. Except for the collection of Copayments, Deductibles or Coinsurance, only those services that are not Covered Services may be billed directly to Beneficiaries, subject to limitations listed above. This paragraph is to be interpreted for the benefit of Beneficiaries and does not diminish the obligation of a Payor to make payments to Practitioner according to the terms of this Agreement.

3. OHG will encourage each Payor to remit any amount owing under this PPO Program Attachment and the Agreement within thirty (30) days after receipt of a complete claim from Practitioner. Payor shall pay claims consistent with Ohio Revised Code sections 3901.381 – 3901.3814. For purposes of this Attachment, a "complete claim" is defined in the Agreement and supplemented by the applicable Payor's Program Manual.

B. Insurance Identification Card

1. Payor shall provide an insurance identification card to each member upon which Program name or Logo shall prominently appear. Insurance identification card information must include at least the Following:

    a.) The member's name and identification number;
    b.) The Group name;
    c.) The Third Party Payor name;
    d.) The address where claims are to be filed;
    e.) The phone number where by the following information can be readily obtained:

        1.) Confirmation of eligibility
        2.) Benefit information
        3.) Prior Authorization for services and procedures
        4.) Electronic claims filing payor identification number

C. OHG Utilization Management

OHG or its designee may be responsible for Utilization Management for a Payor if OHG and such Payor execute a Service Agreement setting forth the terms of such. In that event, the policies, procedures and requirements in the OHG PPO Program Manual are applicable.

D. Utilization Management (Non-OHG)

Pursuant to a specific Service Agreement with OHG, a Payor may require that Utilization Management be conducted by an entity other than OHG or an OHG affiliate. In those situations, the applicable Utilization Management policies, procedures and requirements will be available directly from the Payor.

II. TERM AND TERMINATION

This Attachment to the Agreement is coterminous with the Term of the Master Agreement, and is subject to its termination provisions; provided, however, this Attachment may be terminated without cause upon ninety (90) days' notice to the other party. This Agreement provides for a method of payment of Practitioner charges incurred by the Beneficiary during the existence of this Agreement. It is not a contract for the provision of any services, including Covered Services, to any Beneficiary. Termination of this Agreement terminates the method of payment with regard to services provided after the date of termination. Termination of this Agreement should in no way be construed as affecting the Practitioner's relationship with the patient other than removing Practitioner's participation in the Program.

Sections I.A, I.C, I.D and II shall survive the termination of this Attachment.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the effective date.

Provider:

By: _____

Printed Name: _____

Title:_____

Date: _____

OhioHealth Group, Ltd.

By: _____
Kathryn Savenko
Vice President, Business Operations

Date: _____

EFFECTIVE DATE:

PPO:_____

EXHIBIT A

PPO Reimbursement

The reimbursement arrangement will be the lesser of the OHG PPO Fee Schedule or Practitioner's usual and customary charge, less any applicable coinsurance, copayments, deductibles or PPO administrative fees.

HealthReach
from OhioHealth Group

CARDS ISSUED BY TPAS MAY CARRY THE TPA NAME OR THE EMPLOYER'S NAME, BUT WILL ALSO DISPLAY THE APPROPRIATE OHIOHEALTH GROUP PROGRAM LOGOS. BELOW ARE VARIATIONS, BUT NOT LIMITED TO, OHIOHEALTH GROUP PROGRAM LOGOS:

OhioHealth Group

OHIOHEALTH GROUP, LTD.
OHIOHEALTH GROUP PPO PROGRAM ATTACHMENT
TO
PARTICIPATING PROVIDER AGREEMENT
(Individual Practitioner)

The provisions of this OhioHealth Group PPO Program Attachment (this "Attachment") to Participating Provider Agreement, including the payment terms set forth therein, are subject to the terms set forth in the Participating Provider Agreement by and between OhioHealth Group, Ltd. ("OHG") (the "Agreement") which by this reference is hereby incorporated herein.

PURPOSE

This Attachment is by and between OHG and _____ ("Practitioner"). This Attachment is for the OHG PPO Program entitled **"HealthReach Preferred"** and once executed by both Practitioner and OHG authorizes Practitioner to participate in the Program and provide Covered Services to Beneficiaries of Payors participating in the Program. The terms and provisions of this Attachment and the Agreement are applicable to Covered Services rendered by Practitioner to Beneficiaries of Payors participating in the Program set forth in this Attachment. All of the Program's policies, procedures and requirements in the applicable Program Manual, as revised and amended, (including the applicable Payor's Program Manual) are hereby made a part of this Attachment.

I. PARTIES' OBLIGATIONS

A. Compensation and Billing

1. Practitioner's reimbursement for Covered Services provided to Beneficiaries of Payors participating in this Program shall be the rates set forth and attached hereto in Exhibit A to this Attachment, less applicable Copayments, Deductibles, Coinsurance, and any applicable PPO administrative fees, which shall not exceed 4%. The rates set forth in Exhibit A to this Attachment shall apply to all Health Care Services rendered to Beneficiaries in the PPO Program.

2. Practitioner will look solely to Payor for compensation for Covered Services except for Copayments, Deductibles or Coinsurance. Practitioner agrees, that whether or not there is any unresolved dispute for payment, that under no circumstances will Practitioner directly or indirectly make any charges or claims for Covered Services, other than for Copayments, Deductibles or Coinsurance, against any Beneficiaries or their representatives and that this provision survives termination of this Attachment for services rendered prior to such termination. Except for the collection of Copayments, Deductibles or Coinsurance, only those services that are not Covered Services may be billed directly to Beneficiaries, subject to limitations listed above. This paragraph is to be interpreted for the benefit of Beneficiaries and does not diminish the obligation of a Payor to make payments to Practitioner according to the terms of this Agreement.

3. OHG will encourage each Payor to remit any amount owing under this PPO Program Attachment and the Agreement within thirty (30) days after receipt of a complete claim from Practitioner. Payor shall pay claims consistent with Ohio Revised Code sections 3901.381 – 3901.3814. For purposes of this Attachment, a "complete claim" is defined in the Agreement and supplemented by the applicable Payor's Program Manual.

B. Insurance Identification Card

1. Payor shall provide an insurance identification card to each member upon which Program name or Logo shall prominently appear. Insurance identification card information must include at least the Following:

    a.) The member's name and identification number;
    b.) The Group name;
    c.) The Third Party Payor name;
    d.) The address where claims are to be filed;
    e.) The phone number where by the following information can be readily obtained:

        1.) Confirmation of eligibility
        2.) Benefit information
        3.) Prior Authorization for services and procedures
        4.) Electronic claims filing payor identification number

C. OHG Utilization Management

OHG or its designee may be responsible for Utilization Management for a Payor if OHG and such Payor execute a Service Agreement setting forth the terms of such. In that event, the policies, procedures and requirements in the OHG PPO Program Manual are applicable.

D. Utilization Management (Non-OHG)

Pursuant to a specific Service Agreement with OHG, a Payor may require that Utilization Management be conducted by an entity other than OHG or an OHG affiliate. In those situations, the applicable Utilization Management policies, procedures and requirements will be available directly from the Payor.

II. TERM AND TERMINATION

This Attachment to the Agreement is coterminous with the Term of the Master Agreement, and is subject to its termination provisions; provided, however, this Attachment may be terminated without cause upon ninety (90) days' notice to the other party. This Agreement provides for a method of payment of Practitioner charges incurred by the Beneficiary during the existence of this Agreement. It is not a contract for the provision of any services, including Covered Services, to any Beneficiary. Termination of this Agreement terminates the method of payment with regard to services provided after the date of termination. Termination of this Agreement should in no way be construed as affecting the Practitioner's relationship with the patient other than removing Practitioner's participation in the Program.

Sections I.A, I.C, I.D and II shall survive the termination of this Attachment.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the effective date.

Provider:

By: _____

Printed Name: _____

Title:_____

Date: _____

OhioHealth Group, Ltd.

By: _____
Kathryn Savenko
Vice President, Business Operations

Date: _____

EFFECTIVE DATE:

PPO:_____

EXHIBIT A

PPO Reimbursement

The reimbursement arrangement will be the lesser of the OHG PPO Fee Schedule or Practitioner's usual and customary charge, less any applicable coinsurance, copayments, deductibles or PPO administrative fees.

CARDS ISSUED BY TPAS MAY CARRY THE TPA NAME OR THE EMPLOYER'S NAME, BUT WILL ALSO DISPLAY THE APPROPRIATE OHIOHEALTH GROUP PROGRAM LOGOS. BELOW ARE VARIATIONS, BUT NOT LIMITED TO, OHIOHEALTH GROUP PROGRAM LOGOS:

CARDS FOR THE HEALTHREACH PREFERRED PROGRAM MAY ALSO INCLUDE THE MIDWEST HEALTH COLLABORATIVE LOGO, INCLUDING, BUT NOT LIMITED TO, THE VARIATIONS SET FORTH BELOW, TO BE HONORED AS A HEALTHREACH PREFERRED PROGRAM BY ALL HEALTHREACH PREFERRED PROVIDERS EXCEPT THOSE LOCATED IN THE EXCLUDED COUNTIES (AS DEFINED BELOW). THE "EXCLUDED COUNTIES" ARE COUNTIES IN WHICH THE MIDWEST HEALTH COLLABORATIVE DOES NOT UTLIZE THE HEALTHREACH PREFERRED NETWORK AND FEE SCHEDULE FOR PROVIDERS LOCATED IN THOSE COUNTIES. THE EXCLUDED COUNTIES ARE:

OHIO COUNTIES: Allen, Ashtabula, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Cuyahoga, Darke, Defiance, Fulton, Geauga, Greene, Hamilton, Henry, Holmes, Lake, Lorain, Lucas, Mahoning, Medina, Miami, Montgomery, Ottawa, Portage, Sandusky, Shelby, Stark, Summit, Trumbull, Tuscarawas, Warren, Wayne, Williams, and Wood

INDIANA COUNTIES: Dearborn, Ohio and Ripley

KENTUCKY COUNTIES: Boone, Campbell, Gallatin, Grant, Kenton, Owen and Pendleton

MICHIGAN COUNTIES: Lenawee and Monroe

REVISIONS TO THE LIST OF COUNTIES THAT COMPRISE THE EXCLUDED COUNTIES (THE "LIST") WILL BE SET FORTH IN THE PROGRAM MANUAL ON THE OHIOHEALTH GROUP WEBSITE. OHIOHEALTH GROUP MAY AMEND THE LIST FROM TIME TO TIME AND SUCH AMENDMENT SHALL BE EFFECTIVE WHEN IT IS POSTED BY OHIOHEALTH GROUP ON THE OHIOHEALTH GROUP WEBSITE.