PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and between Mental Health Crisis Center Of Lancaster County ("Provider") and Nebraska Total Care, Inc. ("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 unless Provider of Contracted Provider opts into such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-in. Only those Contracted Providers with respect to whom or which such notice is provided 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. In connection with the carrying out of this Agreement, Health Plan shall not discriminate against any bidder, employee, applicant for employment, or any other person because of race, color, religion, sex, disability, national origin, age, marital status or receipt of public assistance.

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 wil provide written or electronic notice to Provider before using an offset of amounts owed by Provider or a Contracted Provider to Payor or Compnay against amounts owed by the Payor or Company to the Provider or Contracted Provider as a means to recover an overpayment or payment made in error. Payor or its delegate will not implement the offset if, within thirty (30) days after the date of the notice, Provider refunds the overpayment or payment made in error, or initiates an appeal. The notice shall explain the reason and calculation of the overpayment or payment made in error. Appeals shall be made pursuant to procedures set forth in the Policies and/or Provider Manual. 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 non-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. In addition, nothing contained in this Article VI prohibits the parties from pursuing remedies available under the Regulatroy Requirements. In the event litigation is initiated, the Parties agree to waive any right to a trial by jury and that neither Party is entitled to special, indirect, punitive or exemplary damages.

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.

7.2.5. 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.

7.3. 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.

7.4. 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:

Attn: President

Nebraska Total Care, Inc.

_____

_____

To Provider at:

Attn: Director of the Facility

Mental Health Crisis Center Of Lancaster County

825 J St

Lincoln, NE 68508

setherton@lancaster.ne.gov

To Provider at:

Attn: Lancaster County Commissioners
Mental Health Crisis Center of Lancaster County
555 South 10th St. Rm 110
Lincoln, NE 68508

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. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to 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:**
Nebraska Total Care, Inc.	Mental Health Crisis Center Of Lancaster County (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name:	Print Name:
Title:	Title:
Signature Date:	Signature Date:
ECM #: 277782	Tax Identification Number: 47-6006482
To be completed by Health Plan only: Effective Date:	NPI Number: State Medicaid Number: State Medicare Number:

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.

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.

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.

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

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.

5 Long Term Services and Supports ("LTSS") Provider. If Provider or a Contracted Provider is a provider of LTSS services, the following provisions apply.

5.1 Acknowledgement. Health Plan acknowledges that Provider is a provider of LTSS services 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.

5.2 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:

5.2.1 Provider or the applicable Contracted Provider shall notify Health Plan of a Covered Person's visit to the emergency department of any hospital, or of a Covered Person's hospitalization, within twenty-four (24) hours of becoming aware of such visit or hospitalization.

5.2.2 Provider or the applicable Contracted Provider shall notify Health Plan of any change to a Covered Person's plan of care and/or service plan, within twenty-four (24) hours of becoming aware of such change.

5.2.3 Provider or the applicable Contracted Provider shall notify Health Plan if a Covered Person misses an appointment with Provider, within twenty-four (24) hours of becoming aware of such missed appointment.

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

5.2.5 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 twenty-four (24) hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

5.2.6 Provider or the applicable Contracted Provider shall notify Health Plan of any change in Provider's or Contracted Provider's key personnel, within twenty-four (24) hours of such change.

5.3 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.

5.4 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.

5.5 Electronic Visit Verification. If Contracted Provider is a personal care aide, Contracted Provider shall comply with Health Plan's electronic visit verification system requirements where applicable.

5.6 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 within a reasonable time period following the completion thereof. Provider agrees to immediately notify Health Plan of any criminal convictions of any 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: [Reserved]
Attachment C: [Reserved]

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

MEDICAID PRODUCT ATTACHMENT

This PRODUCT ATTACHMENT ("***Attachment***") is made and entered between Nebraska Total Care, Inc. ("***Health Plan***") and Mental Health Crisis Center Of Lancaster County ("***Provider***").

WHEREAS, Health Plan and Provider entered into that certain Participating Provider Agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Provider and its Contracted Providers participate in certain Products offered by or available from or through a Company;

WHEREAS, pursuant to the provisions of the Agreement, this Attachment is identified on the signature page of the Agreement and, as such, the Contracted Providers identified herein will be designated and participate as "***Participating Providers***" in the Product described in this Attachment; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

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

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

1.1 "***Medicaid Product***" refers to those programs and health benefit arrangements offered by Health Plan or other Company pursuant to contract(s) with one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded program(s) and to meet certain performance standards while doing so (each a "***State Contract***"). The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

2. Medicaid Product.

2.1 Medicaid and/or CHIP Product. This Product Attachment constitutes the "***Medicaid Product Attachment***" and is incorporated into the Agreement between Provider and Health Plan. It supplements the Agreement by setting forth specific terms and conditions that apply to the Medicaid Product with respect to which a Participating Provider has agreed to participate, and with which a Participating Provider must comply in order to maintain such participation. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product.

2.2 Participation. Except as otherwise provided in this Product Attachment or the Agreement, Provider and all Contracted Providers under the Agreement will participate as Participating Providers in the Medicaid Product and will provide to Covered Persons enrolled in the Medicaid Product, upon the same terms and conditions contained in the Agreement, as supplemented or modified by this Product Attachment, those Covered Services that are provided by Contracted Providers pursuant to the Agreement. In providing such services, Provider shall, and shall cause Contracted Providers to, comply with and abide by the provisions of this Product Attachment and the Agreement (including the Provider Manual).

2.3 Attachment. This Attachment constitutes the Product Attachment and Compensation Schedule for the Medicaid Product.

2.4 Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict

between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from Health Plan. To the extent any provision of this Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Product Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a Party terminates the participation of the Contracted Provider in this Product in accordance with the applicable provisions of the Agreement or this Product Attachment.

4. State Contract Regulatory Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are applicable to the Medicaid Product under the State Contract.

5. State Mandated Regulatory Requirements. Schedule B to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the applicable state law to be included in the Agreement with respect to the Medicaid Product. Any additional Regulatory Requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference. To the extent that a Coverage Agreement, or a Covered Person, is subject to the law cited in the parenthetical at the end of a provision on Schedule B, such provision will apply to the rendering of Covered Services to a Covered Person with such Coverage Agreement, or to such Covered Person, as applicable.

6. Other Terms and Conditions. Except as modified or supplemented by this Product Attachment, the compensation hereunder for the provision of Covered Services by Contracted Providers to Covered Persons enrolled in or covered by the Medicaid Product is subject to all of the other provisions in the Agreement (including the Provider Manual) that affect or relate to compensation for Covered Services provided to Covered Persons.

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL CONTRACT REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the Nebraska Medicaid Product under the State Contract. All provisions binding on Provider hereunder shall apply to all Contracted Providers, as applicable.

1. Definitions. As used in this Schedule A to Attachment A, all terms, when capitalized, shall have the same meaning as defined in the State Contract.

1.1. "***Agency***" means any state agency, board, or commission other than the University of Nebraska, the Nebraska State colleges, the courts, the Legislature, or any other office or agency established by the Nebraska Constitution.

1.2. "***DHHS***" means the Nebraska Department of Health and Human Services.

1.3. "***Emergency Services***" means covered inpatient and outpatient services that are either furnished by a provider that is qualified to furnish these services under Title 42 CFR, or the services needed to evaluate or stabilize an emergency medical condition.

1.4. "***Long-Term Services and Supports***" or "***LTSS***" means specific Medicaid-covered services including intermediate care facility services for individuals with developmental disabilities, any institutional long-term care or nursing facility services at a custodial level of care, services provided via a Home and Community Based Waiver program, Targeted Case Management, or Medicaid State Plan Personal Assistance Services.

1.5. "***MLTC***" means the Nebraska DHHS, Division of Medicaid and Long-Term Care.

1.6. "***Patient-Centered***" means health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect Covered Persons' wants, needs, and preferences, and that Covered Persons have the education and support they need to make decisions and participate in their own care. Patient-centeredness focuses on the Covered Person, not the illness, and is supported by good provider-patient relations.

1.7. "***Primary Care Provider***" or "***PCP***" A medical professional chosen by or assigned to the member to provide primary care services. Provider types practicing within the scope of their respective Practice Acts may be doctors of medicine (MDs), doctors of osteopathic medicine (DOs), nurse practitioners, and physician assistants.

1.8. "***State Contract***" means the contract between DHHS and Health Plan to provide full-risk, capitated Medicaid managed care program for physical health, behavioral health, and pharmacy services.

1.9. "***State***" means the State of Nebraska.

2. Compliance with State and Federal Laws and Regulations. In connection with Provider's performance of its obligations under the Agreement and this Attachment as it relates to the Nebraska

Medicaid managed care program, Provider shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

3. Cooperation with Other Entities. Provider shall cooperate with Health Plan's efforts to promote care coordination between and among various entities under the State Contract, so as to identify and respond to Covered Persons' behavioral and physical health needs.

4. Audit Requirements. Provider shall maintain books, records, documents, and other evidence pertaining to services rendered, equipment, staff, financial records, health records, and the administrative costs and expenses incurred pursuant to the State Contract as well as medical information relating to Covered Persons as required for purposes of audit; or administrative, civil, or criminal investigations or prosecution per all retention requirements of the State Contract.

5. Protections Against Covered Person Liability. Provider may not bill Covered Persons any amount greater than would be owed if Health Plan provided the services directly (i.e., no balance billing by Provider is permitted).

6. Notice of Births. If Provider is a hospital, Provider shall report births of Covered Persons to Health Plan within 24 hours of birth.

7. General Requirements. Provider shall be appropriately licensed or certified, have a national provider identifier, operate within his or her scope of practice, and enroll as an approved MLTC provider. The services offered under this Agreement must be sufficient in amount, duration, and scope to reasonably be expected to achieve the purpose for which the services are furnished and must be no less than those furnished under fee-for-service Medicaid, as specified in 42 CFR §438.210(a). Upward variances of amount, duration, and scope of these services are allowed. All services covered under this Agreement must be accessible to Covered Persons with comparable timeliness, and in a similar amount, duration, and scope as those available to other insured individuals in the same service area.

8. Behavioral Health Parity. If Provider is a behavioral health provider, Provider shall demonstrate a commitment to principles of rehabilitation and recovery and comply with the Mental Health and Addiction Equity Act ("MHPAEA"). This includes but is not limited to: a) ensuring medical management techniques applied to mental health or substance use disorder benefits are comparable to and applied no more strictly than the medical management techniques that are applied to medical and surgical benefits; b) ensuring compliance with MHPAEA for any benefits offered by Health Plan to Covered Persons beyond those specified in the Medicaid State Plan; c) making the criteria for medical-necessity determinations for mental health or substance use disorder benefits available to any current or potential Covered Person, or contracted provider, on request; d) providing the reason for any denial of reimbursement or payment with respect to mental health or substance use disorder benefits to members; and; and e) providing out-of-network coverage for mental health or substance use disorder benefits when made available for medical and surgical benefits.

9. Telehealth and Telemonitoring Services. If Provider provides telehealth services, Provider shall provide telehealth services in accordance with all applicable State and federal regulations governing Provider's practices and the services that Provider provides. All telehealth communications in connection

therewith shall comply with all applicable federal and State requirements regarding privacy and security, as well as those related to efficiency, economy, and quality of care.

10. EPSDT Services. Provider, as applicable, shall comply with the Early and Periodic Screening, Diagnosis, and Treatment ("EPSDT") statute and federal regulations and ensure that medical, vision and hearing screening components and immunizations are provided in accordance with the American Academy of Pediatrics periodicity schedule.

11. Immunization Requirements. Provider shall use vaccines available without charge to children 18 years old or younger under the Vaccine for Children program. Such immunizations shall be given in conjunction with EPSDT/well child visits or when other appropriate opportunities occur. Provider shall report required immunization data to the Nebraska State Immunization Information System, administered by Department of Health and Human Services/Division of Public Health.

12. Limitations on Abortions. For abortion services provided under the Agreement, Provider shall attach a certification statement to the claim form certifying in writing that, on the basis of Provider's or Contracted Provider's professional judgment, the life of pregnant Covered Person would be endangered if the fetus were carried to term. The certification statement must contain the diagnosis or medical condition that makes the pregnancy life endangering.

13. Medical Services for Special Populations. If Provider is a PCP, Provider shall assess Covered Persons for special health care needs ("SHCN") and notify Health Plan of those Covered Persons who meet SCHN criteria as soon as possible after identification.

14. Ensuring Accurate Provider Information. Provider shall notify Health Plan in a timely fashion regarding changes to Provider's office location(s), hours of operation, roster of Contracted Providers, Provider's and any Contracted Providers' specialty(ies), languages spoken in the office, whether Provider and any Contracted Providers are seeing new patients, and Provider contact information.

15. Medical Records. Provider shall adhere to Health Plan's policies and procedures related to Covered Persons' medical records. Each Covered Person is entitled to a copy of his or her medical record at no cost. If Provider is a PCP, in the event that a Covered Person changes PCPs, Provider shall forward Covered Persons' medical records to new PCP within ten (10) business days from receipt of the request for transfer of the medical records.

16. Hours of Operation. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial members, or comparable Medicaid members if the Provider serves only the Medicaid population.

17. State Contract. Provider shall comply with all requirements set forth in the State Contract.

18. Delivery of Services. Provider shall deliver services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or diverse cultural and ethnic backgrounds. Provider shall provide for interpreters in accordance with 42 CFR §438.206(c)(2).

19. Access Standards. Provider, as applicable, shall comply with the following access standards:

19.1 *Emergency*. Emergency services must be available immediately upon presentation at the service delivery site, 24 hours a day, seven days a week. Covered Persons with emergent behavioral health needs must be referred to services within one hour generally and within two hours in designated rural areas.

19.2 *Urgent*. Urgent care must be available the same day and be provided by the PCP or as arranged by Health Plan.

19.3 *Non-Urgent*. Non-urgent sick care must be available within 72 hours, or sooner if the Covered Person's medical condition(s) deteriorate into an urgent or emergent situation.

19.4 *Family Planning*. Family planning services must be available within seven calendar days.

19.5 *Non-Urgent Preventative Care*. Non-urgent, preventive care must be available within 4 weeks.

19.6 *PCPs*. PCPs who have a one-physician practice must have office hours of at least 20 hours per week. Practices with two or more physicians must have office hours of at least 30 hours per week.

19.7 *Specialty Care*. For high volume specialty care, routine appointments must be available within 30 calendar days of referral. High volume specialists include cardiologists, neurologists, hematologists/oncologists, OB/GYNs, and orthopedic physicians. For other specialty care, consultation must be available within one month of referral or as clinically indicated.

19.8 *Laboratory and X-ray Services*. Laboratory and x-ray services must be available within three weeks for routine appointments and 48 hours (or as clinically indicated) for urgent care.

19.9 *Maternity Care*. Maternity care must be available within 14 calendar days of request during the first trimester, within seven calendar days of request during the second trimester, and within three calendar days of request during the third trimester. For high-risk pregnancies, the Covered Person must be seen within three calendar days of identification of high risk by Health Plan or maternity care provider, or immediately if an emergency exists.

20. Appointment Availability. Wait times for Provider's scheduled appointments shall not exceed 45 minutes, including time spent in the waiting room and the examining room, unless Provider is unavailable or delayed because of an emergency. If Provider is delayed, the Covered Person should be notified immediately. If a wait of more than 90 minutes is anticipated, Provider shall offer the Covered Person a new appointment.

21. Credentialing. As part of Health Plan's credentialing process and if otherwise requested by Health Plan, Provider shall disclose to Health Plan, in accordance with 42 CFR 455.104: a) the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more; b) whether any of the persons named is related to another as spouse, parent, child, or sibling; and c) the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must: 1) keep copies

of all requests and responses; 2) make those requests and responses available to MLTC upon request; and 3) advise MLTC when there is no response to a request.

22. Training. Provider shall and shall require its staff to cooperate with Health Plan regarding trainings related to the requirements of the State Contract, including but not limited to limitations on provider marketing, identification of special needs of Covered Persons (including the LTSS population), and the appropriate utilization of emergency room services, including for behavioral health emergencies.

23. Provider Handbook. In order to permit Health Plan to alert Provider to access Health Plan's website to download updates to the Provider Manual and provider requirements, Provider shall provide Health Plan with a current e-mail address and notify Health Plan if such e-mail address changes.

24. Special Considerations for Pregnant Covered Persons. Provider, if applicable and as requested by Health Plan, shall perform a risk assessment of all of its obstetrical patients who are Covered Persons, including a screen for tobacco, alcohol, and substance use, and have available, accessible, and adequate maternal fetal medicine specialists for high-risk obstetrical patients (i.e., pregnant women for whom one or more risk factors are indicated) requiring further evaluation, consultation, or care and delivery as recommended by the guidelines of the American College of Obstetricians and Gynecologists ("ACOG"). If Provider is a PCP or obstetrician, Provider shall provide prenatal care in accordance with the guidelines of ACOG, and shall counsel the pregnant Covered Person about plans for her child, such as designating the family practitioner or pediatrician who is to perform the newborn exam and choosing a PCP to provide subsequent pediatric care to the child when the child is covered by Health Plan. Provider shall also coordinate with and, when appropriate, refer Covered Persons to the Women, Infant and Children ("WIC") program for nutritional assistance and other needed community resources. Such coordination shall include the referral of Covered Persons who are potentially eligible women, infants, and children, and reporting appropriate medical information to the WIC program.

25. Provider Satisfaction Surveys. Provider shall complete all provider surveys in a timely fashion.

26. Inpatient Hospital Requirements. If Provider is a hospital, Provider shall comply with federal requirements regarding utilization management plans, utilization management committees, plans of care, and medical care evaluation studies, as described in 42 CFR Parts 44, 455 and 456.

27. Program Integrity. Provider shall comply with all federal requirements (42 CFR Part 455) about disclosure reporting. If Provider is a tax-reporting provider that bills or receives Nebraska Medicaid funds as a result of this Agreement, Provider shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455 Subpart B, including at the time of initial contracting, contract renewal, within 45 calendar days of any change to the information on the disclosure form, a minimum of annually, and at any time on request. Provider shall take all the necessary actions to permit Health Plan to comply with the fraud, waste and abuse and erroneous payments requirements included in the State Contract, its contract with MLTC, and State and federal regulations.

28. Exclusion from Federal Programs. Provider shall notify Health Plan if it or any employee or Contracted Provider is excluded by the Medicare, Medicaid, or Children's Health Insurance Programs.

29. Medicaid Fraud and Patient Abuse Unit. Provider shall make available to the Medicaid Fraud and Patient Abuse Unit, on request or as required by the State Contract, State or federal law, any and all administrative, financial, or medical records relating to the delivery of services for which Nebraska Medicaid funds are expended.

30. Provider-Preventable Conditions. Provider shall self-report provider-preventable conditions through Health Plan's claims system.

31. Capitation Arrangements. If Health Plan enters into a capitated reimbursement arrangement with Provider, as a condition of capitation payment, Provider shall submit utilization or encounter data to the same standards of completeness and accuracy, including pricing information, as required for proper adjudication of fee-for-service claims, and with an equivalent level of detail associated with encounters for which Health Plan receives and settles as fee-for-service claims.

32. Third-Party Liability. Provider shall not pursue collection from the Covered Person, but directly from the liable third party(ies), except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004.

33. Dual-Eligible Covered Persons. Provider shall not charge Covered Persons who are dually eligible for Medicare and Medicaid for Covered Services. Provider shall identify third-party liability coverage, including Medicare and long-term care insurance, as applicable, and seek third-party liability payments before submitting claims to Health Plan.

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
FACILITY SERVICES
BEHAVIORAL HEALTH

Mental Health Crisis Center Of Lancaster County

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.

1. **Inpatient Services**. The maximum compensation for Covered Services rendered to a Covered Person during an inpatient stay shall be the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for inpatient Covered Services is the lesser of (i) Allowable Charges; or (ii) the applicable "Contracted Rate" set forth in Table 1.

Table 1

Service Category	Identifier Codes	Contracted Rate
Crisis Stabilization Services	Rev Code: 0100	100% Medicaid in effect on date of service
Psychiatric / Mental Health Services	Rev Codes: 0114, 0124, 0134, 0144, 0154, 0204	100% Medicaid in effect on date of service
Eating Disorder Unit	Rev Codes: 0120, 0130, 0140, 0150	100% Medicaid in effect on date of service
Chemical Dependency / Detoxification / Substance Abuse Services	Rev Codes: 0116, 0126, 0136, 0146, 0156	100% Medicaid in effect on date of service
Residential Services	Rev Codes: TBD	100% Medicaid in effect on date of service

2. **Intermediary (Step Down) Services and Outpatient Services**. The maximum compensation for intermediary (step down) and outpatient Covered Services rendered to a Covered Person shall be the "Allowed Amount" as set forth below. Except as otherwise provided in this Compensation Schedule, the Allowed Amount for intermediary (step down) and outpatient Covered Services is the lesser of: (i) Allowable Charges; or the applicable "Contracted Rate" set forth below in Table 2.

Table 2

Service Category	Identifier Codes	Contracted Rate
Electroconvulsive Therapy (ECT)	Rev Code: 0901	100% Medicaid in effect on date of service
Intensive Outpatient Services - Psychiatric	Rev Code: 0905	100% Medicaid in effect on date of service
Partial Hospitalization Mental Health Services	Rev Codes: 0912, 0913	100% Medicaid in effect on date of service

Service Category	Identifier Codes	Contracted Rate
Psychiatric Clinic	Rev Code: 0513	100% Medicaid in effect on date of service
Psychiatric Clinic Visit/Individual Therapy	Rev Code 0914	100% Medicaid in effect on date of service
Psychiatric Clinic Visit/Psychiatric Testing	Rev Code: 0918	100% Medicaid in effect on date of service
Observation Services (23 hours)	Rev Codes: 0760, 0762	100% Medicaid in effect on date of service

Practitioner Services. The maximum compensation for practitioner (psychiatrist (MD/DO), physician's assistant or advance practice nurses) Covered Services rendered to a Covered Person, shall be the "Allowed Amount". Except as otherwise provided in this Compensation Schedule, the Allowed Amount for practitioner (psychiatrist (MD/DO), physician's assistant or advance practice nurses) is the lesser of (i) Allowable Charges or (ii) one hundred percent (100%) of the Medicaid Fee Schedule by practitioner specialty.

Psychologist (PhD) Services. The maximum compensation for psychologist (PhD) Covered Services rendered to a Covered Person shall be the "Allowed Amount". Except as otherwise provided in this Compensation Schedule, the Allowed Amount for psychologist (PhD) Covered Services is the lesser of: (i) Allowable Charges or (ii) one hundred percent (100%) of the Medicaid Fee Schedule for psychiatrists.

Additional Provisions:

1. Level of Care. All reimbursement under this Compensation Schedule shall correspond to the level of care authorized by Cenpatico.

2. 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.

3. Fee Change Updates. Updates to the fee schedule shall become effective on the effective date of such fee schedule updates, as determined by the Payor ("Fee Change Effective Date"). The date of implementation of any fee schedule updates, i.e. the date on which such fee change is first used for reimbursement ("Fee Change Implementation Date"), shall be the later of: (i) the first date on which Payor is reasonably able to implement the update in the claims payment system; or (ii) the Fee Change Effective Date. Claims processed prior to the Fee Change Implementation Date shall not be reprocessed to reflect any updates to such fee schedule, even if service was provided after the Fee Change Effective Date.

4. Date of Service Requirement. Contracted Provider is required to identify each date of service when submitting claims spanning multiple dates of service.

5. Observation Services. Observation services are services received in an outpatient facility setting, which are reasonable and necessary to evaluate an outpatient condition or determine the need for possible inpatient admission to the Facility. Observation services exceeding 48 hours are not reimbursable under this Agreement.

Observation stays greater than or equal to 23 hours, for which Facility chooses to bill as an inpatient service, require authorization from Cenpatico. Reimbursement for the inpatient admission includes the observation stay.

6. Electroconvulsive Therapy ("ECT"). ECT shall be reimbursed on a per treatment basis in addition to any Contracted Rate made for an inpatient admission or one outpatient date of service. The Contracted Provider must bill the ECT service using the appropriate Revenue codes.

7. Institutional Claim Form. Provider services shall be billed on a CMS-1450 (UB-04) claim form, or its successor, utilizing applicable Revenue Codes and standard coding guidelines. Professional Services shall billed by Facility on a CMS-1500 claim form, or its successor.

8. Inpatient Services. Inpatient psychiatric and substance abuse services must be rendered personally by a psychiatrist, a resident under the personal supervision of a psychiatrist who is a member of the medical faculty at a teaching hospital, or an advanced registered nurse practitioner who has a specialty in mental health.

9. Modifiers. 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.

10. 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 charges 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.

4. **Per Encounter** includes all services rendered to a Covered Person within a 23-hour period unless paid on the basis of an all inclusive Per Diem rate, including, but not limited to, physician and other professional fees billed by the Facility, nursing care, diagnostic and therapeutic services, durable medical equipment, supplies (including, but not limited to anesthesia supplies), medications, facility and ancillary services, and, if applicable, room and board charges. The Encounter commences with the Covered Person's presentment at Facility.

5. **Per Diem** is defined as the Contracted Rate made to Provider for each day of an inpatient admission of a Covered Person or for all outpatient services provided to a Covered Person for one calendar date of service. Unless otherwise specified in this Compensation Schedule, such Contracted Rate shall be considered payment in full for all Covered Services rendered to the Covered Person during each day of the admission including, but not limited to, room and board, nursing, social services and other professional fees billed by Facility, pre-admission testing that occurs within 24 hours prior to admission, observation and treatment room, surgical services, diagnostic and therapeutic services, ancillary services, durable medical equipment, drugs, supplies, training and counseling.

[Reimbursement Hierarchy follows]

Reimbursement Hierarchy

Confinement Scenario	Reimbursement Methodology
Inpatient Services with Residential Treatment Care	Inpatient Services
Inpatient Services with Observation	Inpatient Services
Inpatient Services with Partial Hospitalization	Inpatient Services
Inpatient Services with Intensive Outpatient Services	Inpatient Services
Inpatient Services with Other Outpatient Services	Inpatient Services
Inpatient Services with ECT	Both
Intensive Outpatient Services with Inpatient Services	Inpatient Services
Intensive Outpatient Services with Residential Treatment Care	Residential Treatment Care
Intensive Outpatient Services with Partial Hospitalization Program	Partial Hospitalization Program
Intensive Outpatient Services with Other Outpatient Services	Intensive Outpatient Services
Intensive Outpatient Services with ECT	Both
Partial Hospitalization Program with Inpatient	Inpatient Services
Partial Hospitalization Program with Observation	Observation
Partial Hospitalization Program with Intensive Outpatient Services	Partial Hospitalization Program
Partial Hospitalization Program with Other Outpatient Services	Partial Hospitalization Program
Partial Hospitalization Program with ECT	Both
Observation Services with Inpatient Services	Inpatient
Observation Services with Intensive Outpatient Services	Observation Services
Observation Services with Other Outpatient Services	Observation Services
Observation Services with ECT	Both
Other Outpatient Services with ECT	Both
Residential Treatment with Inpatient	Inpatient
Residential Treatment Care with Observation	Observation
Residential Treatment Care with Partial Hospitalization	Residential Treatment Care
Residential Treatment Care with Intensive Outpatient Services	Residential Treatment Care
Residential Treatment Care with Other Outpatient Services	Residential Treatment Care
Residential Treatment Care with ECT	Both
Residential Treatment Care with Supervised Living	Residential Treatment Care
Residential Treatment Care with Half-way House	Residential Treatment Care
Residential Treatment Care with Group Home	Residential Treatment Care