HEARING CARE SOLUTIONS, INC.
(866) 344-7756

Hearing Care Solutions - Application | Provider Criteria

Thank you for taking the time to join the Hearing Care Solutions provider network; working to bring value and quality hearing to our patients. A participating provider must demonstrate satisfactory professional qualifications and a commitment to the quality standards and cost containment principles of HCS.

Each hearing care provider:

1. Possesses a graduate degree in Audiology (Master or Doctoral degree) from an accredited university, **or** holds state licensure as a Hearing Instrument Specialist.

2. Complies with all applicable licensure and registry requirements in each state where services are rendered.

3. In states where there is no audiology licensure requirement, provider has Board Certification in Audiology from the American Board of Audiology and/or Certificate of Clinical Competency in Audiology (CCC-A) from the American Speech-Language-Hearing Association (ASHA).

4. Maintains professional malpractice insurance with a minimum coverage of $1,000,000 per incident / $3,000,000 aggregate and an acceptable malpractice history.

5. Has an independent practice or practices as an employee of a physician, hospital, medical clinic, audiologist-managed corporation or another audiologist or hearing instrument specialist who satisfies Provider Criteria.

6. Agrees to adhere to the provider instructions and the corresponding HCS Approved Hearing Aids list.

7. Practices at a facility at which all necessary equipment for the evaluation of hearing and the dispensing of hearing aids is available and regularly calibrated. (Site Checklist attached)

8. Maintains regularly scheduled office hours at each facility where services are rendered.

9. Has completed and signed the Provider Application, Agreement, Site Checklist, and sent in office W-9, malpractice insurance, and applicable license(s) and/or certification(s). Below is a checklist to outline what HCS credentialing department needs to process your application.

For each provider, please submit these items to HCS:

- ☐ Hearing Care Solutions Provider Application (this application)
- ☐ Copy of higher education diploma (if applicable)
- ☐ Current state license, or board certification **with** expiration date
- ☐ Current certificate of Professional Liability (Malpractice) Insurance **with** expiration date
- ☐ W – 9 form
- ☐ Hearing Care Solutions Provider Agreement

~ **Please send your application and supporting documents to:** ~

applications@hearingcaresolutions.com

or via Fax: (888) 456-3047

Hearing Care Solutions – Application | Provider Information

Provider Details

Provider Name _____

Professional Title _____ NPI (National Provider Id) # _____

Provider Email _____ Date of Birth _____

Provider Cell _____ Social Security # _____

Professional Credentials

Professional Affiliations _____

Audiologist License # _____ Hearing Aid Dispensing # _____

Board Certified? Yes ☐ No ☐ Expiration Date _____

ASHA CCC-A Yes ☐ No ☐ Expiration Date _____

If Available: Medicare # _____ Medicaid # _____

Work History (Please provide work history for the **past 6 years**, any gaps exceeding 6 months provide an explanation.)

Place of Employment _____

From _____ To _____ Title _____

Responsibilities _____

Place of Employment _____

From _____ To _____ Title _____

Responsibilities _____

Have you ever been asked to resign or been terminated from any of the positions above?

No ☐ Yes ☐ (if yes, please provide explanation)

Additional work history please attach to this application

Education (To be filled out if you omit a copy of your degree / diploma)

Name of School _____

Highest Level ☐ High School ☐ Associates ☐ Bachelors ☐ Masters ☐ Doctorate

Graduation Date Month _____ Year _____

I, _____ understand that by not providing a copy of my degree / diploma with the HCS provider application, I am verbally verifying my degree is valid and that Hearing Care Solutions, Inc. may use this information for any credentialing needs. I attest this information is true and accurate to the best of my knowledge.

Signature of Provider _____ Date _____

Hearing Care Solutions – Application | Office Information

Office Details (For database accuracy, extra offices under the practice will need to fill out an additional office information sheet)

Practice Name _____

DBA Name
(If different than above) _____

Address _____

City _____ State _____ Zip _____

Telephone _____ Tax ID # _____

Fax _____ Website _____

Office Email _____

Location Information

Location Name _____

Providers at Office _____

Additional Languages ☐ Spanish ☐ Mandarin ☐ Hindi/Urdu ☐ Arabic ☐ French ☐ Other _____

Office Hours

Day	From	To
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		

Which manufacturers do you have an account with?

- ☐ Beltone
- ☐ Oticon
- ☐ Rexton
- ☐ ReSound
- ☐ Siemens
- ☐ Starkey
- ☐ Unitron
- ☐ Widex

Site Audit Checklist

This checklist ensures your office is compliant with ADA, NCQA, and CMS standards, please fill out and sign below.

Office Environment	☒ / ☐	Disability Access	☒ / ☐	Administrative	☒ / ☐
Office sign clearly visible	☐	Handicapped parking	☐	Patient info HIPPA compliant	☐
Adequate parking	☐	Path of travel to entrance clear	☐	Provider / operations manual	☐
Adequate seating in waiting room	☐	Man entrance door 32in clear open	☐	Licensed staff with certifications	☐
Accommodation for hearing impaired	☐	All wheelchair ramps accessible	☐	Medical records handled and stored	☐
Public restrooms available	☐	All rooms accessible for disabilities	☐	Confidentiality where appropriate	☐
Smoke detectors/alarms and sprinklers	☐	Public restrooms easily accessible	☐	Access and appointment system	☐
Emergency exits clearly visible	☐	Lavatory wheelchair accessible	☐	At least one staff member CPR cert.	☐
Fire extinguishers visible and checked	☐	Accessible stalls have grab bars	☐	Hearing aids cleaned after use	☐
Evacuation plan of action	☐	Lavatory rim no higher than 34in	☐	Clean and professional office	☐
Equipment cleaned daily	☐	Soap, skink, drier easily usable	☐	Elevators in facility ADA standardized	☐
Medical supplies marked and stored	☐	Mirror mounted 40in from floor	☐	(if applicable)	

Signature of Provider _____ Date _____

By signing above, the office confirms the results of the reviewer and any of the deficiencies will be met to the best of the practioners abilities to comply with CMS, Hearing Care Solutions and industry standards.

Service Details

Insurance Carrier _____

Amount Per Incident $_____ Aggregate $_____

Tinnitus Treatment ☐ Yes ☐ No Pediatric Services ☐ Toddlers ☐ Children

Compliance Check

1. Has your license to practice in any jurisdiction ever been limited, suspended, or revoked?	☐ Yes	☐ No
2. Have you ever been denied membership or renewal therof or been subject to disciplinary action in any medical organization?	☐ Yes	☐ No
3. Are you currently having any medical and/or physical problem(s) which would adversely affect your ability to practice?	☐ Yes	☐ No
4. Do you have any chronic illness and/or communicable infectious disease that may be a potential danger to patients?	☐ Yes	☐ No
5. Are you or have you been involved in a malpractice suit?	☐ Yes	☐ No
6. Has any malpractice carrier ever made an out-of-court settlement or paid a judgment on a professional liability claim on your behalf?	☐ Yes	☐ No
7. Has your malpractice coverage ever been denied or cancelled?	☐ Yes	☐ No
8. Are you currently under indictment for any crime?	☐ Yes	☐ No
9. Have you ever been convicted of or pleaded no contendere to a felony or other criminal offense, including, without limitation, a criminal offense related to Medicare, Medicaid, or any other federal program?	☐ Yes	☐ No
10. Have you ever been expelled, excluded, or suspended from any federal program of from service reimbursement under Medicare or Medicaid?	☐ Yes	☐ No
11. Do you have a history of chemical dependency/substance abuse or currently abuse drugs/alcohol?	☐ Yes	☐ No

If you answered YES to any of the above questions, please attach an explanation.

Applicants Statement

I certify that the answers given by me to the foregoing questions and statements are true and correct without any falsification, omissions, or misleading statements whatsoever. I agree that Hearing Care Solutions, Inc. shall not be held liable in any respect if my participation as a Provider is terminated because of false or misleading statements, answers or omissions by me in this application.

Signature of Provider: _____ Date: _____

Signature above gives permission to provide credentialing information to any contracted or designated third party insurance payor. Notice: You are advised that outside sources are queried during the credentialing process. You will have the right to review/correct any information discovered during this process. You should know that, under federal regulations, adverse credentialing decisions may be reported to certain national databanks (NPDB, HIPDB, EPLS, OIG).

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement ("Agreement") is by and between HEARING CARE SOLUTIONS, INC., a Colorado Corporation, (hereinafter "HCS"),

and _____ ("Provider").

RECITALS

A. HCS has developed a group of providers who have agreed to provide hearing services and products for specified fees to patients participating in hearing care plans administered by HCS (each a "Plan" and collectively, the "Plans").

B. Provider desires to join the HCS group of providers, subject to certain terms and conditions set forth in this Agreement.

AGREEMENT

HCS and Provider hereby covenant and agree as follows:

1. Duties of Provider: During the term of this Agreement, Provider shall have the following duties and responsibilities:
   a. Provider shall fully comply with HCS' contracts with employers, third-party payors and other entities ("Payors") as they relate to Provider, and agrees to furnish patients seeking hearing care products and related services through HCS ("Patients") with such products and services described in **Exhibit 3** (the "Services"). Services will be provided only through audiologists and hearing instrument specialists who have been credentialed by HCS, and only in accordance with terms of the Hearing Care Solutions Provider Instructions (the "Provider Instructions"), as may be amended from time to time by HCS in its sole discretion.
   b. Provider agrees to provide Services without discrimination on the basis of participation in the Plan, source of payment, age, sex, marital status, race, color, ethnicity, religion, sexual orientation, place of residence, HIV status, health status or disability (including any factor related to a Patient's physical or mental condition, claims experience, receipt of health care, medical history, advance directive, genetic information, evidence of insurability or any other basis prohibited by state or federal law) and in the same manner in which services are provided to non-Plan patients, subject to any limitations specified in the various Plans as published by HCS from time to time. This Agreement does not and shall not be interpreted as discouraging or prohibiting Provider from exercising his or her professional discretion to discuss treatment options other than the Services if deemed appropriate by Provider. Provider shall provide information in a culturally-competent manner to Patients, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.
   c. Provider shall comply at all times with the credentialing criteria set forth in this Agreement, including the requirements set forth in **Exhibit 2** or as additionally established from time to time by HCS and/or a Patient's Plan in its or their sole discretion ("Credentialing Criteria"). Credentialing Criteria include, without limitation, participation in federal and state health care programs, satisfaction of all licensure/registry requirements in the state where Services are provided, and in states without audiology licensure, a Certificate of Clinical Competence in Audiology (CCC-A) from the American Speech-Language-Hearing Association (ASHA), and/or Board Certification in Audiology from the American Board of Audiology, and/or Hearing Aid Dispenser licensure. Provider shall furnish updated, corrected information to HCS within thirty (30) days following a change in any facts or circumstances which make the Provider's application to HCS inaccurate or incomplete.
   d. Provider shall maintain an effective compliance program and standards of business conduct as described in this Agreement, and shall require its employees and First Tier, Downstream and Related Entities (as described CMS guidance and Amendment 1 hereto) to act in accordance therewith. HCS will provide its current Standards of Business Conduct to Provider annually or more frequently if required by law.

      Compliance Requirements: Provider shall comply with all laws, regulations and program guidance relevant to Medicare Advantage and/or Part D. Provider shall complete all training required by CMS and HCS, including upon hiring each employee, within 90 days thereafter and annually, and shall monitor for fraud, waste and abuse consistent with CMS guidance.

      Certification of Completion: Provider shall have written arrangements and retain adequate records of employee training, including attendance logs and material distributed at training sessions. Provider must certify at least annually that its employees have received general and specialized compliance training in accordance with Medicare Prescription Drug Manual, Chapter 9, Section 50.2.3.2.
   e. Provider agrees to provide Services in accordance with his or her scope of practice and only when "medically necessary." Based upon generally accepted medical practices in light of conditions at the time of treatment, medically necessary services are: (i) appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the patient's medical condition; (ii) compatible with the standards of acceptable practice

in the community; (iii) provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms; (iv) not provided solely for the convenience of the Patient or the convenience of the Provider; and (v) not primarily custodial care unless custodial care is a covered service or benefit under the Patient's evidence of coverage.

f. HCS will make available on the HCS Provider Portal a fee schedule governing the Services to be furnished by Provider, which may be amended from time to time by HCS in its sole discretion (the "Service Fee Schedule"). Provider agrees to accept the Service Fee Schedule as setting forth the maximum charges and full payment for Services provided to Patients. For the sake of clarity and without limiting the generality of the foregoing, Provider agrees: (i) **not** to bill Patients or Plans for hearing aids, hearing tests or for any Services listed in **Exhibit 3**, Section I for a period of one (1) year following the delivery of hearing aid(s) to a Patient; provided that Provider may bill Patients for such Services following the first anniversary of such delivery, at the rates Provider charges to other patients; and (ii) to bill the Patient for earmolds in accordance with the Provider Instructions and **Exhibit 3**, Section II. Provider agrees to send the order form to faxorders@hearingcaresolutions.com or fax to HCS at (888) 456-3047.

g. Provider agrees that in no event, including but not limited to nonpayment by HCS, insolvency of HCS, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek reimbursement, compensation or remuneration from, or have any recourse against a Patient, Plan or persons (other than HCS) acting on the Patient's behalf for Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting any amounts permissible under Section 1(f) above.

h. Provider shall maintain, at Provider's sole cost and expense, professional liability insurance with a minimum coverage of at least $1,000,000 per claim/$3,000,000 aggregate, or such other amounts as HCS may from time to time require. Provider, at its sole cost, shall provide a copy of a certificate of insurance with verification of required coverages. If Provider becomes uninsured at any time while this Agreement is in effect, Provider shall notify HCS in writing within ten (10) days after the date Provider becomes aware of the expiration or termination of coverage.

i. Neither party shall publish or otherwise distribute, in any form or media, any advertisement, description, or narrative statements about the other party or its programs or services without receiving prior written consent from the other party. Notwithstanding the foregoing, Provider agrees that HCS may include Provider's name, address and contact information in one or more directories of Providers produced and distributed by HCS.

j. Provider agrees to comply with all procedures, rules and regulations for the conduct and governance of HCS' provider group as may be promulgated by HCS from time to time, including, without limitation, requirements for utilization review, record keeping and coordination of benefits. Provider shall participate and cooperate in quality improvement activities, credentialing activities, utilization management activities, Patient grievance procedures, Patient satisfaction activities, medical records review and/or other related programs as established by HCS or Payors, including any reviews and decisions made by a Medicare QIO. Provider hereby consents to HCS' disclosure of aggregate data on quality and utilization to accrediting organizations.

2. Duties of HCS. During the term of this Agreement HCS will:
   a. pay the Service Fees listed on the HCS Provider Portal as made available with each Patient referral, for the provision of Services to Patients;
   b. collect payment for hearing aids from Patients and Plans;
   c. purchase hearing aids from manufacturers;
   d. make all forms and instructions necessary for Providers to service Patients, including but not limited to Order Forms, Return Forms, Provider Instructions, Purchase Agreements, and Approved Hearing Aids lists, available to Providers online on the HCS Provider Portal, or by email if requested by Provider;
   e. charge Patients a restocking fee of $75 per hearing aid upon return of hearing aids and pay the same amount to Providers in states where a restocking fee is not prohibited by law or by the Plan, as outlined in the Provider Instructions. In cases where the Patient has an out-of-pocket expense of less than $75 per hearing instrument, no restocking fee will be collected from the Patient or paid to the Provider.
   f. not interfere with the professional discretion of Provider, including with respect to the diagnosis or treatment of any Patient or the suggestion of treatment alternatives.
3. Covenants of Provider. Provider hereby covenants and agrees that, during the term of this Agreement, Provider will:
   a. maintain Provider's status as a fully qualified and duly licensed or registered audiologist and/or hearing aid dispenser in good standing in the state and, where applicable, any county or municipal subdivision thereof, in which Provider's practice is located; maintain all necessary permits, certificates and licenses in good standing and in accordance with all applicable laws, regulations and codes of ethics; and remain eligible for participating in state and federal health care programs;
   b. conduct Provider's professional practice, including the supervision of all personnel, in compliance with all applicable federal, state and local laws, rules and regulations, including Medicare laws and regulations, reporting requirements and CMS instructions;
   c. promptly update the information submitted in Provider's application to HCS as necessary to ensure its continued accuracy and completeness;

d. maintain an adequate records system in accordance with state and federal law that details all services, charges, dates and other information elements related to the Services rendered under this Agreement;
e. maintain adequate worker's compensation insurance for all of its employees in compliance with state law;
f. indemnify, defend and hold HCS, Plans and state and federal agencies harmless from and against any and all claims, judgements, liabilities, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees (collectively, "Claims"), to the extent such Claims arise from the acts or omissions of Provider or any breach by Provider of this Agreement.

4. Term and Termination.
   a. This Agreement shall commence as of the last date of execution below and remain in force and effect for an initial term of two (2) years, commencing on the date this Agreement is executed by HCS as set forth below. Thereafter, this Agreement will automatically renew for successive one-year terms unless terminated in accordance with this Agreement.
   b. Either party may terminate this Agreement without cause by giving the other party fifteen (15) days advanced written notice.
   c. Either party may terminate this Agreement upon fifteen (15) days written notice to the other party in the event the other party breaches this Agreement (including nonpayment) and fails to cure the breach within the fifteen (15) day notice period.
   d. HCS may immediately terminate this Agreement if Provider fails to maintain the Credentialing Criteria.
   e. Provider understands that it is necessary to cancel any of the duties to be performed in order to comply with Federal or State laws, regulations or policies, HCS may cancel the duties of the provider and be relieved of obligations.
   f. Upon termination of this Agreement for any reason, each party shall be relieved and discharged from all obligations hereunder except as expressly set forth in Section 25. Notwithstanding the foregoing, Provider shall continue to provide Services as outlined in **Exhibit 3** (I.) for up to one year after the date of termination as in accordance with Plan provisions and the terms of this Agreement for Patients for whom Provider was providing Services at the time of termination. Following termination of this Agreement, Provider agrees to promptly comply with any Patient's request for transfer of medical records to another provider of Services designated by the Patient. Provider may charge the Patient a reasonable fee for copies made in accordance with state and federal law. With the approval of the Patient, the content of such medical records may be provided in summary form.
5. Non-Exclusivity. This Agreement in no manner precludes or prohibits Provider from negotiating or entering into similar and/or separate agreements with other managed care entities or networks or contracting directly with third-party payors, nor does it preclude HCS from negotiating or entering into similar and/or separate agreements with other providers.
6. Notices. All notices and other communications required or permitted hereunder shall be in writing and shall be mailed by first-class, registered or certified mail, postage prepaid, or delivered either by hand or by messenger, or sent via facsimile, or email (return receipt confirmed), at such address as each party shall have furnished to the other in writing , or, for changes to this Agreement, by posting information regarding any such changes in the HCS Online Provider Portal. Any notice or other communications so provided shall be deemed to be given when actually sent.
7. Assignment. Neither party shall assign or transfer his/her rights, duties or obligations under this Agreement without the prior written consent of the other party, which such consent will not be unreasonably withheld. Notwithstanding the foregoing, HCS may assign its rights and obligations under this Agreement to a parent, subsidiary or successor, including by operation of law in the course of a merger, stock sale, sale of all or substantially all of assets or any other change of ownership or control.
8. No Third-Party Beneficiary. The rights and obligations of each party to this Agreement shall inure solely to the benefit of the parties hereto, and no person or entity shall be a third-party beneficiary of this Agreement, except with respect to: (i) the limitations on Patient billing in Sections 1(f) and 1(g); (ii) the covenants set for in 3(f); and (iii) Plans with respect to the provision of Services to Plan beneficiaries.
9. Responsibility for Actions.
   a. Provider shall be solely liable for any and all Claims arising from or out of any alleged negligent or intentional act or omission of Provider, his/her agents or employees in the performance of his/her obligations under this Agreement.
   b. HCS shall be solely liable for any and all Claims arising from or out of any alleged negligent or intentional act or omission of HCS, its agents or employees in the performance of its obligations under this Agreement.
10. Confidentiality.
   a. Provider and HCS shall, during and after the term of this Agreement, keep confidential all proprietary business information concerning this Agreement, including, without limitation, financial and fee information, forms, provider instructions, statistical data, reports and standards. Each party shall protect confidential proprietary business information from unauthorized disclosure by its agents and employees and shall not use such information to the competitive disadvantage of or in any way detrimental to the other party.
   b. Each party shall, during and after the termination of this Agreement, comply with all state and federal laws regarding confidentiality and disclosure of medical records, as well as comply with state and federal laws protecting the

confidentiality of enrollee eligibility and demographic information. Each party shall keep confidential the protected health information received or created by such party in the performance of its obligations under this Agreement, including, without limitation, patient records, claim forms, billing records and quality improvement information and reports. Provider shall make its patient records and all other documents related to Provider's performance of services under this Agreement, as well as it premises, physical facilities and equipment, available to HCS, appropriate federal and state regulatory authorities and Plans, upon request and reasonable notice, for the purpose of assessing the quality or appropriateness of services, reconciliation of benefit liabilities, determination of amounts payable, investigating patient or Plan complaints or any other matter as the auditing authority deems necessary.

c. Provider shall permit the Department of Health and Human Services ("HHS"), the Comptroller General, or their designees to inspect, evaluate and audit all books, records, contracts, documents, papers and accounts relating to Provider's performance of this Agreement, including transactions related to any CMS contract (collectively, "Records"), for a period of ten (10) years from the later to occur of any of the following events (the "Audit Period"): (i) the final date of the CMS contract period; (ii) the date of completion of the immediately preceding audit, if any; or (iii) the expiration or termination of this Agreement. Provider shall keep and maintain accurate and complete Records throughout the term of the Agreement and the Audit Period.

11. Amendment. This Agreement may be amended only in a writing signed by both of the parties; provided that HCS may unilaterally amend this Agreement (including, without limitation, any Exhibit hereto or Provider Instruction issued hereunder) by giving Provider written notice of such amendment, including, without limitation, by providing notice through the HCS Online Provider Portal (as further described in Section 6 above).
12. Independent Contractor. Provider and HCS are at all times acting and performing as independent contractors. Nothing herein shall be construed to create between HCS and Provider the relationship of employer-employee, partners or joint venturers. Neither party shall have the authority to enter into any contract on behalf of the other party without the party's express written consent. Nothing in this Agreement shall be construed as or constitute an appointment of either party as an agent for the other.
13. Waiver. A waiver of any of the terms and conditions hereof shall not be construed as a waiver of any other terms or conditions hereof.
14. Severability. The provisions of this Agreement shall be deemed severable, and if any portion shall be held invalid, illegal or unenforceable for any reason, the remainder of this Agreement shall be effective and binding on the parties.
15. Governing Law and Jurisdiction. The validity, interpretation and performance of this Agreement shall be governed and construed in accordance with the laws of the State of Colorado, notwithstanding any choice of law doctrines. Provider hereby consents to exclusive personal and subject matter jurisdiction in the State of Colorado, and any dispute between the parties shall be brought and tried exclusively in the state or federal courts in and for the State of Colorado.
16. Complete Agreement. This Agreement, including its Exhibits, any Amendments hereto and the Provider Instructions, contains a full and complete expression of the agreement of the parties and supersedes all prior agreements or understandings, written or oral, heretofore made by the parties.
17. Binding Effect. This Agreement shall be binding on the parties and their permitted successors and assigns.
18. Compliance with Laws. Provider shall comply with all laws, regulations and instructions from HCS applicable to Provider's performance of Services, including without limitation, compliance with CMS instructions and policies such as Medicare Marketing Guidelines for Medicare Managed Care Clients and any requirements for CMS prior- approval of materials. Provider shall agree to Medicare Advantage and/or Medicare Part D plans that will be consistent with and will comply with the Customer's Medicare Advantage and/or Medicare Part D contractual obligations. Provider shall comply with state and federal laws designed to prevent or ameliorate fraud, waste and abuse, including but not limited to applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.) and the anti-kickback statute (section 1128B(b) of the Social Security Act).
19. Ineligible Persons identification and removal. Upon execution of this Agreement and at least monthly thereafter when providing Services to or for the benefit of Medicare Advantage and/or Medicare Part D members under this Agreement, Provider will review the applicable sources to insure that neither he/she/it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at https://www.sam.gov/) or the HHS/OIG List of Excluded Individuals/Entities (available through the internet at http://exclusions.oig.hhs.gov/). Provider agrees to maintain documentation evidencing compliance with this requirement and agrees to sign a certification consistent with the meaning and requirements of this provision as required by Customer/Vendor contracted with Customer. In the event Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, Provider shall immediately (i) notify HCS of such ineligible person status, and (ii) remove such individual from responsibility for or involvement with providing Services under this Agreement.
20. Monitoring. Provider shall review evidence that its vendors monitor their subcontractors for ineligible employees, contractors, subcontractors or agents on the System for Award Management (SAM) (available through the internet at https://www.sam.gov) and the OIG List of Excluded Individuals/entities (available at

https://oig.hhs.gov/exclusions/index.asp).

21. Conflict of Interest. Providers must be free from any conflicts of interest with respect to the provision of Services. Provider agrees to require its managers, officers and directors responsible for the administration or delivery of Medicare Advantage and/or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Medicare Advantage and/or Part D benefits.
22. Illegal Remunerations. Provider acknowledges that activities to be performed under the Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in § 1128B(b) of the Social Security Act.
23. Application of Civil Rights Laws. Provider acknowledges that payments received from HCS to provide services to Medicare Advantage and/or Medicare Part D enrollees are, in whole or part, derived from federal funds. Therefore, Provider and any of its Downstream and/or Related Entities may be subject to certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, 42 C.F.R. 423.100, 42 C.F.R. Part 422, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans With Disabilities Act; the Rehabilitation Act of 1973 and other laws and regulations applicable to recipients of federal funds.
24. Business Associates. To the limited extent that any activities of HCS under this Agreement are deemed to constitute those of a business associate as defined under the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder, HCS agrees to be bound by the Business Associate Agreement attached hereto as **Exhibit 1**, as may be amended from time to time.
25. Survival. The duties and obligations set forth in Sections 1(g), 3(f), 4(f) and 10 shall survive the termination of this Agreement, regardless of the reason for termination.
26. Limited License. Subject to the terms and conditions of this Agreement, HCS hereby grants Provider a limited, personal, non-exclusive, non-sublicensable, non-transferable, fully paid-up license to use the HCS trademarks specified by HCS from time-to-time solely for the promotion and provision of the Plan pursuant to this Agreement. Provider will comply with all HCS trademark usage guidelines and policies as provided by HCS from time-to-time. Provider will also comply with all requests by HCS to terminate or modify usage of any such trademarks as communicated by HCS from time-to-time and in its sole discretion. Upon any such communication, Provider will immediately cease or modify, as applicable, its use of the HCS trademarks.
27. Non-Disparagement. In consideration of the need for HCS to provide coverage information directly to the health plan's subscribers that can include communication that certain products or services are not covered by HCS under its agreement with the provider, the provider undertakes and covenants to not disparage HCS. Provider also undertakes and covenants that it shall not make statements or take any actions or initiatives that could directly or indirectly prejudice, harm or jeopardize the business reputation of HCS or its products or services.

(Remainder of Page Left Intentionally Blank)

IN WITNESS WHEREOF the parties have duly executed this Agreement.

Print Provider Name

Provider Address

City | State | Zip Code

Provider Fax

Provider Email

Provider Signature | Date

Hearing Care Solutions, Inc.
5889 Greenwood Plaza Blvd Suite 300
Greenwood Village, Colorado 80111

HCS Authorized Agent | Date

Send a copy of this agreement to:
Applications@hearingcaresolutions.com
or fax to: (303) 595-5397

EXHIBIT 1

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ('BAA') is hereby incorporated into the Participating Provider Agreement ('Agreement') by and between Hearing Care Solutions ('HCS') and its participating contracted providers ('Provider').

RECITALS

Whereas, in the event and only to the limited extent HCS is deemed to perform the functions of a Business Associate on behalf of Provider, and in such capacity is either given access to, or is exposed to, certain confidential or individually identifiable protected health information ('PHI'), then this BAA shall apply, and HCS and Provider agree as follows, in accordance with the Health Insurance Portability and Accountability Act of 1996 ('HIPAA') and its implementing regulations, including the Standards for Privacy of Individually Identifiable Health Information (the 'HIPAA Privacy Rule') and the Security Standards for the Protection of Electronic Protected Health Information ('HIPAA Security Rule'):

1. **DEFINITIONS:**
   - 1.1. **BUSINESS ASSOCIATE:** 'Business Associate' shall generally have the same meaning as the term 'business associate' at 45 CFR 160.103, and in reference to the parties to this agreement, shall mean HCS.
   - 1.2. **COVERED ENTITY:** 'Covered Entity' shall generally have the same meaning as the term 'covered entity' at 45 CFR 160.103, and in reference to the parties to this agreement, shall mean Provider.
   - 1.3. **HIPAA RULES:** 'HIPAA Rules' shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.
   - 1.4. **OTHER DEFINITIONS:** All capitalized terms used in this BAA and not otherwise defined herein shall have the meanings ascribed to them under the HIPAA Rules.

2. **OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE AND COVERED ENTITY:** The Business Associate, HCS, and the Covered Entity, Provider, agree to safeguard Protected Health Information in the manner as identified below:
   - 2.1. Not use or disclose protected health information other than as permitted or required by the BAA or as required by law.
   - 2.2. Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the BAA.
   - 2.3. Report to such party any use or disclosure of protected health information not provided for by the BAA of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware as soon as possible, but in no event more than ten business days of such party becoming aware. The Business Associate will handle breach notifications to individuals, the HHS Office for Civil Rights (OCR) and its contracted health plans and affiliates.
   - 2.4. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate or covered entity agree to the same restrictions, conditions and requirements that apply to such party with respect to such information.
   - 2.5. Make available protected health information in a designated record set to the either party as necessary to satisfy such party's obligations under 45 CFR 164.524.
   - 2.6. Make any amendment(s) to protected health information in a designated record set or as directed or agreed to by such party pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy such party's obligations under 45 CFR 164.526.
   - 2.7. Maintain and make available the information required to provide an accounting of disclosures to the individual as necessary to satisfy such party's obligations under 45 CFR 164.528. Such party shall provide the record to the requesting person within ten business days of any request and the record shall include (i) the date of disclosure, (ii) the name and address of the person to whom the disclosure was made, (iii) a brief description of the PHI disclosed, and (iv) the purpose for which the PHI was disclosed as well as a copy of the authorization for disclosure.
   - 2.8. To the extent either party is to carry out one or more of the other party's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to such party in the performance of such obligation(s)
   - 2.9. To retain all books and records related to use and disclosure of PHI for a minimum of ten years and make such party's internal practices, books, and records relating to the use and disclosure of PHI received from the other party available to the Secretary for purposes of determining compliance with the HIPAA Rules.
   - 2.10. To adopt procedures to mitigate deleterious effects from the use or disclosure of PHI in a manner contrary to this BAA or the HIPAA Privacy Rule.

3. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE:

3.1. Business Associate may only use or disclose protected health information as necessary to perform the services set forth in the Agreement. The business associate is authorized to use protected health information to de-identify the information in accordance with 45 CFR 164.514(a)-(c).

3.2. Business Associate may use or disclose protected health information as required by law.

3.3. Business Associate agrees to make uses and disclosures and requests for protected health information consistent with Covered Entity's minimum necessary policies and procedures.

3.4. Business Associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by Covered Entity except for the specific uses and disclosures set forth below:

3.4.1. Business Associate may use protected health information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.

3.4.2. Business associate may disclosed protected health information for the proper management and administration of Business Associate or to carry out the legal responsibilities of the Business Associate, provided the disclosures are required by law, or the Business Associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used for further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached.

3.4.3. Business Associate may provide data aggregation services related to the health care operations of the covered entity

4. PROVISIONS FOR COVERED ENTITY TO INFORM BUSINESS ASSOCIATE OF PRIVACY PRACTICES AND RESTRICTIONS:

4.1. Covered Entity shall notify Business Associate of any limitation(s) in the notice of privacy practices of Covered Entity under CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of protected health information.

4.2. Covered Entity shall notify Business Associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect Business Associate's use or disclosure of protected health information.

4.3. Covered Entity shall notify Business Associate of any restriction on the use or disclosure of protected health information that Covered Entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of protected health information.

5. PERMISSIBLE REQUESTS BY COVERED ENTITY:

5.1. Covered Entity shall not request Business Associate to use or disclose protected health information in any manner that would not be permissible under Subpart E of 45 CFR Part 164 if done by Covered Entity with the exception of the following:

5.1.1. Business Associate will use or disclose protected health information for data aggregation and/or management and administration and legal responsibilities of the Business Associate.

6. TERM AND TERMINATION:

6.1. **TERM.** The Term of this BAA shall be effective as of September 23rd, 2013, and shall terminate on the date Business Associate or Covered Entity terminates for cause as authorized in paragraph (6.2) of this Section.

6.2. **TERMINATION FOR CAUSE.** Business Associate or Covered Entity authorize termination of this BAA by such party, if such party determines the other party has violated a material term of the Agreement that cannot be cured within thirty days after written notice from the terminating party of the specific violation.

6.3. **OBLIGATIONS OF BUSINESS ASSOCIATE UPON TERMINATION:**

6.3.1. Upon termination of this Agreement for any reason, Business Associate, with respect to protected health information received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity, shall:

6.3.1.1. Retain only that protected information which is necessary for Business Associate to continue is proper management and administration or to carry out its legal responsibilities;

6.3.1.2. Return to Covered Entity [or, if agreed to by Covered Entity, destroy] the remaining protected health information that the Business Associate still maintains in any form;

6.3.1.3. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this Section, for as long as Business Associate retains the protected health information;

6.3.1.4. Not use or disclosed the protected health information retained by Business Associate other than for the purposes for which such protected health information was retained and subject to the same conditions as set out at Section 3.4.1 and 3.4.2, which applied prior to termination; and

6.3.1.5. Return to Covered Entity [or if agreed to by Covered Entity, destroy] the protected health information retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

6.3.2. **SURVIVAL.** The obligations of Business Associate under this Section shall survive the termination of this Agreement.

7. MISCELLANEOUS

7.1.1. **REGULATORY REFERENCES.** A reference in this BAA to a section in the HIPAA Rules means the section as in effect or as amended.

7.1.2. **AMENDMENT.** The Parties agree to take such action as is necessary to amend this BAA from time to time as is necessary for compliance with the requirements of the HIPAA Rules and any other applicable law.

7.1.3. **INTEPRETATION.** Any ambiguity in this BAA shall be interpreted to permit compliance with the HIPAA Rules.

EXHIBIT 2

PROVIDER CRITERIA

Provider and its employed professionals providing Services hereunder must demonstrate satisfactory professional qualifications and a commitment to the quality standards and cost containment principles of HCS, including as follows:

1. Possess a graduate degree in Audiology (Master or Doctoral degree) from an accredited university, or hold state licensure as a Hearing Instrument Specialist.

2. Comply with all applicable licensure and registry requirements in each state where Services are rendered.

3. In states where there is no audiology licensure requirement, have Board Certification in Audiology from the American Board of Audiology and/or Certificate of Clinical Competency in Audiology (CCC-A) from the American Speech-Language-Hearing Association (ASHA).

4. Maintain professional malpractice insurance with a minimum coverage of $1,000,000 per incident/$3,000,000 aggregate, and an acceptable malpractice history.

5. Have an independent practice or practice as an employee of a physician, hospital, medical clinic, audiologist-managed corporation or another audiologist or hearing instrument specialist who satisfies Credentialing Criteria.

6. Agree to adhere to the Provider Instructions and the corresponding HCS Approved Hearing Aids list.

7. Practice at a facility at which all necessary equipment for the evaluation of hearing and the dispensing of hearing aids is available and regularly calibrated.

8. Maintain regularly scheduled office hours at each facility where Services are rendered.

9. Have completed and signed the Provider Application, Agreement, Site Checklist, and sent in office W-9, malpractice insurance, and applicable license(s) and/or certification(s).

10. Providers participating under provisional licensure must practice in the same office as a credentialed provider with full licensure. All above mentioned criteria is expected of a provider with full or provisional licensure.

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EXHIBIT 3

I. SERVICES TO PATIENTS

Hearing exams for the purpose(s) of determining hearing aid candidacy are provided to Patients at no charge except as specified in the Provider Instructions. The following Services will be provided to Patients at no charge for one (1) year after hearing aid delivery (fitting):

- Office visits
- Hearing aid adaptation training
- In-office hearing aid repairs
- Reprograming (includes hearing instruments and accessories)
- Tube Changes

II. SERVICE FEE SCHEDULE

- Hearing exams for the purpose(s) of determining hearing aid candidacy are provided to Patients at no charge except as specified in the Provider Instructions.
- If a Patient is a candidate for hearing aids, units should be selected from the current HCS Approved Hearing Aids List
- Hearing aids must be ordered using the HCS Online Provider Portal, L&D excluded.
- HCS collects payments for hearing aids, accessories, and L&D Claims directly from Patients prior to delivery.
- Provider must order earmolds directly from preferred vendor and collect payment from Patient. Excluding Medicaid plans or otherwise specified in the Provider Instructions Price not to exceed:
    - Standard Earmolds – $60 / Earmold
    - RIC/Embedded/Power/Encased Earmolds – $115 / Earmold
    - Starkey Encased Earmolds – $170 / Earmold
- Patients must sign a current HCS Purchase Agreement and Delivery Receipt. Providers must send a copy to:
    - PurchaseAgreements@hearingcaresolutions.com or fax to (888) 456-3047
- Service Fees will be paid by HCS within 15 days after the following conditions have been met:
    - All funds for hearing instruments have been collected in full by HCS in any of these instances:
        - Responsibility for full payment is that of the Patient
        - Responsibility for full payment is that of the Plan
        - Responsibility for payment is shared between the Patient and the Plan
    - HCS has received the completed and signed Purchase Agreement and Delivery Receipt
    - A signed copy of the Care Credit sales slip, and copy of the cardholder or authorized user's license or copy of the Care Credit card is submitted with completed Purchase Agreement when appropriate.
    - The Patient's trial period is complete after fitting date.
- Service fees are outlined in the List of Approved Hearing Aids specific to each Patient (refer to Service Fee sheet).
- Returns or exchanges must be processed within 60 days after delivery.
- In the event of a return, HCS will refund the Patient, less a $75 per hearing aid restocking fee charged in states where permitted by law. The refund will be sent to the Patient after the manufacturer of the device has issued HCS a credit, except if the Patient resides in the State of Maine, in which case the refund will be issued same day. HCS will then pay the restocking fee to the Provider.
- Service fee payments are made in agreement with a provider to complete the 1 year of service obligation. HCS can withhold service fees if the year of servicing is not met.
- RESTOCKING FEE WILL NOT BE PAID IN THE FOLLOWING CASES:
    - In the State of California;
    - The Patient had an out-of-pocket expense of less than $75 per hearing instrument; or
    - HCS is unable to collect the restocking fee from the patient.
- Provider must ship hearing aids that are returned for credit by the Patient to the manufacturer within ten (10) calendar days of Provider's receipt from the Patient. Provider must process and complete such returns through the Online Provider Portal. Provider's failure to comply with these requirements may result in a chargeback of the instrument cost to Provider's account.
- HCS provider service fees are not paid for the following services;
    - Accessories
    - Earmolds
    - Filters, domes, and wax guards
    - L&D during the first year

HEARING CARE SOLUTIONS

PARTICIPATING PROVIDER AGREEMENT AMENDMENT I

This amendment ("Amendment") amends that certain Participating Provider Agreement ("Agreement") between Hearing Care Solutions, Inc. a Colorado Corporation (hereinafter "HCS"), and the organizational provider that is a party to such Agreement ("Provider"). Capitalized terms not otherwise defined herein shall have the meanings ascribed to them in the Agreement. Except as expressly amended herein, the Agreement shall remain in full force and effect. In the case of a conflict, the terms of this Amendment shall govern over those contained in the Agreement.

A. **Compliance Program and Anti-Fraud Initiatives.** Provider shall (and shall cause its Downstream Entities to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse (FWA) relating to the operation of HCS's Medicare Program. Such compliance program shall be appropriate to Provider's or Downstream Entity's organization and operations and shall include:

1) written compliance policies and standards of conduct that are comparable to HCS's compliance policies / HCS Code of Conduct and articulate the entity's commitment to comply with federal and state laws, ethical behavior and compliance program operations. Provider will disseminate either HCS's compliance policies/HCS Code of Conduct or comparable versions to Provider's employees, officers, and Downstream Entities within 90 days of hire/contracting, when updates are made, and annually thereafter;

2) reporting mechanisms communicated to Provider's employees and Downstream Entities for their use in adhering to the expectation that Provider, its employees and its Downstream Entities report potential non-compliance or FWA issues (internally and to HCS, as applicable) and understand their obligation to report. Provider must publicize the reporting methods to Provider employees and Downstream Entities along with a no-tolerance policy for retaliation or retribution for good faith reporting;

3) completion of CMS' Medicare Learning Network® "Medicare Parts C and D Fraud, Waste, and Abuse Training and Medicare Parts C and D General Compliance Training" by Provider employees, officers, and Downstream Entities initially within ninety (90) days of hire/contracting and at least annually thereafter, unless exempt from such training under relevant CMS regulations.
   Training may be completed in one of two ways:
   i. by completing the general compliance and FWA training modules located on the CMS Medicare Learning Network;
   ii. or by downloading, viewing or printing the content of the then current CMS standardized training modules from the HCS provider portal to incorporate into Provider's and/or Downstream Entity's organization's existing compliance training materials/systems. (The CMS training content may not be changed but Provider and/or its Downstream Entities may add to it to cover topics specific to its organization);

4) processes to oversee and ensure that Provider and Provider's Downstream Entities maintain compliance with processes to oversee and ensure that:
   i. HCS and Provider maintain compliance with CMS compliance program requirements, and
   ii. Provider's Downstream Entities perform Medicare Services consistent with this Agreement and the agreement between Provider and such Downstream Entities.
   Provider's oversight under this Agreement shall include:
   iii. imposition of disciplinary actions, as needed, to ensure employee compliance with CMS compliance program requirements, and
   iv. implementation of corrective actions (up to and including contract termination), as needed, with respect to its Downstream Entities to ensure Downstream Entity compliance with applicable CMS requirements, including the CMS compliance program requirements, this Agreement and Provider's contract with the Downstream Entity; and

5) retention of evidence showing that Provider and Provider's Downstream Entities complied with the requirements set forth in this Section. Such evidence must be maintained for at least the period of 10 years and shall be made available to HCS and CMS, upon request. Provider shall complete attestations in the form and manner requested by HCS to confirm its compliance with this section on an annual basis.

B. **Adjustments to Service Fees.** HCS reserves the right to modify the service fee associated with a product in the event of a price decrease. By way of example.

1) A patient requires a CROS or Bicros product, which is currently not available at a technology level for zero out-of-pocket. If the device is determined to be medically necessary and a request is made to provide such a product at a reduced price, the service fee with the approved instrument will be reduced accordingly. The product must be approved by HCS and it should not be assumed that any product can be supplied.

C. **Improper Quoting and Provider Payment.** HCS shall pay Providers Service Fees in accordance with the HCS Service Fee Sheet, listed in the provider portal with each patient referral. The fee sheet outlines provider compensation for the delivery and service of hearing aids to HCS patients when all paperwork is properly submitted with the possible exceptions*;*

1) *Service fee reduction;* when improper quoting by the provider to the patient occurs, HCS may adjust the fit fee to compensate for the misquote as appropriate.

2) *Service fee holding;* a provider that preemptively deliver hearing aid(s) prior to HCS authorization to deliver, the provider service fee(s) may be withheld until the appropriate balances are resolved.

D. **Provider Payment Disputes (PPD) / Provider Payment Reconsideration (PPR) / Provider Dispute Resolutions (PDR);**
HCS has an established fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted provider disputes. The written notice to HCS is appealing or requesting reconsideration of a service fee that has been denied, adjusted or contested or seeking resolution of a service fee determination or other contract dispute or disputing a request for reimbursement of an overpayment of a service fee.

1) *Submission*; provider may submit a payment dispute to HCS given that HCS receives: Provider's Name, Provider's NPI, Contact information, dispute concerns, date of service, clear explanation of disputed payment amount via the following communications:
   i. servicefees@hearingcaresolutions.com or;
   ii. calling provider services at (877) 583-2842

2) *Timeline*; provider may submit a payment dispute to HCS within sixty (60) days of receipt of the remittance advice. If the subsequent dispute is not resolved, a reconsideration appeal may be submitted within sixty (60) days of the original appeal determination.

E. **Timely Filing Requirements for Claims**: Claims and signed and completed Purchase Agreements must be received no later than one (1) calendar year from the claim's date of service. Claims filed after the indicated time frame are denied with no appeal rights. The provider must be a participating provider in the active HCS network during the time the service was provided.

F. **Assignment of Office Closure**: If your office closes prior to being paid, or before completing a patient's year of servicing, the servicing of any existing patients must be transferred to another provider within a close geographic proximity. Any applicable service fees pertaining to patients within their first year of services must be transferred to new ownership along with Patient Health Information (PHI) to ensure that services are transferred by permission and contract. If services cannot be transferred to another provider within a close geographic proximity, all applicable service fees for patients within their year of servicing must be refunded to HCS.

G. **Change of Control:** If your office transfers control ownership including Tax Identification Number, it is your responsibility to contact us to update your account for proper adjustments to payment and reporting. You can report this via the following communications: Emailing providerchanges@hearingcaresolutions.com, Calling Provider Services at (877) 583-2842.

H. **HCS Member:** Any patient referred by Hearing Care Solutions to a participating provider is considered an HCS patient regardless of the originating health plan. Participating providers are required to service all patients referred by HCS regardless of health plan affiliation. Reverse Referrals for HCS contracted health plans are also HCS patients.