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PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("**Agreement**") is made and entered into by and between WellCare Health Plans, Inc. ("WellCare"), on behalf of itself and Health Plan (as such term is defined below) and _____ ("**Contracted Provider**"). WellCare, Health Plan, and Contracted Provider are sometimes referred to together as the "**Parties**" and individually as a "**Party**".

WHEREAS, Health Plan intends to issue 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, WellCare, 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.

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 radiology, laboratory, dental, vision, or hearing services.

2.4 "**Clean Claim**" means a claim for Covered Services that is (i) received timely by Health Plan, (ii) is on a completed, legible CMS 1500 form or UB 04 form, or electronic equivalent, (iii) is true, complete, accurate, and includes all necessary supporting documentation, (iv) includes all relevant information necessary to comply with Laws and Program Requirements and to determine payor liability, (v) is not subject to coordination of benefits, and (vi) is not under review for Medical Necessity. A Clean Claim does not include a claim from a Provider who is under investigation for fraud or abuse.

2.5 "**Covered Services**" means Medically Necessary health care items and services covered under a Benefit Plan.

2.6 "**Credentialing Criteria**" means Health Plan's criteria for the credentialing or re-credentialing of Providers.

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 "**Effective Date**" means the date that Health Plan countersigns this Agreement. Federal law prohibits Health Plan from contracting with individuals or entities that are barred from participation in Federal Health Care Programs. Accordingly, this Agreement shall be null and void if Health Plan determines that Contracted Provider was an Ineligible Person at the execution of this Agreement.

2.9 "**Emergency Services**" shall be as defined in the applicable Program Attachment.

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

2.11 "**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.

2.12 "**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.

2.13 "**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.

2.14 "**Health Plan**" means an existing or future Affiliate of WellCare that issues a Benefit Plan.

2.15 "**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 non-procurement programs, as may be identified in the System for Award Management 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 non-procurement programs as determined by a State Governmental Authority.

2.16 "**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.

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

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

2.19 "**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.

2.20 "**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.

2.21 "**Overpayment**" means the payments a Provider receives from Health Plan or its Affiliates to which the Provider is not entitled, including payments (a) for items and services that are not Covered Services, (b) paid in error, (c) resulting from enrollment errors, (d) resulting from claims payment errors, data entry errors or incorrectly submitted claims, or (e) 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 to satisfy an obligation of a Provider, including refunds of improperly collected Member Expenses to a Member or reimbursement to subcontracted Providers.

2.22 "**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.

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

2.24 "**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.

2.25 "**Program Attachment**" means an attachment to this Agreement describing the terms of a Provider's participation in Health Plan's provider network for a Program.

2.26 "**Program Requirements**" means the requirements of Governmental Authorities governing a Provider's participation in Health Plan's provider network and rendering Covered Services to Members pursuant to a Benefit Plan, including where applicable the requirements of a Government Contract, which include those terms set forth in a Program Attachment.

2.27 "**Provider**" means (a) Contracted Provider or (b) other individual or entity that is employed, or directly or indirectly subcontracted by Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

2.28 "**Provider Manual**" means, collectively, Health Plan's provider manuals, quick reference guides, WellCare Companion Guide, 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. The Provider Manual is available on Health Plan's website.

2.29 "**State**" means any of the 50 United States, the District of Columbia or a U.S. territory.

2.30 "**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.

3.6 Provider shall be a Participating Provider for all Programs identified in this Agreement. In accordance with the terms of this Agreement, WellCare may add Programs by giving Contracted Provider written notice of an amendment to this Agreement. Unless Contracted Provider elects not to participate in a new Program by providing timely written notice to the Health Plan, Provider will become a Participating Provider for the new Program in accordance with the terms of this Agreement.

4. Provider Responsibilities.

4.1 Principals. Contracted Provider shall comply with requirements for disclosure of ownership and control, business transactions, and information for persons convicted of crimes against Federal Health Care Programs as described in section 1124 of the Social Security Act, 42 CFR part 420 subpart C (Program Integrity: Medicare) and 42 CFR part 455 subpart B (Program Integrity: Medicaid). Unless prohibited by Department, prior to the Effective Date of the Agreement, Contracted Provider shall, for itself and its Principals, provide Health Plan with a complete, accurate, and current ownership disclosure form in a form and format acceptable to Health Plan or as required by Governmental Authorities to enroll in a Program. Contracted Provider shall notify Health Plan of any change in the information 30 days prior to the date of such change.

4.2 Providers. Contracted Provider shall provide Health Plan with the information listed on the Attachment titled "Information for Providers" for itself and the Providers as of the Effective Date, in a form and format acceptable to Health Plan. Provider participation in Health Plan's contracted provider network is determined by Health Plan and is subject to the Provider completing credentialing in accordance with this Agreement. Contracted Provider shall provide notice to Health Plan of any change in the information for itself and the Providers within 30 days of the change. When Contracted Provider terminates a Provider, other than for cause, Contracted Provider will give Health Plan at least 90 days prior written notice of the termination.

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. For purposes of this section only, "**Subcontracted Provider**" means a provider who renders Covered Services to Members within the scope of this Agreement, and has a contractual relationship with Contracted Provider but is not Contracted Provider's employee. If Contracted Provider uses Subcontracted Providers to provide or arrange for the provision of health care items and services to Health Plan's Members, Contracted Provider must secure prior written approval from Health Plan and follow Health Plan's procedures with respect to adding Subcontracted Providers to this Agreement. If Contracted Provider has not obtained proper approval by Health Plan or followed the requisite procedures, Contracted Provider's Subcontracted Providers may be deemed, at Health Plan's sole discretion, to be participating under this Agreement and Contracting Provider and its Subcontracted Providers shall assume all applicable obligations stated herein:

(a) Contracted Provider represents and warrants that it has full authority, under power of attorney granted by Subcontracted Providers to Contracted Provider, to bind Subcontracted Providers to this Agreement, and all matters connected to this Agreement, including, but not limited to, the granting any waivers of any of the terms of this Agreement and entering into any amendments or modifications thereof. In the event of false representation or warranty, breach, or failure to comply with this covenant, Contracted Provider shall indemnify and hold harmless Health Plan against any loss, liability, claim, damage and expense arising from such.

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

(c) Contracted Provider shall maintain and enforce written agreements with its 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 (a) entire agreements between itself or other Providers and the subcontracted Providers, or (b) copies of Health Plan's opt-in form. If submitting copies of entire agreements, the compensation terms in such agreements may be redacted unless required by Governmental Authorities. In the event of a conflict, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(d) Contracted 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.

(e) Subcontracted 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. Subcontracted 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.

(f) Each Subcontracted Provider has reviewed its obligations under this Agreement and agrees to the terms and conditions herein. Wherever in the Agreement an action is required to be taken by a Contracted Provider or a Provider, Subcontracted Provider agrees to perform such action. Wherever in the Agreement any representation or warranty is made by a Contracted Provider or a Provider, Subcontracted Provider agrees to comply with such representation or warranty.

(g) Any obligation of Subcontracted Provider in this Agreement shall apply to its Providers to the same extent that it applies to Subcontracted Provider. Subcontracted Provider 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 Agreement. Subcontracted Provider has the authority to bind its subcontracted Providers to this Agreement, and shall require the timely and faithful performance of this Agreement by its subcontracted Providers.

(h) Subcontracted Provider shall not assign any of its rights or delegate any of its duties or obligations under this Agreement, in whole or in part, without the prior written consent of Health Plan.

(i) In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of this 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 (i) shall be construed for the benefit of Members, (ii) does not prohibit collection of Member Expenses where lawfully permitted or required, and (iii) 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.

(j) If this Agreement is terminated for any reason or Contracted Provider goes out of business, ceases operations or becomes insolvent, then Subcontracted Provider: (a) for at least six months, shall continue to provide Covered Services to Members, subject to and in accordance with the terms and conditions of this Agreement, (b) shall accept compensation from

Health Plan for such Covered Services at the fee for service rates set forth in this Agreement for the applicable Benefit Plans or, if this Agreement 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, and (c) after six months, may terminate its continuing participation under this Agreement upon 90 days prior notice to Health Plan.

(k) Any dispute with respect to Subcontracted Provider's performance under this Agreement shall be subject to and resolved in accordance with the dispute resolution procedures in this Agreement.

4.2.3 Credentialing. All Providers must meet the Credentialing Criteria prior to participating in Health Plan's contracted provider networks under this Agreement. 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 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 no later than the next business day after the Member is 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 by the Provider Manual. 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. Before a Provider provides items or services to a Member that are not Covered Services, 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 may contact Health Plan to determine if an item or service is a Covered Service.

4.3.6 Carve Out Agreements. While a Carve Out Agreement is in effect, Covered Services subject to the Carve Out Agreement shall be Non-Contracted Services and are not within the scope of 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. Upon expiration or termination of a Carve Out Agreement, Provider shall provide the Covered Services to Members that were subject to the Carve Out Agreement, subject to and in accordance with the terms of this Agreement, including compensation.

4.4 Claims and Encounter Data / EDI.

4.4.1 Clean Claims. Providers shall prepare and submit Clean Claims to Health Plan within 180 days 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 Additional Reports. If Health Plan requests additional information, data, or reports from a Provider regarding Covered Services provided to Members for risk adjustment data validation or other administrative purposes, even if Health Plan has 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.

4.4.3 NPI Numbers / Taxonomy Codes. 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.

4.4.4 Electronic Transaction Requirements. Provider may submit claims and encounter data to Health Plan electronically. Providers shall (a) follow the requirements for electronic data interchange in accordance with the current HIPAA Administrative Simplification transaction standards and 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.

4.4.5 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 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.

4.4.6 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 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.

4.4.7 Subrogation. Providers shall cooperate and assist Health Plan with its subrogation efforts.

4.4.8 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 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 the 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 15 days after such posting or notice, or 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's 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 or outcome 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, including Records that will enable Health Plan to perform a thorough assessment of the overall care being provided to Members.

4.8 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, and (d) corrective action plans.

4.9 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.

4.10 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.

4.10.1 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.

4.10.2 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).

4.10.3 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 WellCare 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.

4.10.4 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.

4.10.5 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.

(c) If a Governmental Authority imposes a reduction to the Federal or State funds Health Plan receives under a Government Contract, Health Plan may adjust its payments to Provider by an equivalent or comparable amount. Such adjustment shall be effective concurrent with the effective dates such reductions are imposed upon Health Plan.

4.10.6 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.

4.10.7 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.

4.10.8 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.

4.11 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.

4.12 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.

4.13 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.

4.14 Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall notify Health Plan within five business days of Contracted Provider's knowledge, or when Contracted Provider should have known, 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 Provider is under investigation for fraud or a felony, or (h) 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 Overpayments. Overpayment recovery shall be in accordance with Health Plan's Provider Manual and Providers shall refund Overpayments to Health Plan within 30 days (or such other timeframe as required by Laws or Program Requirements) of the Provider's receipt of notice from Health Plan of such Overpayments ("Notice Period") or Provider's knowledge of such Overpayment. This section regarding Overpayments shall survive expiration or termination of this Agreement. Health Plan shall not seek repayment of an Overpayment from a Provider beyond the time period set forth in Health Plan's Provider Manual, unless a longer time is required or permitted by Laws or Program Requirements. Notwithstanding anything to the contrary herein, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud.

5.5.1 Unless prohibited by Laws or Program Requirements, Contracted Provider, for itself and the Providers, authorizes Health Plan to offset Overpayments against any future payments due to Provider.

5.5.2 Except for offsets related to changes in Member eligibility, which shall not require notice prior to deducting Overpayments, Health Plan shall notify Providers that an offset against future payments will occur unless the Provider (a) refunds such amounts within the Notice Period, or (b) provides Health Plan with a written explanation of why the Overpayments should not be refunded along with any supporting documentation. If the Provider does not respond within the Notice Period, Health Plan shall deduct Overpayments from future payments.

5.5.3 If Provider disputes Overpayments within the Notice Period, Health Plan shall review the Provider's explanation and supporting documentation. Health Plan shall notify Provider of its decision to either uphold or overturn its initial determination that the payment at issue was an Overpayment. If Health Plan upholds its decision, the Overpayment will be offset against future payments unless prohibited by Law or Program Requirements.

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. With regard to administering Benefit Plans, Health Plan may delegate administrative functions to third parties, and Provider shall cooperate with such third parties to the same extent Provider is required to cooperate with Health Plan.

6. Records, Access & Audits.

6.1 Maintenance. Contracted Provider shall, and shall cause its Providers and subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data, information, and other documentation related to the Covered Services provided to Members, claims filed, quality and cost outcomes, quality measurements and initiatives, and other services and activities conducted under this Agreement (collectively, "**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, Providers, and their subcontractors. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause Providers and 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, collect, 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. If Provider participates in any health information exchange ("HIE"), Provider hereby consents to the release of any Records contained in such an HIE 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. Notwithstanding the above, the term of this Agreement, including any renewal, may be limited to comply with Laws, an order by a Governmental Authority, or a Government Contract.

7.2 Termination.

7.2.1 Termination for Convenience. Either Party may terminate this Agreement, in whole or with respect to any particular Program, Benefit Plan, or Covered Service, 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 if a Provider is capitated, Health Plan shall pay the Provider 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.

8.1.1 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.

8.2 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.

8.3 Arbitration. Except as barred or excepted by this Agreement, all claims and disputes between the Parties shall be resolved by binding arbitration in [ ], North Carolina. 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. If either Party disputes the arbitrability of a claim or dispute, the arbitrator or panel will decide if this arbitration agreement applies to the claim or dispute. 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 North Carolina 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 [ ], North Carolina 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.

9.7 The following applies to State plans: Contracted Provider shall not, and shall require Providers and their 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 Providers and their 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.

9.8 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) regular U.S. mail, first-class postage prepaid, 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, except for regular U.S. mail, which shall be deemed delivered seven days after the date of mailing. 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 60 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 60 day notice period, and Health Plan may terminate this Agreement for convenience in accordance with this Agreement.

9.11 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.

9.12 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, including any Benefit Plan or Program hereunder, to an Affiliate or any purchaser of the assets or successor to the operations of Health Plan. 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.

9.13 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.

9.14 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.

9.15 WellCare Affiliates. WellCare is the contracting agent and attorney-in-fact for Health Plan. Only the Health Plan entity issuing the Benefit Plan shall incur any liability to Contracted Provider under this Agreement and there shall be no joint liability with WellCare, or other Health Plans, or other Affiliates of WellCare. A list of WellCare's Health Plan Affiliates is available on WellCare's website. The Health Plan issuing a Benefit Plan may also be identified in the Program Attachment.

9.16 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.

9.17 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.

9.18 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.

9.19 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.

9.20 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.

9.21 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.

9.22 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.

9.23 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.

9.24 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.

9.25 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:

9.25.1 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.

9.25.2 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.

9.25.3 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.

9.25.4 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.

The following Attachments are incorporated into and made a part of this Agreement:

Attachment A - Provider Specific Requirements/Covered Services/Information
Attachment B - Program Attachments
Attachment C – Compensation

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

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

WellCare Health Plans, Inc., on behalf of itself and Health Plan	_____
By: THIS DOCUMENT IS NOT EXECUTABLE AND IS FOR REVIEW ONLY	By: THIS DOCUMENT IS NOT EXECUTABLE AND IS FOR REVIEW ONLY
Print Name:	Print Name: _____
Title:	Title: _____
Date: _____	Date: _____
	Fed Tax ID: _____
WellCare and Health Plan Notice Address:	Contracted Provider Notice Address:
_____	
ATTN: Director, Network Management	ATTN: _____
Fax: _____	Fax: _____

Revision # 2015.1

FOR HEALTH PLAN USE ONLY

ATTACHMENT A
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES / INFORMATION

(See following attachments)

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(PROFESSIONAL)

1. Additional Definitions.

   a. "**Assigned Member**" means a Member who selects or is assigned by Health Plan to a Primary Care Provider or (if required by Laws or Program Requirements) an allied health care practitioner supervised by a Physician, as the Member's primary care provider.

   b. "**Covering Physician**" means a Provider who provides health care items and services to another Provider's patients when the other Provider is not available.

   c. "**Nurse Practitioner**" means a Provider who is licensed as a nurse practitioner and certified in advanced or specialized nursing practice, in accordance with applicable state Laws.

   d. "**Physician**" means a Provider who is a doctor of medicine or osteopathy.

   e. "**Primary Care Provider**" means a Physician, Nurse Practitioner, certified nurse midwife, physician assistant, or other duly licensed Provider who spends the majority of his/her 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.

   f. "**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.

   g. "**Specialty Provider**" means a Provider who provides Specialty Services.

   h. "**Specialty Services**" means health care items and services within the scope of a particular medical specialty.

2. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, 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.

3. Contracted Provider shall ensure that (a) Primary Care Providers render Primary Care Services to Members, including their Assigned Members, and (b) Specialty Providers provide Specialty Services to Members upon appropriate referral. If a Provider provides Covered Services that are subject to a Carve-Out Agreement, such services shall be Non-Contracted Services.

4. 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 Provider 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 provider-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.

5. If a Provider provides or arranges for the provision of Specialty 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.

6. 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.

7. 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, including closure of Provider's site to Members.

ATTACHMENT A-2
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
- 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 B
PROGRAM ATTACHMENTS

(See following attachments)

ATTACHMENT B-1
NORTH CAROLINA MEDICAID PROGRAM ATTACHMENT

1. Network Participation. Subject to and in accordance with the terms of the Agreement, including this Attachment, Providers shall participate in Health Plan's contracted provider networks and shall provide Covered Services to Members who are enrolled with Health Plan and covered by North Carolina Medicaid Benefit Plans issued pursuant to the North Carolina Contract.

2. Compensation for Covered Services provided to Members of North Carolina Benefit Plans is set forth in Attachment C.

3. With regard to the North Carolina Medicaid Benefit Plans and the North Carolina Medicaid Program, "**Health Plan**" shall mean **WellCare of North Carolina, Inc**.

4. Additional Definitions.

   a. "**Amendment**" means any change to the terms of a contract, including terms incorporated by reference that modifies fee schedules. A change required by federal or North Carolina state law, rule, regulation, administrative hearing, or court order is not an amendment.

   b. "**Contract**" means this Agreement.

   c. "**Department**" means the North Carolina Department of Health and Human Services.

   d. "**Emergency Medical Condition**" means a medical condition in which the symptoms appear quickly and are severe enough that a person with average knowledge of health and medicine would expect that, in the absence of immediate medical attention, the health or life of the person experiencing the symptoms is in jeopardy or they are at risk of serious damage to a bodily function, organ, or part.

   e. "**Emergency Services**" means inpatient and outpatient services by a qualified provider needed to evaluate or stabilize an emergency medical condition.

   f. "**Health Care Provider**" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

   g. "**Medically Necessary**" or "**Medical Necessity**" means medically necessary covered services and supplies as determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. As required by 10A NCAC 25A.0201, a medically necessary service may not be experimental in nature.

   h. "**North Carolina Contract**" means a contract executed between the Department and Health Plan for Health Plan to provide or arrange for the provision of health care items and services to enrollees in the state's Medicaid managed care Program, as amended from time to time. A North Carolina Contract is a Government Contract as defined in the Agreement.

5. 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. Any obligation of Contracted Provider in this Attachment shall apply to Providers to the same extent that it applies to Contracted Provider. Contracted Provider agrees to include the North Carolina Medicaid Program requirements set forth in this Attachment in contracts with its Providers.

6. North Carolina Medicaid Program Requirements. The Parties acknowledge and agree that Providers participation in Health Plan's North Carolina Medicaid contracted provider network under this Agreement is effective only upon Health Plan and the Department fully executing the North Carolina Contract. Any term, condition or provision now or hereafter required to be included in the Agreement by the Department and the North Carolina Contract shall be deemed incorporated herein and binding upon and enforceable against the Parties, and Health Plan may amend this Agreement upon notice to Contracted Provider to comply with such requirements, which shall be effective upon the Contracted Provider's receipt or as otherwise specified by the Department.

7. North Carolina Contract Requirements.

   a. Health Plan will not require Provider, as a condition of entering into this Agreement, to be a Participating Provider for other health benefit plan products offered by Health Plan, nor will Health Plan automatically enroll Provider in such. This provision shall not apply to facility Providers.

   b. Providers shall provide physical access, reasonable accommodations - including parking, exam and waiting rooms - and accessible equipment for Members with physical or mental disabilities.

   c. Each Provider furnishing services to Members will maintain and share, for care coordination and as appropriate, a Member health record in accordance with professional standards and state and federal law.

   d. Primary Care Physicians shall perform Early and Periodic Screening, Diagnostic and Treatment for Members less than 21 years of age in accordance with the North Carolina Contract.

   e. Providers shall notify Health Plan when a Member is in a high level clinical setting and is being discharged, as more fully described in the Provider Manual.

   f. Providers shall not submit claim or encounter data for services covered under this Agreement directly to the Department.

   g. Provider-Preventable Condition Requirements. Providers shall comply with the requirements of 42 C.F.R. §438.3(g) including, but not limited to, the identification of provider-preventable conditions as a condition of payment, and appropriate reporting to Health Plan.

   h. Contracted Provider and its subcontractors shall have compliance plans that meet the requirements of 42 C.F.R. §438.608, and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005.

   i. Contract Provider shall have policies and procedures that recognize and accept Medicaid as the payer of last resort.

j. Providers shall not bill Members for Covered Services for any amount greater than what would be owed if the provider rendered the service directly as provided in 42 C.F.R. §§438.3(k) and 438.230(c)(1)-(2).

k. Upon termination of the North Carolina Contract, Provider's participation in Health Plan's contracted provider networks for the North Carolina Medicaid Benefit Plans shall automatically terminate.

l. Provider shall be immediately terminated by Health Plan upon a confirmed finding of fraud, waste, or abuse by the Department or the North Carolina Department of Justice Medicaid Investigations Division.

m. In the event of Health Plan's insolvency, administrative duties and records will be transferred to Comprehensive Health Management, Inc., a for-profit corporation organized under the laws of the State of Florida and experienced in the provision of administrative and management services to health maintenance organizations.

n. In the case of insolvency of Health Plan, when Provider is paid on a prepaid basis for Covered Services under this Agreement, Provider shall continue to render inpatient care until the patient is ready for discharge.

o. Credentialing.

   i. Provider must maintain licensure, accreditation, and credentials sufficient to meet Health Plan's network participation requirements pursuant to Health Plan's Credentialing Criteria.

   ii. Provider must notify Health Plan of any changes in the status of any information relating to Provider's professional credentials.

   iii. Provider must be enrolled as a Medicaid provider as required by 45 C.F.R. §455.410, and is subject to termination if such enrollment is not maintained.

   iv. Provider must complete recredentialing pursuant to Health Plan's Credentialing Criteria but, in any event, no less than the following time periods:

      i. During the provider credentialing transition period, as defined by the North Carolina Contract, no less frequently than every five years; and

      ii. During provider credentialing under full implementation of the North Carolina contract, and defined by the same, no less frequently than every three years, except as otherwise permitted by the Department.

p. Providers shall maintain professional liability insurance coverage throughout the term of this Agreement in an amount acceptable to Health Plan and notify Health Plan on a timely basis of any subsequent changes in status of coverage.

q. Notwithstanding the Member Protections section of this Agreement, a Provider and Member shall not be prohibited from agreeing to continue non-covered services at the Member's own expense, so long as Provider has notified Member in advance that Health Plan may not cover, or continue to cover, specific services and that Member will be financially liable for such services.

r. Medical Records. Providers shall maintain Member medical records in accordance with 42 CFR §438.208(b)(5) and shall:

i. Maintain adequate medical and other health records according to industry and Health Plan's standards.

ii. Make copies of such records available to Health Plan and the Department in conjunction with Department's regulation of Health Plan. Such records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

s. Data. Health Plan shall, in accordance with North Carolina Contract requirements, provide data and information to Contracted Provider, as well as changes in such requirements, including:

i. Performance feedback reports, if compensation is related to efficiency criteria.

ii. Information on benefit exclusions, administrative and utilization management requirements, credential verification programs, quality assessment programs, and provider sanction policies.

t. Provider's participation in Health Plan's utilization review and case management programs shall not override the professional or ethical responsibility of Provider, nor shall interfere with the Provider's ability to provide information or assistance to Members.

u. Health Plan shall publish the name of the Provider or Provider group in its directory distributed to Members. Provider authorizes such publication.

v. Assignment. Contracted Provider's duties and obligations under this Program Attachment shall not be assigned, delegated, or transferred without the prior written consent of Health Plan. Health Plan shall notify Contracted Provider in writing of any duties or obligations that are to be delegated or transferred before the delegation or transfer.

w. Funds used for Provider payments pursuant to this Agreement are government funds.

x. Interpreting and Translation Services. Provider shall (i) provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Member; (ii) ensure the Provider's staff are trained to appropriately communicate with Members with various types of hearing loss; and (iii) report to Health Plan, in a format and frequency to be determined by Health Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

y. Pursuant to North Carolina General Statutes, Chapter 58, Insurance:

i. If Health Plan or its authorized representative determines that services, supplies, or other items are covered under its health benefit plan, including any determination under G.S. 58-50-61, Health Plan shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payments for a service, supply, or other item furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the Member or the provider of the service, supply, or other item.

ii. When Health Plan offers a contract to a provider, Health Plan shall also make available its schedule of fees associated with the top 30 services or procedures most commonly billed by that class of provider. Upon the request of a provider, Health Plan shall also make

available the full schedule of fees for services or procedures billed by that class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If a provider requests fees for more than 30 services and procedures, Health Plan may require the provider to specify the additional requested services and procedures and may limit the provider's access to the additional schedule of fees to those associated with services and procedures performed by or reasonably expected to be performed by the provider.

iii. All notices provided under this Agreement shall be sent using one or more of the following methods and shall be deemed delivered: (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this Agreement prohibits the use of an electronic medium for a communication other than an amendment if agreed to by Health Plan and Contracted Provider.

iv. Health Plan shall send any proposed contract Amendment to the notice contact of Contracted Provider pursuant to G.S. 58-50-275. The proposed Amendment shall be dated, labeled "Amendment," signed by Health Plan, and include an effective date for the proposed Amendment.

v. Contracted Provider receiving a proposed Amendment shall be given at least 60 days from the date of receipt to object to the proposed Amendment. The proposed Amendment shall be effective upon Contracted Provider failing to object in writing within 60 days.

vi. If Contracted Provider objects to a proposed Amendment, then the proposed Amendment is not effective and Health Plan shall be entitled to terminate the Agreement upon 60 days' written notice to Contracted Provider.

vii. Nothing in this Agreement prohibits Contracted Provider and Health Plan from negotiating contract terms that provide for mutual consent to an Amendment, a process for reaching mutual consent, or alternative notice contacts.

viii. Health Plan shall provide a copy of its policies and procedures to Health Care Provider prior to execution of a new or amended Contract and annually to Contracted Provider. Such policies and procedures may be provided to the Health Care Provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the website of Health Plan.

ix. The policies and procedures of Health Plan shall not conflict with or override any term of a Contract, including Contract fee schedules. In the event of a conflict between a policy or procedure and the language in a Contract, the Contract language shall prevail.

x. A pharmacy, by or through a pharmacist acting on its behalf as its employee, agent, or owner, may not waive, discount, rebate, or distort a copayment of Health Plan, any policy, or plan, or a Member's coinsurance portion of a prescription drug coverage or reimbursement, and if a pharmacy, by or through a pharmacist's acting on its behalf as its employee, agent or owner, provides a pharmacy service to an enrollee of a health benefit plan that meets the terms and requirements of Health Plan under a health benefit plan, the pharmacy shall provide its pharmacy services to all Members of that health benefit plan on the same terms and requirements of Health Plan. A violation of this subsection shall be a

violation of the Pharmacy Practice Act subjecting the pharmacist as a licensee to disciplinary authority of the North Carolina Board of Pharmacy pursuant to G.S. 90-85.38.

xi. At least 60 days before the effective date of any health benefit plan providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, Health Plan or its designee shall notify, in writing, all pharmacies within the geographical coverage area of the health benefit plan, and offer to the pharmacies the opportunity to participate in the health benefit plan. All pharmacies in the geographical coverage area of the plan shall be eligible to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. Health Plan or its designee, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, shall inform Members of the plan of the names and locations of pharmacies that are participating in the plan as providers of pharmacy services and prescription drugs. Additionally, participating pharmacies shall be entitled to announce their participation to Members through a means acceptable to the pharmacy and Health Plan. The pharmacy notification provisions of this provision shall not apply when a Member is enrolled, but when Health Plan enters a particular county of the State of North Carolina.

8. North Carolina Contract Attachment Elements. The following provisions include requirements of the North Carolina Contract and NCDHHS's Advanced Medical Home Program Policy, Pregnancy Management Program Policy, Care Management for High-Risk Pregnancy Policy, and Care Management for At-Risk Children Policy.

   a. If Provider renders perinatal care, Provider agrees to comply with Department's Pregnancy Management Program:

      i. Complete the standardized risk-screening tool at each initial visit;

      ii. Allow Health Plan or Health Plan's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators;

      iii. Commit to maintaining or lowering the rate of elective deliveries prior to 39 weeks gestation;

      iv. Commit to decreasing the cesarean section rate among nulliparous women;

      v. Offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation;

      vi. Complete a high-risk screening on each pregnant Medicaid Managed Care Member in the program and integrate the plan of care with local pregnancy care management;

      vii. Provider, within one business day of completing a screening of a Member in Department's Care Management of High-Risk Pregnancies program, shall send all screening information and applicable medical record information to the applicable Health Plan, Local Health Department, or other applicable local care management entity contracted with Department for the provision of providing care management services for high-risk pregnancy;

viii. Decrease the primary cesarean delivery rate if the rate is over the Department's designated cesarean rate; and

ix. Ensure comprehensive post-partum visits occur within 56 days of delivery.

b. If Provider is an obstetrician, Provider agrees to comply with Department's Pregnancy Management Program as described above.

c. If Provider is an Advanced Medical Home, Provider agrees to comply with Department's Advanced Medical Home Program:

i. If Provider is a Tier 3 AMH, as such terms is defined in the North Carolina Contract, as amended, comply with all requirements set forth therein pursuant to Department's Advanced Medical Home Policy.

ii. Accept Members and be listed as a primary care provider in Health Plan's Member-facing materials for the purpose of providing care to Members and managing their health care needs.

iii. Provide Primary Care and patient care coordination services to each Member, in accordance with Provider Manual.

iv. Provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, 24 hours per day, 7 days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

v. Provide direct patient care a minimum of 30 office hours per week.

vi. Provide preventive services as required in the North Carolina Contract.

vii. Maintain a unified patient medical record for each Member following the Health Plan's medical record documentation guidelines.

viii. Promptly arrange referrals for medically necessary health care services that are not provided directly and document referrals for specialty care in the medical record.

ix. Transfer the Member's medical record to the receiving provider upon the change of primary care provider at the request of the new primary care provider or Health Plan (if applicable) and as authorized by the Member within 30 days of the date of the request, free of charge.

x. Authorize care for the Member or provide care for the Member based on the standards of appointment availability as defined by Health Plan's network adequacy standards.

xi. Refer for a second opinion as requested by the Member, based on DHHS guidelines and Health Plan standards.

xii. Review and use Member utilization and cost reports provided by Health Plan for the purpose of AMH level utilization management and advise Health Plan of errors, omissions, or discrepancies if they are discovered.

xiii. Review and use the monthly enrollment report provided by Health Plan for the purpose of participating in Health Plan or practice-based population health or care management activities.

d. If Provider is a Local Health Department (LHD) carrying out care management for high-risk pregnancy and for at-risk children, Provider agrees to comply with Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

i. Care Management for High-Risk Pregnancy:

(a) LHDs shall accept referrals from Health Plan for care management for high-risk pregnancy services.

(b) LHD shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy.

(c) LHD shall contact patients identified as having a priority risk factor through claims data (Emergency Department utilization, antepartum hospitalization, utilization of Labor & Delivery triage unit) for referral to prenatal care and to engage in care management.

(d) LHD shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five calendar days of receipt of risk screening forms.

(e) LHD shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome.

(f) LHD shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need.

(g) LHD shall review available Health Plan data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to LHD.

(h) LHD shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

(i) LHD shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk

screenings and all patients directly referred for care management for level of need for care management support.

(j) LHD shall utilize assessment findings, including those conducted by the Health Plan, to determine level of need for care management support.

(k) LHD shall document assessment findings in the care management documentation system.

(l) LHD shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained.

(m) LHD shall assign case status based on level of patient need.

(n) LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging Members and meeting their needs. This includes face-to-face encounters (practice visits, home visits, hospital visits, community encounters), telephone outreach, professional encounters and /or other interventions needed to achieve care plan goals.

(o) LHD shall provide care management services based upon level of Member need as determined through ongoing assessment.

(p) LHD shall develop Member-centered care plans, including appropriate goals, interventions and tasks.

(q) LHD shall utilize NC Resource Platform and identify additional community resources once the Department has certified it as fully functional.

(r) LHD shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Member's Health Plan network.

(s) LHD shall document all care management activity in the care management documentation system.

(t) LHD shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. LHD shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program.

(u) LHD shall establish a cooperative working relationship and mutually-agreeable methods of Member-specific and other ongoing communication with the Pregnancy Management Program providers.

(v) LHD shall establish and maintain effective communication strategies with Pregnancy Management Program providers and other key contacts within the practice within the county or serving residents of the county.

(w) LHD shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of Members in the target population.

(x) LHD shall ensure awareness of Health Plan Members' "in network" status with providers when organizing referrals.

(y) LHD shall ensure understanding of Health Plan's prior authorization processes relevant to referrals.

(z) LHD shall work with Health Plan to ensure program goals are met.

(aa) LHD shall review and monitor Health Plan reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk.

(bb) LHD shall communicate with Health Plan regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers.

(cc) LHD shall participate in pregnancy care management and other relevant meetings hosted by the Health Plan.

(dd) LHD shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by Health Plan and/or the Department, including webinars, new hire orientation or other programmatic training.

(ee) LHD shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by Health Plan and/or the Department.

(ff) LHD shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes.

(gg) LHD shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

(hh) LHD shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications: (i) Registered nurses; (ii) Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program. Care Managers for High- Risk Pregnancy hired prior to September 1, 2011 without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position.

(ii) LHD shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager.

(jj) LHD shall include both registered nurses and social workers in order to best meet the needs of the target population with medical and psychosocial risk factors on their team.

(kk) If the LHD only has a single Care Manager for High-Risk Pregnancy, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.

(ll) LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of Members with both medically and socially complex conditions.

(mm) LHD shall ensure that Pregnancy Care Managers must demonstrate: (i) a high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes; (ii) proficiency with the technologies required to perform care management functions; (iii) motivational interviewing skills and knowledge of adult teaching and learning principles; (iv) ability to effectively communicate with families and Providers; and (v) critical thinking skills, clinical judgment and problem-solving abilities.

(nn) LHD shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include: (i) provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight; (iii) regular meetings with direct service care management staff; (iv) utilization of reports to actively assess individual care manager performance; and (v) compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual.

(oo) LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Health Plan/Department guidance about communication with Health Plan about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery.

(pp) Vacancies lasting longer than 60 days shall be subject to additional oversight by Health Plan.

ii. Care Management for At-Risk Children:

(a) LHD shall accept referrals from Health Plan for child Members identified as requiring Care Management for At-Risk Children.

(b) LHD shall educate patients, Advanced Medical Homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources.

(c) LHD shall communicate regularly with the Advanced Medical Homes and other practice serving children, to ensure that children served by that medical home are appropriately identified for Care Management for At-Risk Children services.

(d) LHD shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for Members who receive services from outside their resident county.

(e) LHD shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population.

(f) LHD shall utilize the NC Resource Platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by the Department.

(g) LHD shall use any claims-based reports and other information provided by Health Plan, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations.

(h) LHD shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population.

(i) LHD shall communicate with the medical home and other primary care clinician about the Care Management for At-Risk Children target group and how to refer to the Care Management for At-Risk Children program.

(j) LHD shall involve families (or legal guardian when appropriate) in the decision-making process through a Member-centered, collaborative partnership approach to assist with improved self-care.

(k) LHD shall foster self-management skill building when working with families of child Members.

(l) LHD shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for child Members in active case status, when possible.

(m) LHD shall use the information gathered during the assessment process to determine whether the child Member meets the Care Management for At-Risk Children target population description.

(n) LHD shall review and monitor Health Plan reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child Member is appropriately linked to preventive and primary care services and to identify Members at risk.

(o) LHD shall use the information gained from the assessment to determine the need for and the level of service to be provided.

(p) LHD shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards.

(q) LHD shall ensure children/families are well-linked to the Member's Advanced Medical Home or other practice; provide education about the importance of the medical home.

(r) LHD shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging Members, meeting their needs and achieving care plan goals.

(s) LHD shall identify and coordinate care with community agencies/resources to meet the specific needs of the Member; use any locally-developed resource list (including NC Resource Platform) to ensure families are well linked to resources to meet the identified need.

(t) LHD shall provide care management services based upon the Member's level of need as determined through ongoing assessment.

(u) LHD shall collaborate with Advanced Medical Home/PCP/care team to facilitate implementation of Member-centered plans and goals targeted to meet individual Member's needs.

(v) LHD shall ensure that changes in the care management level of care, need for Member support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical Home PCP and/or care team.

(w) Where care management is being provided by Health Plan and/or Advanced Medical Home practice in addition to the Care Management for At-Risk program, the Health Plan/AMH practice must explicitly agree on the delineation of responsibility and document that agreement in the Member's Plan of Care to avoid duplication of services

(x) LHD shall ensure that changes in the care management level of care, need for Member support and follow up and other relevant updates (especially during periods of transition) are communicated to the Advanced Medical home PCP and/or care team and to Health Plan.

(y) LHD shall ensure awareness of Health Plan Member's "in network" status with providers when organizing referrals.

(z) LHD shall ensure understanding of Health Plan's prior authorization processes relevant to referrals.

(aa) LHD shall document all care management activities in the care management documentation system in a timely manner.

(bb) LHD shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

(cc) LHD shall participate in Department/Health Plan sponsored webinars, trainings and continuing education opportunities as provided.

(dd) LHD shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high-risk children.

(ee) LHD shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications: (i) Registered nurses; (ii) Social workers with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a Social Worker under the Office of State Personnel guidelines.

(ff) LHD shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of Members with both medically and socially complex conditions.

(gg) LHD shall ensure that Care Management for At-Risk Children Care Managers must demonstrate: (i) Proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system; (ii) ability to effectively communicate with families and providers; (iii) Critical thinking skills, clinical judgment and problem-solving abilities; and (iv) motivational interviewing skills, Trauma Informed Care, and knowledge of adult teaching and learning principles.

(hh) LHD shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors.

(ii) If the LHD has only has a single Care Management for At-Risk Children care manager, the LHD shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline.

(jj) LHD shall maintain services during the event of an extended vacancy.

(kk) In the event of an extended vacancy, LHD shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable.

(ll) LHD shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Department guidance regarding vacancies or extended staff absences and adhering to DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than 60 days will be subject to additional oversight.

(mm) LHD shall ensure that Community Health Workers and other unlicensed staff work under the supervision and direction of a trained Care Management for At-Risk Children Care Manager.

(nn) LHD shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include: (i) provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight;

(iii) regular meetings with direct service care management staff; and (iv) utilization of monthly and on-demand reports to actively assess individual care manager performance.

(oo) LHD shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications.

9. North Carolina Contract Required Language. In accordance with the North Carolina Contract and the Department's instructions, the following language is incorporated into the terms of this Agreement verbatim:

a. Compliance with State and Federal Laws. The Contracted Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to this Agreement and Health Plan's managed care contract with the North Carolina Department of Health and Human Services (NC DHHS), and all persons or entities receiving state and federal funds. The Contracted Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this contract, or any violation of the Health Plan's North Carolina Contract with NC DHHS could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

b. Hold Member Harmless. The Contracted Provider agrees to hold the Member harmless for charges for any covered service. The Contracted Provider agrees not to bill a Member for medically necessary services covered by the Company so long as the Member is eligible for coverage.

c. Liability. The Contracted Provider understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, the Health Plan, its employees, agents or subcontractors. Further, the Contracted Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to the Contracted Provider by the Health Plan or any judgment rendered against the Health Plan.

d. Non-discrimination Equitable Treatment of Members. The Contracted Provider agrees to render Provider Services to Members with the same degree of care and skills as customarily provided to the Contracted Provider's patients who are not Members, according to generally accepted standards of medical practice. The Contracted Provider and Health Plan agree that Members and non-Members should be treated equitably. The Contracted Provider agrees not to discriminate against Members on the basis of race, color, national origin, age, sex, gender, or disability.

e. Department Authority Related to the Medicaid Program. The Contracted Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs.

f. Access to Provider Records. The Contracted Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to this Agreement and any records, books, documents, and papers that relate to this Agreement and/or the Contracted

Provider's performance of its responsibilities under this contract for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions:

i. The United States Department of Health and Human Services or its designee;

ii. The Comptroller General of the United States or its designee;

iii. The North Carolina Department of Health and Human Services (NC DHHS), its Medicaid managed care program personnel, or its designee

iv. The Office of Inspector General

v. North Carolina Department of Justice Medicaid Investigations Division

vi. Any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS;

vii. The North Carolina Office of State Auditor, or its designee

viii. A state or federal law enforcement agency.

ix. And any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

The Contracted Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by the NC Department of Health and Human Services. Nothing in this Section shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation.

g. Provider Ownership Disclosure. The Contracted Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. The Contracted Provider agrees to notify, in writing, the Health Plan and the NC Department of Health and Human Services of any criminal conviction within twenty (20) days of the date of the conviction.

h. G.S. 58-3-225, Prompt Claim Payments Under Health Benefit Plans. Per Section 5.(6).g. of Session Law 2015-245, as amended by Section 6.(b) of Session Law 2018-49 pertaining to Chapter 58 protections, Health Plan shall use the following provision, verbatim except as allowed in 2. above, in all provider contracts, as applicable:

The Contracted Provider shall submit all claims to the Health Plan for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, the Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for the Contracted Provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably

possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required.

i. For Medical claims (including behavioral health):

1. The Health Plan shall within eighteen (18) calendar days of receiving a Medical Claim notify the provider whether the claim is clean, or pend the claim and request from the provider all additional information needed to process the claim.

2. The Health Plan shall pay or deny a clean medical claim at lesser of thirty (30) calendar days of receipt of the claim or the first scheduled provider reimbursement cycle following adjudication.

3. A medical pended claim shall be paid or denied within thirty (30) calendar days of receipt of the requested additional information.

ii. For Pharmacy Claims:

1. The Health Plan shall within fourteen (14) calendar days of receiving a pharmacy claim pay or deny a clean pharmacy claim or notify the provider that more information is needed to process the claim.

2. A pharmacy pended claim shall be paid or denied within fourteen (14) calendar days of receipt of the requested additional information.

iii. If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the Health Plan shall deny the claim per § 58-3-225 (d).

1. The Health Plan shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

iv. If the Health Plan fails to pay a clean claim in full pursuant to this provision, the Health Plan shall pay the Contracted Provider interest and penalty. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

v. Failure to pay a clean claim within thirty (30) days of receipt will result in the Health Plan paying the Contracted Provider a penalty equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.

vi. The Health Plan shall pay the interest and penalty from subsections (iv) and (v) as provided in that subsection, and shall not require the Contracted Provider to request the interest or the penalty.

ATTACHMENT C
COMPENSATION

(See following attachments)

ATTACHMENT C-1
NORTH CAROLINA MEDICAID / CHIP COMPENSATION
(PROFESSIONAL)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under the North Carolina Contract. 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 professional Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:

   [PLACEHOLDER FOR RATES; MAY BE NEGOTIATED WITH PROVIDER]

   Notwithstanding the above, if Department requires that compensation for a Covered Service shall be no less than a specified minimum amount under the North Carolina Medicaid fee schedule, Health Plan shall reimburse Provider accordingly for such Covered Service.

3. Directed Payments. If required by the Department, Health Plan shall make additional, utilization-based directed payments to qualifying Providers in the frequency and amount directed by Department where Health Plan is reimbursed for such by Department, and where permitted in 42 CFR § 438.6(c)(1)(iii)(B).

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. North Carolina Payment Rules. Health Plan follows the Department's guidelines regarding modifiers and only reimburses modifiers reimbursed by North Carolina Medicaid. Health Plan may apply current North Carolina Medicaid payment rules, policies and guidelines related to Provider's claims.

6. Provider Type. The rate paid herein shall be adjusted for Provider and/or Covered Service type delivered. The amount of compensation is based on the treating Provider's licensure and Health Plan's credentialing requirements for that discipline, not on the Provider's academic credentials.

7. With regard to the applicable North Carolina Medicaid fee schedule, Health Plan will determine the Department Medicaid fee schedule that is applicable to Providers and shall apply specific Medicaid fee schedules when so directed by the Department. Health Plan will implement and apply changes to the applicable Department Medicaid fee schedules and rates on the later of: (a) the effective date of the change, (b) 45 days from the date the changes are published on its website, or (c) 45 days after a proposed fee schedule or rate change has received all necessary regulatory approvals. Unless prohibited by Laws or Department, Health Plan will not reprocess claims that were adjudicated prior to the date the Health Plan implemented such changes.

8. Health Plan may implement successor codes for deleted or retired codes as codes are revised or implemented by the Governmental Authorities or coding authorities. Health Plan will, to the extent reasonably possible, tie existing compensation rates for the Covered Services to the successor codes. When applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for Covered Services that are not included in the Department's Medicaid fee schedules and payment systems published on its website.