

## PARTICIPATING PROVIDER AGREEMENT

**THIS PARTICIPATING PROVIDER AGREEMENT** (“**Agreement**”) is made and entered into as of \_\_\_\_\_ (“**Effective Date**”) by and between WellCare Health Insurance of Illinois, Inc. d/ b/a WellCare of Kentucky (“**Health Plan**”) and \_\_\_\_\_ (“**Contracted Provider**”). Health Plan and Contracted Provider are sometimes referred to together as the “**Parties**” and individually as a “**Party**”.

**WHEREAS**, Health Plan issues health benefit plans and seeks to include health care providers in one or more provider networks for such plans; and

**WHEREAS**, Contracted Provider provides or arranges for the provision of health care items and services to the general public by health care providers employed by or subcontracted with Contracted Provider; and

**WHEREAS**, Health Plan and Contracted Provider desire to enter into this Agreement whereby Contracted Provider will provide or arrange for the provision of health care items and services to Health Plan’s health benefit plan enrollees in exchange for payments from Health Plan, all subject to and in accordance with the terms and conditions of this Agreement;

**NOW THEREFORE**, the Parties agree as follows:

1. Construction.

1.1. The base part of this Agreement is designed for use with a variety of providers and Benefit Plans. Provisions specific to particular providers and Benefit Plans are included in Attachments to the Agreement.

1.2. The following rules of construction apply to this Agreement: (a) the word “**include**”, “**including**” or a variant thereof shall be deemed to be without limitation; (b) the word “**or**” is not exclusive; (c) the word “**day**” means calendar day unless otherwise specified; (d) the term “**business day**” means Monday through Friday, except Federal holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms, such as CMS 1500 and UB-04 forms, include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies to it.

2. Definitions. In addition to terms defined elsewhere in this Agreement, the following capitalized terms when used in this Agreement shall have the meanings set forth below. If an identical term is defined in a Program Attachment, the definition in the Program Attachment shall control with respect to Benefit Plans governed by the Program Attachment.

2.1. “**Affiliate**” means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with, the entity. An entity “**controls**” an entity in which it has the power to vote, directly or indirectly, 50 percent or more of the voting interests in such entity or in the case of a partnership if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

2.2. “**Benefit Plan**” means a health benefit policy or other health benefit contract or coverage

document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

2.3. **“Carve Out Agreement”** means an agreement between Health Plan and a third party Participating Provider whereby the third party assumes financial responsibility for or may provide certain management services related to particular Covered Services. Examples of possible Carve Out Agreements include agreements for behavioral health, radiology, laboratory, dental, vision, or hearing services.

2.4. **“Clean Claim”** means a claim for Covered Services provided to a Member that (a) is received timely by Health Plan, (b) has no defect, impropriety, or lack of substantiating documentation from the Member’s medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 83 7 standards and additional Health Plan specific requirements in the WellCare Companion Guide, including all then current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Health Plan to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to Members, and (2) determine payor liability, and ensure timely processing and payment by Health Plan. A Clean Claim does not include a claim from a Contracted Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

2.5. **“Credentialing Criteria”** means Health Plan’s criteria for the credentialing or re-credentialing of Providers.

2.6. **“Covered Services”** means Medically Necessary health care items and services covered under a Benefit Plan.

2.7. **“DHHS”** means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services (“CMS”) and its Office of Inspector General (“OIG”).

2.8. **“Emergency Services”** shall be as defined in the applicable Program Attachment.

2.9. **“Encounter Data”** means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

2.10. **“Federal Health Care Program”** means a Federal health care program as defined in section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid and CHIP.

2.11. **“Government Contract”** means a contract between Health Plan and a Governmental Authority or government authorized entity for Health Plan to provide health benefits coverage for Federal Health Care Program beneficiaries.

2.12. **“Governmental Authority”** means the United States of America, the States, or any department or agency thereof having jurisdiction over Health Plan, a Provider or their respective Affiliates, employees, subcontractors or agents.

2.13. **“Ineligible Person”** means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or nonprocurement programs, as may be identified in the Excluded Parties List System maintained by the

General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or nonprocurement programs as determined by a State Governmental Authority.

2.14. "**Laws**" means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII ("**Medicare**"), XIX ("**Medicaid**") and XXI (State Children's Health Insurance Program or "**CHIP**"), (b) the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), (c) Federal and State privacy laws other than HIPAA, (d) Federal and State laws regarding patients' advance directives, (e) State laws and regulations governing the business of insurance, (f) State laws and regulations governing third party administrators or utilization review agents, and (g) State laws and regulations governing the provision of health care services.

2.15. "**Medically Necessary**" or "**Medical Necessity**" shall be as defined in the applicable Program Attachment.

2.16. "**Member**" means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

2.17. "**Member Expenses**" means copayments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

2.18. "**Non-Contracted Services**" means Covered Services that are (a) subject to Carve Out Agreements and not approved by Health Plan in advance as further described in this Agreement, or (b) provided by an Ineligible Person.

2.19. "**Participating Provider**" means an individual or entity that has entered into an agreement with Health Plan or a Health Plan contractor to provide or arrange for the provision of Covered Services to Members.

2.20. "**Principal**" means a person with a direct or indirect ownership interest of five percent or more in Provider.

2.21. "**Program**" means (a) a Federal Health Care Program, or (b) a commercial insurance program, including a program created under Laws regarding commercial health insurance exchanges.

2.22. "**Program Attachment**" means an attachment to this Agreement describing the terms and conditions of a Provider's participation in Benefit Plans under a Program.

2.23. "**Program Requirements**" means the requirements of Governmental Authorities governing a Benefit Plan, including where applicable the requirements of a Government Contract.

2.24. "**Provider**" means (a) Contracted Provider or (b) other individual or entity that is subject to an employment arrangement or direct or indirect subcontract with Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

2.25. "**Provider Manual**" means, collectively, Health Plan's provider manuals, quick reference guides and educational materials setting forth Health Plan's requirements, rules, policies and

procedures applicable to Participating Providers, as adopted or amended by Health Plan from time to time, including requirements, rules, policies and procedures regarding fraud, waste and abuse; health plan accreditation, credentialing/re-credentialing of providers, Member eligibility verification, prior authorization, submission of claims and encounter data (including the WellCare Companion Guide), claims payment, overpayment recoupment, utilization review/management, disease and case management, quality assurance/improvement, model of care, advance directives, collection of Member Expenses, Member rights, including reimbursement of Member Expenses collected in excess of the maximum out of pocket amount under a Benefit Plan; and Member or provider grievances and appeals.

2.26. “**State**” means any of the 50 United States, the District of Columbia or a U.S. territory.

2.27. “**WellCare**” means WellCare Health Plans, Inc., an Affiliate of Health Plan.

2.28. “**WellCare Companion Guide**” means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to Health Plan or its Affiliates, as amended from time to time. The WellCare Companion Guide is part of the Provider Manual.

### 3. Scope.

3.1. Non-Contracted Services are outside the scope of this Agreement.

3.2. Providers may freely communicate with Members about their treatment regardless of benefit coverage limitations. Health Plan does not dictate or control clinical decisions respecting a Member’s medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by Health Plan. Nothing in this Agreement shall be interpreted to permit interference by Health Plan with communications between a Provider and a Member regarding the Member’s medical condition or available treatment options.

3.3. This is not an exclusive agreement for either Party, and there is no guarantee (a) Health Plan will participate in any particular Program, or (b) any particular Benefit Plan will remain in effect.

3.4. Subject to Laws and Program Requirements, Health Plan reserves the right to create distinct provider networks for a Benefit Plan, and to determine Provider participation in such networks.

3.5. Subject to Laws and Program Requirements, Health Plan reserves the right to approve any Provider’s participation under this Agreement, or to terminate or suspend any Provider from participation under this Agreement or one or more particular Benefit Plans. Health Plan is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider.

### 4. Provider Responsibilities.

4.1. Principals. Contracted Provider warrants and represents that it has provided Health Plan the information listed on the Attachment titled “Information for Contracted Provider / Principals” for itself and all of its Principals as of the Effective Date. Contracted Provider shall provide notice to Health Plan of any change in the information within 30 days of the change.

4.2. Providers. Contracted Provider warrants and represents that it has provided Health Plan with the information listed on Attachment titled “Information for Providers” for itself and the other Providers as of the Effective Date in a form and format acceptable to Health Plan. Contracted Provider

shall provide notice to Health Plan of any change in the information within 30 days of the change.

4.2.1. Employed Providers. Contracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Contracted Provider shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

4.2.2. Subcontracted Providers. The following only applies if Contracted Provider, such as an independent practice association, physician hospital organization or physician group, uses subcontracted Providers:

(a) Contracted Provider shall, and shall require its direct or indirect subcontracted Providers to, maintain and enforce written agreements with their respective subcontracted Providers that are consistent with and require adherence to this Agreement. Upon Health Plan's request, Contracted Provider shall provide Health Plan with copies of agreement templates used by itself and other Providers with their subcontracted Providers, and (1) copies of the first page, signature page and other pages necessary to identify the contracting parties and effective date for each such agreement, or (2) copies of entire agreements between itself or other Providers and the subcontracted Providers. Compensation provisions in copies of such agreements may be redacted, except where compensation information is required by Governmental Authorities. In no event shall an agreement between or among Providers supersede this Agreement respecting matters covered by this Agreement. Notwithstanding anything to the contrary in any such agreement, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(b) Upon Health Plan's request, Contracted Provider shall provide Health Plan with a duly executed Opt In Agreement in the form set forth on the Attachment titled "Form of Opt-In Agreement" from the subcontracted Provider. Each executed Opt In Agreement shall be made a part of and incorporated into this Agreement, and Contracted Provider accepts the appointment in the Opt In Agreement to act on the subcontracted Provider's behalf. If Health Plan requests and does not receive a duly executed Opt In Agreement for a proposed subcontracted provider, Health Plan shall not approve the proposed subcontracted provider or its employed providers as Providers under this Agreement. Provider waives any non-compete provisions in its agreements with subcontracted Providers to the extent that, if enforced, would prohibit a subcontracted Provider from contracting directly with Health Plan pursuant to the Opt-In Agreement.

(c) Subcontracted Providers shall maintain and enforce binding internal policies and procedures or agreements with their employed Providers that are consistent with and require adherence to this Agreement. Subcontracted Providers shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of their employed Providers.

(d) Any obligation of Contracted Provider in this Agreement shall apply to subcontracted Providers to the same extent that it applies to Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by subcontracted Providers.

4.2.3. Credentialing. All Providers must meet the Credentialing Criteria. Subject to Laws and Program Requirements, (a) Health Plan conducts credentialing of providers before they begin

providing Covered Services and re-credentialing from time to time thereafter as required for Health Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Health Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Health Plan authorized Covered Services to Members by the provider shall be subject to Health Plan's policies and procedures for non-participating providers.

4.3. Covered Services. Providers shall provide Covered Services to Members, subject to and in accordance with the terms and conditions of this Agreement.

4.3.1. Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

4.3.2. Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Health Plan provides member eligibility information through Health Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility within 24 hours of the Member being stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Health Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Health Plan.

4.3.3. Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Health Plan may deny payment for Covered Services where a Provider fails to meet Health Plan's requirements for prior authorization.

4.3.4. Referrals. Providers shall not refer Members to other health care providers, including other Participating Providers, for Covered Services without the approval of Health Plan, except (a) in case of Emergency Services, (b) when Member self-referral is permitted by the Benefit Plan, or (c) as permitted in Provider Manual provisions regarding utilization management. When making a referral to another health care provider, a Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

4.3.5. Non-Covered Services. Every time a Provider provides items or services to a Member that are not Covered Services, before providing the items or services the Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider shall contact Health Plan for a coverage determination in any case where Provider is unsure if an item or service is a Covered Service.

4.3.6. Carve Out Agreements. If at any time during the term of this Agreement Health Plan has a Carve Out Agreement in place, for as long as such Carve Out Agreement is in effect Covered

Services subject to the Carve Out Agreement shall not be within the scope of Covered Services contracted for under this Agreement, except for (a) Emergency Services or (b) Covered Services authorized by Health Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Health Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Providers may enter into separate agreements with the third party Participating Provider designated by Health Plan to provide Covered Services to Members subject to a Carve Out Arrangement (“Carve Out Vendors”) and, except as set forth in this paragraph, the compensation in this Agreement shall not apply. Unless otherwise approved by Health Plan in its written notice to Contracted Provider, Providers who do not enter into a separate agreement with Carve Out Vendors will be treated as non-participating with Health Plan and Carve Out Vendor for Covered Services subject to the Carve Out Agreement. If a Carve Out Agreement expires or is terminated, Provider shall thereafter provide the Covered Services that were subject to the Carve Out Agreement to Members, subject to and in accordance with the terms and conditions of this Agreement, including compensation.

#### 4.4. Claims and Encounter Data / EDI.

4.4.1. Clean Claims. Providers shall electronically prepare and submit Clean Claims to Health Plan within one year or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Health Plan may deny payment for any claims that fail to meet Health Plan’s submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

4.4.2. Encounter Data. If Contracted Provider or other Provider is compensated by capitation, Contracted Provider shall, and shall require the other Providers to, electronically submit Encounter Data to Health Plan within 30 days of the last day of the month in which Covered Services were provided, or such shorter period necessary for Health Plan to comply with Laws or Program Requirements.

4.4.3. Additional Reports. If Health Plan requests additional information, data or reports from a Provider regarding Covered Services to Members for any reason, including for purposes of risk adjustment data validation, even if Health Plan has already paid claims or accepted Encounter Data related to the Covered Services, the Provider shall provide the information, data or reports as requested by Health Plan.

4.4.4. NPI Numbers / Taxonomy Codes. Providers shall give Health Plan their National Provider Identification (“NPI”) numbers and Provider taxonomy codes prior to becoming Participating Providers under this Agreement. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or encounter data submitted under this Agreement, and Health Plan may deny payment for Covered Services where a Provider fails to meet these requirements.

4.4.5. Electronic Transaction Requirements. Providers shall submit all claims and encounter data to Health Plan electronically. Providers shall (a) follow the requirements for electronic data interchange in the then current (1) HIPAA Administrative Simplification transaction standards and (2) WellCare Companion Guide, and (b) submit all claims and encounter data either through a clearinghouse used by Health Plan or directly to Health Plan in accordance with the WellCare Companion Guide.

4.4.6. EFT / Remittance Advice. If a Provider is able to accept payments and

remittance advice electronically, (a) the Provider shall register and complete the forms for electronic funds transfer and electronic remittance advice as soon as practicable, but no later than 60 days following Health Plan's confirmation of Provider's status as participating, and (b) Health Plan shall make all payments and remittance advice to the Provider electronically. If a Provider is not able to accept payments and remittance advice electronically, the Provider shall make good faith efforts to be able to accept electronic funds transfer and electronic remittance within 24 months of the Effective Date.

4.4.7. Coordination of Benefits. Health Plan shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and Laws. Providers shall provide Health Plan with electronic versions of explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's Benefit Plan. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then when not prohibited by Laws or Program Requirements, Health Plan's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Member Expenses. Unless prohibited by Laws and Program Requirements, Health Plan may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services.

4.4.8. Subrogation. Providers shall follow Health Plan policies and procedures regarding subrogation activity.

4.4.9. No payment made by Health Plan under this Agreement is intended as a financial incentive or inducement to reduce, limit or withhold Covered Services required by Members.

#### 4.5. Member Protections.

4.5.1. Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.

4.5.2. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the this Agreement, shall a Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall survive termination or expiration of this Agreement regardless of the cause giving rise to termination or expiration, (b) shall be construed for the benefit of Members, (c) does not prohibit collection of Member Expenses where lawfully permitted or required, and (d) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between a Provider and Members or persons acting on their behalf.

4.5.3. Regardless of any denial of a claim or reduction in payment to a Provider by Health Plan, in no event will a Member be responsible for payment for any Covered Services other than Member Expenses. However, Members shall not be responsible for Member Expenses where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement. If payment of an amount sought in a claim is denied or reduced by Health Plan, the Provider shall adjust Member Expenses accordingly.

4.5.4. Except where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement, a Provider shall (a) collect Member Expenses directly from the



Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements regarding prohibited inducements to Federal Health Care Program beneficiaries.

4.5.5. Providers shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements.

4.6. Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Health Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Health Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of material revisions to the Provider Manual, Health Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 30 days after such posting or notice, or as of such other time period required for Health Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Health Plan's provider website, and check for revisions to the Provider Manual from time to time.

4.7. Quality Improvement. Providers shall comply with Health Plan quality improvement programs, including those designed to improve quality measure outcomes in the then current Healthcare Effectiveness Data and Information Set (HEDIS) or other quality measures. Health Plan may audit Providers periodically and upon request Providers shall provide Records to Health Plan for HEDIS or other quality reasons and risk management purposes. Health Plan desires open communication with Providers regarding Health Plan's quality improvement initiatives and activities.

4.8. Bonus Programs. While there is no guarantee under this Agreement, Health Plan may offer certain Providers the opportunity to participate in bonus or incentive programs (" **Bonus Programs**"). If offered, a Bonus Program will be designed to promote preventive care, quality care or ensure the appropriate and cost effective use of Covered Services through appropriate utilization. Bonus Programs may be based in whole or part on Providers achieving certain quality benchmarks using HEDIS or some similar measure, achieving certain Member satisfaction, using electronic funds transfers and remittance or other objective criteria. If offered, Health Plan will set forth the specific terms and conditions of the Bonus Program in a separate policy and the Provider's participation shall be subject to the terms and conditions of this Agreement. Health Plan and Providers agree that no Bonus Program shall limit Medically Necessary services.

4.9. Utilization Management. Providers shall cooperate and participate in Health Plan's utilization review and case management programs. Health Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, (c) requirements regarding referrals to third party Participating Providers, including those that are party to Carve Out Agreements and (d) corrective action plans.

4.10. Member Grievances / Appeals. Providers shall comply with the Provider Manual, Laws and Program Requirements regarding Member grievances and appeals, including by providing information, records or documents requested by Health Plan and participating in the grievance/appeal process.

4.11. Compliance. In performing this Agreement, Providers shall comply with all Laws and Program Requirements. Providers shall (a) cooperate with Health Plan with respect to Health Plan's compliance with Laws and Program Requirements, including downstream requirements that are inherent

to Health Plan's responsibilities under Laws or Program Requirements, and (b) not knowingly take any action contrary to Health Plan's obligations under Laws or Program Requirements.

4.11.1. Privacy / HIPAA. Providers shall maintain Member information and medical records in accordance with Laws, including Federal and State Laws related to privacy and confidentiality of Member information and medical records, including HIPAA, and shall use and disclose such information or records only in accordance with Laws and Program Requirements.

4.11.2. Fraud, Waste and Abuse. Providers shall comply with Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

4.11.3. Accreditation. Providers shall comply with policies and procedures required for Health Plan to obtain or maintain its accreditation from accreditation bodies, including the National Committee for Quality Assurance or Utilization Review Accreditation Commission.

4.11.4. Compliance Program / Reporting. OIG publishes compliance program guidance for health care firms available at <http://oig.hhs.gov/fraud/complianceguidance.asp>. Contracted Provider shall, and shall require its employees and its subcontractors and their employees to, comply with Health Plan compliance program requirements, including Health Plan's compliance training requirements, and to report to Health Plan any suspected fraud, waste, or abuse or criminal acts by Health Plan, Contracted Provider, other Providers, their respective employees or subcontractors, or by Members. Reports may be made anonymously through the We llCare fraud hotline at (866) 678- 8355. Also, if DHHS publishes compliance program requirements that providers must follow as a condition of participation in Federal Health Care Programs, Contracted Provider shall, and shall require its subcontractors to, comply with such requirements.

4.11.5. Acknowledgement of Federal Funding. Claims, data and other information submitted to Health Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Providers receive under this Agreement may be, in whole or in part, from Federal funds.

(a) Providers shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful.

(b) Providers shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as Federally qualified health centers ("FQHCs") or rural health clinics ("RHCs") where applicable.

4.11.6. Ineligible Persons. Contracted Provider warrants and represents as of the Effective Date and throughout the term of the Agreement and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its Principals or any individual or entity it employs or has contracted with to carry out its part of this Agreement is an Ineligible Person.

4.11.7. Compliance Audit. Health Plan shall be entitled to audit Providers with respect

to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. Providers shall cooperate with Health Plan with respect to any such audit, including by providing Health Plan with Records and site access within such time frames as requested by Health Plan.

4.11.8. Fines / Penalties. The following applies if Provider is capitated or Health Plan has delegated activities to Provider pursuant to a separate delegation addendum: Provider shall reimburse Health Plan for any fines, penalties or costs of corrective actions required of Health Plan by Governmental Authorities caused by Provider's failure to comply with Laws or Program Requirements, including failure to submit accurate encounters on a timely basis or to properly perform delegated functions.

4.12. Licensure. Providers shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by them to perform their obligations under this Agreement. As required by Program Requirements, Providers shall meet the conditions of participation and be enrolled in applicable Federal Health Care Programs (including for dual eligible special needs plan Members, both Medicare and Medicaid) and have all accreditations necessary to meet such conditions of participation.

4.13. Insurance. Contracted Provider and its subcontracted Providers shall secure and maintain for themselves and their employees, commercial general liability and professional liability (malpractice) insurance or self insurance coverage for claims arising out of events occurring during the term of this Agreement and any post expiration or termination activities under this Agreement, in amounts required to meet Credentialing Criteria, and worker's compensation insurance as required by State Laws. Contracted Provider and its subcontracted Providers shall, upon request of Health Plan, provide Health Plan with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph. Contracted Provider and the subcontracted Providers shall provide at least 30 days prior notice to Health Plan in advance of any material modification, cancellation or termination of their insurance.

4.14. Proprietary Information. In connection with this Agreement, Health Plan or its Affiliates may disclose to Providers, directly or indirectly, certain information that Health Plan or its Affiliate have taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public ("**Proprietary Information**"). Proprietary Information includes Member lists, the compensation provisions of this Agreement, and other information relating to Health Plan's or its Affiliates' business that is not generally available to the public. Contracted Provider shall, and shall require its subcontractors to, hold in confidence and not disclose any Proprietary Information and not use Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by Laws or legal or regulatory process. Contracted Provider shall, and shall require its subcontractors to, provide Health Plan with prior notice of any such disclosure required by Laws or legal or regulatory process so that Health Plan can seek an appropriate protective order. Contracted Provider shall, and shall require its subcontractors to, disclose Proprietary Information only in order to perform their obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of the Proprietary Information. The requirements of this Agreement regarding Proprietary Information shall survive expiration or termination of this Agreement.

4.15. Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall give notice to Health Plan within two business days of the occurrence of any event that could reasonably be expected to impair the ability of a Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of a Provider to be inaccurate, (b)

a Provider fails to maintain insurance as required by this Agreement, (c) a Provider's license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) a Provider is excluded, suspended or debarred from, or sanctioned under a Federal Health Care Program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) where applicable, a Provider's hospital privileges are suspended, limited, revoked or terminated, (g) a grievance or legal action is filed by a Member concerning a Provider, (h) a Provider is under investigation for fraud or a felony, or (i) a Provider enters into a settlement related to any of the foregoing.

## 5. Health Plan Responsibilities.

5.1. ID Cards. Health Plan shall issue identification cards to Members and instruct them to present their cards to providers when seeking health care items and services.

5.2. Claims Processing. Health Plan shall pay or deny Clean Claims within the time period set forth in Attachment C. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines, and state specific regulations. These software programs may result in claim edits for specific procedure code combinations.

5.3. Compensation. Compensation shall be as set forth in Attachment C. Providers shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs where applicable) as payment in full for Covered Services rendered to Members and all other activities of Providers under this Agreement. Items and services constituting “**never events**” as described in the Provider Manual shall not be paid. Health Plan shall not pay for Non-Contracted Services.

5.4. Medical Record Review. Health Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Health Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary).

5.5. Recoupment. Unless otherwise prohibited by Laws, Contracted Provider, for itself and the other Providers, authorizes Health Plan to deduct from amounts that may otherwise be due and payable to a Provider any outstanding amounts that the Provider may owe Health Plan for any reason, including Overpayments, in accordance with its recoupment policy and procedure. “**Overpayment**” for purposes of this Agreement means any funds that a Provider receives or retains to which the Provider is not entitled, including overpayments (a) for items and services later determined not to be Covered Services, (b) due to erroneous or excess reimbursement, (c) resulting from errors and omissions relating to changes in enrollment, claims payment errors, data entry errors or incorrectly submitted claims, or (d) for claims paid when Health Plan was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Health Plan makes which is the obligation of and not paid by a Provider, including for improperly collected Member Expenses due a Member. Prior to deducting Overpayments, Health Plan shall provide the Provider notice in accordance with Health Plan's recoupment policy that an offset will be performed against future payments unless the Provider within such notice period either refunds or repays such amounts or provides Health Plan with a written explanation, with supporting documentation, disputing that such amounts should be refunded or repaid. If there are no future payments to offset, then the Provider shall repay Overpayments to Health Plan within 30 days, or such other time frame as may be mandated by Laws or Program Requirements, of

the Provider's receipt of notice of such Overpayment. Health Plan agrees not to seek repayment of an Overpayment from a Provider beyond the time period set forth in Health Plan's recoupment policy, unless a longer time is required by Laws or Program Requirements. Notwithstanding the above, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud. This section shall survive expiration or termination of this Agreement.

5.6. Suspension of Payment. If DHHS suspends payments to a Provider while Governmental Authorities investigate a credible allegation of fraud (as determined by DHHS), then Health Plan may suspend the Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments.

5.7. Health Plan Designees. Health Plan may delegate administrative functions related to Benefit Plan management to third parties. Provider shall cooperate with any Health Plan designee performing administrative functions for Health Plan to the same extent that it is required to cooperate with Health Plan.

5.8. Health Plan License. Health Plan is and will remain properly licensed and/or accredited in accordance with Laws.

5.9. Insurance. Health Plan shall maintain such policies of general and professional liability insurance in accordance with Laws and to insure Health Plan against claims regarding Health Plan operations and performance under this Agreement.

## 6. Records, Access & Audits.

6.1. Maintenance. Contracted Provider shall, and shall cause its subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data and other documentation related to the Covered Services provided to Members, claims filed and other services and activities conducted under this Agreement ("**Records**"). Contracted Provider shall ensure that such Records are kept in accordance with Laws, Program Requirements, generally accepted accounting principles (as applicable) and prudent record keeping practices and are sufficient to enable Health Plan to enforce its rights under this Agreement, including this section, and to determine whether Contracted Provider and its subcontractors and their respective employees are performing or have performed Contracted Provider's obligations in accordance with this Agreement, Laws and Program Requirements. Contracted Provider shall, and shall cause its subcontractors to, maintain such Records for the time period set forth in the applicable Program Attachment governing the Benefit Plan. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

6.2. Access & Audit. Health Plan shall have the right to monitor, inspect, evaluate and audit Contracted Provider and its subcontractors. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause its subcontractors to, provide Health Plan with access to all Records, personnel, physical facilities, equipment and other information necessary for Health Plan or its auditors to conduct the audit. Within three business days of Health Plan's written request for Records, or such shorter time period required for Health Plan to comply with requests of Governmental Authorities, Contracted Provider shall, and shall cause its subcontractors to, compile and prepare all such Records and furnish such Records to Health Plan in a format reasonably requested by Health Plan. Copies of such Records shall be at no cost to Health Plan.

6.3. The requirements of this Agreement regarding Records, access and audit shall survive expiration or termination of this Agreement.

7. Term and Termination.

7.1. Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least 90 days before the end of the then current (initial or renewal) term, unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

7.2. Termination.

7.2.1. Termination for Convenience. Either Party may terminate this Agreement, in whole or with respect to any particular Program or Benefit Plan, at any time for any reason or no reason upon 90 days prior notice to the other. Health Plan may terminate this Agreement as to any particular Provider at any time for any reason or no reason upon 90 days prior notice to Contracted Provider.

7.2.2. Termination for Cause.

(a) A Party may terminate this Agreement for material breach by the other Party of any of the terms or provisions of this Agreement by providing the other Party at least 90 days prior notice specifying the nature of the material breach. During the first 60 days of the notice period, the breaching Party may cure the breach to the reasonable satisfaction of the non-breaching Party.

(b) Health Plan may terminate this Agreement as to a particular Provider for a material failure by the Provider to comply with any of the terms or provisions of this Agreement by providing Contracted Provider at least 90 days prior notice specifying the nature of the material failure. During the first 60 days of the notice period, the affected Provider may cure the material failure to the reasonable satisfaction of Health Plan.

7.2.3. Immediate Termination. Health Plan may terminate this Agreement in its entirety, or with respect to a particular Provider, upon immediate notice to Contracted Provider upon the occurrence of any of the following: (a) termination is necessary for health and safety of Members, (b) a Provider suffers the loss, suspension or restriction of a license from a Governmental Authority or accreditation from an accreditation body required to carry out its obligations under this Agreement, including meeting the conditions of participation in applicable Programs, (c)(1) Contracted Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, or (2) another Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, and is not immediately terminated by Contracted Provider, (d) a Governmental Authority orders Health Plan to terminate the Agreement, (e) Health Plan reasonably determines or a Governmental Authority determines or advises that a Provider is engaging or has engaged in fraud or abuse, or has submitted a false claim, (f) a Provider fails to meet Credentialing Criteria, (g) a Provider fails to maintain insurance as required by this Agreement, (h) a Provider undergoes a change of control that is not acceptable to Health Plan, or (i) a Provider becomes insolvent, is adjudicated as bankrupt, has its business come into possession or control of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of its creditors.

7.2.4. Transition of Care. To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third

trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and conditions of this Agreement shall apply to any such post expiration or termination activities, provided that notwithstanding any compensation provisions of this Agreement, Health Plan shall pay Providers for such Covered Services at 100 percent of Health Plan's then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

7.2.5. Notification to Members. Upon expiration or termination of this Agreement, Health Plan will communicate such expiration or termination to Members as required by and in accordance with Laws and Program Requirements. Providers shall obtain Health Plan's prior written approval of Provider communications to Members regarding the expiration or termination of this Agreement. The foregoing sentence shall not prevent a Provider from engaging in communications with his patient regarding the patient's health.

## 8. Dispute Resolution.

8.1. Provider Administrative Review and Appeals. Where applicable, a Provider shall exhaust all Health Plan's review and appeal rights in accordance with the Provider Manual before seeking any other remedy. Where required by Laws or Program Requirements, administrative reviews and appeals shall be subject to and resolved in accordance with administrative law.

8.2. Except as prohibited by State Laws, all claims and disputes between Health Plan and a Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute, except for claims based on fraud, which must be brought within the State statute of limitation governing fraud claims. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

8.3. Negotiation. Before a Party initiates arbitration regarding a claim or dispute under this Agreement, the Parties shall meet and confer in good faith to seek resolution of the claim or dispute. If a Party desires to initiate the procedures under this section, the Party shall give notice (a "**Dispute Initiation Notice**") to the other providing a brief description of the nature of the dispute, explaining the initiating Party's claim or position in connection with the dispute, including relevant documentation, and naming an individual with authority to settle the dispute on such Party's behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a "**Dispute Reply**") to the initiating Party providing a brief description of the receiving Party's position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 30 days after the Parties have commenced discussions regarding the dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein.

8.4. Arbitration. Except as barred or excepted by this Agreement, all claims and disputes between the Parties shall be resolved by binding arbitration in Louisville, Kentucky. The arbitration shall be conducted through the American Arbitration Association ("**AAA**") pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following: Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form in accordance with the Commercial Arbitration Rules setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the demand to the opposing Party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than \$10 million, in which case it will be held before a panel of three

arbitrators. In a case with a single arbitrator, the Parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the Parties are unable to agree on the selection of an arbitrator within such time, AAA shall select an independent arbitrator. In the case of a panel, within 30 days of the date the Demand for Arbitration is filed each Party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within such time, AAA shall select an independent third arbitrator. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the Parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Each Party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the Parties.

9. Miscellaneous.

9.1. Governing Law / Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Kentucky, except where Federal law applies, without regard to principles of conflict of laws. Each of the Parties hereby agrees and consents to be subject to the exclusive jurisdiction and venue of the appropriate State or Federal court located in Jefferson County, Kentucky, in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement.

9.2. Waiver of Jury Trial. Each Party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

9.3. Equitable Relief. Notwithstanding anything in this Agreement, either Party may bring court proceedings to seek an injunction or other equitable relief to enforce any right, duty or obligation under this Agreement.

9.4. Independent Contractors. The Parties are independent contractors. This Agreement shall not be deemed to create a partnership or joint venture, or an employment or agency relationship between the Parties. Neither Party has the right or authority to assume or create any obligation or responsibility on behalf of the other. Neither Party is liable for the acts of the other.

9.5. No Steering. For the term of this Agreement and for one year thereafter, Providers shall not engage in steering or otherwise directly or indirectly solicit any Member to join a competing health plan or induce any Member to cease doing business with Health Plan.

9.6. No Offshore Contracting. No work related to this Agreement may be performed outside of the United States without Health Plan's prior written consent.

In addition, the following applies to State plans: Contracted Provider shall not, and shall require its subcontractors not to, make any payments for items or services provided under a State plan to financial institutions or entities such as provider bank accounts or business agents located outside of the States. Further Contracted Provider shall not, and shall require its subcontractors not to, make payments to telemedicine providers located outside of the States, or payments to pharmacies located outside of the States. Any such funds paid may be recovered by Health Plan or a State Governmental Authority with applicable jurisdiction over a plan.

9.7. Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a



third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

9.8. Notices. Except for non-material revisions to the Provider Manual, all notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile or (e) email, to the addresses of the Parties as set forth on the signature page. Each Party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery. Notice to Contracted Provider shall constitute notice to all Providers. Routine day to day operational communications between the Parties are not notices in accordance with this section.

9.9. Incorporation of Laws / Program Requirements / Accreditation Standards. All terms and conditions of this Agreement are subject to Laws, Program Requirements and accreditation standards. Any term, condition or provision now or hereafter required to be included in the Agreement by Laws, Program Requirements or accreditation standards shall be deemed incorporated herein and binding upon and enforceable against the Parties, regardless of whether or not the term, condition or provision is expressly stated in this Agreement. Health Plan may amend this Agreement upon notice to Contracted Provider to comply with Laws, Program Requirements or accreditation standards, and such amendment shall be effective upon receipt.

9.10. Amendment. Except as otherwise set forth in this Agreement, any amendments to this Agreement shall be in writing and signed by both Parties. However, Health Plan may amend this Agreement upon 30 days prior notice to Contracted Provider, and if Contracted Provider objects to the amendment, Contracted Provider shall notify Health Plan of the objection within the 30 day notice period, and Health Plan may terminate this Agreement for convenience in accordance with this Agreement.

9.11. Assignment. Contracted Provider may not assign, delegate or transfer this Agreement, in whole or in part, without the prior written consent of Health Plan. Health Plan may assign this Agreement, in whole or in part, to any purchaser of the assets or successor to the operations of Health Plan or its Affiliate. As used in this section, the term “**assign**” or “**assignment**” includes a change of control of a Party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such Party.

9.12. Name, Symbol and Service Mark. The Parties shall not use each other's name, symbol, logo, or service mark for any purpose without the prior written approval of the other. However, (a) Providers may include Health Plan's or Benefit Plan names in listings of health plans the providers participate in, and (b) Health Plan may use information about Providers in information or publications identifying Participating Providers or as required by Laws or Program Requirements. Providers shall provide comparable treatment to Health Plan as provided to other managed care organizations with respect to marketing or the display of cards, plaques or other logos provided by Health Plan to identify Participating Providers to Members.

9.13. Other Agreements. If a Provider participates as a Participating Provider under more than one agreement with Health Plan for a particular Program, Health Plan will compensate the Provider for Covered Services it provides to Members of Benefit Plans in that Program under the agreement selected by Health Plan.

9.14. Health Plan Affiliates. If a Provider renders covered services to a member of a benefit plan issued or administered by a Health Plan Affiliate, the Health Plan Affiliate may pay for such covered services, and the Provider shall accept, the lowest fee for service rates set forth in this Agreement. A list

of Health Plan Affiliates is available in the Provider Manual or on Health Plan's provider website. There shall be no joint liability between or among Health Plan and its Affiliates.

9.15. Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Health Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

9.16. Severability. When possible, each provision of this Agreement shall be interpreted in such manner as to be effective, valid and enforceable under Laws. If any provision of this Agreement is held to be prohibited by, or invalid or unenforceable under Laws, such provision shall be ineffective only to the express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

9.17. Waiver. No waiver shall be effective unless in writing and signed by the waiving Party. A waiver by a Party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

9.18. Entire Agreement. This Agreement, including the Attachments each of which are made a part of and incorporated into this Agreement, the Provider Manual and any addenda or amendments comprises the complete agreement between the Parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

9.19. Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

9.20. Interpretation. Both Parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a Party's favor on the basis that the other Party drafted the provision containing the ambiguity.

9.21. Survival. Any provision of this Agreement, including an Attachment, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

9.22. Rights Cumulative. Except as set forth herein, all rights and remedies of a Party in this Agreement are cumulative, and in addition to all legal rights and remedies available to such Party.

9.23. Counterparts / Electronic Signature. This Agreement may be executed in any number of counterparts. The exchange of copies of this Agreement and of signature pages by facsimile transmission or electronic mail shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes.

9.24. Warranties and Representations. Each Party warrants and represents, as of the Effective Date and continuously thereafter throughout the entire term of this Agreement and during the post expiration or termination transition period described herein, as follows:

9.24.1. The Party is a corporation or other legally recognized entity duly incorporated or organized, validly existing and in good standing under the laws of the State in which it is incorporated, organized or operating and it has the authority to transact business in each State in which it operates.

9.24.2. The Party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

9.24.3. This Agreement has been duly executed and delivered by the Party, and constitutes a legal, valid, and binding agreement that is enforceable against such Party in accordance with its terms, except as limited by applicable bankruptcy, reorganization, moratorium and similar Laws affecting the enforcement of creditors' rights.

9.24.4. The execution and delivery of this Agreement and the performance of the Party's obligations hereunder do not (a) conflict with or violate any provision of the Party's organizational documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the Party.

SIGNATURE PAGE FOLLOWS

**SIGNATURE PAGE**

**IN WITNESS WHEREOF**, the undersigned, with t he intent to b e legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

**WellCare Health Insurance of Illinois, Inc. d/b/a WellCare of Kentucky      Contracted Provider:**

By: \_\_\_\_\_

By: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

Notice Address:

Notice Address:

WellCare Health Insurance of Illinois, Inc. d/b/a  
WellCare of Kentucky  
P.O. Box 437000

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Louisville, KY 40253

Attn: Network Management

Attn:

Fax: 877-338-3745

Fax:

E-mail: KentuckyProject@wellcare.com

Email:

Revision # 08-11

**ATTACHMENT A**  
**PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES / INFORMATION**

**(See following attachments)**

**ATTACHMENT A-1**  
**PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES**  
**(IPA / PHYSICIAN GROUP / PHYSICIAN / NURSE PRACTITIONER)**

1. Additional Definitions.
  - a. **“Assigned Member”** means a Member who selects or is assigned by Health Plan to a Primary Care Provider as the Member’s primary care provider.
  - b. **“Physician”** means a Provider who is a doctor of medicine or osteopathy.
  - c. **“Primary Care Provider”** means a Physician, nurse practitioner, certified nurse midwife or other duly licensed Provider who spends the majority of his clinical time providing Primary Care Services to patients, and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.
  - d. **“Primary Care Services”** means health care items or services available from Primary Care Providers within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.
  - e. **“Specialty Provider”** means a Provider who provides Specialty Provider Services.
  - f. **“Specialty Provider Services”** means health care items and services within the scope of a particular medical specialty.
2. Subject to and in accordance with the terms and conditions of this Agreement, Contracted Provider shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications. Contracted Provider shall be responsible to ensure that (a) Primary Care Providers provide Primary Care Services to Members, including their Assigned Members, and (b) Specialty Providers provide Specialty Provider Services to Members upon appropriate referral.
3. If a Provider provides or arranges for the provision of Primary Care Services to Assigned Members:
  - a. The Provider shall have primary responsibility for arranging and coordinating the overall health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Providers and appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan, and (ii) managing and coordinating the performance of administrative

functions relating to the delivery of Covered Services to Assigned Members.

- b. The Provider shall ensure Primary Care Providers make all reasonable efforts to (i) establish satisfactory physician-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.
4. If a Provider provides or arranges for the provision of Specialty Provider Services, the Provider shall ensure that Specialty Providers (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Provider on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Provider when scheduling a hospital admission or other procedure requiring the Primary Care Provider's approval.
5. Except for Emergency Services: When a Member requires a hospital admission by a Primary Care Provider or other Provider that the Primary Care Provider has referred a Member to, the Primary Care Provider shall, or shall arrange for the other Provider to, secure authorization for such admission from Health Plan prior to the admission. Providers shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.
6. Subject to Laws and Program Requirements regarding provider to patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Contracted Provider shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.
7. Primary Care Providers will accept the minimum number of Members required by Laws and Program Requirements at each Primary Care Provider location prior to giving notice of the closure of the physician's site to Members. This requirement shall not be construed as a guarantee that Health Plan will refer or assign a minimum number of Members to, or maintain a minimum number of Members with, any Provider under this Agreement.

**ATTACHMENT A-2**  
**INFORMATION FOR CONTRACTED PROVIDER / PRINCIPALS**

1. Contracted Provider is a:

- Sole Proprietor
- Corporation
- Partnership
- Limited Liability Company
- Professional Association

2. The Principals of Contracted Provider are:

NAME	ADDRESS	PERCENT OWNERSHIP	TITLE	DATE



**ATTACHMENT A-3**  
**INFORMATION FOR PROVIDERS**

Contracted Provider shall provide the following information for (1) Contracted Provider, (2) each other Provider and (3) each of their respective medical facilities:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Completed sample CMS 1500 form or UB-04 claim form
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation “E” for employed or “C” for subcontracted.
- For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation “E” for employed or “C” for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person

**ATTACHMENT A-4  
FORM OF OPT IN AGREEMENT  
(SUBCONTRACTED PROVIDER)**

**THIS OPT IN AGREEMENT (“Opt In Agreement”)** is made by and between Health Plan and the subcontracted Provider identified below (“**Subcontractor**”).

WHEREAS, Health Plan and Contracted Provider (as defined in the PPA) are Parties to the Participating Provider Agreement (as now or hereafter amended, the “PPA”); and

**WHEREAS**, Subcontractor is a subcontracted Provider under the PPA and will receive substantial benefits from the PPA;

**NOW, THEREFORE**, in consideration of those benefits and Health Plan entering into the PPA and this Opt In Agreement, Subcontractor agrees to the following:

1. Subcontractor has reviewed the PPA. The PPA is made a part of and incorporated into this Opt In Agreement. Capitalized terms not defined in this Opt In Agreement have the same definition as given in the PPA.
2. Subcontractor agrees to the terms and conditions of the PPA. Wherever in the PPA an action is required to be taken by Contracted Provider or a Provider, Subcontractor agrees to perform such action. Wherever in the PPA any representation or warranty is made by Contracted Provider or a Provider, Subcontractor agrees to comply with such representation or warranty.
3. Any obligation of Subcontractor in this Opt In Agreement or the PPA shall apply to Subcontractor’s Providers to the same extent that it applies to Subcontractor. Subcontractor shall maintain and enforce internal policies and procedures or written agreements with its employed Providers that are consistent with and require adherence to the terms and conditions of this Opt In Agreement and the PPA. Subcontractor has the authority to bind its subcontracted Providers to this Opt In Agreement and PPA, and shall require the timely and faithful performance of this Opt In Agreement and the PPA by its subcontracted Providers.
4. Subcontractor hereby grants to Contracted Provider a power of attorney, coupled with an interest, to represent and bind Subcontractor in connection with all matters related to the PPA and this Opt In Agreement including granting any waivers of any of the terms of the PPA and this Opt In Agreement, and entering into any amendments or modifications of the PPA or this Opt In Agreement.
5. Subcontractor shall not assign any of its rights or delegate any of its duties or obligations under this Opt In Agreement or the PPA, in whole or in part, without the prior written consent of Health Plan.
6. If the PPA is terminated for any reason or Contracted Provider goes out of business, ceases operations or becomes insolvent, then (a) for at least six months Subcontractor shall continue to provide Covered Services to Members, subject to and in accordance with the terms and conditions of the PPA and this Opt In Agreement, (b) Health Plan shall pay Subcontractor for such Covered Services at the fee for service rates set forth in the PPA for the applicable Benefit Plans or, if the PPA does not include fee for service rates, at 100 percent of Health Plan’s then current fee for service rates for the applicable Benefit Plans, (c) Health Plan may terminate Subcontractor’s participation in one or more Programs or Benefit Plans upon notice to Subcontractor, and (d) after six months, Subcontractor may terminate its continuing participation under the PPA and this Opt-In Agreement upon 90 days prior notice to Health Plan.

7. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the PPA or this Opt In Agreement, shall Subcontracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall be construed for the benefit of Members, (b) does not prohibit collection of Member Expenses where lawfully permitted or required, and (c) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Subcontracted Provider and Members or persons acting on their behalf.
8. This Opt In Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Kentucky, except where Federal law applies, without regard to principles of conflict of laws.
9. Any dispute with respect to this Opt In Agreement or the PPA or Subcontractor's performance under this Opt In Agreement or PPA shall be subject to and resolved in accordance with the dispute resolution procedures in the PPA.
10. Subcontracted Provider warrants and represents that the Providers listed on the attached schedule are included in and subject to this Opt In Agreement.

**WellCare Health Insurance of Illinois, Inc. d/b/a WellCare of Kentucky**      **Subcontractor:**

By: \_\_\_\_\_

By: \_\_\_\_\_

Print Name: \_\_\_\_\_

Print Name: \_\_\_\_\_

Title: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Date: \_\_\_\_\_

**OPT IN AGREEMENT  
SCHEDULE OF PROVIDERS**

The following Providers are included in and subject to the attached Opt In Agreement and the PPA (attach additional sheets as necessary):

Name: \_\_\_\_\_ Date: \_\_\_\_\_

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**ATTACHMENT B  
PROGRAM ATTACHMENTS**

**(See following attachments)**

**ATTACHMENT B-1  
KENTUCKY MEDICAID AND CHIP  
PROGRAM ATTACHMENT**

1. Participation in Kentucky Contracts. Subject to and in accordance with the terms and conditions of the Agreement, including this Attachment, Contracted Provider shall participate in Benefit Plans offered or administered by Health Plan under Kentucky Contracts (as defined below).
2. Compensation for Covered Services provided to Members of Benefit Plans under Kentucky Contracts is set forth in Attachment C.
3. Additional Definitions.
  - a. “**Cabinet**” means the Kentucky Cabinet for Health and Family Services.
  - b. “**Commonwealth**” or “**State**” means the Commonwealth of Kentucky.
  - c. “**Department**” means Cabinet’s Department for Medicaid Services.
  - d. “**Emergency Medical Condition**” means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. [907 KAR 1:320(7)]
  - e. “**Emergency Services**” or “**Emergency Care**” means (i) covered inpatient and outpatient services furnished by a qualified provider that are needed to evaluate or stabilize an emergency medical condition that is found to exist using the prudent layperson standard; or (ii) emergency ambulance transport. [907 KAR 1:320(6)]
  - f. “**Finance**” means the Kentucky Cabinet for Finance and Administration.
  - g. “**Kentucky Contract**” means a contract between the Commonwealth and Health Plan for Health Plan to provide or arrange for the provision of health care items and services to enrollees in the Kentucky managed care programs for Medicaid or CHIP, as amended from time to time, including any requests for proposal issued by the Commonwealth and incorporated into such a contract, including RFP 758 1100000276 (“**RFP**”), as amended from time to time. A Kentucky Contract is a Government Contract as defined in the Agreement.
  - h. Items and services that are “**Medically Necessary**” or a “**Medical Necessity**” are those that are (i) reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy; (ii) appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice; (iii) provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons; (iv) provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided; (v) needed, if used in reference to an emergency medical service, to exist using the prudent layperson standard; (vi) provided in accordance with early and periodic screening, diagnosis, and treatment (EPSDT) requirements established in Federal laws and regulations for

individuals under twenty-one (21) years of age; and (vii) sufficient in amount, duration, and scope to reasonably achieve its purpose, subject to appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. [907 KAR 3:130(2)(1)(b); 907 KAR 1:320(13)]

- i. **“Member”** means an individual enrolled in a Benefit Plan issued by Health Plan pursuant to a Kentucky Contract.
4. All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Program described in this Attachment except to the extent a provision of the Agreement exceeds the minimum requirements of the Attachment. Any obligation of Contracted Provider in this Attachment shall apply to Providers to the same extent that it applies to Contracted Provider.
  5. Emergency Services. Providers shall not be required to seek prior authorization for Emergency Care before the Member has been stabilized. Once a Member who receives Emergency Care is stabilized, Providers shall seek prior authorization for post-stabilization care services for the Member in accordance with the Provider Manual.
  6. Kentucky Statutory Requirements.
    - a. Member Hold Harmless. Provider may not, under any circumstance, including: (i) nonpayment of moneys due the Provider by Health Plan, (ii) insolvency of Health Plan, or (iii) breach of the provider agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member, dependent of a Member, or any persons acting on their behalf, for services provided in accordance with the provider agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services. [KRS § 304.17A-527(1)(a)]
    - b. Continuity of Care. If an agreement between Provider and Health Plan is terminated for any reason, other than a quality of care issue or fraud, Provider shall continue to provide services and Health Plan shall continue to reimburse Provider in accordance with the agreement until the Member or dependent of the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the agreement is terminated. [KRS § 304.17A-527(1)(b)]
    - c. Survivorship. The foregoing hold harmless clause and continuity of care clause shall survive the termination of the Agreement. [KRS § 304.17A-527(1)(c)]
    - d. Health Plan will, upon request of Provider, provide or make available to Provider, when contracting or renewing an existing contract with Provider, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under the contract for Provider’s services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of the amendment pursuant to KRS § 304.17A-577. [KRS § 304.17A-527(1)(d)]
    - e. If Provider enters into any subcontract agreement with another Provider to provide their licensed health care services to a Member or dependent of the Member of Health Plan where the

subcontracted Provider will bill Health Plan or Member directly for the subcontracted services, the subcontract agreement must meet all requirements of KRS subtitle 304.17A and all such subcontract agreements shall be filed with the commissioner in accordance with this paragraph. [KRS § 304.17A-527(1)(e)]

- f. As used in this section, unless the context requires otherwise: (1) “material change” means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider’s payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider’s administrative expense; and (2) “participating provider” means a physician licensed under KRS Chapter 311, an advanced practice registered nurse licensed under KRS Chapter 314, a psychologist licensed under KRS Chapter 319, or an optometrist licensed under KRS Chapter 320 that has entered into an agreement with an insurer to provide health care services.
  - i. If Health Plan makes a material change to an agreement it has entered into with a participating provider for the provision of health care services, Health Plan shall provide the participating provider with at least ninety (90) days’ written notice of the material change. The notice shall include a description of the material change and a statement that the participating provider has the option to withdraw from the agreement prior to the material change becoming effective pursuant to the following paragraph of this section.
  - ii. A participating provider who opts to withdraw following notice of a material change pursuant to the foregoing paragraph of this section shall send written notice of withdrawal to Health Plan no later than forty-five (45) days prior to the effective date of the material change.
  - iii. If Health Plan makes a change to an agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, Health Plan shall provide notice of the change to the participating provider at least fifteen (15) days prior to the change. [KRS § 304.17A-578]

7. Kentucky Contract Requirements. [Cites are to applicable sections of Kentucky Contract]

- a. Neither Provider, nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over the Provider or who directly or indirectly conducts the day-to-day operation of Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the Balanced Budget Act or under a Commonwealth health care program. [4.6]
- b. Provider shall comply with the requirements of 42 CFR 438, as applicable. [5.3F]
- c. During the term of this Agreement, Provider agrees as follows:
  - i. Provider will not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. Provider will take affirmative action to ensure



- that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.
- ii. Provider will, in all solicitations or advancements for employees placed by or on behalf of the contractor, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.
  - iii. Provider will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of the Provider's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.
  - iv. Provider will comply with all applicable provisions of Executive Order No. 11246 of September 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.
  - v. Provider will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.
  - vi. In the event of Provider's noncompliance with the nondiscrimination clauses of this Agreement or with any of such rules, regulations, or orders, this Agreement may be cancelled, terminated, or suspended in whole or in part and Provider may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.
  - vii. Provider will include the provisions of this section 7(c) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. Provider will take such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance: Provided, however, that in the event Provider becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, Provider may request the United States to enter into such litigation to protect the interests of the United States.  
[6.3]
- d. The Equal Employment Opportunity Act of 1978, KRS 45.560 – 45.640 applies to all State government projects with an estimated value exceeding \$500,000. Provider shall comply with all terms and conditions of the Act. [6.3G]

- e. Provider shall comply with the following laws:
  - i. Title VI of the Civil Rights Act of 1964 (Public Law 88-352);
  - ii. Rules and regulations prescribed by the United States Department of Labor in accordance with 41 CFR Part 60-741; and
  - iii. Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112). [6.4]
- f. Access to Premises.
  - i. Upon reasonable notice, Provider shall allow duly authorized agents or representatives of the Commonwealth or federal government or the independent external quality review organization required by Section 1902(a)(30)(c) of the Social Security Act, 42 U.S. Code Section 1396a(a)(30), access to the Provider's premises during normal business hours to inspect, audit, investigate, monitor or otherwise evaluate the performance of the Provider and/or its subcontractors. Provider and/or its subcontractors shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.
  - ii. In the event right of access is requested under this section, the Provider or subcontractor shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the Commonwealth, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of the Provider's or its subcontractors' activities. Provider will be given twenty (20) business days to respond to any findings of an audit made by Finance, the Department or their agent before the findings are finalized. Provider shall cooperate with Finance, the Department or their agent as necessary to resolve audit findings. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations. [6.6]
- g. Hold Harmless Provisions.
  - i. Provider will indemnify, defend and hold harmless the Commonwealth, its officers, agents, and employees, and each and every Member from any liability whatsoever arising in connection with this Agreement for the payment of any debt of or the fulfillment of any obligation of the Provider.
  - ii. Provider further covenants and agrees that in the event of a breach of this Agreement by the Health Plan, termination of this Agreement, or insolvency of the Health Plan, Provider shall provide all services and fulfill all of its obligations pursuant to this Agreement for the remainder of any month for which the Department has made payments to the Health Plan, and shall fulfill all of its obligations respecting the transfer of Members to other providers, including record maintenance, access and reporting requirements all such covenants, agreements, and obligations of which shall survive the termination of the Kentucky Contract and this Agreement. [7.1]
- h. The Commonwealth is the intended third-party beneficiary of this Agreement and, as such, the Commonwealth is entitled to all remedies entitled to third-party beneficiaries under law. [7.21]

- i. Provider shall submit encounter records in the format specified by the Department so that Health Plan can meet the Department's specifications required by the Kentucky Contract. [7.2J]
- j. This Agreement incorporates all provisions of the Kentucky Contract to the fullest extent applicable to the service or activity to be performed under the Agreement, including without limitation, the obligation to comply with all applicable federal and Commonwealth law and regulations, including but not limited to, KRS 205.8451-8483, all rules, policies and procedures of Finance and the Department, and all standards governing the provision of Covered Services and information to Members, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information, all rights of Finance, the Department, the Office of the Inspector General, the Attorney General, Auditor of Public Accounts and other authorized federal and Commonwealth agents to inspect, investigate, monitor and audit operations, all indemnification and insurance requirements, and all obligations upon termination. [7.2K]
- k. In no event shall the Commonwealth, Finance, the Department or Member be liable for the payment of any debt or fulfillment of any obligation of Health Plan or any Provider to any subcontractor, supplier, out-of-network provider or any other party, for any reason whatsoever, including the insolvency of Health Plan or any Provider. Provider agrees that any subcontract will contain a hold harmless provision. [14.2]
- l. Provider is prohibited from directly receiving payment or any type of compensation from the Member, except for Member co-pay s or deductibles from Members for providing Covered Services. Member co-pay, co-insurance or deductible amounts cannot exceed amounts specified in 907 KAR 1:604. [15.2]
- m. Provider will report/submit all encounter records in an accurate and timely fashion. [17.1]
- n. Primary care Providers in Health Plan's participating provider network shall connect to the Kentucky Health Information Exchange within one year of the effective date of its provider agreement or other schedule as determined by the Department. Health Plan encourages all other Providers in Health Plan's Participating Provider network to establish connectivity with the Kentucky Health Information Exchange. [18]
- o. Quality Assessment/Performance Improvement ("QAPI") program activities of Provider, if separate from Health Plan's QAPI activities, shall be integrated into the overall QAPI program. Requirements to participate in QAPI activities, including submission of complete encounter record, are hereby incorporated into this Agreement and Provider subcontracts and employment agreements. [19.3]
- p. Consistent with 42 CFR sections 438.6(h) and 422.208, compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to a Member. [20.6]
- q. Provider's service locations shall meet all requirements of the Americans with Disabilities Act, and all Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures which are applicable to health care facilities. [22.1]
- r. A provider cannot enroll in Health Plan's Participating Provider network if the provider has active sanctions imposed by Medicare or Medicaid or CHIP, if required licenses and certifications

are not current, if money is owed to the Medicaid program, or if the Office of the Attorney General has an active fraud investigation involving the provider or the provider otherwise fails to satisfactorily complete the credentialing process. Health Plan shall obtain access to the National Practitioner Database as part of their credentialing process in order to verify the provider's eligibility for network participation. [28.3]

- s. Provider shall have a Medicaid number assigned by the Department as a condition to participating in Health Plan's Participating Provider networks under Kentucky Contracts. [28.5]
- t. Any Provider who engages in activities that result in suspension, termination, or exclusion from the Medicare or Medicaid program shall be terminated from participation under this Agreement effective as of the date of such suspension, termination or exclusion. [28.6]
- u. If coverage of any Medicaid service provided by Provider requires the completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation. Provider shall retain the form in the event of audit and a copy shall be submitted to the Department upon request. [30.1]
- v. The following applies if Provider is a primary care provider: Provider shall have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavior health problems and disorders. [33.7]
- w. The following applies if Provider provides behavioral health services: Provider shall ensure that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within fourteen (14) days from the date of discharge. Provider will contact Members who have missed appointments within twenty-four (24) hours to reschedule appointments. [33.8]
- x. Provider shall maintain its accounting systems in accordance with statutory accounting principles, generally accepted accounting principles, or other generally accepted system of accounting. The accounting system shall clearly document all financial transactions between Health Plan and Provider. These transactions shall include, but not be limited to, claims payment, refunds and adjustment of payments. [37.14]
- y. Provider shall provide access to the medical record of Members to Health Plan, the Department, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing. Additionally, when a Member changes primary care providers, the medical records or copies of medical records shall be forwarded by Provider to the new primary care provider or Health Plan within ten (10) days from receipt of request. Primary care Providers shall have Members sign a release of Medical Records before a Medical Record transfer occurs. [38.1]
- z. Provider shall provide written notice to Health Plan, so that Health Plan may meet its obligation to notify Finance pursuant to the terms of the Kentucky Contract, of any legal action or notice listed below, within two (2) days following the date Provider becomes aware of:
  - i. Any action, proposed action, lawsuit or counterclaim filed against Provider, related in any way to the Kentucky Contract;
  - ii. Any administrative or regulatory action, or proposed action, respecting the business or operations of Provider, related in any way to the Kentucky Contract;

- iii. The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider; and
- iv. The payment of a civil fine or conviction of any person who has an ownership or controlling interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in a program under Medicare, Medicaid, or Title XX of the Social Security Act, or of fraud, or unlawful manufacture, distribution, prescription or dispensing of a controlled substance, as specified in 42 USC 1320a-7.

A complete copy of all documents, filings or notices shall accompany the notice to Health Plan. A complete copy of all further filings and other documents generated in connection with any such legal action shall be provided to Health Plan within five (5) days following the date Provider receives such documents. [40.1]

- aa. Provider shall abide by the rules and regulations regarding the confidentiality of protected health information as defined and mandated by the Health Insurance Portability and Accountability Act (42 USC 1320d) and set forth in federal regulations at 45 CFR Parts 160 and 164. [40.12]

8. Kentucky RFP Requirements. [Cites are to applicable sections of RFP]

- a. Provider shall make all of its books, documents, papers, provider records, medical records, data, surveys and computer databases (collectively "Records") available for examination and audit by Health Plan, the Department, the Attorney General of the Commonwealth of Kentucky, the Kentucky Department of Insurance, authorized federal or Commonwealth personnel, or the authorized representatives of the governments of the United States and the Commonwealth of Kentucky including, without limitation, any employee, agent, or subcontractor of the Department, Cabinet, CMS, or the Department's fiscal agent.

Access shall be at the discretion of the requesting authority and shall be either through on site review of records or by submission of records to the office of the requesting authority. Any records requested shall be produced immediately for on-site reviews or sent to the requesting authority by mail within fourteen (14) days following a request. All records shall be provided at the sole cost and expense of Provider including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Department shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Provider. [RFP § 030.090.170]

- b. Provider shall comply with the provisions of the Privacy Act of 1974 and instruct its employees to use the same degree of care as it uses with its own data to keep confidential information concerning client data, the business of the Commonwealth, its financial affairs, its relations with its citizens and its employees, as well as any other information which may be specifically classified as confidential by the Commonwealth in writing to Health Plan. All Federal and State regulations and statutes related to confidentiality shall be applicable to Provider. Provider shall have an appropriate agreement with its employees to that effect, provided however, that the foregoing will not apply to: (i) information which the Commonwealth has released in writing from being maintained in confidence; (ii) information which at the time of disclosure is in the public domain by having been printed and published and available to the public in libraries or other public places where such data is usually collected; or (iii) information, which, after disclosure, becomes part of the public domain as defined above, through no act of Provider.

Provider shall have an appropriate agreement with its subcontractors extending these confidentiality requirements to all subcontractors' employees. [RFP § 40.115]

**ATTACHMENT C  
COMPENSATION**

**(See following attachments)**

**ATTACHMENT C-1**  
**KENTUCKY MEDICAID AND CHIP COMPENSATION**  
**(PHYSICIAN SERVICES)**  
**(FEE FOR SERVICE)**

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Kentucky Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.
2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's billed charges, or the following, less Member Expenses:
  - a. Primary Care Services:

100 percent of Health Plan's Medicaid physician rate schedule, based on the Kentucky Medicaid physician fee schedule on the date the Covered Services are rendered, as adjusted in this Attachment.
  - b. Specialty Physician Services:

100 percent of Health Plan's Medicaid physician rate schedule, based on the Kentucky Medicaid physician fee schedule on the date the Covered Services are rendered, as adjusted in this Attachment.
3. Payment of compensation is subject to coordination of benefits and subrogation activities and adjustments.
4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days of its receipt of the Clean Claim. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.
5. Health Plan may automatically update Health Plan's Medicaid rate schedules without notice to Contracted Provider or amendment to the Agreement to include successor code numbers for the same services or delete retired codes, as such are revised or implemented by the Department. Upon request of Contracted Provider, Health Plan will provide to Contracted Provider Health Plan's applicable Medicaid rate schedules with then current codes no more frequently than annually. Health Plan will include in Health Plan's Medicaid rate schedules those Covered Services and corresponding rates that are not included in the Kentucky Medicaid rate schedule.
6. Health Plan will implement and prospectively apply changes to Health Plan's Medicaid rate schedules based on the Department's Kentucky Medicaid rate changes (a) on the Kentucky Medicaid effective date, if the Department publishes the rate change at least 45 days prior to the Kentucky Medicaid effective date, or (b) no more than 45 days after the date the Department publishes the rate change, if the publication date is less than 45 days before or after the Kentucky Medicaid effective date. Health Plan will not retrospectively apply increases or decreases to Health Plan's Medicaid rate schedule to any claims that have already been paid.