FORSYTH COUNTY
BOARD OF COMMISSIONERS

MEETING DATE: OCTOBER 24, 2019 **AGENDA ITEM NUMBER:** 5

SUBJECT: **RESOLUTION AUTHORIZING AGREEMENTS BETWEEN FORSYTH COUNTY, ON BEHALF OF ITS DEPARTMENT OF PUBLIC HEALTH, AND NORTH CAROLINA MEDICAID PREPAID HEALTH PLAN PROVIDERS, AMERIHEALTH CARITAS OF NORTH CAROLINA, INC., BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, UNITEDHEALTHCARE OF NORTH CAROLINA, INC., AND WELLCARE OF NORTH CAROLINA, INC.**
(FORSYTH COUNTY DEPARTMENT OF PUBLIC HEALTH)

COUNTY MANAGER'S RECOMMENDATION OR COMMENTS: Recommend Approval

SUMMARY OF INFORMATION:

In 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a predominantly fee-for-service structure to managed care. The NC Department of Health and Human Services (DHHS) will remain responsible for all aspects of Medicaid. Under Managed Care, instead of contracting directly with providers, the State will contract with insurance companies, called Prepaid Health Plans or PHPs. These insurance companies will be paid a predetermined set rate per person to provide all services, known as a capitated rate. Approximately 1.6 million Medicaid beneficiaries will transition to one of Medicaid Managed Care PHPs. Medicaid services will not change, but the health plans may offer enhanced services to their plan members.

In 2018, North Carolina received federal approval from the Center for Medicare & Medicaid Services (CMS) to transition to Medicaid managed care and make other changes related to Medicaid Transformation.

With formal approval from the CMS, DHHS conducted a procurement and evaluation process to select PHPs. Statewide PHP contracts were awarded to the following entities, which will offer Standard Plans in all regions in North Carolina: AmeriHealth Caritas North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, UnitedHealthcare of North Carolina, Inc., and WellCare of North Carolina, Inc.

The Forsyth County Department of Public Health has historically billed and received reimbursement from NC State Medicaid for its clinical-laboratory, dental, case management, and pharmacy services.

With the transformation of Medicaid, the Department of Public Health will need to contract with each PHP in order to continue to bill and receive reimbursement for Medicaid participants. The rates for covered service compensation are set by the DHHS NC Medicaid Fee Schedule or the CMS Medicare Fee Schedule.

ATTACHMENTS: [X] YES [ ] NO

SIGNATURE: J. Dudley Watts, Jr. /AMS
COUNTY MANAGER

DATE: October 21, 2019

RESOLUTION AUTHORIZING AGREEMENTS BETWEEN FORSYTH COUNTY, ON BEHALF OF ITS DEPARTMENT OF PUBLIC HEALTH, AND NORTH CAROLINA MEDICAID PREPAID HEALTH PLAN PROVIDERS, AMERIHEALTH CARITAS OF NORTH CAROLINA, INC., BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, UNITEDHEALTHCARE OF NORTH CAROLINA, INC., AND WELLCARE OF NORTH CAROLINA, INC.
(FORSYTH COUNTY DEPARTMENT OF PUBLIC HEALTH)

WHEREAS in 2015, the NC General Assembly enacted Session Law 2015-245, directing the transition of Medicaid from a predominantly fee-for-service structure to managed care;

WHEREAS in 2018, the Center for Medicare & Medicaid Services (CMS) approved North Carolina's transition to Medicaid managed care;

WHEREAS statewide, the Department of Health and Human Services through a procurement process selected four prepaid health plans to manage the healthcare of Medicaid recipients;

WHEREAS by November 15, 2019, providers that offer covered services for Medicare recipients must enter into an agreement with each of the four prepaid health plans in order to continue to be reimbursed for its Medicaid covered services;

WHEREAS effective February 1, 2020, the State of North Carolina will be a managed-care state for Medicaid recipients; and

WHEREAS Forsyth County Department of Public Health has historically billed and been reimbursed for covered Medicaid services including clinic and pharmacy services;

NOW, THEREFORE, BE IT RESOLVED, by the Forsyth County Board of Commissioners that the Chair or County Manager and the Clerk to the Board are hereby authorized to execute, on behalf of Forsyth County and its Department of Public Health, prepaid health provider agreements with AmeriHealth Caritas North Carolina, Inc., Blue Cross and Blue Shield of North Carolina, UnitedHealthcare of North Carolina, Inc., and WellCare of North Carolina, Inc., to bill and be reimbursed for Medicaid covered services, subject to a pre-audit certificate thereon, by the County Chief Financial Officer, if applicable, and approval as to form and legality by the County Attorney.

Adopted this the 24th day October 2019.

AMERIHEALTH CARITAS NORTH CAROLINA, INC.

PHYSICIAN PROVIDER AGREEMENT

With

Forsyth County, North Carolina DBA Department of Public Health
TIN: 56-6000450

AMERIHEALTH CARITAS NORTH CAROLINA, INC.
PHYSICIAN PROVIDER AGREEMENT

This Physician Provider Agreement (the "Agreement"), dated as of the Effective Date (defined below), is made by and between **AmeriHealth Caritas North Carolina, Inc.**, a corporation organized under the laws of the State of North Carolina, (hereinafter referred to as ("ACNC)" and the Provider ("Provider") identified on the signature page.

WHEREAS, ACNC is a managed care organization that is responsible for providing or arranging for the provision of health care services to its Members; and

WHEREAS, Provider and ACNC mutually desire to enter into this Agreement, whereby Provider shall render services to Members enrolled with ACNC and be compensated by ACNC in accordance with the terms and conditions hereof.

NOW, THEREFORE, in consideration of the mutual promises made herein, it is mutually agreed by and between ACNC and Provider as follows:

1. DEFINITIONS

As used in this Agreement, each of the following terms shall have the meaning specified herein, unless the context clearly requires otherwise.

1.1 **AFFILIATES.** An Affiliate is any corporation or other organization that is identified as an Affiliate in a written notice to Provider and is owned or controlled, either directly or through parent or subsidiary corporations, by or under common control with, ACNC shall give Provider thirty (30) days advance written notice of the addition of Affiliates added under this provision. Unless otherwise specified in this Agreement or any other attachment hereto, references to "ACNC" shall include the Affiliates referenced in **Appendix D**.

1.2 **AGENCY.** The State and/or Federal governmental agency that administers the Program(s) under which ACNC is obligated to provide or arrange for the provision of Covered Services.

1.3 **AGENCY CONTRACT.** The contract or contracts between ACNC and the Agency, as in effect from time to time, pursuant to which ACNC is responsible for coordinating health care services and supplies for Program recipients enrolled with ACNC.

1.4 **CLEAN CLAIM.** A claim for payment for a health care service, which has been received by ACNC, has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation or a particular circumstance requiring special treatment that prevents timely payment from being made on the claim. Consistent with **42 CFR §447.45(b)**, the term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim, or a claim under review for medical necessity.

1.5 **COVERED SERVICES.** Those Medically Necessary health care services and supplies to which Members are entitled pursuant to the Agency Contract, and which shall be provided to Members by Provider, as described more specifically in **Appendix A**. Covered Services shall be furnished in the amount, duration and scope required under the Program.

1.6 **EFFECTIVE DATE.** The later of (i) the effective date on the signature page of this Agreement or (ii) the effective date of the Agency Contract, provided that Provider has been successfully credentialed by ACNC and that all required regulatory approvals have been obtained by ACNC.

1.7 **EMERGENCY MEDICAL CONDITION.** Health care services provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(a) Placing the health of the Member (or with respect to a pregnant woman, the health of the Member or her unborn child) in serious jeopardy;

(b) Serious impairment to bodily functions; or

(c) Serious dysfunction of any bodily organ or part.

1.8 **EMERGENCY SERVICES.** Covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services under 42 C.F.R. Section 438.114(a) and 42 U.S.C. Section 1932(b)(2) and that are needed to screen, evaluate, and stabilize an Emergency Medical Condition.

1.9 **GROUP PHYSICIAN.** A physician who practices with Provider as an employee, partner, shareholder, or contractor.

1.10 **MEDICALLY NECESSARY.** Medical necessity is 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.

1.11 **MEMBER.** An individual that is eligible for a Program and who has enrolled in ACNC under the Program.

1.12 **MEMBER APPEAL PROCEDURES.** The written procedures describing ACNC's standards for the prompt resolution of Member problems, grievances and appeals, as described in the Provider Manual.

1.13 **PARTICIPATING PROVIDER.** A physician duly licensed to practice medicine in the State of North Carolina participating in or eligible to participate in the North Carolina Medicaid program, and who is a member of the medical staff of a(n) ACNC- participating hospital, or a licensed, appropriately supervised allied health professional, either of whom has entered into, or who is recognized by ACNC as a member of a group which has entered into, an agreement with ACNC to provide medical services to Members under the Program.

1.14 **PRIMARY CARE PROVIDER.** A duly licensed pediatrician, internist, family practitioner, or doctor of general medicine, obstetrician/gynecologist or group thereof or a licensed, appropriately supervised allied health professional, who has been successfully credentialed by, and is a Participating Provider with ACNC, and who is responsible for the supervision, coordination, and provision of primary care services to Members who have selected, or have been assigned to, that provider. The Primary Care Provider also is responsible for initiating any required referrals for specialty care needed by a Member and maintaining overall continuity of a Member's care.

1.15 **PRIMARY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional services specified as Primary Care Services in the Provider Manual, as updated or amended from time to time. All Covered Services shall be provided in the amount, duration and scope set forth in the State Contract and as otherwise required under the Program.

1.16 **PROGRAM.** The Medicaid managed care model of the North Carolina Medicaid and NC Health Choice programs.

1.17 **PROVIDER MANUAL.** The ACNC manual of standards, policies, procedures and corrective actions together with amendments or modifications ACNC may adopt from time to time. The Provider Manual is herein incorporated by reference and made part of this Agreement. The Provider Manual may be amended or modified by ACNC from time to time in accordance with Section 4.8 herein below.

1.18 **QUALITY MANAGEMENT PROGRAM.** An ongoing review process and plan which functions to define, monitor, review, and recommend corrective action for managing and improving the quality of health care services to Members.

1.19 **SPECIALTY CARE PROVIDER**. A duly licensed physician who has been successfully credentialed by ACNC and who has entered into an agreement to provide Specialty Care Services to Members in accordance with the referral and preauthorization requirements of the Provider Manual.

1.20 **SPECIALTY CARE SERVICES.** Covered Services specified in **Appendix A** hereto and any additional specified as "Specialty Care Services" in the Provider Manual, as updated and amended from time to time.

1.21 **UTILIZATION MANAGEMENT PROGRAM.** A process of review of the medical necessity, appropriateness and efficiency of health care services, procedures, equipment, supplies, and facilities rendered to Members.

2. SERVICES:

2.1 Provider agrees to provide and cause its Group Physicians to provide, as applicable, (i) Primary Care Services to Members who have selected, or are otherwise assigned to, Provider as their Primary Care Provider, and (ii) Specialty Care Services to Members who have been referred to Provider. Covered Services shall be provided in accordance with the terms of this Agreement and ACNC referral, preauthorization and other Utilization Management Program polices as described in the Provider Manual, other than Emergency Services, which will be provided as needed. Provider will refer Members to providers participating in the ACNC network whenever Provider is unable to provide Medically Necessary services and/or when consistent with sound medical judgment and accepted standards of care. Provider and Group Physicians shall provide such services in the same manner and with the same availability as services provided to other patients without regard to reimbursement and shall further provide these services in accordance with the clinical quality of care and performance standards which are professionally recognized as industry practice and/or otherwise adopted, accepted or established by ACNC.

2.2 Provider will deliver office-based medical services to Members only at those office locations set forth in **Appendix B** hereto as such appendix is modified from time to time by mutual agreement of the parties. Provider shall notify ACNC at least sixty (60) days prior to making any addition or change to office locations.

2.3 Primary Care Providers shall accept as patients those Members who have selected or have been assigned to Provider, and Specialty Care Providers shall accept as patients those Members who have been referred to Provider, in either case without regard to the health status or medical condition of such Members. Primary Care Providers may decline to accept additional Members (excluding persons already in Provider's practice that enroll in ACNC) by giving ACNC written notice of such intent ninety (90) days in advance of the effective date of such closure. Provider agrees to accept any Members selecting the Primary Care Provider's practice during the ninety (90) day notice period.

2.4 Provider shall provide ACNC with complete and accurate statements of all Covered Services provided to Members in conformance with ACNC billing procedures, including without limitation, use of complete applicable diagnosis, procedure and revenue codes. ACNC will not be liable for any bills relating to services that are submitted the later of: (a) after twelve (12) months from the date the services were provided (consistent with **42 CFR §447.45(d)**), or (b) after sixty (60) days of the date of the Explanation of Benefits from another payor when services are first billed by Provider to another payor. Any appeal or request for adjustment of a payment by Provider must be made in accordance with applicable provisions of the Provider Manual and ACNC policies and procedures and, in any case, must be received by ACNC within sixty (60) days of the original payment or denial. Provider may not bring legal action on claims which have not been appealed through the appeal mechanisms described herein.

Encounter Data and Other Reports. Provider shall deliver all reports and clinical information required to be submitted to ACNC pursuant to this Agreement for reporting purposes, including but not limited to encounter data, Healthcare Effectiveness Data and Information Set (HEDIS), Agency for Healthcare Research and Quality (AHRQ), and EPSDT data in a format which will allow ACNC to transmit required data to the Agency electronically and in a format identical to or consistent with the format used or otherwise required by ACNC and the Agency. Provider shall submit this information to ACNC within the time frames set forth in the Provider Manual or as otherwise required by the Agency. Provider shall submit all encounter data to the same standards of completeness and accuracy as required for proper adjudication of fee-for-service claims by ACNC.

2.5 In accordance with ACNC policies and procedures, only successfully credentialed Participating Providers may provide Covered Services to Members under this Agreement.

3. COMPENSATION:

3.1 ACNC shall pay Provider for Covered Services provided to Members pursuant to the terms of this Agreement. ACNC shall have the right to offset claims payments to Provider by any amount owed by Provider to ACNC, following at least thirty (30) days' written notice. Notwithstanding the foregoing, Provider shall not be entitled to reimbursement if the Member was not eligible at the time services were rendered, and ACNC may immediately recover any amounts paid for services rendered to an ineligible recipient.

3.2 ACNC agrees to pay Provider the amount set forth in **Appendix C** for Covered Services rendered by Provider to Members. Provider understands and agrees that any payments ACNC makes directly or indirectly to Provider under this Agreement shall not be made as an inducement to reduce, limit, or delay Medically Necessary Covered Services to any Member. Except as may be otherwise specifically set forth in **Appendix C**, in no event will ACNC's payment exceed submitted charges. Provider recognizes and accepts the fees set forth in **Appendix C** as payment in full, and no additional charges will be made by Provider to ACNC for Covered Services provided hereunder.

3.3 Under no circumstances, including ACNC's failure to pay for Covered Services, termination of this Agreement, or the insolvency of ACNC, will Provider or any Group Physician bill or collect from, or make any charges or claims against any Member directly or indirectly for Covered Services authorized by ACNC, except for authorized co-payments, co-insurance and/or deductible. Provider and Group Physicians shall look only to ACNC for compensation for Covered Services. Provider shall not deny Covered Services to a Member in the event that a Member is unable to pay any authorized co-payment amounts. **42 CFR §447.15.**

3.4 Provider may directly bill Members for non-Covered Services if the Member is advised in writing before the service is rendered of: (i) the nature of the service(s) to be rendered; (ii) that ACNC does not cover the services; and (iii) that the Member will be financially responsible for the services if the Member elects to receive the services. Furthermore, Provider shall hold harmless ACNC for any claim or expense arising from such services.

3.5 ACNC shall pay all Clean Claims for Covered Services in accordance with applicable laws, regulations and Agency requirements; and ACNC will in any event meet the claim payment timeframes required under **42 CFR §447.45(d)**. ACNC will establish payment policies, including but not limited to the application of claim edits. In its processing of claims, ACNC will apply claim edits based on sources that include CMS and state-specific policy, as set forth in the Provider Manual.

4. ADMINISTRATION:

4.1 Throughout the term of this Agreement, Provider and all Group Physicians shall: (a) have and maintain, without restriction, all licenses, certificates, registrations and permits as are required under applicable State and federal statutes and regulations to provide the Covered Services furnished by Provider and/or other related activities delegated by ACNC under this Agreement. Provider shall obtain a unique identifier (national provider identifier) in accordance with the system established under Section 1173(b) of the Social Security Act, submit such identifier number to ACNC, and include such identifier on all claims. At all times during the term of this Agreement, Provider shall be eligible for participation in the North Carolina Medicaid program; and, if required by the North Carolina Medicaid program as a condition of furnishing services to North Carolina Medicaid recipients, Provider shall participate in the North Carolina Medicaid program. Provider shall ensure that all services provided pursuant to this Agreement are within the Provider's and, if applicable, Group Physicians' scope of professional responsibility.

4.2 During the term of this Agreement and in the event of termination of this Agreement for any reason, Provider and its Group Physicians will fully cooperate with each Member and with ACNC in arranging for the transfer of copies of Member medical records to other Participating Providers.

4.3 Record Maintenance, Inspection, Reporting and Auditing.

(a) Record Retention. As required by **42 CFR 434.6(a)(7)** and otherwise in accordance with the standards of ACNC, Provider and Group Physicians shall maintain an adequate record system for recording services, service providers, charges, dates and all other commonly required information elements for services rendered to Members pursuant to this Agreement (including but not limited to such records as are necessary for the evaluation of the quality, appropriateness, and timeliness of services performed under this Agreement and the Agency Contract).

(b) All records originated or prepared in connection with Provider's performance of its obligations under this Agreement will be retained and safeguarded by Provider in accordance with the terms and conditions of the Agency Contract and other relevant State and federal law. Provider agrees to retain all financial and programmatic records, supporting documents, statistical records and other records of Members relating to the delivery of care or service under the Agency Contract and as further required by the Agency, for a period of no less than ten (10) years from the expiration date of the Agency Contract, including any contract extension(s). If any audit, litigation, claim, or other actions involving the records have been initiated prior to the expiration of the ten (10) year period, the records shall be retained until completion of the action and resolution of all issues which arise from it or until the end of the ten (10) year period, whichever is later. If Provider stores records on microfilm or microfiche or other electronic means, Provider agrees to produce, at its expense, legible hard copy records promptly upon the request of state or federal authorities.

(c) Medical Record Maintenance. Provider shall ensure that all medical records are in compliance with the medical record keeping requirements set forth in the Provider Manual, the Agency Contract and Agency guides. Provider shall maintain up-to-date medical records at the site where medical services are provided for each Member enrolled under this Agreement. Each Member's record must be accurate, legible and maintained in detail consistent with good medical and professional practice which permits effective internal and external quality review and/or medical audit and facilitates an adequate system of follow-up treatment.

(d) ACNC shall be entitled to audit, examine and inspect Provider's books and records, including but not limited to medical records, financial information and administrative information pertaining to Provider's relationship with ACNC, at any time during normal business hours, upon reasonable notice. Provider agrees to provide ACNC, at no cost to ACNC, with such medical, financial and administrative information, and other records as may be necessary for ACNC to meet its obligations related to the Agency Contract and other regulatory obligations, Utilization Management Program and Quality Management Program standards, including NCQA standards, and other relevant accreditation standards which ACNC may require of ACNC participating providers.

4.4. Whether announced or unannounced, Provider agrees to, and shall cause its Group Physicians to, cooperate with, participate in, and abide by internal or external quality assessment reviews, Member Appeal Procedures, Utilization Management Program procedures, and Quality Management Program procedures established by ACNC, and to follow practice guidelines as described in the Provider Manual, the Agency Contract and the applicable Program manuals. Provider shall permit a representative of ACNC, or its designee, to review medical records concurrently as well as retrospectively. Provider shall provide copies of such medical records, either in paper or electronic form, to ACNC or its designee upon request. The Utilization Management and Quality Management Programs are described in the Provider Manual.

4.5 Provider authorizes ACNC to include Provider's and its Group Physicians' name(s), address(es), telephone number(s), medical specialty(ies), hospital affiliations, and other similar information relevant to Provider and/or Group Physicians, Provider's operations and its staff in the ACNC provider directory and in various marketing materials identifying Provider and/or Group Physicians as a provider(s) of services to Members. Provider agrees to afford ACNC the same opportunity to display brochures, signs, or advertisements in Provider's office(s) as Provider affords any other insurance company or other third party payor.

4.6 While both parties support Provider's open and active communication with Members concerning Medically Necessary services, available treatment alternatives, benefit coverage information and/or any other information pertaining to the provider-patient relationship, neither Provider nor any of its Group Physicians shall, during the term of this Agreement, and any renewal thereof, solicit or require any Member, either orally or in writing, to subscribe to or enroll in any managed care plan other than ACNC. The provisions of this **Section 4.6** shall similarly apply to Provider's employees, agents and/or contractors (including all Group Physicians).

4.7 Provider shall cooperate with ACNC in the identification of other sources of payment available to Members, such as other health insurance, government programs, liability coverage, motor vehicle coverage or worker's compensation coverage, as applicable. Provider shall be responsible for reporting all applicable third party resources to ACNC in a timely manner.

Provider will cooperate with ACNC in coordinating benefits with other payors in accordance with coordination of benefits claim processing rules and requirements outlined in the Provider Manual, the Agency Contract and applicable Program manuals, as amended from time to time. Provider will make a reasonable attempt to determine whether any other payor has primary responsibility for the payment of a claim for services that Provider rendered to a Member and bill that payor before billing ACNC. Unless otherwise prohibited by applicable law, ACNC retains the right to recover payments made to Provider if ACNC determines that another payor is primarily responsible for all or a portion of the claim.

4.8 ACNC shall furnish or otherwise make available to Provider a copy of the Provider Manual, as amended from time to time. Provider Manual updates will become effective thirty (30) days from the date of notification, unless otherwise specified in writing by ACNC.

4.9 ACNC shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction, where necessary, to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which the Provider practices and/or the standards established by ACNC, the Agency, or their respective designees. Provider shall cooperate with and abide by any corrective action plan initiated by ACNC and/or required by the Agency or any other State or federal regulatory agency with governing authority over the services provided under this Agreement.

4.10 Provider agrees that to the extent penalties, fines or sanctions are assessed against ACNC by the Agency or another regulatory agency with governing authority over the services provided under this Agreement as a result of Provider's or any Group Physician's failure to comply with their respective obligations under this Agreement, including but not limited to, failure or refusal to respond to the Agency's request for medical records, credentialing information, and other information required to be provided under this Agreement, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACNC, ACNC shall have the right to offset claims payments to Provider by the amount owed by Provider to ACNC.

4.11 Provider will assist ACNC in providing orientation services to Provider staff, to the extent ACNC may reasonably request.

4.12 Fraud and Abuse. Provider recognizes that payments made by ACNC pursuant to this Agreement are derived from federal and State funds, and acknowledges that it may be held civilly and/or criminally liable to ACNC and/or the Agency, in the event of non-performance, misrepresentation, fraud or abuse for services rendered to Members, including but not limited to,

the submission of false claims/statements for payment by Provider, its employees or agents. Provider shall be required to comply with all policies and procedures as developed by ACNC and the Agency, including but not limited to the requirements set forth in the Provider Manual and the Agency Contract, for the detection and prevention of fraud and abuse. Such compliance may include, but not be limited to, referral of suspected or confirmed fraud or abuse to ACNC.

4.13 Provider Protections.

(a) ACNC shall not exclude or terminate Provider or a Group Physician from ACNC's provider network because the Provider or Group Physician advocated on behalf of a Member including in the context of a utilization management appeal or another dispute with ACNC over appropriate medical care, provided that such advocacy is consistent with the degree of learning and skill ordinarily possessed by a health care provider practicing in accordance with the applicable standard of care.

(b) Provider shall not be excluded or terminated from participation with ACNC due to the fact that the Provider may have a practice that includes a substantial number of patients with expensive medical conditions.

(c) Provider shall not be excluded from participation, nor shall this Agreement be terminated, because Provider objects to the provision of or refuses to provide a healthcare service on moral or religious grounds.

5. PROFESSIONAL LIABILITY INSURANCE/ADVERSE ACTIONS:

5.1 Provider, at his/her sole expense, shall provide professional liability, comprehensive general liability, and medical malpractice insurance coverage (including coverage for vicarious liability, if any, for the acts of employees, agents and representatives of Provider (including without limitation all Group Physicians)) upon execution of this Agreement and at all times during the term of this Agreement, as follows:

(a) Amounts and extent of such insurance coverage as deemed necessary by ACNC to insure against any claim or claims for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with Provider's performance of any service pursuant to this Agreement; in no event shall such coverage be less than the amounts required by law.

(b) Provider shall provide ACNC with written verification of the existence of such coverage upon execution of this Agreement and as otherwise requested by ACNC throughout the term of the Agreement, which may include providing copies of face sheets of such coverage. Provider shall notify ACNC reasonably in advance of any change or cancellation of such coverage.

5.2 Provider shall immediately notify ACNC in writing, by certified mail, of any written or oral notice of any adverse action, including, without limitation, litigation, investigation, complaint, claim or transaction, regulatory action or proposed regulatory action, or other action naming or otherwise involving Provider or a Group Physician, or any other event, occurrence or situation which may reasonably be considered to have a material impact on Provider's or a Group Physician's ability to perform Provider's duties or obligations under this Agreement. Provider also shall immediately notify ACNC of any action against any applicable license, certification or participation under Title XVIII or other applicable provision of the Social Security Act or other State or federal law, State and/or DEA narcotic registration certificate, or medical staff privileges at any facility, and of any

material change in the ownership or business operations of Provider or a Group Physician. All notices required by this Section 5.2 shall be furnished as provided in Section 10.6 of this Agreement.

5.3 ~~Provider agrees to defend, indemnify and hold harmless ACNC and its officers, directors and employees from and against any and all claims, costs and liabilities (including the fees and expenses of counsel) as a result of a breach of this Agreement by Provider, the negligent or willful misconduct of Provider and/or Provider's employees, agents and representatives (including without limitation Group Physicians), and from and against any death, personal injury or malpractice arising in connection with the performance of any services by the Provider and all Group Physicians in connection with this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.~~

ACNC agrees to defend, indemnify and hold harmless Provider and its officers, directors and employees from and against all claims, costs and liabilities (including the fees and expenses of counsel) as a result of ACNC's breach of this Agreement or the negligent or willful misconduct of ACNC and/or ACNC's employees, agents and representatives in connection with ACNC's performance under this Agreement. This section shall survive the termination or expiration of this Agreement for any reason.

6. CONFIDENTIALITY:

ACNC and Provider shall each comply with all applicable State and federal laws respecting the confidentiality of the medical, personal or business affairs of Members acquired in the course of providing services pursuant to this Agreement. Each party shall maintain as confidential and shall not disclose to third parties financial, operating, proprietary or business information relating to the other party which is not otherwise public information. The payment rates in this Agreement are confidential and proprietary and shall not be disclosed by either party. However, nothing herein shall prohibit either party from making any disclosure or transmission of information to the extent that such disclosure or transmission is required by CMS or an applicable state regulatory agency, or is necessary or appropriate to enable the disclosing party to perform its obligations or enforce its rights under this Agreement, or is required by law or legal process. Should disclosure be required by law or legal process, the disclosing party shall immediately notify the other party of the disclosure. Notwithstanding, any information considered confidential shall be marked as such and state the basis for exclusion under public records law.

7. COOPERATION; RESOLUTION OF DISPUTES:

7.1 Cooperation. To the extent compatible with separate and independent management of each, ACNC and Provider shall at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits to Members at the most reasonable cost consistent with high standards of care. ACNC and Provider shall use best efforts to exchange information regarding material matters directly or indirectly related to this Agreement.

7.2 Resolution of Disputes. ACNC and Provider shall both fully cooperate in resolving any and all controversies among or between said parties, their employees, agents, or representatives pertaining to their respective duties under this ~~Agreement. Such disputes shall be submitted for resolution in accordance with the provider appeal procedures as referenced in the Provider Manual and ACNC policies and procedures. Neither ACNC nor Provider shall permit a dispute between the parties to disrupt or interfere with the provision of services to Members.~~

8. TERM; TERMINATION:

8.1 The term of this Agreement shall commence as of the Effective Date and, unless earlier terminated in accordance herewith, shall continue for an initial one (1) year term. ~~Thereafter, this Agreement shall automatically renew for successive one (1) year terms unless the Agreement is terminated pursuant to this Section 8 as set forth herein.~~

8.2 Either party may terminate this Agreement at the end of the initial term or at any time thereafter by providing the other party with at least ninety (90) days prior written notice of its intention to terminate this Agreement. The effective date of termination will be on the first of the month following the expiration of the notice period.

8.3 Either party may terminate this Agreement for cause due to a material breach by giving ninety (90) days' prior written notice. The notice of termination for cause will not be effective if the breaching party cures the breach within the first sixty (60) days of the ninety (90) day notice period. In the event that the breaching party does not cure the breach within the sixty (60) day period, the effective date of termination will be the first of the month following the expiration of the ninety (90) day notice period.

8.4 Termination of this Agreement for any reason, including without limitation the insolvency of ACNC, shall not release Provider from his or her obligations to serve Members when continuation of a Member's treatment is Medically Necessary.

8.5 In the event any change in federal or State laws, rules and regulations or the Program would have a material adverse impact on either ACNC or Provider in connection with the performance of this Agreement (the "Mandated Changes") such that the basis for the financial bargain of this Agreement is undermined, then the affected party shall have the right to require the other, by written notice, to enter into negotiations regarding the affected or pertinent terms of this Agreement while still maintaining the original Agreement purposes. If renegotiated, such terms shall become effective no later than thirty (30) days after the parties have reached agreement on the renegotiated terms. The parties agree to make a good faith attempt to renegotiate the Agreement to the extent necessary to comply with any Mandated Changes. If, after good faith renegotiations, the parties fail to reach an agreement satisfactory to both parties within thirty (30) days of the request for renegotiation, the party requesting such renegotiation may terminate this Agreement upon ninety (90) days prior written notice to the other party.

8.6 Notwithstanding the above, ACNC may terminate this Agreement immediately in the event any of the following occur:

(a) If Provider (or, if Provider is a group, any Group Physician) or a person with an ownership or control interest in Provider is expelled, disciplined, barred from participation in, or suspended from receiving payment under any state's Medicaid program, Children's Health Insurance Program (CHIP), the Medicare Program under Section 1128 or 1128A of the Social Security Act or any other federal health care program.

(b) If Provider (or, if Provider is a group, any Group Physician) is debarred, suspended or otherwise excluded from procurement or non-procurement activities under the Federal Acquisition Regulations.

(c) If Provider (or, if Provider is a group, any Group Physician) is convicted of any felony or of any crime related to the practice of medicine.

(d) Upon the loss or suspension of the Provider's professional liability coverage set forth under Section 5 of this Agreement.

(e) The suspension or revocation of Provider's license or other certification or authorization necessary for Provider to render Primary Care Services and/or Specialty Care Services, as applicable, or upon ACNC's reasonable determination that the health, safety or welfare of any Member may be in jeopardy if this Agreement is not terminated.

(f) If Provider (or, if Provider is a group, any Group Physician) fails to satisfy any or all of the credentialing requirements of ACNC or fails to cooperate with or abide by the Quality Management Program.

(g) If Provider (or, if Provider is a group, a Group Physician) breaches a material provision of this Agreement or is engaged in any conduct which would injure the business of ACNC.

8.7 With respect to a Group Physician, if ACNC decides to suspend or terminate the Agreement, ACNC shall give the Group Physician written notice, to the extent required under CMS regulations, of the reasons for the action, including, if relevant, the standards and the profiling data the organization used to evaluate the Group Physician and the numbers and mix of Participating Physicians ACNC needs. Such written notice shall also set forth the Group Physician's right to appeal the action and the process and timing for requesting a hearing.

8.8 Upon termination of this Agreement for any reason, ACNC shall notify affected Members of the termination of Provider (or, if Provider is a group, any Group Physician) in accordance with the notification requirements under **42 C.F.R. §422.111(e)**. Regardless of the reason for termination, Provider shall promptly supply to ACNC all information necessary for the reimbursement of outstanding claims. **42 CFR 434.6(a)(6)**.

9. PROGRAM REQUIREMENTS:

Attached hereto and incorporated herein by reference is **Schedule 9**, setting forth such terms and conditions as are necessary to meet State and Federal statutory and regulatory requirements, and other Agency requirements, of the Program. **Schedule 9** is consecutively sub-numbered as necessary for each Program under which Provider is furnishing services under this Agreement. Provider acknowledges that the specific terms as set forth in **Schedule 9** are subject to amendment in accordance with federal and/or State statutory and regulatory changes to the Program. Such amendment shall not require the consent of the Provider or ACNC and will be effective immediately on the effective date thereof, as set forth in Section 10.3. In the event of a conflict between the terms of this Provider Agreement and the requirements set forth in **Schedule 9**, **Schedule 9** shall control.

10. MISCELLANEOUS:

10.1 It is understood that Provider is an independent contractor and in no way is Provider to be considered an employee, agent, or representative of ACNC. It is further understood that Provider provides specified services to Members in exchange for an agreed upon fee. This Agreement shall not create, nor be deemed or construed to create any relationship between ACNC and Provider other than that of independent contractors, contracting with each other solely for the purpose of performing this Agreement and each party shall be liable solely for their own activities and neither ACNC nor Provider shall be liable to any third party for the activities of the other party to this Agreement.

10.2 This Agreement, being for the purpose of retaining the professional services of Provider, shall not be assigned, subcontracted, or delegated by Provider without the express written consent of ACNC.

10.3 No alterations or modifications of the terms of this Agreement shall be valid unless such alterations or modifications are incorporated into the Agreement through a written amendment, signed by both parties hereto, and attached to this Agreement; provided, however, ACNC may amend this Agreement with sixty (60) days' notice to Provider via a(n) ACNC bulletin or other written communication provided in accordance with the notice provisions in Section 10.6, and unless Provider notifies ACNC, as applicable, of any objection, such amendment shall then take effect. Any amendment to this Agreement subject to prior regulatory approval(s) shall be effective once such regulatory approval(s) has been received.

Notwithstanding the foregoing, amendments required because of legislative, regulatory or governmental agency requirements do not require the consent of Provider or ACNC and shall be effective immediately on the effective date thereof. This Agreement remains subject to the approval of the State of North Carolina, and may be amended by ACNC to comply with any requirements of the State of North Carolina. Provider acknowledges that all Agency requirements, as may be amended from time to time, are incorporated to this Agreement.

10.4 This Agreement shall be deemed to have been made and shall be construed and interpreted in accordance with the laws of the State of North Carolina.

10.5 This Agreement and its exhibits, appendices, schedules, addenda or other attachments constitute the entire understanding and agreement between the parties concerning the subject matter hereof. This Agreement supersedes all prior written or oral agreements or understandings existing between the parties concerning the subject matter hereof including, but not limited to, any such agreement which may have been previously executed between Provider and ACNC or any of its Affiliates relating to the provision of Covered Services under the Program. In the event of a conflict between the terms of this Agreement and the Provider Manual, the terms of the later document shall control.

10.6 Written notices to be given hereunder shall be sent by Certified Mail, Return Receipt Requested, or by an overnight delivery service which provides a written receipt evidencing delivery to the address set forth by the party, or by confirmed facsimile followed by written notice through the U.S. postal service. All notices called for hereunder shall be effective upon receipt.

If to Provider: 201 N Chestnut Street, Winston-Salem, NC 27102

Attn: ~~Frederick P. Johnson~~ <<Please put the contact for the appropriate member of the FCPHD

With a copy to:

If to AmeriHealth Caritas North Carolina, Inc.:

8041 Arco Corporate Drive
Raleigh, NC 27617
Attention: Provider Network Management

With a copy to: General Counsel
AmeriHealth Caritas
200 Stevens Drive

Philadelphia, PA 19113

10.7 Both parties agree that there shall be no discrimination in the performance of this Agreement against any patient or other person as the result of that individual's race, color, religion, gender, sexual orientation, handicap, age, national origin, source of payment, or any other basis prohibited by law.

10.8 The failure of any of the parties to insist upon strict performance of any of the terms of this Agreement shall not be deemed a waiver of any of their respective rights or remedies, and shall not be deemed a waiver of any subsequent breach or default in any of the terms contained in this Agreement.

10.9 In the event that any provision under this Agreement is declared null or void, for any reason, the remaining provisions of this Agreement shall remain in full force and effect.

10.10 The parties will use reasonable care and due diligence in performing this Agreement. Provider will be solely responsible for the services provided under this Agreement.

10.11 All captions contained in this Agreement are solely for the convenience of the parties hereto and shall not be deemed part of the content of this Agreement.

10.12 All terms used in this Agreement are deemed to refer to the masculine, feminine, neuter, singular or plural as the content may require.

10.13 Non-Discrimination. Provider shall comply with (i) Title VI of the Civil Rights Act of 1964 and the rules, regulations, and order; (ii) the Rehabilitation Act of 1973 and the rules, regulations, and orders thereunder; (iii) the Americans With Disabilities Act of 1990 and the rules, regulations, and orders thereunder; and (iv) any and all applicable laws, rules and regulations prohibiting discriminatory practices. Furthermore, in accordance with Title VI of the Civil Rights Act of 1964 and the rules, regulations and orders thereunder, Provider shall take adequate steps to ensure that Members with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this Agreement (see 42 U.S.C. 2000d et seq. and 45 C.F.R. Part 80, 2001 as amended).

10.14 No Offshore Contracting. No Covered Services under this Agreement may be performed outside of the United States without ACNC's prior written consent. In addition, Provider will not hire any individual to perform any services under this Agreement if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

10.15 Addition of Programs or Products. ACNC anticipates providing coverage under and/or sponsoring managed care plans under programs other than the North Carolina Medicaid and NC Health Choice programs, including but not necessarily limited to products under the Affordable Care Act Exchange. Provider may elect to participate in all such ACNC-sponsored products as appropriate within Provider's scope of practice, subject to mutual written agreement that may be set forth in an amendment to this Agreement or in a separate provider contract. Nothing herein shall be construed to require Provider's participation in any future ACNC-sponsored product as a condition of entering into this Agreement.

[SIGNATURES ON FOLLOWING PAGE; REMAINDER OF PAGE INTENTIONALLY BLANK]

IN WITNESS WHEREOF, and intending to be legally bound hereby, the parties hereto, each by its officers duly authorized, hereby affix their hands as of the date written below.

PROVIDER	**AmeriHealth Caritas North Carolina, Inc.**
__Ronda D. Tatum_____ Print Name	_____ Name
_____ Signature	_____ Signature
_Deputy County Manager_____ Title	_____ Title
201 N Chestnut Street, Winston-Salem, NC 27102 Address	_____ Date
_1154475424_____ National Provider ID Number	**Effective Date of Agreement:** _____ [To be completed by AmeriHealth Caritas North Carolina, Inc.]
_1154475424_____ Medicaid ID Number	
_56-6000450_ _____ Group Tax ID Number Group Medicare #/PTAN	
_____ Date	
Assignment of Payment ***(applicable to Group Physician only)*:** **By signing below, Provider hereby assigns and transfers all Provider's right to and interest in compensation payable by ACNC pursuant to this Agreement to the party identified below, and Provider therefore directs ACNC to pay such compensation to said party:**	
_____ Provider Signature	
_____ Name of Group	
_____ Address	
_____ _____ Group Tax ID Number Group Medicare #/PTAN	
Check and initial if Assignment of Payment Not Applicable: ☐ Provider Initials _____	

APPENDIX A

COVERED SERVICES

Primary Care Services
In Provider's capacity as a Primary Care Provider, Provider shall provide all Primary Care Services to Members who have selected or been assigned to Provider as their Primary Care Provider including the following:

1. All primary ambulatory care visits and routine office procedures;
2. Periodic physical examinations;
3. Routine injections and immunizations, including vaccinations;
4. Arrange for and/or provide inpatient medical care at ACNC participating hospital providers;
5. Referrals, as required, to Specialty Care Providers;
6. Referrals, as required, to ACNC participating providers for lab, radiology and other appropriate services;
7. Provision or arrangement for Primary Care Services twenty-four (24) hours a day, seven (7) days a week; and
8. Exercise primary responsibility for arranging and coordinating the delivery of Medically Necessary health care services to Members.

Specialty Care Services
In Specialty Provider's capacity as a Specialty Care Provider, Provider shall provide all Specialty Care Services to Members including the following:

1. Ambulatory care visits;
2. Arrange for and/or provide inpatient medical care at ACNC participating hospital providers; and
3. Emergency or consultative Specialty Care Services twenty-four (24) hours a day, seven (7) days a week.

APPENDIX B

PROVIDERS AND OFFICE LOCATIONS COVERED BY AGREEMENT

PRIMARY/SPECIALTY CARE PROVIDER(S)	**PRIMARY/SPECIALTY CARE PROVIDER(S)**
Name	Name
Name	Name
Name	Name
Name	Name
Name	Name
PRACTICE LOCATION ADDRESS	**PRACTICE LOCATION ADDRESS**
Address	Address
City, State, ZIP	City, State, ZIP
Phone Number	Phone Number

APPENDIX C
COMPENSATION

Primary Care Provider Compensation
Commencing on the Effective Date, ACNC will compensate Provider for all Primary Care Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of **100% of the Medicaid Fee Schedule(s)** in effect on the date that Primary Care Services were rendered, less applicable co-insurance and deductibles. Payments will be made in accordance with North Carolina Medicaid payment policies, and with retroactive effective dates as necessary to coincide with the effective dates of changes made by the Agency to its fee schedule. In no event will ACNC's payment exceed Provider's charges.

Specialty Care Provider Compensation
Commencing on the Effective Date, ACNC will compensate Provider for all Specialty Care Services rendered by Provider to Members in accordance with the terms of this Agreement at a rate of **100% of the Medicaid Fee Schedule(s)** in effect on the date that the Specialty Care Services were rendered, less applicable co-insurance and deductibles. Payments will be made in accordance with North Carolina Medicaid payment policies, and with retroactive effective dates as necessary to coincide with the effective dates of changes made by the Agency to its fee schedule. In no event will ACNC's payment exceed Specialty Provider's charges.

Value-Based Program Participation
By participating with ACNC as a participating provider, the Members assigned to the participating provider's associated PCPs will be included in the applicable PerformPlus® value-based program(s), as determined by provider type and specialty. The provider-specific program will be implemented pursuant to a written addendum to, and will thereby become incorporated to, this Agreement. For the first year of the program, there will be no downside risk as the program will qualify as meeting state-based requirements. For ongoing participation in a PerformPlus value-based program beyond the first year, the parties agree to negotiate in good faith within one-hundred twenty (120) days of the end of the first year of this Agreement to agree to terms for a value-based model that may include an element of downside risk. In the absence of such an agreement, the PerformPlus value-based program will terminate at the conclusion of the first year of the program.

Advanced Medical Homes (AMH)
Tier-Specific Reimbursement Schedule:

AMH Tier 1
- Medical Home Fee: $1 PMPM – all assigned beneficiaries

AMH Tier 2
- Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries
- Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group
- Optional: Value-Based Performance Incentive Payments

AMH Tier 3
- Medical Home Fee: $2.50 PMPM – non-ABD beneficiaries
- Medical Home Fee: $5.00 PMPM – members of the ABD eligibility group
- Care Management Fee: TBD
- Value-Based Performance Incentive Payments: See attached Addendum and/or Exhibit TBD

APPENDIX D
PHYSICIAN PROVIDER

ACNC AFFILIATES

ACNC Affiliates Covered by Agreement – None.

Schedule 9-1

Federal Requirements – Medicaid and Medicaid Managed Care

(Rev. 7/1/17)

1. No payment will be made to Provider for provider-preventable conditions or health care-acquired conditions. For purposes hereof:

    a. **Health care-acquired condition** ("HAC") means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary of the U.S. Department of Health and Human Services ("HHS") under section 1886(d)(4)(D)(iv) of the Social Security Act (the "Act") for purposes of the Medicare program identified in the State plan as described in section 1886(d)(4)(D)(ii) and (iv) of the Act, other than deep vein thrombosis/pulmonary embolism as related to total knee replacement or hip replacement surgery in pediatric and obstetric patients.

    b. **Other provider-preventable condition** means a condition occurring in any health care setting that meets the following criteria: (i) is identified in the North Carolina Medicaid plain; (ii) has been found by the North Carolina, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines (iii) has a negative consequence for the Member; (iv) is auditable; and (v) includes, at a minimum, wrong surgical or other invasive procedure performed on a patient, surgical or other invasive procedure performed on the wrong body part, or surgical or other invasive procedure performed on the wrong patient.

    c. **Provider-preventable condition** ("PPC") means a condition that meets the definition of "health care-acquired condition" or an "other provider-preventable condition."

    No reduction in payment will be made for a PPC when the condition existed prior to the initiative of treatment for that patient by Provider. Provider shall identify PPCs when submitting claims for payment or, if no claim will be submitted, if Medicaid payment would otherwise be available for the course of treatment in which the PPC occurred, or as otherwise required by the State. **42 CFR §§438.3(g), 434.6(a)(12) and 447.26.**

2. Physician Incentives. Provider shall disclose to ACNC annually any Physician Incentive Plan (PIP) or risk arrangements Provider may have with physicians, either within Provider's group practice or other physicians not associated with Provider's group practice, even if there is no substantial financial risk between ACNC and the physician or physician group. The term "substantial financial risk" means a financial risk set at greater than twenty-five percent (25%) of potential payments for Covered Services, regardless of the frequency of assessment (i.e., collection) or distribution of payments. The term "potential payments" means simply the maximum anticipated total payments that the physician or physician group could receive if the use or cost of referral services were significantly low. **42 CFR §§438.3(i), 422.208, 422.210**.

3. Provider Discrimination Prohibited. ACNC may not, with respect to Provider participation, compensation or indemnification under this Agreement, discriminate against Provider to the extent that the Provider is acting within the scope of his, her or its license or certification under applicable State law, solely on the basis of that license or certification. Without limiting the foregoing, ACNC shall not discriminate against Provider for serving high-risk populations or

specializing in conditions that require costly treatment. Nothing herein shall be construed to: (i) require ACNC to contract with Provider if not necessary to meet the needs of Members; (ii) preclude ACNC from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or (iii) preclude ACNC from establishing measures that are designed to maintain quality of services and control costs and are consistent with ACNC's responsibilities to Members. **42 CFR §§438.12, 438.214(c).**

4. Member Rights. Provider shall adhere to all applicable Federal and State laws that pertain to Member rights, and shall take such rights into account when furnishing services to Members. **42 CFR §438.100(a)(2).**

5. Provider-Member Communications. Nothing in this Agreement shall be construed to prohibit, restrict or impede Provider's ability to freely and openly discuss with Members, within the Provider's lawful scope of practice, all available treatment options and any information the Member may need in order to decide among all relevant treatment options, including but not limited to the risks, benefits and consequences of treatment or non-treatment, regardless of whether the services may be considered Covered Services in accordance with this Agreement. Further, nothing in this Agreement shall be construed to prohibit, restrict or impede Provider from discussing Medically Necessary care and advising or advocating appropriate medical care with or on behalf of a Member, including: information regarding the nature of treatment options, risks of treatment, alternative treatments or the availability of alternative therapies, consultation or tests that may be self-administered, and the Member's right to participate in decisions regarding his or her care, including the right to refuse treatment and to express preferences about future treatment decisions. **42 CFR §438.102(a).**

6. Member Hold Harmless. Provider shall accept the final payment made by ACNC as payment in full for Covered Services provided pursuant to this Agreement. Provider agrees that in no event, including, but not limited to, nonpayment by the Agency to ACNC, nonpayment by ACNC to Provider, the insolvency of ACNC, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, solicit or accept any surety or guarantee of payment, or have any recourse against Members or persons other than ACNC acting on their behalf (including parent(s), guardian, spouse or any other person legally, or potentially legally, responsible person of the Member) for Covered Services listed in this Agreement. This provision shall not prohibit collection of supplemental charges or co-payments on ACNC's behalf made in accordance with terms of an enrollment agreement between ACNC and Members.

   Provider further agrees that:

   a. this hold harmless provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members; and that

   b. this hold harmless provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

   42 CFR §§438.106, 447.15.

7. Coverage and Payment for Emergency Services. ACNC shall cover and pay for Emergency Services rendered by Provider and obtained when a Member had an Emergency Medical

Condition, or when a representative of ACNC has instructed the Member to seek Emergency Services. **42 CFR §438.114(c)(1)(ii)**.

8. Timely Access. Provider shall meet Agency standards for timely access to care and services, taking into account the urgency of the need for services. Provider shall offer hours of operation to Members that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if Provider serves only Medicaid enrollees. Provider services shall be available 24 hours a day, 7 days a week, when medically necessary. Provider shall provide physical access, reasonable accommodations, and accessible equipment for Members with physical or mental disabilities. **42 CFR §438.206(c)**.

9. Excluded Providers. Pursuant to **42 CFR §438.214(d)**, ACNC may not employ or contract with providers, or have a relationship with a person or entity that is excluded from participation in Federal health care programs under either Section 1128 or 1128A of the Act. ACNC may not knowingly have a Prohibited Relationship (defined hereinafter) with the following: (a) an entity or individual that is debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549; or (b) an individual or entity who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR §2.101 of a person described in the **subparagraph 9(a)**. For purposes of this **paragraph 9**, "Prohibited Relationship" includes a subcontractor of ACNC and a network provider or person with an employment, consulting or other arrangement with ACNC for the provision of items or services that are significant and material to ACNC's obligations under the Agency Contract. Provider shall comply with the disclosure, screening and enrollment requirements of **42 C.F.R. Part 455, Subparts B and E** and, upon reasonable request, provide such information to ACNC in accordance with the requirements specified therein. **42 CFR §§438.608(b), 438.610**

   Provider represents and warrants that neither it, nor any of its contractors or employees who will furnish goods or services under the Agreement, directors or officers, or any person with an ownership interest in Provider of five percent (5%) or more, is or ever has been: (i) debarred, suspended or excluded from participation in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP) or any other Federal health care program; (ii) convicted of a criminal offense related to the delivery of items or services under the Medicare or Medicaid program; (iii) had any disciplinary action taken against any professional license or certification held in any state or U.S. territory, including disciplinary action, board consent order, suspension, revocation, or voluntary surrender of a license or certification; or (iv) debarred or suspended from participation in procurement or non-procurement activities by any federal agency (collectively, "Sanctioned Persons"). Provider shall screen all employees and contractors who will furnish goods or services under this Agreement to determine whether they have been excluded from participation in any Federal health care program, by searching applicable Federal and State databases (including but not limited to the OIG's LEIE and the NPDB) upon initial employment or engagement of or contracting with a contractor, employee, director or officer, and on a monthly basis thereafter.

   Provider shall immediately notify ACNC upon knowledge by Provider that any of its contractors or employees who furnish goods or services under the Agreement, directors, officers or owners has become a Sanctioned Person, or is under any type of investigation which may result in their becoming a Sanctioned Person. In the event that Subcontractor cannot provide reasonably satisfactory assurance to ACNC that a Sanctioned Person will not receive payment from ACNC under this Agreement, ACNC may immediately terminate this Agreement. ACNC reserves the right to recover all amounts paid by ACNC for items or services furnished by a Sanctioned

Person. Further, and without limiting Provider's indemnification obligations set forth elsewhere in this Agreement, to the extent penalties, fines or sanctions are assessed against ACNC as a result of Provider's having a relationship with a Sanctioned Person, Provider shall be responsible for the immediate payment of such penalties, fines or sanctions. In the event such payment is not made in a timely manner to ACNC, ACNC shall have the right to offset claims payments to Provider by the amount owed by Provider to ACNC.

10. State and Federal Regulator Access. Provider acknowledges that the U.S. Department of Health and Human Services (HHS), Centers for Medicare and Medicaid Services (CMS), Office of the Inspector General, the Comptroller General, the Agency **[SPECIFY STATE AGENCIES/REPRESENTATIVES]**, and their designees may at any time inspect and audit any records or documents of Provider pertinent to this Agreement, including those pertaining to the quality, appropriateness and timeliness of services; and may at any time inspect the premises, physical facilities and equipment where Medicaid-related activities or work is conducted. The right to audit under this paragraph exists for ten (10) years from the final date of the Agency Contract or from the completion of any audit, whichever is later. **42 CFR §§434.6(a)(5), 438.3(h)**.

Commented [JFP1]: I'm assuming this should be NCDHHS, bt am uncertain

11. Provider shall safeguard information about Members as required by Part 431, Subpart D of 42 CFR. **42 CFR §434.6(a)(8)**.

12. Any permitted subcontracts entered into by Provider in order to carry out its obligations under this Agreement must be in writing and fulfill the requirements of 42 CFR Part 438 that are appropriate to the service or activity delegated under the subcontract, in accordance with 42 CFR **§438.230**. **42 CFR §§434.6(a)(11), (b), 438.3(k)**.

13. Provider must retain, as applicable, the following information for a period of not less than ten (10) years:

    a. Member grievance and appeal records in 42 CFR §438.416;

    b. Base data used to determine capitation rates, in 42 CFR §438.5(c);

    c. MLR reports in 42 CFR §438.8(k); and

    d. The data, information and documentation specified in 42 CFR §§438.604 , 438.606, 438.608 and 438.610.

    42 CFR §438.3(u).

14. Provider shall maintain and share, as appropriate, an enrollee health record in accordance with professional standards. **42 CFR §438.208(b)(5)**.

15. To the extent Provider conducts UM activities on behalf of ACNC, Provider's compensation under this Agreement shall not be structured so as to provide incentives for Provider to deny, limit or discontinue medically necessary services to any Member. **42 CFR §438.210(e)**.

16. Delegation. The following provisions shall apply to the extent any of ACNC's activities or obligations under the Agency Contract are delegated to Provider:

a. The delegated activities and related reporting responsibilities will be specified in the Agreement or in a separate delegation contract;

b. Provider agrees to perform the delegated activities and reporting responsibilities in company with ACNC's Agency Contract obligations;

c. ACNC may impose corrective actions, up to and including revocation of the delegated activities or obligations, in instances where the Agency or ACNC determine that Provider has not performed satisfactorily.

d. To the extent Provider is delegated responsibilities for coverage of services and payment of claims, Provider shall implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste and abuse that meet the requirements of **42 CFR §438.608(a)**.

Notwithstanding the foregoing, ACNC maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of the Agency Contract. **42 CFR §438.230(b)(c)**.

17. Provider agrees to comply with all applicable Medicaid laws, regulations (including applicable sub-regulatory guidance) and Agency Contract provisions. Provider agrees that:

    a. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate and inspect any books, records, contracts, computer or other electronic system of Provider, or of any subcontractors, that pertain to any aspect of services and activities performed, or determination of amounts payable under the Agency Contract.

    b. Provider will make available, for purposes of an audit, evaluation or inspection under subparagraph 17(a), its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to ACNC's Members.

    c. The right to audit under subparagraph 17(a) will exist through ten (10) years from the final date of the Agency Contract or from the date of completion of any audit, whichever is later.

    d. If the State, CMS or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the state, CMS or the HHS Inspector General may inspect, evaluate and audit Provider at any time.

    42 CFR §438.230(c)(2), (3)

18. ACNC may terminate this Agreement immediately upon notification from the Agency that Provider cannot be enrolled in the State Medicaid program, or if Provider has not enrolled in the State Medicaid Program within 120 days of the effective date of this Agreement. **42 CFR §438.602(b)(2)**.

Schedule 9-2

State of North Carolina Requirements – Medicaid and Medicaid Managed Care

Unless defined in this **Schedule 9-2** or elsewhere in the Agreement, all capitalized terms used herein shall have their respective meanings given to them in the Agency Contract between the State of North Carolina Department of Health and Human Services ("Agency") and AmeriHealth Caritas North Carolina (Plan) dated as of February 4, 2019 (the "Agency Contract").

The provisions set forth herein are intended to set forth the minimum requirements for provider contracts as required by the Agency in the Agency Contract. Citations herein are to Section VII.G of the Agency Contract ("Required Standard Provisions for PHP and Provider Contracts") unless otherwise specified. This Agreement, including this **Schedule 9-2**, is subject to Agency review and approval, and may be amended by the Plan as necessary to comply with Agency requirements, in accordance with Section V.D.2.c of the Agency Contract.

1. Agreement Term. Notwithstanding anything in this Agreement to the contrary, the term of this Agreement shall not exceed the term of the Agency Contract. (**Agency Contract Section VII.G.1.c**)

2. Termination. Without limiting the termination provisions set forth in Section 8 of the Agreement, Plan may immediately terminate this Agreement upon a confirmed finding of fraud, waste, or abuse by the Agency or the North Carolina Department of Justice Medicaid Investigations Division. (**Agency Contract Section VII.G.1.d**)

3. Survival. In addition to the indemnification and hold harmless provisions in the Agreement that shall survive its termination, in the event of Plan's insolvency, Provider shall not be relieved of its obligation to serve Members when continuation of a Member's treatment is Medically Necessary. Without limiting the foregoing, inpatient care shall be continued until the Member is ready for discharge. Further in the event of Plan's insolvency, any necessary transition of administrative duties and records will be conducted in accordance with the requirements of the North Carolina Department of Insurance and other applicable regulatory authorities, which will be determined based on the specific facts and circumstances of Plan's insolvency. Plan will provide written notice to Provider of transitional activities as they are determined.

   (**Agency Contract Section VII.G.1.e**)

4. Credentialing. Provider shall at all times maintain licensure, accreditation, and credentials sufficient to meet Plan's network participation requirements as outlined in Plan's credentialing and re-credentialing policies and procedures; and Provider shall promptly notify Plan of changes in the status of any information relating to Provider's professional credentials. Without limiting the foregoing:

   a. Provider shall at all times be enrolled in the North Carolina Medicaid program, in accordance with 42 CFR 455.410. Failure to enroll or maintain enrollment constitutes grounds for immediate termination of this Agreement by Plan.

   b. Provider shall re-enroll in the North Carolina Medicaid program no less frequently than every five (5) years during the Provider Credentialing Transition Period. For purposes hereof, as set forth in Section V.D.2 of the Agency Contract, "Provider Credentialing Transition Period" is that period of time before the Agency's Provider Data

Management/Credential Verification Organization (PDM/CVO) has achieved full implementation. Once the PDM/CVO has been fully implemented, Provider shall re-enroll in North Carolina Medicaid no less frequently than every three (3) years, except as otherwise permitted by the Agency.

(Agency Contract Section VII.G.1.f)

5. Liability Insurance. Provider's obligation to maintain professional liability coverage is set forth in the Agreement. Provider shall notify Plan of subsequent changes in status of professional liability insurance on a timely basis. **(Agency Contract Section VII.G.1.g)**

6. Member Billing. Provider shall not bill any Member for Covered Services, except for specified co-insurance, copayments and applicable deductibles. This restriction shall not prohibit Provider from agreeing with a Member to continue non-Covered Services at the Member's own expense, as long as Provider has notified the Member in advance that the Plan may not cover or continue to cover the non-Covered Services. **(Agency Contract Section VII.G.1.h)**

7. Provider Accessibility. Provider shall arrange for call coverage or other back-up to provider service in accordance with Plan's standards for provider accessibility as set forth in the Provider Manual. **(Agency Contract Section VII.G.1.i)**

8. Eligibility Verification. Provider is responsible for verifying Member eligibility, prior to rendering health care services, by using the mechanism provided by Plan. **(Agency Contract Section VII.G.1.j)**

9. Medical Records. As required by 42 CFR 438.208(b)(5), Provider shall maintain and share, as appropriate, a health record for each Member who receives care or services from Provider in accordance with professional standards. Without limiting the foregoing, Provider shall: (a) maintain confidentiality of Member medical records and personal health information and other health records as required by law; (b) maintain adequate medical and other health records according to industry and Plan standards; and (c) make copies of such records available to Plan and the Agency in conjunction with its regulation of Plan. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party. **(Agency Contract Section VII.G.1.k)**

10. Member Appeals and Grievances. Provider shall cooperate with Plan in regard to Member appeals and grievance procedures. **(Agency Contract Section VII.G.1.l)**

11. Provider Payment. Nothing in this Agreement shall be construed as providing for an automatic increase in payment rates to Provider, and any provision in this Agreement to the contrary shall be void. **(Agency Contract Section VII.G.1.m)**

12. Data to Provider. Plan shall furnish Provider with such data and information as may be necessary for Provider to fulfill its obligations to Plan under this Agreement. Such data and information shall include, but is not necessarily limited to: (a) performance feedback reports or information if compensation is related to efficiency criteria; (b) information on benefit exclusions, administrative and utilization management requirements, credential verification programs, quality assessment programs, and provider sanction policies; and (c) notification of changes in these requirements. Plan may provide such information through its Provider Manual and periodic updates thereto. **(Agency Contract Section VII.G.1.n)**

13. Utilization Management. Provider shall comply with Plan's utilization management programs, quality management programs, and provider sanctions programs; provided that none of these

programs shall override the professional or ethical responsibility of the Provider, or interfere with Provider's ability to provide information or assistance to its patients. (**Agency Contract Section VII.G.1.o**)

14. Provider Directory. Plan shall include Provider's name (and Provider's group name, if applicable), in the Plan's Provider Directory distributed to Members. Provider authorizes Plan to publish Provider's name and relevant practice information in the Plan Provider Directory. (**Agency Contract Section VII.G.1.p**)

15. Dispute Resolution. Plan and Provider shall follow the provider dispute process as set forth in the Agreement, the details of which are included in the Provider Manual and Plan policies and procedures made available to Provider. Plan's provider dispute process shall comply with the Agency's guidelines on Provider Grievance and Appeals as found in Section V.D.5 of the Agency Contract "Provider Grievances and Appeals." (**Agency Contract Section VII.G.1.q**) Provider shall exhaust Plan's internal appeal process before seeking other legal or administrative remedies under state or federal law. (**Agency Contract Section V.D.2.c.xi**). Notwithstanding anything to the contrary the County shall not be required to submit to arbitration, nor shall it be required to submit to litigation outside of Forsyth County, North Carolina.

16. Assignment. Provider's duties and obligations under the Agreement shall not be assigned, delegated or transferred without the prior written consent of Plan. Plan shall notify Provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer, in the event Plan consents to an assignment by Provider. (**Agency Contract Section VII.G.1.r**)

17. Government Funds. The funds used by Plan to make payments to Provider under this Agreement are government funds. (**Agency Contract Section VII.G.1.s**)

18. Interpreting and Translation Services.

    a. Provider must provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for a Member.

    b. Provider must ensure Provider's staff are trained to appropriately communicate with patients with various types of hearing loss.

    c. Provider shall report to Plan, in a format and frequency to be determined by Plan, whether hearing loss accommodations are needed and provided, and the type of accommodation provided.

    (**Agency Contract Section VII.G.1.t**)

19. Perinatal Care Providers. To the extent Provider furnishes perinatal care, the following shall apply, pursuant to the Agency's Pregnancy Management Program Policy as set forth in Section VII, Attachment M-3 of the Agency Contract:

    a. Provider shall complete the Pregnancy Management Program (PMP) standardized risk-screening tool (as determined by the Agency) at each initial visit.

    b. Provider shall allow Plan or Plan's designated vendor access to Member medical records for auditing purposes to measure performance on specific quality indicators.

c. Provider commits to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation.

d. Provider commits to decreasing the cesarean section rate among nulliparous women.

e. Provider shall offer and provider 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.

f. Provider shall complete a high-risk screening of each pregnant Member in the Pregnancy Management Program and integrate the plan of care with local pregnancy care management. When Provider refers a high-risk pregnancy to Plan, Plan is responsible for arranging intake of the Member into the statewide Care Management for High Risk Pregnant Women program, and shall inform Provider when the Member has entered to program.

g. Provider commits to decreasing the primary cesarean delivery rate if the rate is over the Agency's designated cesarean rate. [Note: the Agency will set the rate annually, which will be at or below twenty percent (20%).]

h. Provider shall ensure that comprehensive post-partum visits occur within fifty-six (56) days of delivery.

i. Provider shall send all screening information and applicable medical record information for Members in the Care Management of High-Risk Pregnancies to the applicable Prepaid Health Plans (PHPs) and the Local Health Departments (LHDs) or other applicable local care management entities that are contracted for the provision of providing care management services for high-risk pregnancy within one (1) business day of the Provider completing the screening.

Without limiting the foregoing, if Provider is an obstetrician, Provider agrees to comply with the Agency's Pregnancy Management Program. (**Agency Contract Section VII.G.1.u**)

20. Advanced Medical Homes. To the extent Provider is an Advanced Medical Home (AMH), as defined in the Agency Contract, Provider agrees to comply with the Agency's Advanced Medical Home Program. Without limiting the foregoing, Provider shall:

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

b. Provide Primary Care and Patient Care Coordination services to each Member, in accordance with Plan policies;

c. Provide or arrange for Primary Care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement;

d. Provide direct patient care a minimum of thirty (30) office hours per week;

e. Provide preventive services, in accordance with *Section VII. Attachment M. Table 1: Required Preventive Services* of the Agency Contract;

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

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

h. 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 Plan (if applicable) and as authorized by the Member within thirty (30) days of the date of the request, free of charge;

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

j. Refer for a second opinion as requested by the Member, based on Agency guidelines and Plan standards;

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

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

In addition, if Provider is a Tier 3 AMH, the requirements set forth in the Agency's Advanced Medical Home Policy at Section VII, Attachment M-2 of the Agency Contract, as may be amended from time to time by the Agency, shall apply. Such requirements will be appended to this Agreement if Provider is a Tier 3 AMH.

(Agency Contract Section VII.G.1.v)

21. Local Health Departments. To the extent Provider is a LHD carrying out care management for high-risk pregnancy and for at-risk children, Provider shall comply with the Agency's Care Management for High-Risk Pregnancy Policy (at Section VII, Attachment M-4 of the Agency Contract) and Care Management for At-Risk Children Policy (at Section VII, Attachment M-5 of the Agency Contract). The care management requirements set forth in these Agency Policies (as may be amended by the Agency from time to time) are further defined in the Provider Manual and will also be appended to this Agreement if Provider is an LHD carrying out care management for high-risk pregnancy and/or at-risk children. **(Agency Contract Section VII.G.1.w)**

22. Chapter 58 (Insurance) Requirements. Pursuant to 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, the following provisions shall apply:

    a. Coverage Determinations. As required by G.S. 58-3-200(c), if Plan or its authorized representative determines that services, supplies or other items are Covered Services, including any utilization management determination made by Plan, 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 Plan's determination, unless the determination was based on a material misrepresentation about the Member's health condition that was knowingly made by the Member or Provider.

b. Prompt Pay. Plan and Provider shall each be bound by the relevant provisions of the North Carolina prompt pay statute codified at G.S. 58-3-225, as in effect from time to time (the "Prompt Pay Statute"). Without limiting the applicability of the entirety of the Prompt Pay Statute, Provider shall submit all claims to Plan for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Provider to submit the claim within that time. In such case, the claim should be submitted as promptly 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. Plan shall, within eighteen (18) calendar days of receiving a Medical claim, notify Provider whether the claim is clean, or pend the claim and request from Provider all additional information needed to process the claim.

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

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

ii. For Pharmacy claims:

1. Plan shall, within fourteen (14) calendar days of receiving a pharmacy claim , pay or deny a pharmacy Clean Claim or notify Provider that more information is needed to process the claim.

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

iii. Plan shall re-process medical and pharmacy claims in a timely and accurate manner as described in this section (including interest and penalties if applicable. If the requested additional information on a pended medical or pharmacy claim is not submitted within ninety (90) days of the notice requesting the required additional information, Plan shall deny the claim, per G.S. 58-3-225(d).

iv. If Plan fails to pay a Clean Claim in full pursuant to this section, Plan shall pay Provider interest and penalty. Late payments will bear interest at the annual rate of eighteen percent (18%) 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 Plan paying the Provider a penalty equal to one percent (1%) of the total amount of the claim per day, beginning on the date following the date on which the claim should have been paid or was underpaid.

vi. Plan shall pay the interest and penalty from subsections G.S. 58-3-225(e) and G.S. 58-3-225(f) as provided in those subsections, and shall not require Provider to request the interest or the penalty.

vii. Plan shall provide no less than thirty (30) days' advance written notice of its intent to recover an overpayment from Provider, which recovery may be made through an offset against future claim payments. Plan may not recover overpayments more than two (2) years after the date of the original claim payment unless Plan has reasonable belief of fraud or other intentional misconduct by Provider or its agents. Provider may not seek recovery of underpayments from Plan more than two (2) years after the date of the original claim adjudication.

(Agency Contract Section VII.G.3.h)

c. Fee Schedule; Claim Submission. In accordance with G.S. 58-3-227, Plan shall make available its schedule of fees associated with the top thirty (30) services or procedures most commonly billed by the class of providers to which Provider belongs (e.g., primary care provider, specialist, hospital, etc.). Plan's claim submission and reimbursement policies are set forth in the Provider Manual, which shall be made available on Plan's website. Plan shall furnish advance notice to Provider of any changes to the information required to be furnished to Provider under G.S. 58-3-227 in accordance with the notice requirements set forth in the Agreement, but in no event less than thirty (30) days prior to the change.

d. Notice Contact. In accordance with G.S. 58-3-275, Plan and Provider shall indicate notice contacts as provided in the applicable section of the Agreement. Notwithstanding anything therein to the contrary, the means for providing notice shall be one of the following, calculated as: (i) five business days following the date the notice is placed, first-class postage prepaid, in the U.S. 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.

e. Contract Amendments. Notwithstanding anything in the Agreement to the contrary, in accordance with G.S. 58-50-280, if Plan initiates an amendment to the Agreement, Plan shall send any proposed contract amendment to Provider's notice contact with at least sixty (60) days' advance notice. The proposed amendment shall be dated, labeled "Amendment," signed by Plan, and include an effective date for the proposed amendment. Provider's failure to object in writing to the proposed amendment within the 60-day notice period shall constitute Provider's assent to and acceptance of the proposed amendment. If Provider objects to the proposed amendment, then the proposed amendment shall not be effective with respect to Provider, and Plan shall be entitled to terminate the Agreement with sixty (60) days' advance written notice to Provider. Nothing herein shall be deemed to prohibit Plan and Provider from amending the Agreement on mutually agreed terms within mutually agreed time periods. Further, Plan's right to terminate the Agreement as provided in this section shall not be deemed to be an affirmative obligation; and Plan and Provider may negotiate a mutually acceptable alternative to the proposed amendment in order to prevent termination of the Agreement.

In accordance with G.S. 58-50-270(1), (2), for purposes of the foregoing, "amendment" shall mean any change to the terms of this Agreement, including terms incorporated by reference, that modifies Provider's compensation under this Agreement. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an amendment. References in the foregoing and elsewhere throughout this Agreement

refer to this contract under which Provider is providing health care services on an in-network basis to Plan's Members.

Notwithstanding the foregoing section 22(c), all amendments must be in writing signed by both parties.

f. Policies and Procedures. In accordance with G.S. 58-50-285, Plan shall provide a copy of its policies and procedures, in the form of the Provider Manual, to Provider, prior to execution of this Agreement or any amendment to the Agreement, and at least annually. Plan may meet this requirement by posting its Provider Manual on its website. In the event of a conflict between Plan policies and procedures and this Agreement, the language of this Agreement shall prevail.

(Agency Contract Section VII.G.1.x)

23. Compliance with State and Federal Laws. 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 the 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. 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 Plan's 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. **(Agency Contract Section VII.G.3.a)**

24. Hold Member Harmless. Provider agrees to hold the Member harmless for charges for any Covered Service. Provider agrees not to bill a Member for Medically Necessary services covered by Plan so long as the Member is eligible for coverage. **(Agency Contract Section VII.G.3.b)**

25. Liability. Provider understands and agrees that the NC DHHS does not assume liability for the actions of, or judgments rendered against, Plan, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against NC DHHS for any duty owed to Provider by Plan or any judgment rendered against Plan. **(Agency Contract Section VII.G.3.c)**

26. Non-discrimination; Equitable Treatment of Members. Provider agrees to render services to Members with the same degree of care and skills as customarily provided to Provider's patients who are not Members, according to generally accepted standards of medical practice. Provider and Plan agree that Members and non-Members should be treated equitably. Provider agrees not to discriminate against Members on the basis of race, color, national origin, age, sex, gender or disability. **(Agency Contract Section VII.G.3.d)**

27. Department Authority Related to the Medicaid Program. 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. **(Agency Contract Section VII.G.3.e)**

28. Access to Provider Records. Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to the Agreement and any records, books, documents, and papers that relate to the Agreement and/or the Provider's performance of its responsibilities under this Agreement 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:

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

    b. The Comptroller of the United States or its designee;

    c. NC DHHS, its Medicaid managed care program personnel, or its designee;

    d. The Office of Inspector General;

    e. North Carolina Department of Justice Medicaid Investigations Division;

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

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

    h. A State or federal law enforcement agency; and

    i. Any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

    Provider shall cooperate with all announced and unannounced site visits, audits, investigations, post-payment reviews, or other program integrity activities conducted by NC DHHS.

    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.

    (Agency Contract Section VII.G.3.f)

29. Provider Ownership Disclosure. 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.

    Provider agrees to notify, in writing, Plan and NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction.

    (Agency Contract Section VII.G.3.g)

30. Providers who are primary care providers shall perform EPSDT screenings for Members less than twenty-one (21) years of age, in accordance with Section V.C.2 of the Agency Contract, "Early

and Periodic Screening, Diagnosis and Treatment (EPSDT)." (**Agency Contract Section V.D.2.c.xiii**)

31. Hospital Providers shall notify Plan when a Member in a high-level clinical setting is being discharged. (**Agency Contract Section V.D.2.c.xiv**) "High-level clinical settings" include, but are not necessarily limited to: (a) hospitals/inpatient acute care and long-term acute care; (b) nursing facility; (c) adult care home; (d) inpatient behavioral health services; (e) facility-based crisis services for children; (f) facility-based crisis services for adults; and (g) alcohol & drug abuse treatment center (ADATC).

32. Nothing in this Agreement shall be construed to violate G.S. 58-50-295. Accordingly, no provision of this Agreement shall do any of the following:

    a. Prohibit, or grant Plan an option to prohibit, Provider from contracting with another health insurance carrier to provide health care services at a rate that is equal to or lower than the payment specified in this Agreement;

    b. Require Provider to accept a lower payment rate from Plan in the event Provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in this Agreement;

    c. Require, or grant Plan an option to require, termination or renegotiation of this Agreement in the event Provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in this Agreement;

    d. Require, or grant Plan an option to require, Provider to disclose, directly or indirectly, Provider's contractual rates with another health insurance carrier;

    e. Require, or grant Plan an option to require, the non-negotiated adjustment by Plan of the Provider's contractual rate to equal the lowest rate Provider has agreed to charge to any other health insurance carrier; or

    f. Require, or grant Plan an option to require, Provider to charge another health insurance carrier a rate that is equal to or more than the reimbursement rate specified in this Agreement.

    (**Agency Contract Section V.D.2.c.xvi**)

33. Provider shall not submit claim or encounter data for Covered Services directly to NC DHHS. (**Agency Contract Section V.D.2.c.xviii**)

Schedule 9-3

Medicaid Managed Care Addendum for Indian Health Care Providers

1. **Purpose of Addendum; Supersession.**
The purpose of this Medicaid Managed Care Addendum for Indian Health Care Providers (IHCPs) is to apply special terms and conditions necessitated by federal law and regulations to the network IHCPs agreement by and between (herein "Managed Care Plan") and (herein "Indian Health Care Provider (IHCP)"). To the extent that any provision of the Managed Care Plan's network IHCP agreement or any other addendum thereto is inconsistent with any provision of this Addendum, the provisions of this Addendum shall supersede all such other provisions.

2. **Definitions.**
For purposes of this Addendum, the following terms and definitions shall apply:

(a) "**Indian**" means any individual defined at 25 U.S.C. §§ 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 C.F.R. § 136.12. This means the individual is a Member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria:

i. Is a Member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the state in which they reside, or who is a descendant, in the first or second degree, of any such Member;

ii. Is an Eskimo or Aleut or other Alaska Native;

iii. Is considered by the Secretary of the Interior to be an Indian for any purpose;

iv. Is determined to be an Indian under regulations issued by the Secretary.

The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.

(b) "**Indian Health Care Provider (IHCP)**" means a health care program operated by the Indian Health Service (IHS) or by an Indian Tribe, Tribal Organization, or Urban Indian Organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(c) "**Managed Care Plan**" includes a Managed Care Organization (MCO), Prepaid Ambulatory Health Plan (PAHP), Prepaid Inpatient Health Plan (PIHP), Primary Care Case Management (PCCM) or Primary Case Managed Care Entity (PCCM entity) as those terms are used and defined in 42 C.F.R. 438.2, and any subcontractor or instrumentality of such entities that is engaged in the operation of a Medicaid managed care contract.

(d) "**Indian Health Service or IHS**" means the agency of that name within the U.S. Department of Health and Human Services established by the IHCIA Section 601, 25 U.S.C. § 1661.

(e) "**Indian tribe**" has the meaning given in the IHCIA Section 4(14), 25 U.S.C. § 1603(14).

(f) "**Tribal health program**" has the meaning given in the IHCIA Section 4(25), 25 U.S.C. § 1603(25).

(g) "**Tribal organization**" has the meaning given in the IHCIA Section 4(26), 25 U.S.C. § 1603(26).

(h) "**Urban Indian organization**" has the meaning given in the IHCIA Section 4(29), 25 U.S.C. § 1603(29).

3. **Description of IHCP.**
The IHCP identified in Section 1 of this Addendum is (check the appropriate box):
/_/ IHS.
/_/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. §450 et seq.
/_/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C.§ 450 et seq.
/_/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).
/_/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

4. **Cost-Sharing Exemption for Indians; No Reduction in Payments.**
The Managed Care Plan shall not impose any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge shall be imposed against an Indian who is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization or Urban Indian Organization or through referral under contract health services.

Payments due to the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or a health care IHCP through referral under contract health services for the furnishing of an item or service to an Indian who is eligible for assistance under the Medicaid program may not be reduced by the amount of any enrollment fee, premium, or similar charge, and no deduction, copayment, cost sharing, or similar charge. Section 1916(j) of the Social Security Act, and 42 C.F.R. 447.53 and §457.535.

5. **Enrollee Option to Select the IHCP as Primary Health Care IHCP.**
The Managed Care Plan shall allow any Indian otherwise eligible to receive services from an IHCP to choose the IHCP as the Indian's primary health care provider if the IHCP has the capacity to provide primary care services to such Indian, and any referral from such IHCP shall be deemed to satisfy any coordination of care or referral requirement of the Managed Care Plan. Section 1932(h)(1) of the Social Security Act, 42 C.F.R. § 438.14((b)(3) and 457.1209.

6. **Agreement to Pay IHCP.**
The Managed Care Plan shall pay the IHCP for covered Medicaid managed care services in accordance with the requirements set out in Section 1932(h) of the Social Security Act and 42 C.F.R. §§ 438.14 and 457.1209.

7. **Persons Eligible for Items and Services from IHCP.**
(a) Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136.

(b) No term or condition of the Managed Care Plan's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

8. **Applicability of Federal Laws not Generally Applicable to other Providers.**
Certain federal laws and regulations apply to IHCPs, but not other providers. IHCPs cannot be required to violate those laws and regulations as a result of serving MCO enrollees. Applicable provisions may include, but are not limited to, those laws cited in within this Contract.

9. **Non-Taxable Entity.**
To the extent the IHCP is a non-taxable entity, the IHCP shall not be required by a Managed Care Plan to collect or remit any federal, state, or local tax.

10. **Insurance and Indemnification.**

(a) Indian Health Service. The IHS shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability. This is because the IHS is covered by the Federal Tort Claims Act (FTCA), which means that the United States consents to be sued in place of federal employees for any damages to property or for personal injury or death caused by the negligence or wrongful act or omission of federal employees acting within the scope of their employment. Nothing in the managed care plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate any IHS employee to perform any act outside the scope of his/her employment.

(b) Indian Tribes and Tribal Organizations. A provider which is an Indian tribe, a tribal organization, or employee of a tribe or tribal organization (including contractors) shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed Care Plan will be held harmless from liability to the extent that the provider is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement (including any addendum) shall be interpreted to authorize or obligate such Provider, any employee of such provider, or any personal services contractor to operate outside of the scope of FTCA coverage.

(c) Urban Indian Organizations. A provider which is an urban Indian organization shall not be required to obtain or maintain insurance (including professional liability insurance), provide indemnification, or guarantee that the managed care plan will be held harmless from liability to the extent the provider is covered by the FTCA. Nothing in the Managed Care Plan network provider agreement or any addendum thereto shall be interpreted to authorize or obligate such Provider or any employee of such Provider to operate outside of the scope of the FTCA.

11. **Licensure and Accreditation.**
Pursuant to 25 U.S.C. §§ 1621t and 1647a, the managed care organization shall not apply any requirement that any entity operated by the IHS, an Indian tribe, tribal organization or urban Indian organization be licensed or recognized under the state or local law where the entity is located to furnish health care services, if the entity meets all the applicable standards for such licensure or recognition. In addition, the managed care organization shall not require the licensure of a health professional employed by such an entity under the state or local law where the entity is located, if the professional is licensed in another state.

12. **Dispute Resolution.**
In the event of any dispute arising under the Managed Care Plan's network IHCP agreement or any addendum thereto, the parties agree to meet and confer in good faith to resolve any such disputes. Notwithstanding any provision in the Managed Care Plan's network agreement, the IHCP shall not be required to submit any disputes between the parties to binding arbitration.

13. **Governing Law.**
The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail.

Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

14. **Medical Quality Assurance Requirements.**
To the extent the Managed Care Plan imposes any medical quality assurance requirements on its network IHCPs, any such requirements applicable to the IHCP shall be subject to Section 805 of the IHCIA, 25 U.S.C. § 1675.

15. **Claims Format.**
The Managed Care Plan shall process claims from the IHCP in accordance with Section 206(h) of the IHCIA, 25 U.S.C. § 1621e(h), which does not permit an issuer to deny a claim submitted by a IHCP based on the format in which submitted if the format used complies with that required for submission of claims under Title XVIII of the Social Security Act or recognized under Section 1175 of such Act.

16. **Payment of Claims.**
The Managed Care Plan shall pay claims from the IHCP in accordance Section 1932(h)(2) of the Act and 42 C.F.R. §§ 438.14(c)(2) and 457.1209, and shall pay at either the rate provided under the State plan in a Fee-for-Service payment methodology, or the applicable encounter rate published annually in the Federal Register by the Indian Health Service, whichever is higher.

17. **Hours and Days of Service.**
The hours and days of service of the IHCP shall be established by the IHCP. The IHCP agrees that it will consider input from the Managed Care Plan as to its hours and days of service. At the request of the Managed Care Plan, such IHCP shall provide written notification of its hours and days of service.

18. **Purchase/Referred Care Requirements.**
The Provider may make referrals to in-network providers and such referrals shall be deemed to meet any coordination of care and referral obligations of the Managed Care Plan. The Provider shall comply with coordination of care and referral obligations of the Managed Care Plan issuer except only in specific circumstances in which such obligations would conflict with requirements applicable to Purchased/Referred Care at 42 C.F.R. Part 136. The Provider will notify the Managed Care Plan issuer when such circumstances occur.

19. **Sovereign Immunity.**
Nothing in the Managed Care Plan's network IHCP agreement or in any addendum thereto shall constitute a waiver of federal or tribal sovereign immunity.

20. **Endorsement.**
IHS or IHCP names and positions may not be used to suggest official endorsement or preferential treatment of the managed care plan.

APPROVALS

For the Managed Care Plan:	**For the IHCP:**
_____	_____
Signature	*Signature*
_____	_____
Date	*Date*

(a) The IHS as an IHCP:

(1) Anti-Deficiency Act, 31 U.S.C. § 1341;
(2) ISDEAA, 25 U.S.C. § 450 et seq.;
(3) Federal Tort Claims Act ("FTCA"), 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Federal Privacy Act of 1974 ("Privacy Act"), 5 U.S.C. § 552a, 45 C.F.R. Part 5b;
(6) IHCIA, 25 U.S.C. § 1601 et seq.

(b) An Indian tribe or a Tribal organization that is an IHCP:

(1) ISDEAA, 25 U.S.C. § 450 et seq.;
(2) IHCIA, 25 U.S.C. § 1601 et seq.;
(3) FTCA, 28 U.S.C. §§ 2671-2680;
(4) Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653;
(5) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;

(c) An urban Indian organization that is an IHCP:

(1) IHCIA, 25 U.S.C. § 1601 et seq.
(2) Privacy Act, 5 U.S.C. § 552a, 45 C.F.R. Part 5b;

Name According to W-9 Form with d/b/a: _____

BLUE CROSS NC
MEDICAID PROVIDER AGREEMENT

This Medicaid Provider Agreement (hereinafter "Agreement") is made and entered into by and between Blue Cross Blue Shield of North Carolina or an Affiliate (hereinafter "Blue Cross NC") and the undersigned Provider (hereinafter "Provider"), effective as of the date next to Blue Cross NC's signature (the "Effective Date"). In consideration of the mutual promises and covenants herein contained, the sufficiency of which is acknowledged by the parties, the parties agree as follows:

ARTICLE I
DEFINITIONS

"Affiliate" means any entity that is: (i) owned or controlled, either directly or through a parent or subsidiary entity, by Blue Cross NC, or any entity which controls or is under common control with Blue Cross NC, and/or (ii) that is identified as an Affiliate on a designated web site as referenced in the provider manual(s). Unless otherwise set forth in the Participation Attachment(s), an Affiliate may access the rates, terms and conditions of this Agreement.

"Agency" means a federal, state or local agency, administration, board or other governing body with jurisdiction over the governance or administration of a Health Benefit Plan.

"Audit" means a review of the Claim(s) and supporting clinical information submitted by Provider to ensure payment accuracy. The review ensures Claim(s) comply with all pertinent aspects of payment including, but not limited to, contractual terms, Regulatory Requirements, Coded Service Identifiers (as defined in the PCS) guidelines and instructions, Blue Cross NC medical policies and clinical utilization management guidelines, reimbursement policies, and generally accepted medical practices. Audit does not include medical record review for quality and risk adjustment initiatives.

"Blue Cross NC Rate" means the lesser of Eligible Charges for Covered Services, or the total reimbursement amount that Provider and Blue Cross NC have agreed upon as set forth in the Plan Compensation Schedule ("PCS"). The Blue Cross NC Rate includes applicable Cost Shares, and shall represent payment in full to Provider for Covered Services.

"Claim" means either the uniform bill claim form or electronic claim form in the format prescribed by Blue Cross NC submitted by a provider for payment by Blue Cross NC for Health Services rendered to a Member.

"CMS" means the Centers for Medicare & Medicaid Services, an administrative agency within the United States Department of Health & Human Services ("HHS").

"Cost Share" means, with respect to Covered Services, an amount which a Member is required to pay under the terms of the applicable Health Benefit Plan. Such payment may be referred to as an allowance, coinsurance, copayment, deductible, penalty or other Member payment responsibility, and may be a fixed amount or a percentage of applicable payment for Covered Services rendered to the Member.

"Covered Services" means Medically Necessary Health Services, as determined by Blue Cross NC and described in the applicable Health Benefit Plan, for which a Member is eligible for coverage.

"Government Contract" means the contract between Blue Cross NC and an applicable party, such as an Agency, which governs the delivery of Health Services by Blue Cross NC to Member(s) pursuant to a Government Program.

"Government Program" means any federal or state funded program under the Social Security Act, and any other federal, state, county or other municipally funded program or product in which Blue Cross NC maintains a contract to furnish services. For purposes of this Agreement, Government Program does not include the Federal Employees Health Benefits Program ("FEHBP"), or any state or local government employer program.

"Health Benefit Plan" means the document(s) that set forth Covered Services, rules, exclusions, terms and conditions of coverage. Such document(s) may include but are not limited to a Member handbook, a health certificate of coverage, or evidence of coverage.

"Health Service" means those services, supplies or items that a health care provider is licensed, equipped and staffed to provide and which he/she/it customarily provides to or arranges for individuals.

"Medically Necessary" or "Medical Necessity" means the definition as set forth in the applicable Participation Attachment(s).

"Member" means any individual who is eligible, as determined by Blue Cross NC, to receive Covered Services under a Health Benefit Plan. For all purposes related to this Agreement, including all schedules, attachments, exhibits, provider manual(s), notices and communications related to this Agreement, the term "Member" may be used interchangeably with the terms Insured, Covered Person, Covered Individual, Enrollee, Subscriber, Dependent Spouse/Domestic Partner, Child, Beneficiary or Contract Holder, and the meaning of each is synonymous with any such other.

"Network" means a group of providers that support, through a direct or indirect contractual relationship, one or more product(s) and/or program(s) in which Members are enrolled.

"Other Payors" means persons or entities, pursuant to an agreement with Blue Cross NC or an Affiliate, that access the rates, terms or conditions of this Agreement with respect to certain Network(s), excluding Government Programs unless otherwise set forth in any Participation Attachment(s) for Government Programs. Other Payors include, without limitation, employers or insurers providing Health Benefit Plans pursuant to partially or wholly insured, self-administered or self-insured programs.

"Participating Provider" means a person, including but not limited to, a physician or other health care professional or entity, including but not limited to a hospital, health care facility, a partnership of such professionals, or a professional corporation, or an employee or subcontractor of such person or entity, that is party to an agreement to provide Covered Services to Members that has met all applicable required Blue Cross NC credentialing requirements, standards of participation and accreditation requirements for the services the Participating Provider provides, and that is designated by Blue Cross NC to participate in one or more Network(s). Unless otherwise specifically delineated, all references herein to "Provider" may also mean and refer to "Participating Provider".

"Participation Attachment(s)" means the document(s) attached hereto and incorporated herein by reference, and which identifies the additional duties and/or obligations related to Network(s), Government Program(s), Health Benefit Plan(s), and/or Blue Cross NC programs such as quality and/or incentive programs.

"Plan Compensation Schedule" ("PCS") means the document(s) attached hereto and incorporated herein by reference, and which sets forth the Blue Cross NC Rate(s) and compensation related terms for the Network(s) in which Provider participates. The PCS may include additional Provider obligations and specific Blue Cross NC compensation related terms and requirements.

"Regulatory Requirements" means any requirements, as amended from time to time, imposed by applicable federal, state or local laws, rules, regulations, guidelines, instructions, Government Contract, or otherwise imposed by an Agency or government regulator in connection with the procurement, development or operation of a Health Benefit Plan, or the performance required by either party under this Agreement. The omission from this Agreement of an express reference to a Regulatory Requirement applicable to either party in connection with their duties and responsibilities shall in no way limit such party's obligation to comply with such Regulatory Requirement.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Member Identification. Blue Cross NC shall provide a means of identifying Member either by issuing a paper, plastic, electronic, or other identification document to Member or by a telephonic, paper or electronic communication to Provider. This identification need not include all information necessary to determine Member's eligibility at the time a Health Service is rendered, but shall include information necessary to contact Blue Cross NC to determine Member's participation in the applicable Health Benefit Plan. Provider acknowledges and agrees that possession of such identification document or ability to access eligibility information telephonically or electronically, in and of itself, does not qualify the holder thereof as a Member, nor does the lack thereof mean that the person is not a Member.

2.2 Provider Non-discrimination. Provider shall provide Health Services to Members in a manner similar to and within the same time availability in which Provider provides Health Services to any other individual. Provider will not differentiate, or discriminate against any Member as a result of his/her enrollment in a Health Benefit Plan, or because of race, color, creed, national origin, ancestry, religion, sex, marital status, age, disability, payment source, state of health, need for Health Services, status as a litigant, status as a Medicare or Medicaid beneficiary, sexual orientation, gender identity, or any other basis prohibited by law. Provider shall

not be required to provide any type, or kind of Health Service to Members that he/she/it does not customarily provide to others. Additional requirements may be set forth in the applicable Participation Attachment(s).

2.3 Publication and Use of Provider Information. Provider agrees that Blue Cross NC or their designees may use, publish, disclose, and display, for commercially reasonable general business purposes, either directly or through a third party, information related to Provider, including but not limited to demographic information, information regarding credentialing, affiliations, performance data, Blue Cross NC Rates, and any other information related to Provider for transparency initiatives.

2.4 Use of Symbols and Marks. Neither party to this Agreement shall publish, copy, reproduce, or use in any way the other party's symbols, service mark(s) or trademark(s) without the prior written consent of such other party. Notwithstanding the foregoing, the parties agree that they may identify Provider as a participant in the Network(s) in which he/she/it participates.

2.5 Submission and Adjudication of Claims. Provider shall submit, and Blue Cross NC shall adjudicate, Claims in accordance with the applicable Participation Attachment(s), the PCS, the provider manual(s) and Regulatory Requirements. If Provider submits Claims prior to receiving notice of Blue Cross NC's approval pursuant to section 2.13, then such Claims must be submitted in accordance with prior authorization requirements, and shall be processed as out of network. Blue Cross NC shall not make retroactive adjustments with respect to such Claims.

2.6 Payment in Full and Hold Harmless.

2.6.1 Provider agrees to accept as payment in full, in all circumstances, the applicable Blue Cross NC Rate whether such payment is in the form of a Cost Share, a payment by Blue Cross NC, or a payment by another source, such as through coordination of benefits or subrogation. Provider shall bill, collect, and accept compensation for Cost Shares. Provider agrees to make reasonable efforts to verify Cost Shares prior to billing for such Cost Shares. In no event shall Blue Cross NC be obligated to pay Provider or any person acting on behalf of Provider for services that are not Covered Services, or any amounts in excess of the Blue Cross NC Rate less Cost Shares or payment by another source, as set forth above. Consistent with the foregoing, Provider agrees to accept the Blue Cross NC Rate as payment in full if the Member has not yet satisfied his/her deductible.

2.6.2 Except as expressly permitted under Regulatory Requirements, Provider agrees that in no event, including but not limited to, nonpayment by Blue Cross NC, insolvency of Blue Cross NC, breach of this Agreement, or Claim payment denials or adjustment requests or recoupments based on miscoding or other billing errors of any type, whether or not fraudulent or abusive, shall Provider, or any person acting on behalf of Provider, bill, charge, collect a deposit from, seek compensation from, or have any other recourse against a Member, or a person legally acting on the Member's behalf, for Covered Services provided pursuant to this Agreement. Notwithstanding the foregoing, Provider may collect reimbursement from the Member for the following:

2.6.2.1 Cost Shares, if applicable;

2.6.2.2 Health Services that are not Covered Services. However, Provider may seek payment for a Health Service that is not Medically Necessary or is experimental/investigational only if Provider obtains a written waiver that meets the following criteria:

a) The waiver notifies the Member that the specifically listed Health Service is likely to be deemed not Medically Necessary, or experimental/investigational;

b) The waiver notifies the Member of the Health Service being provided and the date(s) of service;

c) The waiver notifies the Member of the approximate cost of the Health Service;

d) The waiver is signed by the Member, or a person legally acting on the Member's behalf, prior to receipt of the Health Service.

2.6.2.3 Any reduction in or denial of payment as a result of the Member's failure to comply with his/her utilization management program pursuant to his her/her Health Benefit Plan, except when Provider has been designated by Blue Cross NC to comply with utilization management for the Health Services provided by Provider to the Member.

2.7 Recoupment/Offset/Adjustment for Overpayments. Blue Cross NC shall be entitled to offset and recoup an amount equal to any overpayments or incorrect payments made by Blue Cross NC to Provider against any payments due and payable by Blue Cross NC to Provider with respect to any Health Benefit Plan under this Agreement. Provider shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Blue Cross NC that any recoupment, improper payment, or overpayment is due from Provider, Provider must refund the amount to Blue Cross NC within thirty (30) days of when Blue Cross NC notifies Provider. If such reimbursement is not received by Blue Cross NC within the thirty (30) days following the date of such notice, Blue Cross NC shall be entitled to offset such overpayment against any Claims payments due and payable by Blue Cross NC to Provider under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider agrees that all future Claim payments applied to satisfy Provider's repayment obligation shall be deemed to have been paid in full for all purposes, including section 2.6.1. Should Provider disagree with any determination by Blue Cross NC that Provider has received an overpayment, Provider shall have the right to appeal such determination under Blue Cross NC's procedures set forth in the provider manual, and such appeal shall not suspend Blue Cross NC's right to recoup the overpayment amount during the appeal process unless prohibited under Regulatory Requirements. Blue Cross NC reserves the right to employ a third party collection agency in the event of non-payment.

2.8 Use of Subcontractors. Provider and Blue Cross NC may fulfill some of their duties under this Agreement through subcontractors. For purposes of this provision, subcontractors shall include, but are not limited to, vendors and non-Participating Providers that provide supplies, equipment, staffing, and other services to Members at the request of, under the supervision of, and/or at the place of business of Provider. Provider shall provide Blue Cross NC with thirty (30) days prior notice of any Health Services subcontractors with which Provider may contract to perform Provider's duties and obligations under this Agreement, and Provider shall remain responsible to Blue Cross NC for the compliance of his/her/its subcontractors with the terms and conditions of this Agreement as applicable, including, but not limited to, the Payment in Full and Hold Harmless provisions herein.

2.9 Compliance with Provider Manual(s) and Policies, Programs and Procedures. Provider agrees to cooperate and comply with, Blue Cross NC's provider manual(s), and all other policies, programs and procedures (collectively "Policies") established and implemented by Blue Cross NC, applicable to the Network(s) in which Provider participates. Blue Cross NC or its designees may modify the provider manual(s) and its Policies by making a good faith effort to provide notice, including electronic notice, to Provider at least thirty (30) days in advance of the effective date of material modifications thereto.

2.10 Referral Incentives/Kickbacks. Provider represents and warrants that Provider does not give, provide, condone or receive any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a Member, and if a Claim for payment is attributable to an instance in which Provider provided or received an incentive or kickback in exchange for the referral, such Claim shall not be payable and, if paid in error, shall be refunded to Blue Cross NC.

2.11 Networks and Provider Panels. Provider shall be eligible to participate only in those Networks designated on the Provider Networks Attachment of this Agreement. Provider shall not be recognized as a Participating Provider in such Networks until the later of: 1) the Effective Date of this Agreement or; 2) as determined by Blue Cross NC in its sole discretion, the date Provider has met Blue Cross NC's applicable credentialing requirements, standards of participation and accreditation requirements. Provider acknowledges that Blue Cross NC may develop, discontinue, or modify new or existing Networks, products and/or programs. In addition to those Networks designated on the Provider Networks Attachment, Blue Cross NC may also identify Provider as a Participating Provider in additional Networks, products and/or programs designated in writing from time to time by Blue Cross NC unless specifically prohibited by Regulatory Requirements. The terms and conditions of Provider's participation as a Participating Provider in such additional Networks, products and/or programs shall be on the terms and conditions as set forth in this Agreement unless otherwise agreed to in writing by Provider and Blue Cross NC.

In addition to and separate from Networks that support some or all of Blue Cross NC's products and/or programs (e.g., HMO, PPO and Indemnity products), Provider further acknowledges that certain Health Services, including by way of example only, laboratory services, may be provided exclusively by designated Participating Providers (a "Health Services Designated Network"), as determined by Blue Cross NC. Provider agrees to refer Members to such designated Participating Providers in a Health Services Designated Network for the provision of certain Health Services, even if Provider performs such services. Notwithstanding any other provision in this Agreement, if Provider provides a Health Service to a Member for which Provider is not a designated Participating Provider in a Health Services Designated Network, then Provider agrees that he/she/it shall not be reimbursed for such services by Blue Cross NC, or the Member, unless Provider was authorized to provide such Health Service by Blue Cross NC.

2.12 Change in Provider Information. Provider shall immediately send written notice, in accordance with the Notice section of this Agreement, to Blue Cross NC of:

2.12.1 Any legal, governmental, or other action or investigation involving Provider which could affect Provider's credentialing status with Blue Cross NC, or materially impair the ability of Provider to carry out his/her/its duties and obligations under this Agreement, except for temporary emergency diversion situations; or

2.12.2 Any change in Provider accreditation, affiliation, hospital privileges (if applicable), insurance, licensure, certification or eligibility status, or other relevant information regarding Provider's practice or status in the medical community.

2.13 Provider Credentialing, Standards of Participation and Accreditation. Provider warrants that he/she/it meets all applicable Blue Cross NC credentialing requirements, standards of participation, and accreditation requirements for the Networks in which Provider participates. A description of the applicable credentialing requirements, standards of participation, and accreditation requirements, are set forth in the provider manual(s) and/or in the PCS. Provider acknowledges that until such time as Provider has been determined to have fully met Blue Cross NC's credentialing requirements, standards of participation, and accreditation requirements, as applicable, Provider shall not be entitled to the benefits of participation under this Agreement, including without limitation the Blue Cross NC Rates set forth in the PCS attached hereto.

2.14 Provider Staffing and Staff Privileges. Provider agrees to maintain professional staffing levels to meet community access standards and where applicable, agrees to facilitate and to expeditiously grant admitting privileges to Participating Providers who meet facility's credentialing standards.

2.15 Adjustment Requests. If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to Blue Cross NC, Provider must submit a request for an adjustment to Blue Cross NC in accordance with the provider manual(s).

2.16 Provision and Supervision of Services. In no way shall Blue Cross NC be construed to be providers of Health Services or responsible for, exercise control, or have direction over the provision of such Health Services. Provider shall be solely responsible to the Member for treatment, medical care, and advice with respect to the provision of Health Services. Provider agrees that all Health Services provided to Members under this Agreement shall be provided by Provider or by a qualified person under Provider's direction. Provider warrants that any nurses or other health professionals employed by or providing services for Provider shall be duly licensed or certified under applicable law. In addition, nothing herein shall be construed as authorizing or permitting Provider to abandon any Member.

2.17 Coordination of Benefits/Subrogation. Subject to Regulatory Requirements, Provider agrees to cooperate with Blue Cross NC regarding subrogation and coordination of benefits, as set forth in Policies and the provider manual(s), and to notify Blue Cross NC promptly after receipt of information regarding any Member who may have a Claim involving subrogation or coordination of benefits.

2.18 Cost Effective Care. Provider shall provide Covered Services in the most cost effective, clinically appropriate setting and manner. In addition, in accordance with the provider manual(s) and Policies, Provider shall utilize Participating Providers, and consistent with Medical Necessity, refer and transfer Members to Participating Providers for all Covered Services, including but not limited to specialty, laboratory, ancillary and supplemental services.

2.19 Facility-Based Providers. Provider agrees to require its contracted facility-based providers or those with exclusive privileges with Provider to obtain and maintain Participating Provider status with Blue Cross NC.

Until such time as facility-based providers enter into agreements with Blue Cross NC, Provider agrees to fully cooperate with Blue Cross NC to prevent Members from being billed amounts in excess of the applicable Blue Cross NC non-participating reimbursement for such Covered Services. Facility-based providers may include, but are not limited to, anesthesiologists, radiologists, pathologists, neonatologists, hospitalists and emergency room physicians.

ARTICLE III
CONFIDENTIALITY/RECORDS

3.1 Proprietary and Confidential Information. Except as otherwise provided herein, all information and material provided by either party in contemplation of or in connection with this Agreement including, but not limited to, (i) the negotiation of this Agreement or any amendments to the Agreement (including all reimbursement rate negotiations), (ii) this Agreement, or any copies thereof, (iii) any documents, information, or data from the Blue Cross and Blue Shield Association or other Blues Plan, (iv) any of Blue Cross NC's programs, policies, or data, and (v) Blue Cross NC's trade secret information shall be and remain confidential. (Collectively, subsections (i), (ii) and (iii) above are referred to as the "Proprietary or Confidential Information"). Neither party shall disclose any Proprietary or Confidential Information to the other, or use such information or material except: (1) as otherwise set forth in this Agreement; (2) as may be required to perform obligations hereunder; (3) as required to deliver Health Services or administer a Health Benefit Plan; (4) to Blue Cross NC or its designees; (5) upon the express written consent of the parties; or (6) as required by Regulatory Requirements. Notwithstanding the foregoing, either party may disclose such information to its legal advisors, lenders and business advisors, provided that such legal advisors, lenders and business advisors agree to maintain confidentiality of such information. Provider and Blue Cross NC shall each have a system in place that meets all applicable Regulatory Requirements to protect all records and all other documents relating to this Agreement which are deemed confidential by law. Any disclosure or transfer of Proprietary or Confidential Information by Provider or Blue Cross NC will be in accordance with applicable Regulatory Requirements. Provider shall immediately notify Blue Cross NC if Provider is required to disclose any Proprietary or Confidential Information at the request of an Agency or pursuant to any federal or state freedom of information act request. Notwithstanding, a party may disclose information as required by law, including public records law.

3.2 Confidentiality of Member Information. Both parties agree to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH Act"), and as both may be amended, as well as any other applicable Regulatory Requirements regarding confidentiality, use, disclosure, security and access of the Member's personally identifiable information ("PII") and protected health information ("PHI"), (collectively "Member Information"). Provider shall review all Member Information received from Blue Cross NC to ensure no misrouted Member Information is included. Misrouted Member Information includes but is not limited to, information about a Member that Provider is not currently treating. Provider shall immediately destroy any misrouted Member Information or safeguard the Member Information for as long as it is retained. In no event shall Provider be permitted to misuse or re-disclose misrouted Member Information. If Provider cannot destroy or safeguard misrouted Member Information, Provider must contact Blue Cross NC to report receipt of misrouted Member Information.

3.3 Network Provider/Patient Discussions. Notwithstanding any other provision in this Agreement and regardless of any benefit or coverage exclusions or limitations associated with a Health Benefit Plan, Provider shall not be prohibited from discussing fully with a Member any issues related to the Member's health including recommended treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by Blue Cross NC or any other party. In addition, nothing in this Agreement shall be construed to, create any financial incentive for Provider to withhold Covered Services, or prohibit Provider from disclosing to the Member the general methodology by which Provider is compensated under this Agreement, such as for example, whether Provider is paid on a fee for service, capitation or Percentage Rate basis. Blue Cross NC shall not refuse to allow or to continue the participation of any otherwise eligible provider, or refuse to compensate Provider in connection with services rendered, solely because Provider has in good faith communicated with one or more of his/her/its current, former or prospective patients regarding the provisions, terms or requirements of a Health Benefit Plan as they relate to the health needs of such patient. Nothing in this section shall be construed to permit Provider to disclose Blue Cross NC Rates or specific terms of the compensation arrangement under this Agreement.

3.4 Blue Cross NC Access to and Requests for Provider Records. Provider and its designees shall comply with all applicable state and federal record keeping and retention requirements, and, as set forth in the provider manual(s) and/or Participation Attachment(s), shall permit Blue Cross NC or its designees to have, with appropriate working space and without charge, on-site access to and the right to perform an Audit, examine,

copy, excerpt and transcribe any books, documents, papers, and records related to Member's medical and billing information within the possession of Provider and inspect Provider's operations, which involve transactions relating to Members and as may be reasonably required by Blue Cross NC in carrying out its responsibilities and programs including, but not limited to, assessing quality of care, complying with quality initiatives/measures, Medical Necessity, concurrent review, appropriateness of care, accuracy of payment, risk adjustment assessment as described in the provider manual(s), including but not limited to completion of the Encounter Facilitation Form (also called the "SOAP" note), compliance with this Agreement, and for research. In lieu of on-site access, at Blue Cross NC's request, Provider or its designees shall submit records to Blue Cross NC, or its designees via photocopy or electronic transmittal, within thirty (30) days, at no charge to Blue Cross NC from either Provider or its designee. Provider shall make such records available to the state and federal authorities involved in assessing quality of care or investigating Member grievances or complaints in compliance with Regulatory Requirements. Any examination or Audit of Provider records shall be performed using generally accepted, statistically valid or industry standard methodology. Provider acknowledges that failure to submit records to Blue Cross NC in accordance with this provision and/or the provider manual(s), and/or Participation Attachment(s) may result in a denial of a Claim under review, whether on pre-payment or post-payment review, or a payment retraction on a paid Claim, and Provider is prohibited from balance billing the Member in any of the foregoing circumstances.

3.5 Transfer of Medical Records. Following a request, Provider shall transfer a Member's medical records in a timely manner, or within such other time period required under applicable Regulatory Requirements, to other health care providers treating a Member at no cost to Blue Cross NC, the Member, or other treating health care providers.

3.6 Clinical Data Sharing. Blue Cross NC and Provider desire to collaborate by sharing data, including Member information, to enhance certain health care operations activities, primarily to help improve quality and efficiency of health care. Each party's access to better clinical and administrative data is critical to the mutual goal of Blue Cross NC and Provider improving health care quality as it relates to their respective Members and patients. Therefore and upon request, Provider agrees to provide data to Blue Cross NC for treatment purposes, for payment purposes, for health care operations purposes consistent with those enumerated in the first two paragraphs of the health care operations definition in HIPAA (45 CFR 164.501), or for purposes of health care fraud and abuse detection or compliance. Provider shall provide data as set forth in Policies or the provider manual(s), as applicable.

ARTICLE IV
INSURANCE

4.1 Blue Cross NC Insurance. Blue Cross NC shall self-insure or maintain insurance as required under applicable Regulatory Requirements to insure Blue Cross NC and its employees, acting within the scope of their duties.

4.2 Provider Insurance. Provider shall self-insure or maintain insurance acceptable to Blue Cross NC as set forth in the provider manual(s), Participation Attachment(s), PCS, or as required under applicable Regulatory Requirements.

ARTICLE V
RELATIONSHIP OF THE PARTIES

5.1 Relationship of the Parties. For purposes of this Agreement, Blue Cross NC and Provider are and will act at all times as independent contractors. Nothing in this Agreement shall be construed, or be deemed to create, a relationship of employer or employee or principal and agent, partnership, joint venture, or any relationship other than that of independent entities contracting with each other for the purposes of effectuating this Agreement.

5.2 Provider Representations and Warranties. Provider represents and warrants that it has the corporate power and authority to execute and deliver this Agreement on its own behalf, and on behalf of any other individuals or entities that are owned, employed or subcontracted with or by Provider to provide services under this Agreement. Provider further certifies that individuals or entities that are owned, employed or subcontracted with Provider agree to comply with the terms and conditions of this Agreement.

ARTICLE VI
INDEMNIFICATION AND LIMITATION OF LIABILITY

6.1 Indemnification. Blue Cross NC and Provider shall each indemnify, defend and hold harmless the other party, and his/her/its directors, officers, employees, agents, Affiliates and subsidiaries ("Representatives"), from and against any and all losses, claims, damages, liabilities, costs and expenses (including without limitation, reasonable attorneys' fees and costs) arising from third party claims resulting from the Indemnifying party's or his/her/its Representative's failure to perform the indemnifying party's obligations under this Agreement, and/or the indemnifying party's or his/her/its Representative's violation of any law, statute, ordinance, order, standard of care, rule or regulation. The obligation to provide indemnification under this Agreement shall be contingent upon the party seeking indemnification providing the indemnifying party with prompt written notice of any claim for which indemnification is sought, allowing the indemnifying party to control the defense and settlement of such claim, provided however that the indemnifying party agrees not to enter into any settlement or compromise of any claim or action in a manner that admits fault or imposes any restrictions or obligations on an indemnified party without that indemnified party's prior written consent which will not be unreasonably withheld, and cooperating fully with the indemnifying party in connection with such defense and settlement.

6.2 Limitation of Liability. Regardless of whether there is a total and fundamental breach of this Agreement or whether any remedy provided in this Agreement fails of its essential purpose, in no event shall either of the parties hereto be liable for any amounts representing loss of revenues, loss of profits, loss of business, the multiple portion of any multiplied damage award, or incidental, indirect, consequential, special or punitive damages, whether arising in contract, tort (including negligence), or otherwise regardless of whether the parties have been advised of the possibility of such damages, arising in any way out of or relating to this Agreement. Further, in no event shall Blue Cross NC be liable to Provider for any extracontractual damages relating to any claim or cause of action assigned to Provider by any person or entity.

ARTICLE VII
DISPUTE RESOLUTION AND ARBITRATION

7.1 Dispute Resolution. All disputes between Blue Cross NC and Provider arising out of or related in any manner to this Agreement shall be resolved using the dispute resolution and arbitration procedures as set forth below. Provider shall exhaust any other applicable provider appeal/provider dispute resolution procedures under this Agreement and any applicable exhaustion requirements imposed by Regulatory Requirements as a condition precedent to Provider's right to pursue the dispute resolution and arbitration procedures as set forth below.

7.1.1 In order to invoke the dispute resolution procedures in this Agreement, a party first shall send to the other party a written demand letter that contains a detailed description of the dispute and all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information that the Blue Cross NC provider manual(s) may require Provider to submit with respect to such dispute. If the total amount in dispute as set forth in the demand letter is less than two hundred thousand dollars ($200,000), exclusive of interest, costs, and attorneys' fees, then within twenty (20) days following the date on which the receiving party receives the demand letter, representatives of each party's choosing shall meet to discuss the dispute in person or telephonically in an effort to resolve the dispute. If the total amount in dispute as set forth in the demand letter is two hundred thousand dollars ($200,000) or more, exclusive of interest, costs, and attorneys' fees, then within ninety (90) days following the date of the demand letter, the parties shall engage in non-binding mediation in an effort to resolve the dispute unless both parties agree in writing to waive the mediation requirement. The parties shall mutually agree upon a mediator, and failing to do so, Judicial Arbitration and Mediation Services ("JAMS") shall be authorized to appoint a mediator.

7.2 Arbitration. Any dispute within the scope of subsection 7.1.1 that remains unresolved at the conclusion of the applicable process outlined in subsection 7.1.1 shall be resolved by binding arbitration in the manner as set forth below. Except to the extent as set forth below, the arbitration shall be conducted pursuant to the JAMS Comprehensive Arbitration Rules and Procedures, provided, however, that the parties may agree in writing to further modify the JAMS Comprehensive Arbitration Rules and Procedures. The parties agree to be bound by the findings of the arbitrator(s) with respect to such dispute, subject to the right of the parties to appeal such findings as set forth herein. No arbitration demand shall be filed until after the parties have completed the dispute resolution efforts described in section 7.1 above. If the dispute resolution efforts described in section 7.1 cannot be completed within the deadlines specified for such efforts despite the parties' good faith efforts to meet such deadlines, such deadlines may be extended as necessary upon mutual agreement of the parties. Enforcement of this arbitration clause, including the waiver of class actions, shall be determined under the Federal Arbitration Act ("FAA"), including the FAA's preemptive effect

on state law. The parties agree that the arbitration shall be conducted on a confidential basis pursuant to Rule 26 of the JAMS Comprehensive Arbitration Rules and Procedures. Subject to any disclosures that may be required or requested under Regulatory Requirements, the parties further agree that they shall maintain the confidential nature of the arbitration, including without limitation, the existence of the arbitration, information exchanged during the arbitration, and the award of the arbitrator(s). Nothing in this provision, however, shall preclude either party from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

7.2.1 Location of Arbitration. The arbitration hearing shall be held in North Carolina. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

7.2.2 Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than four million dollars ($4,000,000), exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by a single arbitrator selected, and replaced when required, in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is four million dollars ($4,000,000) or more, exclusive of interest, costs, and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three (3) arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator.

7.2.3 Appeal. If the total amount of the arbitration award is five million dollars ($5,000,000) or more, inclusive of interest, costs, and attorneys' fees, or if the arbitrator(s) issues an injunction against a party, the parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. A decision that has been appealed shall not be enforceable while the appeal is pending. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

7.2.4 Waiver of Certain Claims. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree to and do hereby waive any right to join or consolidate claims in arbitration by or against other individuals or entities or to pursue, on a class basis, any dispute; provided however, if there is a dispute regarding the applicability or enforcement of the waiver provision in this subsection 7.2.4, that dispute shall be decided by a court of competent jurisdiction. If a court of competent jurisdiction determines that such waiver is unenforceable for any reason with respect to a particular dispute, then the parties agree that section 7.2 shall not apply to such dispute and that such dispute shall be decided instead in a court of competent jurisdiction.

7.2.5 Limitations on Injunctive Relief. The parties, on behalf of themselves and those that they may now or hereafter represent, each agree that any injunctive relief sought against the other party shall be limited to the conduct relevant to the parties to the arbitration and shall not be sought for the benefit of individuals or entities who are not parties to the arbitration. The arbitrator(s) are not authorized to issue injunctive relief for the benefit of an individual or entity who is not a party to the arbitration. The arbitrator shall be limited to issuing injunctive relief related to the specific issues in the arbitration.

7.3 Attorney's Fees and Costs. The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator) will be shared equally between the parties. Each party shall be responsible for the payment of its own specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

7.4 Period of Limitations. Unless otherwise provided for in this Agreement or a Participation Attachment(s), neither party shall commence any action at law or equity, including but not limited to, an arbitration demand, against the other to recover on any legal or equitable claim arising out of this Agreement ("Action") more than two (2) years after the events which gave rise to such Action; provided, however, this two (2) year limitation shall not apply to Actions by Blue Cross NC against Provider related to fraud, waste or abuse which shall be subject to the period of limitations set forth in applicable Regulatory Requirements. In the situation where Provider believes that Blue Cross NC underpaid a Claim, the Action arises on the date when Blue Cross NC first denies the Claim or first pays the Claim in an amount less than expected by Provider. In the situation where Blue Cross NC believes that it overpaid a Claim, the Action arises when Provider first

contests in writing Blue Cross NC's notice to it that the overpayment was made. The deadline for initiating an Action shall not be tolled by the appeal process, provider dispute resolution process or any other administrative process. To the extent an Action is timely commenced, it will be administered in accordance with Article VII of this Agreement.

ARTICLE VIII
TERM AND TERMINATION

8.1 Term of Agreement. The initial term of this Agreement shall commence at 12:01 AM on the Effective Date for a term of one (1) year ("Initial Term"), and shall continue automatically in effect thereafter for a consecutive four (4) year term unless otherwise terminated as provided herein. Pursuant to Section 9.1.3, the term may be further extended upon sixty (60) days prior written notice to Provider.

8.2 Termination Without Cause. After the Initial Term, either party may terminate this Agreement without cause at any time by giving at least one hundred eighty (180) days prior written notice of termination to the other party. Notwithstanding the foregoing, should a Participation Attachment(s) contain a longer without cause termination period, the Agreement shall continue in effect only for such applicable Participation Attachment(s) until the termination without cause notice period in the applicable Participation Attachment(s) ends.

8.3 Breach of Agreement. Except for circumstances giving rise to the Immediate Termination section, if either party fails to comply with or perform when due any material term or condition of this Agreement, the other party shall notify the breaching party of its breach in writing stating the specific nature of the material breach, and the breaching party shall have thirty (30) days to cure the breach. If the breach is not cured to the reasonable satisfaction of the non-breaching party within said thirty (30) day period, the non-breaching party may terminate this Agreement by providing written notice of such termination to the other party. The effective date of such termination shall be no sooner than sixty (60) days after such notice of termination.

8.4 Immediate Termination.

8.4.1 This Agreement or any Participation Attachment(s) may be terminated immediately by Blue Cross NC if:

8.4.1.1 Provider commits any act or conduct for which his/her/its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations or to provide Health Services are lost or voluntarily surrendered in whole or in part; or

8.4.1.2 Provider commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which Provider submits to Blue Cross NC or to a third party or upon a confirmed finding of fraud, waste, or abuse by State Agency or the North Carolina Department of Justice Medicaid Investigations Division; or

8.4.1.3 Provider files a petition in bankruptcy for liquidation or reorganization by or against Provider, if Provider becomes insolvent, or makes an assignment for the benefit of its creditors without Blue Cross NC's written consent, or if a receiver is appointed for Provider or its property; or

8.4.1.4 Provider's insurance coverage as required by this Agreement lapses for any reason; or

8.4.1.5 Provider fails to maintain compliance with Blue Cross NC's applicable credentialing requirements, accreditation requirements or standards of participation; or

8.4.1.6 Blue Cross NC reasonably believes based on Provider's conduct or inaction, or allegations of such conduct or inaction, that the well-being of patients may be jeopardized; or

8.4.1.7 Provider has been abusive to a Member, an Blue Cross NC employee or representative; or

8.4.1.8 Provider and/or his/her/its employees, contractors, subcontractors, or agents are ineligible, excluded, suspended, terminated or debarred from participating in a

Government Program, and in the case of an employee, contractor, subcontractor or agent, Provider fails to remove such individual from responsibility for, or involvement with, the Provider's business operations related to this Agreement, or if Provider has voluntarily withdrawn his/her/its participation in any Government Program as the result of a settlement agreement; or

8.4.1.9 Provider is convicted or has been finally adjudicated to have committed a felony or misdemeanor, other than a non-DUI related traffic violation; or

8.4.1.10 A Government Contract between the applicable State Agency and Blue Cross NC terminates or expires or ends for any reason or is modified to eliminate a Medicaid Program.

8.4.2 This Agreement may be terminated immediately by Provider if:

8.4.2.1 Blue Cross NC commits any act or conduct for which its license(s), permit(s), or any governmental or board authorization(s) or approval(s) necessary for business operations are lost or voluntarily surrendered in whole or in part; or

8.4.2.2 Blue Cross NC commits fraud or makes any material misstatements or omissions on any documents related to this Agreement which it submits to Provider or to a third party; or

8.4.2.3 Blue Cross NC files for bankruptcy, or if a receiver is appointed.

8.5 Partial Termination of Participating Providers. Blue Cross NC shall be entitled to terminate this Agreement as it applies to one or a number of Participating Providers under the terms of this Article VIII, without terminating the Agreement in its entirety, and in such case, the Agreement shall continue in full force and effect in connection with Provider and/or any and all Participating Providers as to which the Agreement has not been terminated. Notwithstanding the foregoing, Blue Cross NC reserves the right to terminate Participating Provider(s) from any or all Network(s) under the terms of this Article VIII while continuing the Agreement for the remaining Participating Provider(s).

8.6 Transactions Prior to Termination. Except as otherwise set forth in this Agreement, termination shall have no effect on the rights and obligations of the parties arising out of any transaction under this Agreement occurring prior to the date of such termination.

8.7 Continuation of Care Upon Termination. If this Agreement or any Participation Attachment terminates for any reasons other than one of the grounds set forth in the "Immediate Termination" section, then Provider shall, at Blue Cross NC's discretion, continue to provide Covered Services to all designated Members under this Agreement or any terminating Participation Attachment, as applicable, in accordance with Regulatory Requirements. During such continuation period, Provider agrees to: (i) accept reimbursement from Blue Cross NC for all Covered Services furnished hereunder in accordance with this Agreement and at the rates set forth in the PCS attached hereto; and (ii) adhere to Blue Cross NC's Policies, including but not limited to, Policies regarding quality assurance requirements, referrals, pre-authorization and treatment planning.

8.8 Survival. The provisions of this Agreement set forth below shall survive termination or expiration of this Agreement or any Participation Attachment(s):

8.8.1 Publication and Use of Provider Information;

8.8.2 Payment in Full and Hold Harmless;

8.8.3 Recoupment/Offset/Adjustment for Overpayments;

8.8.4 Confidentiality/Records;

8.8.5 Indemnification and Limitation of Liability;

8.8.6 Dispute Resolution and Arbitration;

8.8.7 Continuation of Care Upon Termination; and

8.8.8 Any other provisions required in order to comply with Regulatory Requirements.

ARTICLE IX
GENERAL PROVISIONS

9.1 Amendment. This Agreement may be amended by written mutual agreement of the parties, or as follows:

9.1.1 Changes in Law. In the event that Blue Cross NC determines that Regulatory Requirements or an applicable accrediting organization requires amendments to this Agreement, Blue Cross NC will make good faith efforts to provide sixty (60) days' prior written notice of such amendments. Provider acknowledges and agrees that such amendments may include, but are not limited to, modifications to the Agreement mandated by State Agency (as hereinafter defined) pursuant to its approval and review of the Agreement template. Such modifications may occur at any time during the course of the Agreement. Except as otherwise required by Regulatory Requirements or an applicable accrediting organization, this Agreement will be automatically amended to include the amendments set forth in the written notice from Blue Cross NC no earlier than sixty (60) days following delivery of such amendment.

9.1.2 Changes to Fee Schedules. Pursuant to N.C.G.S. §§ 58-50-270 through 58-50-285 or successor thereto, Blue Cross NC will provide at least sixty (60) days' prior written notice of a proposed change to the terms of the Agreement, including terms incorporated by reference, that modifies Provider's fee schedule(s) and that is not a change required by Regulatory Requirements, administrative hearing, or court order ("Proposed Change" or "Proposed Change to a Fee Schedule"). The Proposed Change shall be dated, labeled "Amendment," signed by Blue Cross NC, and include an effective date for the Proposed Change. The effective date shall be at least sixty (60) days from the date of receipt of the Proposed Change, or greater if otherwise required by the Agreement. If Provider does not notify Blue Cross NC within sixty (60) days from the date of the receipt of a Proposed Change, such Proposed Change shall be effective upon the effective date specified in the Proposed Change unless Blue Cross NC notifies Provider that Blue Cross NC will not implement the Proposed Change. If Provider objects to the Proposed Change, then the Proposed Change is not effective and, notwithstanding any other provisions of the Agreement, Blue Cross NC shall be entitled to terminate this Agreement upon sixty (60) days' prior written notice. Notwithstanding the foregoing, the parties may negotiate terms providing for mutual consent to a Proposed Change, a process for reaching mutual consent, or alternative addresses for providing notice as described in Section 9.11.

9.1.3 All Other Terms. Except as otherwise provided in this Section 9.1 or elsewhere in this Agreement, Blue Cross NC may amend any terms of this Agreement by providing no fewer than sixty (60) days' prior written notice to Provider.

9.1.4 Notwithstanding the foregoing section 9.1, all amendments must be in writing signed by both parties

9.2 Assignment. This Agreement may not be assigned by Provider without the prior written consent of Blue Cross NC. Any assignment by Provider without such prior consent shall be voidable at the sole discretion of Blue Cross NC. Blue Cross NC may assign this Agreement in whole or in part; provided, however, that to the extent required under applicable Regulatory Requirements, Blue Cross NC shall notify Provider, in writing, of any duties or obligations that are to be delegated or transferred, before the delegation or transfer. In the event of a partial assignment of this Agreement by Blue Cross NC, the obligations of the Provider shall be performed for Blue Cross NC with respect to the part retained and shall be performed for Blue Cross NC's assignee with respect to the part assigned, and such assignee is solely responsible to perform all obligations of Blue Cross NC with respect to the part assigned. The rights and obligations of the parties hereunder shall inure to the benefit of, and shall be binding upon, any permitted successors and assigns of the parties hereto.

9.3 Scope/Change in Status.

9.3.1 Blue Cross NC and Provider agree that this Agreement applies to Health Services rendered at the Provider's location(s) on file with Blue Cross NC. Blue Cross NC may, in its discretion, limit this Agreement to Provider's locations, operations, business or corporate form, status or structure in existence on the Effective Date of this Agreement and prior to the occurrence of any of the events set forth in subsections 9.3.1.1 – 9.3.1.5. Unless otherwise required by Regulatory Requirements, Provider shall provide at least ninety (90) days prior written notice of any such event.

9.3.1.1 Provider (a) sells, transfers or conveys his/her/its business or any substantial portion of his/her/its business assets to another entity through any manner including but not limited to a stock, real estate or asset transaction or other type of transfer; (b) is otherwise acquired or controlled by any other entity through any manner, including but not limited to purchase, merger, consolidation, alliance, joint venture, partnership, association, or expansion; or

9.3.1.2 Provider transfers control of his/her/its management or operations to any third party, including Provider entering into a management contract with a physician practice management company or with another entity which does not manage Provider as of the Effective Date of this Agreement, or there is a subsequent change in control of Provider's current management company; or

9.3.1.3 Provider acquires or controls any other medical practice, facility, service, beds or entity; or

9.3.1.4 Provider changes his/her/its locations, business or operations, corporate form or status, tax identification number, or similar demographic information; or

9.3.1.5 This provision intentionally left blank.

9.3.2 Notwithstanding the termination provisions of Article VIII, and without limiting any of Blue Cross NC's rights as set forth elsewhere in this Agreement, Blue Cross NC shall have the right to terminate this Agreement by giving at least sixty (60) days written notice to Provider if Blue Cross NC determines, that as a result of any of the transactions listed in subsection 9.3.1, Provider cannot satisfactorily perform the obligations hereunder, or cannot comply with one or more of the terms and conditions of this Agreement, including but not limited to the confidentiality provisions herein; or Blue Cross NC elects in its reasonable business discretion not to do business with Provider, the successor entity or new management company, as a result of one or more of the events as set forth in subsection 9.3.1.

9.3.3 Provider shall provide Blue Cross NC with thirty (30) days prior written notice of:

9.3.3.1 Addition or removal of individual provider(s) who are employed or subcontracted with Provider, if applicable. Any new individual providers must meet Blue Cross NC's credentialing requirements or other applicable standards of participation prior to being designated as a Participating Provider; or

9.3.3.2 A change in mailing address.

9.3.4 If Provider is acquired by, acquires or merges with another entity, and such entity already has an agreement with Blue Cross NC, Blue Cross NC will determine in its sole discretion which Agreement will prevail.

9.4 Definitions. Unless otherwise specifically noted, the definitions as set forth in Article I of this Agreement will have the same meaning when used in any attachment, the provider manual(s) and Policies.

9.5 Entire Agreement. This Agreement, exhibits, attachments, appendices, and amendments hereto, and the provider manual(s), together with any items incorporated herein by reference, constitute the entire understanding between the parties and supersedes all prior oral or written agreements between them with respect to the matters provided for herein. If there is an inconsistency between any of the provisions of this Agreement and Policies, then this Agreement shall govern. In addition, if there is an inconsistency between the terms of this Agreement and the terms provided in any attachment to this Agreement, then the terms provided in that attachment shall govern.

9.6 Force Majeure. Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of his/her/its obligations hereunder for any reason beyond his/her/its reasonable control, including without limitation, acts of God, natural or man-made disasters, acts of any public enemy, statutory or other laws, regulations, rules, orders, or actions of the federal, state, or local government or any agency thereof.

9.7 Compliance with Regulatory Requirements. Blue Cross NC and Provider agree to comply with all applicable Regulatory Requirements, as amended from time to time, relating to their obligations under this Agreement, and maintain in effect all permits, licenses and governmental and board authorizations and approvals as necessary for business operations. Provider warrants that as of the Effective Date, he/she/it is and shall remain licensed and certified for the term of this Agreement in accordance with all Regulatory Requirements (including those applicable to utilization review and Claims payment) relating to the provision of Health Services to Members. Provider shall supply evidence of such licensure, compliance and certifications to Blue Cross NC upon request. If there is a conflict between this section and any other provision in this Agreement, then this section shall control.

9.7.1 In addition to the foregoing, Provider warrants and represents that at the time of entering into this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors, principals or agents are ineligible, excluded, suspended, terminated or debarred from participating in a Government Program ("Ineligible Person"). Provider shall remain continuously responsible for ensuring that his/her/its employees, contractors, subcontractors, principals or agents are not Ineligible Persons. If Provider or any employees, subcontractors, principals or agents thereof becomes an Ineligible Person after entering into this Agreement or otherwise fails to disclose his/her/its Ineligible Person status, Provider shall have an obligation to (1) immediately notify Blue Cross NC of such Ineligible Person status and (2) within ten (10) days of such notice, remove such individual from responsibility for, or involvement with, Provider's business operations related to this Agreement.

9.8 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of North Carolina, unless such state laws are otherwise preempted by federal law. However, coverage issues specific to a Health Benefit Plan are governed by the state laws where the Health Benefit Plan is issued, unless such state laws are otherwise preempted by federal law.

9.9 Intent of the Parties. It is the intent of the parties that this Agreement is to be effective only in regards to their rights and obligations with respect to each other; it is expressly not the intent of the parties to create any independent rights in any third party or to make any third party a third party beneficiary of this Agreement, except to the extent specified in the Payment in Full and Hold Harmless section of this Agreement, or in a Participation Attachment(s).

9.10 Non-Exclusive Participation. None of the provisions of this Agreement shall prevent Provider or Blue Cross NC from participating in or contracting with any provider, preferred provider organization, health maintenance organization/health insuring corporation, or any other health delivery or insurance program. Provider acknowledges that Blue Cross NC does not warrant or guarantee that Provider will be utilized by any particular number of Members.

9.11 Notice. Any notice required to be given pursuant to the terms and provisions of this Agreement shall be in writing and shall be delivered by hand, facsimile, electronic mail (except for the notice required under Section 9.1.2), or mail. Notice shall be deemed to be effective: (a) when delivered by hand, (b) upon transmittal when transmitted by facsimile transmission or by electronic mail, (c) by registered or certified mail, postage prepaid, on the date on the return receipt (d) on the next business day if transmitted by national overnight courier, or (e) if sent by regular mail, first class postage prepaid, five (5) days from the date the notice is placed. Unless specified otherwise in writing by a party, Blue Cross NC shall send Provider notice to the contact set forth on the signature page to this Agreement; provided, however, that should Provider provide alternative or additional contact information to Blue Cross NC as part of the credentialing process, notice provided to such address(es) shall be considered valid under this Agreement until such time that Provider notifies Blue Cross NC in writing that such address(es) are no longer valid and provides replacement contact information. Provider shall send Blue Cross NC notice to Blue Cross NC's address as set forth in the provider manual(s). Notwithstanding the foregoing, and unless otherwise prohibited by Regulatory Requirements, Blue Cross NC may post updates to its provider manual and Policies on its web site and unilateral amendments extending the term of the Agreement pursuant to Section 8.1.

9.12 Severability. In case any one or more of the provisions of this Agreement shall be invalid, illegal, or unenforceable in any respect, the remaining provisions shall be construed liberally in order to effectuate the purposes hereof, and the validity, legality and enforceability of the remaining provisions shall not in any way be affected or impaired thereby. If one or more provisions of the Agreement are invalid, illegal or unenforceable and an amendment to the Agreement is necessary to maintain its integrity, the parties shall make commercially reasonable efforts to negotiate an amendment to this Agreement and any attachments

or addenda to this Agreement which could reasonably be construed not to contravene such statute, regulation, or interpretation. In addition, if such invalid, unenforceable or materially affected provision(s) may be severed from this Agreement and/or attachments or addenda to this Agreement without materially affecting the parties' intent when this Agreement was executed, then such provision(s) shall be severed rather than terminating the Agreement or any attachments or addenda to this Agreement.

9.13 Waiver. Neither the waiver by either of the parties of a breach of any of the provisions of this Agreement, nor the failure of either of the parties, on one or more occasion, to enforce any of the provisions of this Agreement, shall thereafter be construed as a waiver of any subsequent breach of any of the provisions of this Agreement.

9.14 Construction. This Agreement shall be construed without regard to any presumption or other rule requiring construction against the party causing this Agreement to be drafted.

9.15 Counterparts and Electronic Signatures.

9.15.1 This Agreement and any amendment hereto may be executed in two (2) or more counterparts, each of which shall be deemed to be an original and all of which taken together shall constitute one and the same agreement.

9.15.2 Either party may execute this Agreement or any amendments by valid electronic signature, and such signature shall have the same legal effect of a signed original.

Each party warrants that it has full power and authority to enter into this Agreement and the person signing this Agreement on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this Agreement.

THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION WHICH MAY BE ENFORCED BY THE PARTIES

Provider shall be designated as a Participating Provider in the Networks set forth on the Provider Network Attachment on the later of: (1) the Effective Date of this Agreement or; (2) as determined by Blue Cross NC in its sole discretion, the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements.

PROVIDER LEGAL NAME ACCORDING TO W-9 FORM WITH D/B/A:

By: _____ _____
Signature, Authorized Representative of Provider(s) Date

Printed: _____ _____
Name Title

Address _____ _____
Street City State Zip

Tax Identification Number (TIN): _____

(Note: If any of the following is not applicable, please leave blank)

Group NPI Number: _____

Blue Cross Blue Shield of North Carolina

BLUE CROSS NC INTERNAL USE ONLY

By: _____ _____
Signature, Authorized Representative of Blue Cross NC Date

Printed: Mark Werner Vice President, Provider Network and Transformation
Name Title

PROVIDER NETWORKS ATTACHMENT

Provider shall be designated as a Participating Provider in the following Networks on the later of: 1) the Effective Date of this Agreement or; 2) as determined by Blue Cross NC in its sole discretion, the date Provider has met applicable credentialing requirements, standards of participation and accreditation requirements:

Health Benefit Plans:

Health Benefit Plans issued pursuant to an agreement between Blue Cross NC and Agency in which Members have access to a network of providers and receive an enhanced level of benefits when they obtain Covered Services from Participating Providers regardless of product licensure status. Provider participates in one or more of the following Networks which support such Health Benefit Plans:

- Medicaid

MEDICAID
PARTICIPATION ATTACHMENT TO THE
BLUE CROSS NC
MEDICAID PROVIDER AGREEMENT

This is a Medicaid Participation Attachment ("Attachment") to the Blue Cross NC Medicaid Provider Agreement ("Agreement"), entered into by and between Blue Cross NC and Provider and is incorporated into the Agreement.

ARTICLE I
DEFINITIONS

The following definitions shall apply to this Attachment. Terms not otherwise defined in this Attachment shall carry the meaning set forth in the Agreement.

"Clean Claim" means, unless otherwise prohibited by applicable state Regulatory Requirements, an accurate and timely filed Claim submitted pursuant to this Attachment, that has no defect or impropriety, for which all information necessary to process such Claim and make a benefit determination is included. This includes but is not limited to, the claim being submitted in a nationally accepted format in compliance with standard coding guidelines, and which does not require adjustment, or alteration by Provider of the services in order to be processed and paid.

"Medicaid Program(s)" means, for purposes of this Attachment, a medical assistance program provided under a Health Benefit Plan approved under Title XVI, Title XIX and/or Title XXI of the Social Security Act or any other federal or state funded program or product as designated by Blue Cross NC.

"Medicaid Covered Services" means, for purposes of this Attachment, only those Covered Services provided under Blue Cross NC's Medicaid Program(s).

"Medicaid Member" means, for purposes of this Attachment, a Member who is enrolled in Blue Cross NC's Medicaid Program(s).

"Medically Necessary/Medical Necessity" Medical necessity is 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.

"State Agency" means the North Carolina Department of Health and Human Services.

ARTICLE II
SERVICES/OBLIGATIONS

2.1 Participation-Medicaid Network. As a participant in Blue Cross NC's Medicaid Network, Provider will render Medicaid Covered Services to Medicaid Members in accordance with the terms and conditions of the Agreement and this Attachment. Such Medicaid Covered Services provided shall be within the scope of Provider's licensure, expertise, and usual and customary range of services pursuant to the terms and conditions of the Agreement and this Attachment, and Provider shall be responsible to Blue Cross NC for his/her/its performance hereunder. Except as set forth in this Attachment or the Plan Compensation Schedule ("PCS"), all terms and conditions of the Agreement will apply to Provider's participation in Blue Cross NC's Medicaid Network. The terms and conditions set forth in this Attachment are limited to the provision of and payment for Health Services provided to Medicaid Members.

2.2 Provider's Duties and Obligations to Medicaid Members. All of Provider's duties and obligations to Members set forth in the Agreement shall also apply to Medicaid Members unless otherwise specifically set forth in this Attachment. Provider shall not discriminate in the acceptance of Medicaid Members for treatment, and shall provide to Medicaid Members the same access to services, including but not limited to, hours of operation, as Provider gives to all other patients. Provider shall furnish Blue Cross NC with at least ninety (90) days prior written notice if Provider plans to close its practice to new patients or ceases to continue in Provider's current practice.

2.2.1 To the extent mandated by Regulatory Requirements, Provider shall ensure that Medicaid Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS.

2.2.2 Unless otherwise prohibited under Regulatory Requirements, a PCP, as defined in the PCS, shall provide Covered Services or make arrangements for the provision of Covered Services to Medicaid Members on a twenty-four (24) hour-per-day, seven (7) day-per-week basis to assure availability, adequacy, and continuity of care to Medicaid Members. If Provider is unable to provide Covered Services, Provider shall arrange for another Participating Provider to cover Provider's patients in accordance with Blue Cross NC's Policies, which may include, but is not limited to, arranging for call coverage or other backup. Provider and any PCPs employed by or under contract with Provider may arrange for Covered Services to Medicaid Members to be performed by a Specialist Physician only in accordance with Blue Cross NC's Policies.

2.2.3 If Provider is furnishing Specialist Physician services under this Attachment, Provider and the Specialist Physician(s) employed by or under contract with Provider, shall accept as patients all Medicaid Members and may arrange for Covered Services to Medicaid Members to be performed by Specialist Physician only in accordance with Blue Cross NC's Policies.

2.2.4 Provider must cooperate with Medicaid Member appeals and grievance procedures.

2.2.5 If Provider is a PCP, Provider shall perform EPSDT screenings for Medicaid Members less than twenty-one (21) years of age in accordance with the Government Contract.

2.3 Provider Responsibility. Blue Cross NC shall not be liable for, nor will it exercise control or direction over, the manner or method by which Provider provides Health Services to Medicaid Members. Provider shall be solely responsible for all medical advice and services provided by Provider to Medicaid Members. Provider acknowledges and agrees that Blue Cross NC may deny payment for services rendered to a Medicaid Member which it determines are not Medically Necessary, are not Medicaid Covered Services under the applicable Medicaid Program(s), or are not otherwise provided or billed in accordance with the Agreement and/or this Attachment. A denial of payment or any action taken by Blue Cross NC pursuant to a utilization review, referral, discharge planning program or claims adjudication shall not be construed as a waiver of Provider's obligation to provide appropriate Health Services to a Medicaid Member under applicable Regulatory Requirements and any code of professional responsibility. However, this provision does not require Provider to provide Health Services if Provider objects to such service on moral or religious grounds.

2.4 Reporting Fraud and Abuse. Provider shall cooperate with Blue Cross NC's anti-fraud compliance program. If Provider identifies any actual or suspected fraud, abuse or misconduct in connection with the services rendered hereunder in violation of Regulatory Requirements, Provider shall promptly report such activity directly to the compliance officer of Blue Cross NC or through the compliance hotline in accordance with the provider manual(s). In addition, Provider is not limited in any respect in reporting other actual or suspected fraud, abuse, or misconduct to Blue Cross NC.

2.5 Blue Cross NC Marketing/Information Requirements. Provider agrees to abide by Blue Cross NC's marketing/information requirements. Provider shall forward to Blue Cross NC for prior approval all flyers, brochures, letters and pamphlets Provider intends to distribute to Medicaid Members concerning its payor affiliations, or changes in affiliation or relating directly to the Medicaid population. Provider will not distribute any marketing or recipient informing materials without the consent of Blue Cross NC or the applicable State Agency.

2.6 Schedule of Benefits and Determination of Medicaid Covered Services. Blue Cross NC shall make available upon Provider's request the applicable Health Benefit Plan for applicable Medicaid Program(s), and will notify Provider in a timely manner of any material amendments or modifications.

2.7 Medicaid Member Verification. Provider shall verify a Medicaid Member's eligibility for Medicaid Covered Services prior to rendering services, except in the case of an Emergency Medical Condition, as defined in the PCS, where such verification may not be possible. In the case of an Emergency Medical Condition, Provider shall verify a Medicaid Member's eligibility as soon as reasonably practical. Blue Cross NC shall provide a system for Providers to contact Blue Cross NC to verify a Medicaid Member's eligibility twenty-four (24) hours a day, seven (7) days per week. Nothing contained in this Attachment or the Agreement shall, or shall be construed to, require advance notice, coverage verification, or pre-authorization for Emergency Services, as defined in the PCS, provided in accordance with the federal Emergency Medical Treatment and Active Labor Act ("EMTALA") prior to Provider's rendering such Emergency Services.

2.8 Hospital Affiliation and Privileges. To the extent required under Blue Cross NC's credentialing requirements, Provider or any Participating Providers employed by or under contract or subcontract with Provider shall

maintain privileges to practice at one (1) or more of Blue Cross NC's Participating Provider hospitals. In addition, in accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately notify Blue Cross NC in the event any such hospital privileges are revoked, limited, surrendered, or suspended at any hospital or health care facility.

2.9 Participating Provider Requirements. If Provider is a group provider, Provider shall require that all Participating Providers employed by or under contract or subcontract with Provider comply with all terms and conditions of the Agreement and this Attachment. Notwithstanding the foregoing, and unless prohibited under Regulatory Requirements, Provider acknowledges and agrees that Blue Cross NC is not obligated to accept as Participating Providers all providers employed by or under contract or subcontract with Provider.

2.10 Coordinated and Managed Care. Provider shall participate in utilization management, care management, and provider sanctions programs designed to facilitate the coordination of services as referenced in the applicable provider manual(s). None of the foregoing programs shall be construed to override the professional or ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to Medicaid Members. In accordance with N.C.G.S. § 58-3-200(c), if Blue Cross NC or its authorized representative determines that services, supplies, or other items are covered under a Health Benefit Plan, including any determination under N.C.G.S §. 58-50-61, Blue Cross NC shall not subsequently retract its determination after such 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 Medicaid Member's health condition that was knowingly made by the insured or the provider of the service, supply, or other item.

2.10.1 Notice of Discharge from High Level Clinical Setting. Provider shall notify Blue Cross NC when a Medicaid Member in a high level clinical setting is discharged.

2.11 Representations and Warranties. Provider represents and warrants that all information provided to Blue Cross NC is true and correct as of the date such information is furnished, and that Provider is unaware of any undisclosed facts or circumstances that would make such information inaccurate or misleading. Provider further represents and warrants that Provider: (i) is legally authorized to provide the services contemplated hereunder; (ii) is qualified to participate in all applicable Medicaid Program(s); (iii) is not in violation of any licensure or accreditation requirement applicable to Provider under Regulatory Requirements; (iv) has not been convicted of bribery or attempted bribery of any official or employee of the jurisdiction in which Provider operates, nor made an admission of guilt of such conduct which is a matter of record; (v) is capable of providing all data related to the services provided hereunder in a timely manner as reasonably required by Blue Cross NC to satisfy its internal requirements and Regulatory Requirements, including, without limitation, data required under the Health Employer Data and Information Set ("HEDIS") and National Committee for Quality Assurance ("NCQA") requirements; and (vi) is not, to Provider's best knowledge, the subject of an inquiry or investigation that could foreseeably result in Provider failing to comply with the representations set forth herein. In accordance with the Change in Provider Information Section of the Agreement, Provider shall immediately provide Blue Cross NC with written notice of any material changes to such information.

2.12 Credentialing: Compliance with Government Contract Requirements. In addition to the Provider Credentialing, Standards of Participation and Accreditation of this Agreement, and in accordance with 45 C.F.R. § 455.410, Provider must be enrolled in Medicaid Program(s) in which it offers Medicaid Covered Services. Failure to maintain enrollment in such Medicaid Program(s) may result in immediate termination of this Attachment as applied to such Medicaid Program(s). Provider shall complete re-enrollment/re-credentialing before contract renewal and in accordance with the following: (1) during the Provider Credentialing Transition Period, no less frequently than every five (5) years (as described in the Government Contract); (2) during Provider Credentialing under Full Implementation, no less frequently than every three (3) years (as described in the Government Contract), except as otherwise permitted by State Agency.

2.13 Obligation to Provide Data. Blue Cross NC shall provide data and information to Provider, such as: (1) performance feedback reports or information to Provider, if compensation is related to efficiency criteria, (2) information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies, and (3) notification of changes in these requirements, allowing Provider time to comply with such changes.

2.14 Provider Directory. Provider authorizes Blue Cross NC to include, and Blue Cross NC shall include, Provider's name in the provider directory distributed to Medicaid Members.

2.15 Interpreting and Translation Services. Provider must (1) provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for a Medicaid Member, (2) ensure that Provider's staff are trained to appropriately communicate with patients with various types of hearing loss, and (3) report to Blue Cross NC, in a format and frequency to be determined by Blue Cross NC, whether hearing loss accommodations are needed and provided and the type of accommodation provided.

2.16 Perinatal Care. If Provider provides perinatal Medicaid Covered Services, Provider will arrange for perinatal Medicaid Covered Services in a manner consistent with State Agency's Pregnancy Management Program (as defined and described in the Government Contract). Provider shall comply with State Agency's Pregnancy Management Program.

2.17 Advanced Medical Homes. If Provider is an Advanced Medical Home (as defined in the Government Contract), Provider will follow a care management model and requirements consistent with State Agency's Advanced Medical Home Program (as defined and described in the Government Contract). Provider agrees to comply with State Agency's Advanced Medical Home Program.

2.18 Local Health Departments. If Provider is a Local Health Department (as defined in the Government Contract) carrying out care management for high-risk pregnancy and for at-risk children, Provider will follow requirements consistent with State Agency's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy (each policy as defined and described in the Government Contract). Provider agrees to comply with the Department's Care Management for High-Risk Pregnancy Policy and Care Management for At-Risk Children Policy.

ARTICLE III
COMPENSATION AND AUDIT

3.1 Submission and Adjudication of Medicaid Claims. Unless otherwise instructed, or prohibited by Regulatory Requirements, Provider shall submit Claims to Blue Cross NC, using appropriate and current Coded Service Identifier(s), within one hundred eighty (180) days from the date the Health Services are rendered, or, from the date the Medicaid Member is discharged, or Blue Cross NC may refuse payment. If Blue Cross NC is the secondary payor, the one hundred eighty (180) day period will not begin until Provider receives notification of primary payor's responsibility. Provider shall not submit Claims or Encounter Data (as defined in the PCS) for Medicaid Covered Services directly to State Agency to the extent Blue Cross NC covers such Medicaid Covered Services.

3.1.1 Provider agrees to submit Claims in a format consistent with industry standards and acceptable to Blue Cross NC either (a) electronically through electronic data interchange ("EDI"), or (b) if electronic submission is not available, utilizing paper forms as defined by the National Uniform Claim Committee ("NUCC").

3.1.2 Provider agrees to provide to Blue Cross NC, unless otherwise instructed, at no cost to Blue Cross NC, or the Medicaid Member, all information necessary for Blue Cross NC to determine its payment liability. Such information includes, without limitation, accurate and Clean Claims for Covered Services. If Blue Cross NC asks for additional information so that Blue Cross NC may process the Claim, Provider must provide that information within sixty (60) days, or before the expiration of the one hundred eighty (180) day period referenced in Section 3.1 above, whichever is longer.

3.1.3 Once Blue Cross NC determines Blue Cross NC has any payment liability, all Clean Claims will be adjudicated in accordance with the terms and conditions of a Medicaid Member's Health Benefit Plan, the PCS, the provider manual(s), and the Regulatory Requirements applicable to Blue Cross NC's Medicaid Program(s).

3.2 This provision intentionally left blank.

3.3 Audit for Compliance with CMS Guidelines. Notwithstanding any other terms and conditions of the Agreement, this Attachment, or the PCS, Blue Cross NC has the same rights as CMS, to review and/or Audit and, to the extent necessary recover payments on any claim for Medicaid Covered Services rendered pursuant to this Attachment and the Agreement to ensure compliance with CMS Regulatory Requirements.

3.4 Medicaid Member Records. In accordance with 42 C.F.R. § 438.208(b)(5), Provider must (1) maintain confidentiality of Medicaid Member medical records and personal information and other health records as required by law; (2) maintain adequate medical and other health records according to industry and Blue

Cross NC standards; and (3) make copies of such records available to Blue Cross NC and State Agency in conjunction with its regulation of Blue Cross NC. The records shall be made available and furnished immediately upon request in either paper or electronic form, at no cost to the requesting party.

3.5 Access to Fee Schedules. Blue Cross NC shall make available its schedule of fees associated with the top thirty (30) services or procedures most commonly billed by Provider's class of provider. Upon the request of Provider, Blue Cross NC shall also make available the full schedule of fees for services or procedures billed by Provider's class of provider or for each class of provider in the case of a contract incorporating multiple classes of providers. If Provider requests fees for more than thirty (30) services and procedures, Blue Cross NC may require Provider to specify the additional requested services and procedures and may limit 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 Provider.

ARTICLE IV
COMPLIANCE WITH FEDERAL REGULATORY REQUIREMENTS

4.1 Federal Funds. Provider acknowledges that payments Provider receives from Blue Cross NC to provide Medicaid Covered Services to Medicaid Members are, in whole or part, from federal funds. Therefore, Provider and any of his/her/its subcontractors are subject to certain laws that are applicable to individuals and entities receiving federal funds, which may include but are not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973, lobbying restrictions as implemented by 45 CFR Part 93 and 31 USC 1352, Title IX of the Educational Amendments of 1972, as amended (30 U.S.C. sections 1681, 1783, and 1685-1686) and any other regulations applicable to recipients of federal funds.

4.2 Surety Bond Requirement. If Provider provides home health services or durable medical equipment, Provider shall comply with all applicable provisions of Section 4724(b) of the Balanced Budget Act of 1997, including, without limitation, any applicable requirements related to the posting of a surety bond.

4.3 Laboratory Compliance. If Provider renders lab services in the office, it must maintain a valid Clinical Laboratory Improvement Amendments ("CLIA") certificate for all laboratory testing sites and comply with CLIA regulations at 42 CFR Part 493 for all laboratory testing sites performing Health Services pursuant to this Attachment.

ARTICLE V
COMPLIANCE WITH STATE REGULATORY REQUIREMENTS

5.1 ~~Indemnification of State. In addition to the indemnification provision of the Agreement, Provider shall indemnify and hold harmless the State, its agencies, officers, and employees from all claims and suits, including court costs, attorney's fees, and other expenses, brought because of injuries or damages received or sustained by any person, persons, or property that is caused by any act or omission of Provider.~~

5.2 Medicaid Hold Harmless. Provider agrees that Blue Cross NC's payment constitutes payment in full for any Medicaid Covered Services rendered to Medicaid Members. Provider agrees it shall not seek payment from the Medicaid Member, his/her representative or the State for any Health Services rendered pursuant to this Attachment, with the exception of Cost Shares, if any, or payment for non-Medicaid Covered Services otherwise requested by, and provided to, the Medicaid Member if the Medicaid Member agrees in writing to pay for the service prior to the service being rendered. The form of agreement must specifically state the admissions, services or procedures that are non-Medicaid Covered Services and the approximate amount of out of pocket expense to be incurred by the Medicaid Member. Provider agrees not to bill Medicaid Members for missed appointments while enrolled in the Medicaid Programs. This provision shall remain in effect even in the event Blue Cross NC becomes insolvent.

5.3 State Agency Government Contract. Provider shall comply with the terms applicable to providers set forth in the Government Contract, including incorporated documents, between Blue Cross NC and the applicable State Agency, which applicable terms are incorporated herein by reference. Blue Cross NC agrees to provide Provider with a description of the applicable terms upon request.

5.4 Performance Within the U.S. Provider agrees that all services to be performed herein shall be performed in the United States of America. Breach, or anticipated breach, of the foregoing shall be a material breach of

this Attachment and, without limitation of remedies, shall be cause for immediate termination of the Agreement and this Attachment.

5.5 No Payment Outside the United States. Provider agrees that Blue Cross NC shall not provide any payments for items or services provided under the Agreement to any financial institution or entity located outside the United States of America.

5.6 Dispute Resolution. Any disputes arising out of this Attachment or the Agreement shall be handled consistent with the provider grievances and appeals guidelines set forth in the Government Contract and the provider manual. To the extent there is a conflict between the provider grievances and appeals guidelines set forth in the Government Contract and the dispute resolution procedures set forth in the provider manual, this Attachment or the Agreement, the provider grievances and appeals guidelines set forth in the Government Contract shall govern. Except as otherwise set forth in this section, all other terms and conditions related to dispute resolution provided in the Agreement remain in full force and effect.

5.7 Government Funds. Provider acknowledges that the funds used for payments under this Attachment are government funds.

5.8 Provider Preventable Conditions. Provider shall comply with 42 C.F.R. § 438.3. Provider agrees to comply with the reporting requirements set forth under federal law and the Government Contract as a condition of payment from Blue Cross NC. Provider shall not be entitled to payment for provider preventable conditions.

5.9 Required Government Contract Language: All Provider Types. In the event of a conflict between this section and other terms and conditions in this Agreement, this section shall prevail. Except as otherwise provided in this section, all other terms and conditions provided in this Agreement remain in full force and effect.

5.9.1 Compliance with State and Federal Laws. 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 the Agreement and the Government Contract, and all persons or entities receiving state and federal funds. 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 Agreement, or any violation of the Government Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

5.9.2 Hold Medicaid Member Harmless. Provider agrees to hold the Medicaid Member harmless for charges for any Medicaid Covered Service. Provider agrees not to bill a Medicaid Member for Medically Necessary Covered Services covered by Blue Cross NC so long as the Medicaid Member is eligible for coverage.

5.9.3 Liability. Provider understands and agrees that State Agency does not assume liability for the actions of, or judgments rendered against, Blue Cross NC, its employees, agents or subcontractors. Further, Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against State Agency for any duty owed to Provider by Blue Cross NC or any judgment rendered against Blue Cross NC.

5.9.4 Non-Discrimination: Equitable Treatment of Medicaid Members. Provider agrees to render Covered Services to Medicaid Members with the same degree of care and skills as customarily provided to Provider's patients who are not Medicaid Members, according to generally accepted standards of medical practice. Provider and Blue Cross NC agree that Medicaid Members and non-Medicaid Members should be treated equitably. Provider agrees not to discriminate against Medicaid Members on the basis of race, color, national origin, age, sex, gender, or disability.

5.9.5 Department Authority Related to the Medicaid Program. Provider agrees and understands that in the State of North Carolina, State Agency 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.

5.9.6 Access to Provider Records. Provider agrees to provide at no cost to the following entities or their designees, prompt, reasonable, and adequate access to Blue Cross NC and the Agreement and any records, books, documents, and papers that relate to the Blue Cross NC and the Agreement and/or 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 State Agency 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. State Agency, 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 State Agency; 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 State Agency, or any other entity engaged by State Agency. 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.

5.9.7 Provider Ownership Disclosure. 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. Provider agrees to notify, in writing, Blue Cross NC and State Agency of any criminal conviction within twenty (20) days of the date of the conviction.

5.9.8 N.C.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, Provider shall submit all Claims to Blue Cross NC for processing and payments within one hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Provider's failure to submit a Claim within this time will not invalidate or reduce any Claim if it was not reasonably possible for 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. Blue Cross NC shall within eighteen (18) calendar days of receiving a Medical Claim notify Provider whether the Claim is a Clean Claim, or pend the Claim and request from Provider all additional information needed to process the Claim. 2. Blue Cross NC shall pay or deny a medical Clean 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. Blue Cross NC shall within fourteen (14) calendar days of receiving a pharmacy Claim pay or deny a pharmacy Clean Claim or notify 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, Blue Cross NC shall deny the Claim per § 58-3-225 (d). 1. Blue Cross NC 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 Blue Cross NC fails to pay a Clean Claim in full pursuant to this provision, Blue Cross NC shall pay Provider interest and penalty. Late Payments will bear interest at the annual rate of eighteen percent (18%) 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 Blue Cross NC paying Provider a penalty equal to one percent (1%) 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. Blue Cross NC shall pay the interest and penalty from subsections 58-3-225(e) and (f) as provided in that subsection, and shall not require Provider to request the interest or the penalty.

ARTICLE VI

6.1 This Article intentionally left blank.

ARTICLE VII
GENERAL PROVISIONS

7.1 Regulatory Amendment. Notwithstanding the Amendment provision in the Agreement, this Attachment shall be automatically modified to conform to required changes to Regulatory Requirements related to Medicaid Programs without the necessity of executing written amendments.

7.2 Inconsistencies. In the event of an inconsistency between terms and conditions of this Attachment and the terms and conditions as set forth in the Agreement, the terms and conditions of this Attachment shall govern. Except as set otherwise forth herein, all other terms and conditions of the Agreement remain in full force and effect.

7.3 Disclosure Requirements. In accordance with Regulatory Requirements, Provider agrees to disclose to Blue Cross NC complete ownership, control and relationship information ("Disclosures") in accordance with 42 CFR 455.100 through 455.106. Provider shall provide required Disclosures to Blue Cross NC at the time of initial contract, upon contract renewal, and/or upon request by Blue Cross NC. Provider further agrees to notify Blue Cross NC within fourteen (14) days of any changes to the Disclosures. Failure to provide Disclosures as required under Regulatory Requirements shall be deemed a material breach of this Attachment and the Agreement.

7.4 Survival of Attachment. Provider further agrees that: (1) the hold harmless and continuation of care sections shall survive the termination of this Attachment or disenrollment of the Medicaid Member; and (2) these provisions supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Medicaid Member or persons acting on their behalf that relates to liability for payment for, or continuation of, Medicaid Covered Services provided under the terms and conditions of these provisions.

ADVANCED MEDICAL HOME PROVIDER ADDENDUM TO THE MEDICAID PARTICIPATION ATTACHMENT OF THE BLUE CROSS MEDICAID PROVIDER AGREEMENT

The following are required provisions for Advanced Medical Home ("AMH") Providers. These provisions are independent of practices' agreements with the North Carolina Department of Health and Human Services and CCNC around Carolina ACCESS, and will not affect those agreements. The Department will review all PHP (prepaid health plans) and AMH practice contract templates prior to use to ensure that standard contract terms are incorporated.

Any capitalized terms not otherwise defined herein shall have the meaning set forth in the Agreement or the Government Contract, as applicable.

ARTICLE I
SERVICES/OBLIGATIONS FOR AMH PRACTICES

1. Provider shall accept Medicaid Members and be listed as a PCP in Blue Cross NC's member-facing materials for the purpose of providing care to members and managing their health care needs.

2. Provider shall provide primary care and member care coordination services to each member.

3. Provider shall provide or arrange for primary care coverage for services, consultation or referral, and treatment for emergency medical conditions, twenty-four (24) hours per day, seven (7) days per week. Automatic referral to the hospital emergency department for services does not satisfy this requirement.

4. Provider shall provide direct patient care a minimum of thirty (30) office hours per week.

5. Provider shall provide preventive services in accordance with the Preventive Health Requirements set forth in the Provider Manual and Government Contract.

6. Provider shall establish and maintain hospital admitting privileges or a formal arrangement for management of inpatient hospital admissions of Medicaid Members.

7. Provider shall maintain a unified medical record for each Medicaid Member following Blue Cross NC's medical record documentation guidelines.

8. Provider shall promptly arrange referrals for Medically Necessary Health Services that are not provided directly and document referrals for specialty care in the medical record.

9. Provider shall transfer the Medicaid Member's medical record to the receiving practice upon the change of PCP at the request of the new PCP or Blue Cross NC (if applicable) and as authorized by the Medicaid Member within thirty (30) days of the date of the request.

10. Provider shall authorize care for Medicaid Members or provide care for Medicaid Members based on the standards of appointment availability as defined by Blue Cross NC's network adequacy standards.

11. Provider shall refer for a second opinion as requested by the Medicaid Member, based on State Agency guidelines and Blue Cross NC's standards.

12. Provider shall review and use Medicaid Member utilization and cost reports provided by Blue Cross NC for the purpose of AMH level utilization management and advise Blue Cross NC of errors, omissions, or discrepancies if they are discovered.

13. Provider shall review and use the monthly enrollment report provided by Blue Cross NC for the purpose of participating in Blue Cross NC or practice-based population health or care management activities.

ARTICLE II
Standard Terms and Conditions for Tier 3 AMH Practices

The terms and conditions set forth in this Article II shall apply to the extent Provider is a Tier 3 AMH practice (as defined in the Government Contract). Unless otherwise specified, any required element may be performed either by

the Tier 3 AMH practice itself or by a clinically-integrated network ("CIN") with which the practice has a contractual agreement that contains equivalent contract requirements.

2.1 Provider must be able to risk stratify all empaneled Medicaid Members.

2.1.1 Provider must ensure that assignment lists transmitted to the practice by Blue Cross NC are reconciled with the practice's panel list and up to date in the clinical system of record.

2.1.2 Provider must use a consistent method to assign and adjust risk status for each assigned Medicaid Member.

2.1.3 Provider must use a consistent method to combine risk scoring information received from Blue Cross NC with clinical information to score and stratify the Medicaid Member panel.

2.1.4 Provider must, to the greatest extent possible, ensure that the method is consistent with the State Agency's program Policy of identifying "priority populations" for care management.

2.1.5 Provider must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.

2.1.6 Provider must define the process and frequency of risk score review and validation.

2.2 Provider must be able to define the process and frequency of risk score review and validation.

2.2.1 Provider must use its risk stratification method to identify Medicaid Members who may benefit from care management.

2.2.2 Provider must perform a Comprehensive Assessment (as described below and in Policies) on each Medicaid Member identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:

1. Medicaid Member' immediate care needs and current services;
2. Other State or local services currently used;
3. Physical health conditions;
4. Current and past behavioral and mental health and substance use status and/or disorders;
5. Physical, intellectual developmental disabilities;
6. Medications;
7. Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);
8. Available informal, caregiver, or social supports, including peer supports.

2.2.3 Provider must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need Medicaid Members.

2.2.4 For each high-need Medicaid Member, Provider must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

2.2.5 Provider must use a documented Care Plan for each high-need Medicaid Member receiving care management.

2.2.6 Provider must develop the Care Plan within 30 days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.

2.2.7 Provider must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including Medicaid Member and family participation where possible.

2.2.8 Provider must incorporate findings from the PHP Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the Medicaid Member into the Care Plan.

2.2.9 Medicaid Member must include, at a minimum, the following elements in the Care Plan:

1. Measurable Medicaid Member (or Medicaid Member and caregiver) goals
2. Medical needs including any behavioral health needs;
3. Interventions;
4. Intended outcomes; and
5. Social, educational, and other services needed by the Medicaid Member.

2.2.10 Provider must have a process to update each Care Plan as Medicaid Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.

2.2.11 Provider must have a process to document and store each Care Plan in the clinical system of record.

2.2.12 Provider must periodically evaluate the care management services provided to high-risk, high-need Medicaid Members by the practice to ensure that services are meeting the needs of empaneled Medicaid Members, and refine the care management services as necessary.

2.2.13 Provider must track empaneled Medicaid Members' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled Medicaid Members are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.

2.2.14 Provider or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below):

1. Real time (minutes/hours) response to outreach from EDs relating to Medicaid Member care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission;
2. Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;
3. Within a several-day period to address outpatient needs or prevent future problems for high risk Medicaid Members who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge).

2.3 Providers must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled Medicaid Members who have an ED visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.

2.3.1 Provider must have a methodology or system for identifying Medicaid Members in transition who are at risk of readmissions and other poor outcomes that considers all of the following:

1. Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;
2. Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;
3. NICU discharges;
4. Clinical complexity, severity of condition, medications, risk score.

2.3.2 For each Medicaid Member in transition identified as high risk for admission or other poor outcome with transitional care needs, Provider must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

2.3.3 Provider must include the following elements in transitional care management:

1. Ensuring that a care manager is assigned to manage the transition;
2. Facilitating clinical handoffs;
3. Obtaining a copy of the discharge plan/summary;
4. Conducting medication reconciliation;
5. Following-up by the assigned care manager rapidly following discharge;
6. Ensuring that a follow-up outpatient, home visit or face to face encounter occurs;
7. Developing a protocol for determining the appropriate timing and format of such outreach.

2.3.4 Provider must use electronic data to promote care management.

1. Provider must receive claims data feeds (directly or via a CIN) and meet Department-designated security standards for their storage and use.

PLAN COMPENSATION SCHEDULE ("PCS")

ARTICLE I
DEFINITIONS

The definitions set forth below shall apply with respect to all of the terms outlined in this PCS. Terms not otherwise defined in this PCS and defined elsewhere in the Agreement shall carry the meanings set forth in the Agreement.

"Capitation" means the amount paid by Blue Cross NC to a provider or management services organization on a per member per month basis for either specific services or the total cost of care for Covered Services.

"Case Rate" means the all-inclusive Blue Cross NC Rate for an entire admission or one outpatient encounter for Covered Services.

"Chargemaster" or "Charge Master" means facility's listing of facility charges for products, services and supplies.

"Coded Service Identifier(s)" means a listing of descriptive terms and identifying codes, updated from time to time by CMS or other industry source, for reporting Health Services on the CMS 1500 or CMS 1450/UB-04 claim form or its successor as applicable based on the services provided. The codes include but are not limited to, American Medical Association Current Procedural Terminology ("CPT®-4"), CMS Healthcare Common Procedure Coding System ("HCPCS"), International Classification of Diseases, 10th Revision ("ICD-10"), National Uniform Billing Committee ("Revenue Code") and National Drug Code ("NDC") or their successors.

"Cost to Charge Ratio" ("CCR") means the quotient of cost (total operating expenses minus other operating revenue) divided by charges (gross patient revenue) expressed as a decimal, as defined by Regulatory Requirements.

"Diagnosis-Related Group" ("DRG") means Diagnosis Related Group or its successor as established by CMS or other grouper, including but not limited to, a state mandated grouper or other industry standard grouper.

"DRG Rate" means the all-inclusive dollar amount which is multiplied by the appropriate DRG Weight to determine the Blue Cross NC Rate for Covered Services.

"DRG Weight" means the weight applicable to the specific DRG methodology set forth in this PCS, including but not limited to, CMS DRG weights as published in the Federal Register, state agency weights, or other industry standard weights.

"Eligible Charges" means those Provider Charges that meet Blue Cross NC's conditions and requirements for a Health Service to be eligible for reimbursement. These conditions and requirements include: Member program eligibility, Provider program eligibility, benefit coverage, authorization requirements, provider manual guidelines, Blue Cross NC administrative, clinical and reimbursement policies, code editing logic, and coordination of benefits. Eligible Charges do not include Provider Charges for any items or services that Provider receives and/or provides free of charge.

"Emergency Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual, or in the case of a pregnant woman, the health of the woman or her unborn child; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

"Emergency Services" means those Covered Services furnished by a provider qualified to furnish emergency services, and which are services furnished or required to screen for or treat an Emergency Condition until the Emergency Condition is stabilized.

"Encounter Data" means Claim information and any additional information submitted by a provider under capitated or risk-sharing arrangements for Health Services rendered to Members.

"Encounter Rate" means the Blue Cross NC Rate that is all-inclusive of professional, technical and facility charges including evaluation and management, pharmaceuticals, routine surgical and therapeutic procedures, and diagnostic testing (including laboratory and radiology) capable of being performed on site.

"Fee Schedule(s)" means a list of the maximum per unit allowed amounts established for Covered Services based on applicable Coded Service Identifier(s).

"Global Case Rate" means the all-inclusive Blue Cross NC Rate which includes facility, professional and physician services for specific Coded Service Identifier(s) for Covered Services.

"Inpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered inpatient, is assigned a licensed bed within the facility, remains assigned to such bed and for whom a room and board charge is made.

"Observation" means the services furnished on the facility's premises, including use of a bed and periodic monitoring by nursing or other staff, which are Medically Necessary to evaluate a Member's condition and determine if the Member requires an inpatient admission to the facility. Such determination shall be in compliance with Policies or Regulatory Requirements.

"Outlier Rate" means the payment applied to an admission which exceeds the outlier threshold as set forth in the PCS or in compliance with Policies or Regulatory Requirements.

"Outpatient Services" means Covered Services provided by a facility to a Member who is admitted and treated as a registered outpatient within the facility.

"Patient Day" means each approved calendar day of care that a Member receives in the facility, to the extent such day of care is a Covered Service under the terms of the Member's Health Benefit Plan, but excluding the day of discharge.

"Percentage Rate" means the Blue Cross NC Rate that is a percentage of Eligible Charges billed by a provider for Covered Services.

"Per Diem Rate" means the Blue Cross NC Rate that is the all-inclusive fixed payment for Covered Services rendered on a single date of service.

"Per Hour Rate" means the Blue Cross NC Rate that is payment based on an increment of time for Covered Services.

"Per Relative Value Unit" ("RVU") means the Blue Cross NC Rate for each unit of service based on the CMS, State Agency or other (e.g., Anesthesia Society of America (ASA)) defined Relative Value Unit (RVU).

"Per Service Rate" means the Blue Cross NC Rate that is payment for each service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Unit Rate" means the Blue Cross NC Rate that is payment for each unit of service allowed based on applicable Coded Service Identifier(s) for Covered Services.

"Per Visit Rate" means the Blue Cross NC Rate that is the all-inclusive fixed payment for one encounter for Covered Services.

"Provider Charges" means the regular, uniform rate or price Provider determines and submits to Blue Cross NC as charges for Health Services provided to Members. Such Provider Charges shall be no greater than the rate or price Provider submits to any person or other health care benefit payor for the same Health Services provided, regardless of whether Provider agrees with such person or other payor to accept a different rate or price as payment in full for such services. Notwithstanding the foregoing, consistent with N.C.G.S. § 58-50-295, nothing contained in this Provider Charges definition shall be construed to require Provider to agree to reimbursement for any Health Service with a health care benefit payor that is greater than or equal to that applicable to Blue Cross NC.

"Short Stay" means an inpatient hospital stay that is less than a specified number of calendar days in compliance with Policies and/or Regulatory Requirements.

ARTICLE II
GENERAL PROVISIONS

Billing Form and Claims Reporting Requirements. Provider shall submit all Claims on a CMS 1500 or CMS 1450/UB-04 claim form or its successor form(s) as applicable based on the services provided in accordance with Policies or applicable Regulatory Requirements. Provider shall report all Health Services in accordance with the Coded Service Identifier(s) reporting guidelines and instructions using HIPAA compliant billing codes. In addition, Blue Cross NC

shall not pay any Claim(s) nor accept any Encounter Data submitted using non-compliant codes. Blue Cross NC audits that result in identification of Health Services that are not reported in accordance with the Coded Service Identifier(s) guidelines and instructions, will be subject to recovery through remittance adjustment or other recovery action as may be set forth in the provider manual(s).

Claim Submissions for Pharmaceuticals. Each Claim submitted for a pharmaceutical product must include standard Coded Service Identifier(s), a National Drug Code ("NDC") number of the covered medication, a description of the product, and dosage and units administered. Unless otherwise required under Regulatory Requirements, Blue Cross NC shall not reimburse for any pharmaceuticals that are not administered to the Member and/or deemed contaminated and/or considered waste.

Coding Updates. Coded Service Identifier(s) used to define specific rates are updated from time to time to reflect new, deleted or replacement codes. Blue Cross NC shall use commercially reasonable efforts to update all applicable Coded Service Identifiers within sixty (60) days of release by CMS or other applicable authority. When billing codes are updated, Provider is required to use appropriate replacement codes for Claims for Covered Services, regardless of whether this Agreement has been amended to reflect changes to standard billing codes. If Provider bills a revised code prior to the effective date of the revised code, the Claim will be rejected and Provider shall resubmit Claim with correct code. In addition, Claims with codes which have been deleted will be rejected.

Coding Software. Updates to Blue Cross NC's Claims processing filters, code editing software, pricers, and any edits related thereto, as a result of changes in Coded Service Identifier(s) reporting guidelines and instructions, shall take place automatically and do not require any notice, disclosure or amendment to Provider. Blue Cross NC reserves the right to use a code editing software as reasonably required by Blue Cross NC to ensure Claims adjudication in accordance with industry standards, including, but not limited to, determining which services are considered part of, incidental to, or inclusive of the primary procedure and ensuring medically appropriate age, gender, diagnosis, frequency, and units billed.

Modifiers. All appropriate modifiers must be submitted in accordance with industry standard billing guidelines, if applicable.

New/Expanded Service or New/Expanded Technology. In accordance with the Scope/Change in Status section of the Agreement, as of the Effective Date of this Agreement, any New/Expanded Service or New/Expanded Technology (defined below) is not reimbursable under this Agreement. Notwithstanding the foregoing, Provider may submit the following documentation to Blue Cross NC at least sixty (60) days prior to the implementation of any New/Expanded Service or New/Expanded Technology for consideration as a reimbursable service: (1) a description of the New/Expanded Service or New/Expanded Technology; (2) Provider's proposed charge for the New/ Expanded Service or New/ Expanded Technology; (3) such other reasonable data and information required by Blue Cross NC to evaluate the New/Expanded Service or New/Expanded Technology. In addition, Blue Cross NC may also need to obtain approval from applicable Agency prior to Blue Cross NC making determination that New/Expanded Service or New/Expanded Technology can be considered a reimbursable service. If Blue Cross NC agrees that the New/Expanded Service or New/ Expanded Technology may be reimbursable under this Agreement, then Blue Cross NC shall notify Provider, and both parties agree to negotiate in good faith, a new Blue Cross NC Rate for the New/Expanded Service or New/Expanded Technology within sixty (60) days of Blue Cross NC's notice to Provider. If the parties are unable to reach an agreement on a new Blue Cross NC Rate for the New/Expanded Service or New/Expanded Technology before the end of the sixty (60) day period, then such New/Expanded Service or New/Expanded Technology shall not be reimbursed by Blue Cross NC, and the Payment in Full and Hold Harmless provision of this Agreement shall apply.

a. "New/Expanded Service" shall be defined as a Health Service: (a) that Provider was not providing to Members as of the Effective Date of this Agreement and; (b) for which there is not a specific Blue Cross NC Rate as set forth in this PCS.

b. "New/Expanded Technology" shall be defined as a technological advancement in the delivery of a Covered Service which results in a material increase to the cost of such service. New/ Expanded Technology shall not include a new device, or implant that merely represents a new model or an improved model of a device or implant used in connection with a service provided by Provider as of the Effective Date of this Agreement.

Non-Priced Codes for Covered Services. Blue Cross NC reserves the right to establish a rate for codes that are not priced in this PCS or in the Fee Schedule(s), including but not limited to, Not Otherwise Classified Codes ("NOC"), Not Otherwise Specified ("NOS"), Miscellaneous, Individual Consideration Codes ("IC"), and By Report ("BR") (collectively "Non-Priced Codes"). Blue Cross NC shall only reimburse Non-Priced Codes for Covered Services in the following situations: (i) the Non-Priced Code does not have a published dollar amount on the then current

applicable Blue Cross NC, State or CMS Fee Schedule, (ii) the Non-Priced Code has a zero dollar amount listed, or (iii) the Non-Priced Code requires manual pricing. In such situations, such Non-Priced Code shall be reimbursed at a rate established by Blue Cross NC for such Covered Service. Notwithstanding the foregoing, Blue Cross NC shall not price Non-Priced Codes that are not Covered Services under the Members Health Benefit Plan. Blue Cross NC may require the submission of medical records, invoices, or other documentation prior to the adjudication of Claims for Non-Priced Codes.

Reimbursement for Blue Cross NC Rate Based on Eligible Charges. Notwithstanding any reimbursement amount set forth herein, Provider shall only be allowed to receive such reimbursement if such reimbursement is for an Eligible Charge. In addition, if Provider reimbursement is under one or more of the following methodologies: Capitation, Case Rate, DRG Rate, Encounter Rate, Global Case Rate, Per Diem Rate, Per Relative Value Unit (RVU), and Per Visit Rate, then individual services billed shall not be reimbursed separately, unless otherwise specified in Article IV of this PCS.

Reimbursement for Subcontractors. Blue Cross NC shall not be liable for any reimbursement in addition to the applicable Blue Cross NC Rate as a result of Provider's use of a subcontractor. Provider shall be solely responsible to pay subcontractors for any Health Services, and shall via written contract, contractually prohibit such subcontractors from billing, collecting or attempting to collect from Blue Cross NC, or Members. Notwithstanding the foregoing, if Blue Cross NC has a direct contract with the subcontractor, the direct contract shall prevail over this Agreement and the subcontractor shall bill Blue Cross NC under the direct contract for any subcontracted services, with the exception of nursing services provided for Home Infusion Therapy, or unless otherwise agreed to by the parties.

Tax Assessment and Penalties. The Blue Cross NC Rates in this Agreement include all sales and use taxes and other taxes on Provider revenue, gross earnings, profits, income and other taxes, charges or assessments of any nature whatsoever (together with any related interest or penalties) now or hereafter imposed against or collectible by Provider with respect to Covered Services, unless otherwise required by Agency pursuant to Regulatory Requirements. Neither Provider nor Blue Cross NC shall add any amount to or deduct any amount from the Blue Cross NC Rates, whether on account of taxes, assessments, tax penalties or tax exemptions.

Updates to Blue Cross NC Rate(s) Based on External Sources. Unless otherwise required by Regulatory Requirements, and notwithstanding any proprietary fee schedule(s)/rate(s)/methodologies, Blue Cross NC shall use commercially reasonable efforts to update the Blue Cross NC Rate(s) based on External Sources, which include but are not limited to, i) CMS Medicare fee schedule(s)/rate(s)/methodologies; ii) Medicaid or State Agency fee schedule(s)/rate(s)/methodologies; iii) vendor fee schedule(s)/rate(s)/methodologies; or iv) any other entity's published fee schedule(s)/rate(s)/methodologies (collectively "External Sources") no later than sixty (60) days after Blue Cross NC's receipt of the final fee schedule(s)/rate(s)/methodologies change from such External Sources, or on the effective date of such final fee schedule(s)/rate(s)/methodologies change, whichever is later. The effective date of such final fee schedule(s)/rate(s)/methodologies change shall be the effective date of the change as published by External Sources. Fee schedule(s)/rate(s)/methodologies will be applied on a prospective basis. Claims processed prior to the implementation of the new Blue Cross NC Rate(s) in Blue Cross NC's payment system shall not be reprocessed, however, if reprocessing is required by Regulatory Requirements, and such reprocessing could result in a potential under and/or over payment to a Provider, then Blue Cross NC may reconcile the Claim adjustments to determine the remaining amount Provider owes Blue Cross NC, or that Blue Cross NC owes to Provider. Any resultant overpayment recoveries (i.e. Provider owes Blue Cross NC) shall occur automatically without advance notification to Provider to the extent permitted under Regulatory Requirements. Unless otherwise required by Regulatory Requirements, Blue Cross NC shall not be responsible for interest payments that may be the result of a late notification by External Sources to Blue Cross NC of fee schedule(s)/rate(s)/methodologies change.

ARTICLE III
PROVIDER TYPE

Participating Provider(s) shall be limited to performing those Covered Services for which Participating Provider(s) is credentialed and licensed to perform.

"Acute Care General Hospital" means an institution providing medical, nursing and surgical treatment for sick or injured Members, usually for a short term illness or condition.

"Ambulance Provider (Air AMB)" means air transportation by fixed wing or rotary wing equipped aircraft and used only to transport the sick and injured for the purpose of, or related to, medical treatment. Air AMB shall be licensed and operated according to Regulatory Requirements.

"Ambulance Provider (Ground AMB)" means local ground transportation by a vehicle designed, equipped, and used only to transport the sick and injured for the purpose of, or related to, medical treatment. Ground AMB shall be licensed and operated according to Regulatory Requirements.

"Ambulatory Event Monitoring (AEM)" means services related to event recording with a pre or post memory loop, twenty-four (24) hour attended monitoring, receipt of recorded data and analysis of data. It shall not include holter monitoring, pacemaker checks, medical equipment and/or supplies, ambulatory blood pressure monitoring, or mobile cardiac telemetry or "real time" monitoring.

"Ambulatory Infusion Suite Provider (AIS)" means a health care provider that is a licensed pharmacy which offers intravenous administration of drugs or other substances that require infusion to be administered, subcutaneous treatments or administered injections on an outpatient basis in a licensed ambulatory infusion suite when ordered by a physician or other authorized health care professional.

"Ambulatory Surgical/Surgery Center (ASC)" means a free-standing facility with an organized staff of providers, which has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient basis and provides treatment by or under the supervision of physicians and nursing services whenever the patient is in the facility.

"Audiologist Provider" means an individual who (a) is licensed as an audiologist and (b) who practices audiology and presents himself/herself to the public by any title or description of services incorporating the words audiologist, hearing clinician, hearing therapist, or any similar title or description of services. For purposes of this PCS, audiology means the application of non-medical and non-surgical principles, methods and procedures of measurement, testing, evaluation, prediction, consultation, counseling, instruction, habilitation, or rehabilitation related to hearing and disorders of hearing for the purpose of evaluating, identifying, preventing, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

"Behavioral Health Facility" means a facility that provides psychiatric and/or substance abuse services usually for multiple levels of care with appropriate state licensure and quality accreditation certification. Behavioral health levels of care may include all of the following or a combination thereof – inpatient acute mental health, inpatient acute detoxification, inpatient acute substance abuse rehabilitation, substance abuse residential treatment, psychiatric residential treatment, partial hospital programs (sometimes called day treatment), and intensive outpatient programs.

"Behavioral Health Practitioner" means a licensed or certified mental health and/or substance abuse practitioner, or a group of licensed or supervised practitioners with varying specialties, who work either in an independent private practice, a group setting in one or more locations, or at an appropriately licensed clinic/facility or agency providing behavioral health and/or substance abuse Health Services.

"Cardiology Event Monitoring (CEM)" means the provision and hook-up of equipment to monitor the electrical and mechanical activity of the heart muscle, the monitoring and recording of such activity.

"Chiropractor Provider" means an individual who is licensed as a doctor of chiropractic (DC). For the purposes of this PCS, the practice of chiropractic means the adjustment of the twenty-four (24) movable vertebrae of the spinal column, and assisting nature for the purpose of normalizing the transmission of nerve energy, but does not include the use of surgery, obstetrics, osteopathy or the administration or prescribing of any drugs, medicines, serums or vaccines.

"Community Mental Health Center (CHMC)" means an entity which provides medical and behavioral care staffed by licensed practitioners including but not limited to licensed practitioners and/or licensed or certified mental health and/or substance abuse practitioner, or a group of licensed or supervised practitioners with varying specialties, who work either in an independent private practice, a group setting in one or more locations, or at an appropriately licensed clinic/facility or agency.

"Critical Access Hospital (CAH)" means a hospital certified under a set of CMS Conditions of Participation ("CoP"), which are structured differently than an Acute Care General Hospital by providing essential service in rural communities.

"Custodial Care/Nursing Home" means a nursing home, convalescent home, skilled nursing facility ("SNF"), care home, rest home or intermediate care facility that provides a type of residential care. It is a place of residence for people who require continual nursing care and have significant difficulty performing activities of daily living.

"Developmental Disability Service" means services to treat a severe, lifelong disability that substantially limits the functioning ability in three or more life activities, such as self-care, receptive and expressive language, learning, mobility, self-direction, independent living, and employability.

"Diagnostic Treatment Center" means a medical facility with one or more organized Health Services not part of an inpatient hospital facility or vocational rehabilitation center primarily engaged in providing services and facilities to out-of-hospital or ambulatory patients by or under the supervision of a physician for the prevention, diagnosis and, treatment of human disease, pain, injury, deformity or physical condition.

"Dialysis Facility" means a facility, either freestanding or within a facility, providing outpatient dialysis and other similar therapeutics.

"Federally Qualified Health Center (FQHC)" means an outpatient clinic that qualifies for a reimbursement designation from the Bureau of Primary Health Care and CMS of the United States Department of Health and Human Services.

"Flu Clinics/Immunization Provider" means a provider licensed to administer immunizations at employer group work-sites, promotional health events, local health departments and/or other designated sites.

"Free Standing Birthing Center" means a facility as designated by the applicable Agency, other than a hospital's maternity facilities or a physician's office, which provides a setting for prenatal, labor, delivery, and immediate post-partum care as well as immediate care of new born infants.

"Health Professional Practitioner (Employed)" means any state or nationally licensed or certified health professional such as Nurse Practitioners, Midwives, Registered Nurse Anesthetists, Clinical Nurse Specialists, Physician Assistants, Registered Nurse First Assistant.

"Health Professional Practitioner (Independent)" means any state or nationally licensed or certified health professional such as Nurse Practitioners, Midwives, Registered Nurse Anesthetists, Clinical Nurse Specialists, Physician Assistants, Registered Nurse First Assistant.

"Hearing Aid Supplier (HAS)" means a provider that sells hearing aids to improve hearing acuity in compliance with the Regulatory Requirements governing such sales, if any, of the state in which the hearing aids are sold.

"Home and Community Based Services (HCBS)" means a provider managing long-term care services. Long-term care services include, but are not limited to, assistance doing everyday tasks for older, infirmed or disabled Members who may no longer be able to do these tasks for themselves. These services provide opportunities for Members to receive services in their own home or community rather than institutions or other isolated settings.

"Home Health Agency (HHA)" means a health care provider which provides skilled nursing and other skilled services on a part time, episodic, or intermittent basis in the Member's current residence; and is responsible for supervising the delivery of such services under a Plan of Care. "Plan of Care" means the program written by the Member's attending physician, setting forth the diagnosis and the prescribed Covered Services for the Member, prescribed and approved in writing by the attending physician.

"Home Infusion Therapy Provider (HIT)" means a health care provider that is a licensed pharmacy which offers intravenous administration of drugs or other substances that require infusion to be administered, subcutaneous treatments or administered injections in a home setting when ordered by a physician or other authorized health care professional.

HIT Provider provides a wide range of services required to safely and effectively administer home infusion, nutritional therapies, specialty drugs, and disease state and care management services in a home setting. Typical therapies include but are not limited to, antibiotic therapy, total parenteral nutrition, chemotherapy and pain management. Provider offers supplies and clinical services to a Member who is under the care of a physician, or other healthcare provider. Such supplies and clinical services are provided in an integrated manner under a plan established and periodically reviewed by the ordering physician or other healthcare provider. Routine supplies, as defined by CMS, are included in these services.

"Hospice Services" means Covered Services designed to give supportive care to Members in the final phase of a terminal illness. Services include, but are not limited to, Routine Home Care Day, Continuous Home Care Day, Inpatient Respite Care Day and General Inpatient Care Day.

1. Routine Home Care Day – means Covered Services for a day on which a Member who has elected to receive hospice care at current residence and is not receiving continuous care.

2. Continuous Home Care Day – means Covered Services for a day on which a Member who has elected hospice care is at home and receives hospice care consisting predominately of nursing care on a continuous basis at home. A continuous home care day is only furnished during brief periods of crisis, and only as necessary to maintain the terminally ill patient at home with a minimum of eight (8) hours of care being furnished on a particular day to qualify as a continuous home care day.

3. Inpatient Respite Care Day – means Covered Services for a day on which a Member who has elected Hospice care receives services in an inpatient facility (skilled nursing facility, hospital or inpatient hospice house) on a short-term basis when necessary to relieve family members or others caring for the Member, for respite.

4. General Inpatient Care Day – means Covered Services for a day on which the Member who has elected Hospice care receives inpatient services for pain control or acute or chronic symptom management which cannot be managed in other settings.

"Independent Laboratory (LAB)" means an entity that provides Health Services involving the procurement, transportation, testing (which includes clinical and anatomic/surgical pathology), reporting of specimens and consulting services provided by the LAB. LAB does not include providers of laboratory services rendered in connection with an inpatient service, outpatient surgery, observation room stay and pre-surgery testing.

"Independent Practice Association (IPA)" means a legal entity organized and operated on behalf of individual participating medical professionals for the primary purpose of collectively entering into contracts to provide Health Services to Members.

"Indian Health Services Unit" means a provider who provides comprehensive health services for American Indians and Alaska Natives who are members of federally recognized Tribes across the United States.

"Intellectual Disability Services" means services to treat a disability characterized by significant limitations in both intellectual functioning and in adaptive behavior, which covers many everyday social and practical skills.

"Intermediate Care Facility (ICF)" means a facility for Members with Intellectual Disability which is an optional Medicaid benefit that enables states to provide comprehensive and individualized health care and rehabilitation services to Member to promote their functional status and independence.

"Invitro Fertilization Clinic" shall mean an entity which provides infertility treatment and reproductive services.

"Long Term Services and Support (LTSS)" means a spectrum of health and social services that support Members with disabilities who need help with daily living tasks.

"Medical Equipment" shall mean Durable Medical Equipment, Orthotics, Prosthetics, Respiratory Therapy Equipment and Supplies.

"Durable Medical Equipment (DME)" shall mean items prescribed by a provider which can withstand repeated use; are primarily used to serve a medical purpose; are generally not useful to a person in the absence of illness, injury, or disease; and are appropriate for use for activities of daily living.

"Orthotics" shall mean devices prescribed by a provider that are rigid or semi-rigid which support, restore or protect body function and restrict or eliminate motion of a weak or diseased body part.

"Prosthetics" means appliances prescribed by a provider that replace all or part of a body organ (including contiguous tissue), or replace all or part of the function of a permanently inoperative, absent or malfunctioning body part.

"Respiratory Therapy Equipment" shall mean equipment prescribed by a physician used to introduce dry or moist gases into the lungs to treat illness or injury.

"Supplies" shall mean medical items prescribed by a physician that need replacement on a frequent basis.

"Methadone Treatment Provider" means a provider who offers a comprehensive treatment program which involves the long-term prescribing of methadone as an alternative to the opioid on which the Member was dependent.

Central to methadone treatment is the provision of counseling, case management and other medical and psychosocial services. Provider must have a dispensing unit, counseling offices, examining rooms and an administrative area. In addition to dispensing medication, Provider must also provide counseling and other medical services. At all times during the term of this Agreement, Provider agrees to maintain certification by the Substance Abuse and Mental Health Services Administration (SAMHSA).

"Multispecialty Group Practice" means a group of licensed practitioners with varying specialties who provide Health Services to Members.

To the extent required by Regulatory Requirements or an accrediting body, upon termination without cause, Provider will provide timely, sixty (60) day, notice to affected Member(s) of termination of this Agreement or termination of individual Network participation.

"Multispecialty Physician" means a licensed medical practitioner who: (1) agrees to be primarily responsible for managing and coordinating the overall health care needs of Members (a "PCP") and; (2) has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered (a "Specialty Physician/Provider").

To the extent required by Regulatory Requirements or an accrediting body, upon termination without cause, Provider will provide timely, sixty (60) day, notice to affected Member(s) of termination of this Agreement or termination of individual Network participation.

"Nurse Midwives" means an individual who is certified/licensed as a certified nurse midwife to assist women in childbirth or obstetrics.

"Optometrist" means a provider who is licensed in the professional practice of primary eye and vision care that includes the measurement of visual refractive power and the correction of visual defects.

"Oral Surgeon" means a physician specialist expert in the surgical treatment of the jaw, face, teeth and associated structures.

"PCP Group" means one or more licensed medical practitioners who agree to be primarily responsible for managing and coordinating the overall health care needs of Members.

"PCP Group (Non-MD or DO)" means one or more licensed medical practitioners who agree to be primarily responsible for managing and coordinating the overall health care needs of Members.

"PCP Individual" means a licensed medical practitioner who agrees to be primarily responsible for managing and coordinating the overall health care needs of Members.

"PCP Individual (Non-MD or DO)" means a licensed medical practitioner who agrees to be primarily responsible for managing and coordinating the overall health care needs of Members.

"Pharmacist" means a provider licensed as a pharmacist and meeting the requirements to perform immunizations and diabetic education in the state in which they render services.

"Physical Therapy (PT)" means corrective rehabilitation provided by licensed practitioners through the use of physical, chemical and other properties of heat, light, water, electricity, sound, massage and active, passive and resistive exercise.

"Occupational Therapy (OT)" means the development of adaptive skills, increased performance capacity, and those factors that may impede or restrict ability to function provided by licensed practitioners.

"Speech Therapy (ST)" means the evaluation and treatment of disorders that result in impaired or ineffective communication provided by licensed practitioners.

"Physician Hospital Organization (PHO)" means a separate legal entity formed by one or more physicians and one or more hospitals whose objective it is to provide and arrange for Health Services to Members.

"Primary Care Physician" or "Primary Care Provider" ("PCP") means a Participating Provider who (a) is primarily responsible for supervising, managing and coordinating the overall health care needs of Members; (b) is credentialed in accordance with this Agreement; (c) provides Primary Care Services; and (d) practices in the medical specialty

areas of general practice, internal medicine, pediatrics, family medicine, or such other medical specialty areas as are specified to provide Primary Care Services in an applicable Government Contract.

To the extent mandated by Regulatory Requirements, Provider shall ensure that Members have access to twenty-four (24) hour-per-day, seven (7) day-per-week urgent and Emergency Services, as defined in the PCS.

Unless otherwise required under Regulatory Requirements, PCP shall provide Covered Services or make arrangements for the provision of Covered Services to Members on a twenty-four (24) hour per day, seven (7) day a week basis to assure availability, adequacy, and continuity of care to Members. If Provider is unable to provide Covered Services, Provider will arrange for another Participating Provider to cover Provider's patients in accordance with Policies. Provider and any Primary Care Providers employed by or under contract with Provider may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

Primary Care Services means (a) those Covered Services provided to a Member involving primary medical care, including, but not limited to, the Covered Services specifically identified as primary care services in an applicable Government Contract, and (b) the supervision and coordination of the delivery of these Covered Services to a Member.

"Private Duty Nursing (PDN)" means the provision of medically necessary, complex skilled nursing care in the home by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN).

The purpose of private duty nursing is to assess, monitor and provide skilled nursing care in the home on an hourly basis; to assist in the transition of care from a more acute setting to home; and to teach competent caregivers the assumption of this care when the condition of the Member is stabilized. The length and duration of private duty nursing services is intermittent and temporary in nature and not intended to be provided on a permanent ongoing basis. The private duty nurse cannot be a member of the Member's immediate family or anyone living in the home.

"Psychiatric Medical Institute for Children (PMIC)" means a facility licensed to provide in-patient psychiatric treatment to Members under the age of twenty-one (21).

"Radiology Imaging Center" means a free standing facility which has equipment for diagnostic imaging services such as X-rays, computerized axial tomography ("CAT") scans, and magnetic resonance imaging ("MRI").

"Registered Dietician, Nutritionist" means an individual certified to specialize in the study and regulation of diets.

"Rehabilitation Facility" means a facility which is licensed to provide comprehensive rehabilitation services, including but not limited to, therapy and training for rehabilitation, occupational therapy, physical therapy and speech therapy to Members for the alleviation of disabling effects of illness or intended to achieve the goal of maximizing the self-sufficiency of the Member.

"Residential Treatment Facility (RTF)" means an inpatient psychiatric or substance abuse facility that provides psychiatric, substance abuse and other therapeutic and clinically informed services to Members whose immediate treatment needs require a structured twenty four (24) hour residential setting that provides all required services (including schooling) on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, parent guidance, substance abuse education/counseling (when indicated) and other support services including on site education (where appropriate), designed to assist the person to achieve success in a less restrictive setting.

"Respite Care" means the temporary care of a dependent elderly, ill, or handicapped person, providing relief for their usual caregivers.

"Rural Health Clinic (RHC)" means a clinic that is located in an area that is designated both by the U.S. Census Bureau as rural and by the Secretary of Health and Human Services as medically underserved. RHCs provide primarily outpatient services that are typically furnished in a physician's office.

"School Based Health Centers" means a model of health care services provided to youth in a convenient and accessible environment consisting of onsite school-based health care delivery by an interdisciplinary team of health professionals, which can include primary care and mental health clinicians.

"Shockwave Therapy Provider (Shockwave Therapy - Lithotripsy)" means a provider which provides extracorporeal shockwave therapy services in a facility setting.

"Skilled Nursing Facility" means a facility which mainly provides inpatient skilled nursing and related services to Members requiring convalescent and rehabilitation care given by or under the supervision of a qualified/certified practitioner as licensed in the state, following a hospitalization, for a limited period.

"Sleep Clinics" means an entity certified for the diagnosis and treatment of sleep disorders.

"Specialty Physician Group" means one or more licensed or certified medical practitioners who have specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

If Provider is furnishing Specialty Physician services under this Agreement, Provider, and the Specialty Physician(s) employed by or under contract with Provider, shall accept as patients all Members and may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

"Specialty Physician Individual" means a licensed or certified medical practitioner who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

If Provider is furnishing Specialty Physician services under this Agreement, Provider, and the Specialty Physician(s) employed by or under contract with Provider, shall accept as patients all Members and may arrange for Covered Services to Members to be performed by a Specialty Physician only in accordance with Policies.

"Specialty Provider Group (Non-MD or DO)" means one or more licensed or certified medical practitioner(s) who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Covered Services are rendered.

"Specialty Provider Individual (Non-MD or DO)" means a licensed or certified medical practitioner who has specialized education, training or experience in accordance with the Regulatory Requirements of the state in which Health Services are rendered.

"Flu Clinics/Immunization Services" means a provider licensed to administer immunizations at local health departments in accordance with applicable Regulatory Requirements.

"Subacute Care" means a level of care needed by a Member who does not require hospital acute care, but who requires more intensive skilled nursing care than is provided to the majority of Members in a Skilled Nursing Facility.

"Surgical/Surgery Suite" means a group of rooms, typically attached to a physician's office, which has permanent equipment for the primary purpose of performing surgical procedures on an outpatient basis.

"Urgent Care Center (UCC)" means an entity which provides treatment and diagnosis of conditions that require prompt attention in order to prevent serious deterioration to the Member's health, but would not generally be considered to require treatment in an emergency room.

"Walk-In Doctor's Office" means a physician practice that treats patients without requiring that they be an existing patient or that they have an appointment and that can provide routine care and treatment of common family illnesses for adults and/or children.

"Walk-In Medical Center" means an entity which typically provides both routine medical care and urgent care (non-emergent) services.

ARTICLE IV
SPECIFIC REIMBURSEMENT TERMS

MEDICAID

For purposes of determining the Blue Cross NC Rate, the total reimbursement amount that Provider and Blue Cross NC have agreed upon for the applicable provider type(s) for Covered Services provided under this Agreement shall be one hundred percent (100%) of the Blue Cross NC Medicaid Fee Schedule(s) in effect on the date of service.

The parties acknowledge and agree that the Blue Cross NC Medicaid Fee Schedule(s) are subject to modification by Blue Cross NC at any time during the term of this Agreement and will be applied on a prospective basis.

Reimbursement Specific to Provider Type

The following will be reimbursed for facility services only: Acute Care Hospital, ASC, Behavioral Health Facility, Free Standing Birthing Center, Rehabilitation Facility and SNF.

Ambulance Provider Air and/or Ground shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an Blue Cross NC Rate, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

Hospice reimbursement is inclusive of skilled nursing, home health aide, medical social worker services, dietary, pastoral, bereavement counseling, DME, medical supplies and administration of medication.

Specialty Provider Individual and/or group (Non-MD or DO) shall be reimbursed in accordance with Regulatory Requirements for the applicable methodology based on the referenced fee schedule. If such reimbursement is based on an Blue Cross NC proprietary fee schedule, the applicable state methodology on which such fee schedule is based, shall be used to determine the appropriate level of reimbursement.

"Ambulatory Patient Group" ("APG") means the Blue Cross NC Rate that is a fixed reimbursement to a facility for Outpatient Services and which incorporates data regarding the reason for the visit and patient data.

"Ambulatory Payment Classification" ("APC") or its successor shall have the meaning set forth in the Medicare law and CMS regulations and guidance.

"Blue Cross NC DMEPOS and PEN Fee Schedule" means the applicable Blue Cross NC DMEPOS and PEN Fee Schedule for the market(s) and program(s) covered by the Agreement. The parties acknowledge and agree that the Blue Cross NC DMEPOS and PEN Fee Schedule is subject to modification by Blue Cross NC at any time during the term of the Agreement. Blue Cross NC DMEPOS and PEN Fee Schedule and/or rate changes will be applied on a prospective basis.

"Blue Cross NC Reference Laboratory Fee Schedule" means the Blue Cross NC Rate that is the Blue Cross NC Reference Laboratory Fee Schedule that is based on the Medicare Fee Schedule and may contain additional CPT/HCPCS codes. Blue Cross NC Reference Laboratory Fee Schedule and/or rate changes will be applied on a prospective basis.

"Blue Cross NC Medicaid Fee Schedule(s)/ Rate(s)/ Methodologies" means the proprietary rate that may be based on, but is not limited to, the applicable North Carolina Medicaid Fee Schedule(s)/ Rate(s)/ Methodologies, CMS and/or Medicare Fee Schedule(s)/ Rate(s)/ Methodologies, or the Fee Schedule(s)/ Rate(s)/ Methodologies developed by Blue Cross NC in accordance with industry standards.

"CMS Outpatient Prospective Payment System" ("OPPS") shall have the meaning set forth in Medicare law and CMS regulations and guidance.

"Medical Care Management Rate" means the amount paid by Blue Cross NC to Provider on a per member per month basis for facilitation of collaborative programs meant to manage medical/social/mental health conditions more effectively.

"Medicare Fee Schedule" means the applicable Medicare Fee Schedule for the provider type(s) identified herein, including payment conversion factor, where applicable, and in effect on the date of the service is initiated to Members. Medicare Fee Schedule and/or rate changes will be applied on a prospective basis.

"Medicare LUPA National Base Rate" means the Medicare LUPA ("Low Utilization Payment Adjustment") National Base rate in effect as of the date of service for the market(s) and program(s) covered by the Agreement at the time the Covered Services are initiated to the Member. Medicare LUPA National Base Rate changes will be applied on a prospective basis.

"Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule" means the Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule (or successor) in effect as of the date of service for the market(s) and programs covered

by the Agreement at the time the Covered Services is initiated to the Member. Medicare Part B Drug Average Sales Price ("ASP") Fee Schedule and/or rate changes will be applied on a prospective basis.

"North Carolina Medicaid Rate(s)/Fee Schedule(s)/Methodologies" means the North Carolina Medicaid Rate(s)/Fee Schedule(s)/Methodologies in effect on the date of service for the provider type(s)/service(s) identified herein for the applicable Medicaid Program(s).

Medical Group Participation Agreement

This Agreement is entered into by and between UnitedHealthcare of North Carolina, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare Insurance Company, contracting on behalf of itself and the other entities that are United's Affiliates (collectively referred to as "United"), and Forsyth County Department of Public Health ("Medical Group").

This Agreement is effective on the later of _____ or the first day of the first calendar month that begins at least 30 days after the date this Agreement has been executed by all parties (the "Effective Date").

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Medical Group is a provider of health care services.

United wishes to make Medical Group's services available to Customers. Medical Group wishes to provide such services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I.
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 **Benefit Plan** means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 **Covered Service** is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 **Customary Charge** is the fee for health care services charged by Medical Group that does not exceed the fee Medical Group would ordinarily charge another person regardless of whether the person is a Customer.

1.4 **Customer** is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 **Medical Group Physician** is a physician, as defined by the laws of the jurisdiction in which Covered Services are provided and duly licensed and qualified under those laws, who practices as a shareholder, partner, employee or Subcontractor of Medical Group.

1.6 **Medical Group Non-Physician Provider** is a healthcare professional other than a Medical Group Physician, who is duly authorized under the laws of the jurisdiction in which Covered Services are provided, and who renders Covered Services as an employee or Subcontractor of Medical Group.

UnitedHealthcare Confidential and Proprietary

1.7 **Medical Group Professional** is a Medical Group Physician or a Medical Group Non-Physician Provider.

1.8 **Payment Policies** are the guidelines adopted by United for calculating payment of claims to providers of health care services. The Payment Policies operate in conjunction with the specific reimbursement rates and terms set forth in the Payment Appendix or Payment Appendices to this Agreement. The Payment Policies may change from time to time as described in section 6.1 of this Agreement.

1.9 **Payer** is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized by United to access Medical Group's services under this Agreement.

1.10 **Protocols** are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Medical Group in providing services and doing business with United and Payers under this Agreement. Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, concurrent review, or other similar United or Payer programs. Protocols may change from time to time as described in section 5.4 of this Agreement.

1.11 **Subcontractor** is an individual or entity contracted or otherwise engaged by a party to this Agreement. For purposes of Medical Group Professionals, a Subcontractor is a Medical Group Professional only with respect to services rendered to patients of Medical Group and billed under Medical Group's Taxpayer Identification Number(s). Additionally, a Subcontractor is not a Medical Group Professional with regard to any services rendered in a physician's office or other non-facility location other than those locations listed in Appendix 1.

1.12 **United Affiliates** are those entities controlling, controlled by, or under common control with UnitedHealthcare Insurance Company.

Article II.
Representations and Warranties

2.1 **Representations and warranties of Medical Group.** Medical Group, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) Medical Group is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) Medical Group has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Medical Group have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Medical Group and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Medical Group, enforceable against Medical Group in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization,

moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by Medical Group do not and will not violate or conflict with (a) the organizational documents of Medical Group, (b) any material agreement or instrument to which Medical Group is a party or by which Medical Group or any material part of its property is bound, or (c) applicable law. Medical Group has the unqualified authority to bind, and does bind, itself and Medical Group Professionals to all of the terms and conditions of this Agreement, including any Appendices, Attachments and Exhibits, as applicable.

iv) Medical Group has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

v) Medical Group has been given an opportunity to review the Protocols and Payment Policies. See the Additional Manuals Appendix for additional information regarding the Protocols and Payment Policies applicable to Customers enrolled in certain Benefit Plans.

vi) Each submission of a claim by Medical Group pursuant to this Agreement will be deemed to constitute the representation and warranty by it to United that (a) the representations and warranties of it set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (b) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (c) the charge amount set forth on the claim is the Customary Charge and (d) the claim is a valid claim.

2.2 **Representations and warranties of United.** United, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

i) United is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

ii) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by United and (assuming the due authorization, execution and delivery of this Agreement by Medical Group) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

iii) The execution, delivery and performance of this Agreement by United do not and will not violate or conflict with (a) the organizational documents of United, (b) any material agreement or instrument to which United is a party or by which United or any material part of its property is bound, or (c) applicable law.

iv) United has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III.
Applicability of this Agreement

3.1 Medical Group's services.

i) This Agreement applies to Covered Services provided at Medical Group's service locations set forth in Appendix 1. If a service location is not listed in Appendix 1, this section 3.1 and this Agreement should nevertheless be understood as applying to Medical Group's actual service locations that existed when this Agreement was executed, rather than to a billing address, post office box, or any other address set forth in Appendix 1.

In the event Medical Group begins providing services at other service locations, or under other Tax Identification Number(s), those additional service locations or Taxpayer Identification Numbers will become subject to this Agreement 30 days after United receives the notice required under section 5.7(v) of this Agreement. This subsection 3.1(i) applies to cases when Medical Group adds the location itself (such as through new construction) and when Medical Group acquires, merges with, or otherwise becomes affiliated with an existing provider that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers.

ii) In the event Medical Group acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements. Similarly, if Medical Group buys assets of, or leases space from, a medical group that was under contract directly with United or one of United's Affiliates to participate in a network of health care providers at the time of the asset purchase or leasing arrangement, and Medical Group provides services at that location but does not assume the United contract held by the prior operator, Covered Services rendered at that location will be subject to the same rates and other key terms (including term and termination) as applied under the prior operator's contract.

iii) Medical Group may transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Medical Group, but only if Medical Group requests that United approve the assignment of this Agreement as it relates to those Covered Services and only if the other entity agrees to assume this Agreement. This subsection 3.1(iii) does not limit United's right under section 10.4 of this Agreement to elect whether to approve the assignment of this Agreement. This subsection 3.1(iii) applies to arrangements under which another provider leases space from Medical Group, or enters into a subcontract with Medical Group to perform services, after the Effective Date of this Agreement, so that Covered Services that were subject to this Agreement as of the Effective Date of this Agreement are rendered and billed instead by the other provider rather than by Medical Group after the lease or subcontract takes place.

3.2 **Payers and Benefit Plans.** United may allow Payers to access Medical Group's services under this Agreement for certain Benefit Plans, as described in Appendix 2. United may modify Appendix 2 without amendment to include or exclude Benefit Plans in Appendix 2 by providing 30 days prior written or electronic notice to Medical Group.

In addition to changes allowed above, United may make additional changes to Appendix 2 as described in section 3 of that appendix.

Section 9.3 of this Agreement will apply to Covered Services provided to Customers covered by Benefit Plans that are added to the list in Appendix 2 of Benefit Plans excluded from this Agreement as described above.

3.3 **Patients who are not Customers.** This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 7.6 of this Agreement addresses circumstances in which claims for services rendered to those patients are inadvertently paid by a Payer.

3.4 **Health care.** This Agreement and Benefit Plans do not dictate the health care provided by Medical Group Professionals, or govern Medical Group Professionals' determination of what care to provide patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Medical Group Professionals and with Customers, and not with United or any Payer.

3.5 **Communication with Customers.** Nothing in this Agreement is intended to limit Medical Group's or Medical Group Professional's right or ability to communicate fully with a Customer regarding the Customer's health condition and treatment options. Medical Group and Medical Group Professionals are free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Medical Group and Medical Group Professionals are free to discuss with a Customer any financial incentives Medical Group may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement.

Article IV.
Participation of Medical Group Professionals in United's Network

4.1 **Medical Group Professionals as participating providers.** Except as described in section 4.2, all Medical Group Professionals must participate in United's network. Medical Group has the authority to bind, and will bind, all new Medical Group Professionals to the obligations of this Agreement. Medical Group will provide to United the information described in the Medical Group Professional Roster to this Agreement.

4.2 **Medical Group Professionals who are not participating providers.** The following Medical Group Professionals are not participating providers in United's network:

i) A Medical Group Professional who has been denied participation in United's credentialing program, whose credentialing application has not been submitted (to the extent United's credentialing program applies to the Medical Group Professional), or whose credentialing application remains pending; or

ii) A Medical Group Professional who has been terminated from participation in United's network under this Agreement or any other agreement with United through which the Medical Group Professional participated in United's network.

4.3 **Credentialing.** Medical Group and Medical Group Professionals will participate in and cooperate with United's credentialing program to the extent that program applies to Medical Group and Medical Group Professionals. To the extent Medical Group and Medical Group Professionals are subject to credentialing, Medical Group and Medical Group Professionals must be credentialed by United or its delegate prior to furnishing any Covered Services under this Agreement.

4.4 **New Medical Group Professionals.** Medical Group will notify United at least 30 days before a physician or other healthcare professional becomes a Medical Group Professional. In the event that the Medical Group's agreement with the new Medical Group Professional provides for a starting date that would make it impossible for Medical Group to provide 30 days advance notice to United, then Medical Group will give notice to United as soon as reasonably possible but no later than five business days after reaching agreement with the new Medical Group Professional. In either case, the new Medical Group Professional will submit a credentialing application to United or its delegate within 30 days of the new Medical Group Professional's agreement to join Medical Group, unless the new Medical Group Professional already has been credentialed by United and is already a participant in United's network or unless United's credentialing program does not apply to the new Medical Group Professional. In addition, Medical Group will provide to United the information described in the Medical Group Professional Roster to this Agreement with respect to the new Medical Group Professional.

4.5 **Termination of a Medical Group Professional from United's network.** United may terminate a Medical Group Professional's participation in United's network, without terminating this Agreement, immediately, upon becoming aware of any of the following:

i) the material breach of this Agreement by the Medical Group Professional that is not cured by Medical Group and/or the Medical Group Professional within 30 days after United provided notice to Medical Group of the breach;

ii) the suspension, revocation, condition, limitation, qualification or other material restriction on a Medical Group Professional's license, certification and/or permit by any government agency under which the Medical Group Professional is authorized to provide health care services;

iii) the suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any licensed hospital, nursing home or other facility at which the Medical Group Physician has staff privileges during the term of this Agreement;

iv) for any criminal charge related to the practice of Medical Group Professional's profession or for an indictment, arrest, or conviction for a felony;

v) a sanction imposed by any governmental agency or authority, including Medicare or Medicaid; or

vi) the failure to meet the requirements of United's credentialing program to the extent that those requirements apply to the Medical Group Professional.

United will notify Medical Group of the Medical Group Professional's termination according to the notice provision set forth in section 10.8 of this Agreement.

4.6 **Covered Services by Medical Group Professionals who are not participating providers.** Medical Group will staff its service locations so that Covered Services can appropriately be rendered to Customers by Medical Group Professionals who participate in United's network. A Medical Group Professional who does not participate in United's network, pursuant to section 4.2 of this Agreement, will not render Covered Services to a Customer.

In the event Covered Services are rendered by a Medical Group Professional who does not participate in United's network, neither Medical Group nor the Medical Group Professional will submit a claim or other request for payment to United or Payer, and will not seek or accept payment from the Customer.

Article V.
Duties of Medical Group

5.1 **Provide Covered Services.** Medical Group will provide Covered Services to Customers.

5.2 **Nondiscrimination.** Medical Group will not discriminate against any patient, with regard to quality or accessibility of services, on the basis that the patient is a Customer. Medical Group will not require a Customer to pay a "membership fee" or other fee in order to access Medical Group for Covered Services (except for co-payments, coinsurance and/or deductibles provided for under Customer's Benefit Plan) and will not discriminate against any Customer based on the failure to pay such a fee.

5.3 **Accessibility.** Medical Group will be open during normal business hours and will provide or arrange for the provision of advice and assistance to Customers in emergency situations 24 hours a day, seven days a week.

5.4 **Protocols.**

i) **Cooperation with Protocols**. Medical Group will cooperate with and be bound by United's and Payers' Protocols. The Protocols include, but are not limited to, all of the following:

a) For non-emergency Covered Services, Medical Group will assist Customers to maximize their benefits by referring or directing Customers only to other providers that participate in United's network, except as otherwise authorized by United through United's process for approving out-of-network services at in-network benefit levels.

b) If the Customer's Benefit Plan requires the Customer to receive certain Covered Services from or upon referral by a primary care physician, Medical Group Professionals must adhere to the following additional protocols:

1) Notify Customer's primary care physician of referrals to other participating or non-participating providers.

2) Render Covered Services pursuant to the terms and limitations of the referral notification issued by or on behalf of the Customer's primary care physician.

3) Notify the Customer's primary care physician of all admissions.

c) Medical Group will provide notification for certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information, as required by United or Payer as described in the Protocols.

ii) **Availability of Protocols**. The Protocols will be made available to Medical Group online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications. Currently, the Protocols may be found at www.UHCprovider.com or as indicated in the Additional Manual Appendix, if applicable. United will notify Medical Group of any changes in the location of the Protocols.

iii) **Changes to Protocols.** United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Medical Group at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Medical Group's consent if the change is applicable to all or substantially all of the medical groups in United's network located in the same state as Medical Group and that practice the same specialty as Medical Group. Otherwise, changes to the Protocols proposed by United to be applicable to Medical Group are subject to the requirements regarding amendments in section 10.2 of this Agreement.

5.5 Licensure. Medical Group and Medical Group Professionals will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable Medical Group and Medical Group Professionals to lawfully perform this Agreement.

5.6 Liability insurance. Medical Group will ensure that Medical Group and all Medical Group Professionals are covered by liability insurance. Except to the extent coverage is a state mandated placement, the liability coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. The liability insurance will be, at a minimum, of the types and in the amounts set forth below. Medical malpractice insurance will be either occurrence or claims made with an extended period reporting option. Upon request, Medical Group will submit to United in writing evidence of insurance coverage.

Type of Insurance	Minimum Limits
Medical malpractice and/or professional liability insurance	If Medical Group insures all Medical Group Professionals in a single policy: $3,000,000.00 per occurrence and $5,000,000.00 aggregate. OR If Medical Group insures each Medical Group Professional separately, $1,000,000.00 per occurrence and $3,000,000.00 aggregate for each Medical Group Professional.
Commercial general and/or umbrella liability insurance	$1,000,000.00 per occurrence and aggregate.

In lieu of purchasing the insurance coverage required in this section, Medical Group may self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Medical Group will maintain a separate reserve for its self-insurance. If Medical Group uses the self-insurance option described in this paragraph, Medical Group will provide to United, prior to the Effective Date, a statement verified by an independent auditor or actuary that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Medical Group will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Medical Group will assure that its self-insurance fund will comply with applicable laws and regulations.

5.7 Notices by Medical Group. Medical Group will give notice to United within 10 days after any event that causes Medical Group to be out of compliance with section 5.5 or 5.6 of this Agreement. Medical Group will give notice to United at least 30 days prior to any change in Medical Group's name, ownership, control, or Taxpayer Identification Number.

In addition, Medical Group will give written notice to United within 10 days after it learns of any of the following:

i) any suspension, revocation, condition, limitation, qualification or other material restriction on a Medical Group Professional's licenses, certifications and permits by any government agency under which a Medical Group Professional is authorized to provide health care services;

ii) any suspension, revocation, condition, limitation, qualification or other material restriction of a Medical Group Physician's staff privileges at any hospital, nursing home or other facility at which a Medical Group Physician has staff privileges during the term of this Agreement;

iii) an indictment, arrest or conviction of a Medical Group Professional for a felony, or for any criminal charge related to the practice of the Medical Group Professional's profession;

iv) the departure of any Medical Group Professional from Medical Group; or

v) any changes to the information contained in Appendix 1.

5.8 Customer consent to release of medical record information. Medical Group will obtain any Customer consent required in order to authorize Medical Group to provide access to requested information or records as contemplated in section 5.9 of this Agreement, including copies of the Medical Group's medical records relating to the care provided to Customer.

5.9 Maintenance of and access to records.

i) **Maintenance.** Medical Group will maintain medical, financial and administrative records related to Covered Services rendered by Medical Group under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

ii) **Access.** Medical Group will provide access to these records as follows:

a) to United or its designees, in connection with United's utilization management, quality assurance and improvement and for claims payment, health care operations and other administrative obligations, including reviewing Medical Group's compliance with the terms and provisions of this Agreement and appropriate billing practice. Medical Group will provide access during ordinary business hours within 14 days after a request is made, except in cases of a United billing audit involving an allegation of fraud or abuse or the health and safety of a Customer (in which case, access must be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable United to reasonably meet the timelines for determining the appeal or grievance). If records are requested to adjudicate a claim or to make a decision regarding a request for correction under section 7.10, to review an appeal, Medical Group will provide copies of the requested records within 14 days after the request is made; and

b) to agencies of the government, in accordance with applicable law, to the extent that access is necessary to comply with regulatory requirements applicable to Medical Group, United, or Payers.

Medical Group will cooperate with United on a timely basis in connection with any such record request including, among other things, in the scheduling of and participation in an interview to review findings, within 30 days after United's request.

Medical Group will provide copies of records requested by United free of charge.

5.10 Access to data. Medical Group represents that in conducting its operations, it collects and reviews certain quality data relating to care rendered by Medical Group that is reported in a manner which has been validated by a third party as having a clear, evidence-based link to quality or safety (e.g., AHRQ standards) or which has been created by employer coalitions as proxies for quality (e.g., Leapfrog standards).

United recognizes that Medical Group has the sole discretion to select the metrics which it will track from time to time and that Medical Group's primary goal in tracking quality data is to advance the quality of patient care. If the information that Medical Group chooses to report on is available in the public domain in a format that includes all data elements required by United, United will obtain quality information directly from the source to which Medical Group reported. If the Medical Group does not report metrics in the public domain, on a quarterly basis, Medical Group will share these metrics with United as tracked against a database of all commercial patients (including patients who are not Customers). United may publish this data to entities to which United renders services or seeks to render services, and to Customers.

5.11 Compliance with law. Medical Group will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

5.12 Electronic connectivity. When made available by United, Medical Group will do business with United electronically. Medical Group will use www.UHCprovider.com to check eligibility status, claims status, and submit requests for claims adjustment for products supported by UnitedHealthcare Online® or other online resources as supported for additional products. Medical Group will use www.UHCprovider.com for additional functionalities (for instance, notification of admission) after United informs Medical Group that these functionalities have become available for the applicable Customer.

5.13 **Employees and Subcontractors.** Medical Group will ensure that its employees, affiliates and any individuals or entities subcontracted by Medical Group to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit Medical Group's obligations and accountability under this Agreement with regard to those services.

5.14 **Laboratory Services.** Medical Group will be reimbursed for Covered Services that are laboratory services only if, (i) Medical Group is certified through the Clinical Laboratory Improvement Amendments (CLIA) to perform those services, or (ii) those services have "waived" status under CLIA and Medical Group is performing those services pursuant to a CLIA Certificate of Waiver. Medical Group must not bill Customers for any other laboratory services.

Article VI.
Duties of United and Payers

6.1 **Payment of claims.** As described in further detail in Article VII of this Agreement, Payers will pay Medical Group for rendering Covered Services to Customers. United will make its Payment Policies available to Medical Group online and upon request. United may change its Payment Policies from time to time, and will make information available describing the change.

6.2 **Liability insurance.** United will procure and maintain professional and general liability insurance and other insurance, as United reasonably determines may be necessary, to protect United and United's employees against claims, liabilities, damages or judgments that arise out of services provided by United or United's employees under this Agreement.

6.3 **Licensure.** United will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable United to lawfully perform this Agreement.

6.4 **Notice by United.** United will give written notice to Medical Group within 10 days after any event that causes United to be out of compliance with section 6.2 or 6.3 of this Agreement, or of any change in United's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in United being owned or controlled by an entity with which it was already affiliated prior to the change.

6.5 **Compliance with law.** United will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

6.6 **Electronic connectivity.** United will do business with Medical Group electronically by providing eligibility status, claims status, and accepting requests for claim adjustments, for those Benefit Plans supported by www.UHCprovider.com. United will communicate enhancements in www.UHCprovider.com functionality as they become available, as described in Section 5.12, and will make information available as to which Benefit Plans are supported by www.UHCprovider.com.

6.7 **Employees and Subcontractors.** United will assure that its employees, affiliates and any individuals or entities subcontracted by United to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or Subcontractors to render services in connection with this Agreement will not limit United's obligations and accountability under this Agreement with regard to those services.

Article VII.
Submission, Processing, and Payment of Claims

7.1 Form and content of claims. Medical Group must submit claims for Covered Services as described in the Protocols, using current, correct, and applicable coding.

Medical Group will submit claims only for services performed by Medical Group or Medical Group staff. Pass-through billing is not payable under this Agreement.

7.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Medical Group will use electronic submission for all of its claims under this Agreement that United is able to accept electronically.

7.3 Time to file claims. Unless a longer timeframe is required under applicable law, all information necessary to process a claim must be received by United no more than 90 days from the date Covered Services are rendered. If Payer is not the primary payer on a claim, and Medical Group is pursuing payment from the primary payer, the period in which Medical Group must submit the claim will begin on the date Medical Group receives the claim response from the primary payer.

7.4 Payment of claims for Covered Services. Payer will pay claims for Covered Services according to the least of the contract rates in the applicable Payment Appendix, the Medical Group's Customary Charge or as otherwise described in the Payment Appendix. Payment will be subject to Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable law.

The obligation for payment under this Agreement is solely that of Payer and not that of United unless United is the Payer.

Ordinarily, fee amounts listed in the Payment Appendix(ices) are based upon primary fee sources. United reserves the right to use gap-fill fee sources where primary fee sources are not available.

United routinely updates its payment appendices: (1) to remain current with applicable coding practices; (2) in response to price changes for immunizations and injectable medications; and (3) to remain in compliance with HIPAA requirements. United will not attempt to communicate routine updates of this nature. Ordinarily, United's fee schedule is updated using similar methodologies for similar services.

United will give Medical Group at least 90 days written or electronic notice of non-routine fee schedule changes which will substantially alter the overall methodology or reimbursement level of the fee schedule. In the event such changes will reduce Medical Group's overall reimbursement under this Agreement, Medical Group may terminate this Agreement by giving 60 days written notice to United, provided that the notice is given by Medical Group within 30 days after the notice of the fee schedule change.

7.5 Denial of claims for not following Protocols, for not filing timely, for services not covered under the Customer's Benefit Plan, or for lack of medical necessity.

i) **Non-compliance with Protocol.** Payment may be denied in whole or in part if Medical Group does not comply with a Protocol or does not file a timely claim as required under section 7.3 of this Agreement. Medical Group may request reconsideration of the denial and the denial will be reversed if Medical Group can show one or more of the following:

a) the denial was incorrect because Medical Group complied with the Protocol.

b) at the time the Protocols required notification or prior authorization, Medical Group (i) did not know and was unable to reasonably determine that the patient was a Customer, (ii) Medical Group took reasonable steps to learn that the patient was a Customer and (iii) Medical Group promptly submitted a claim after learning the patient was a Customer.

A claim is also subject to denial for other reasons permitted under the Agreement. Reversal of a claim denial under this subsection (i) does not preclude United from upholding a denial for one of these other reasons.

ii) **Non-Covered Services.** Services not covered under the applicable Benefit Plan are not subject to the rates or discounts of this Agreement. Medical Group may seek and collect payment from a Customer for such services (provided that Medical Group obtained the Customer's prior written consent).

iii) **Denials for lack of medical necessity through the prior authorization process.** If a service would otherwise be a Covered Service, but is not a Covered Service under the applicable Benefit Plan because it is determined through the prior authorization process to not meet the requirement of medical necessity, as defined in the Benefit Plan or applicable law (or not meet a similar concept in the Benefit Plan, such as not being consistent with nationally recognized scientific evidence as available, or not being consistent with prevailing medical standards and clinical guidelines), Medical Group may seek or collect payment from the Customer, if, prior to receiving the service, the Customer had knowledge of the determination of non-coverage and specifically agreed in writing to be responsible for payment of those charges.

7.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Medical Group will ask the patient to present his or her Customer identification card. In addition, Medical Group may contact United to obtain the most current information available to United on the patient's status as a Customer.

However, such information provided by United is subject to change retroactively, under any of the following circumstances:

i) if United has not yet received information that an individual is no longer a Customer;

ii) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium;

iii) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or

iv) if eligibility information United receives is later proven to be false.

If Medical Group provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services are not payable under this Agreement, and any payments made with regard to those services may be recovered as overpayments under the process described in section 7.10 of this Agreement. Medical Group may then directly bill the individual, or other responsible party, for those services.

7.7 **Payment under this Agreement is payment in full.** Payment as provided under section 7.4 of this Agreement, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Medical Group will not seek to recover, and will not accept any payment from Customer, United, Payer or anyone acting on any of their behalves, in excess of payment in full as provided in this section 7.7, regardless of whether that amount is less than Medical Group's billed charge or Customary Charge.

7.8 **Customer hold harmless.** Medical Group will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Medical Group's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

i) Medical Group's failure to comply with the Protocols,

ii) Medical Group's failure to file a timely claim,

iii) Payer's Payment Policies,

iv) inaccurate or incorrect claim processing,

v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in these circumstances, or

vi) a denial based on lack of medical necessity or based on consistency with nationally recognized scientific evidence as available, and prevailing medical standards and clinical guidelines, except as permitted under section 7.5 of this Agreement.

This obligation to refrain from billing Customers applies even in those cases in which Medical Group believes that United or Payer has made an incorrect determination. In such cases, Medical Group may pursue remedies under this Agreement against United or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by the above clause v) of this section 7.8, Medical Group may seek payment directly from the Payer or from Customers covered by that Payer if Medical Group first inquires in writing to United as to whether the Payer has defaulted and, if so confirmed, gives United 15 days prior written notice of Medical Group's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a

systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

Section 7.7 and this section 7.8 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

7.9 **Consequences for failure to adhere to Customer protection requirements.** If Medical Group collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 7.7 or 7.8 of this Agreement, Medical Group will be in breach of this Agreement. This section 7.9 will apply regardless of whether Customer or anyone purporting to act on Customer's behalf has executed a waiver or other document of any kind purporting to allow Medical Group to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Medical Group, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer and otherwise enforcing sections 7.7 through 7.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision will be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

7.10 **Correction of claims payments.** If Medical Group does not seek correction of a given claim payment or denial by giving notice to United within 12 months after the claim was initially processed, Medical Group will have waived any right to subsequently seek such correction under this section 7.10, or through dispute resolution under Article VIII of this Agreement or in any other forum.

Medical Group will repay overpayments within 30 days of written or electronic notice of the overpayment. Medical Group will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return the overpayment to United within 30 days after posting it as a credit balance.

Recovery of overpayments may be accomplished by offsets against future payments.

7.11 **Claims payment issues arising from departure of Medical Group Professionals from Medical Group.** In the event a Medical Group Professional departs from Medical Group, and uncertainty arises as to whether Medical Group or some other entity is entitled to receive payment for certain services rendered by such former Medical Group Professional, the parties will cooperate with each other in good faith in an attempt to resolve the situation appropriately.

In the event that Medical Group's failure to give timely notice under section 5.7 (iv) of this Agreement resulted in claims payments being made incorrectly to Medical Group, Medical Group will promptly notify United and return such payments to United. ~~In the event Medical Group fails to do so, United may hold Medical Group liable for any attorneys' fees, costs, or administrative expenses incurred by United as a result.~~

In the event that both Medical Group and some other entity assert a right to payment for the same service rendered by the former Medical Group Professional, United may refrain from paying either entity until the entity to which payment is owed is determined. Provided that United acts in

good faith, Medical Group will waive any right to receive interest or penalties under any applicable law relating to the prompt payment of claims.

Article VIII.
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them ("Disputes") including, but not limited to the existence, validity, scope or termination of this Agreement or any term thereof, ~~and all questions of arbitrability, with the exception of any question regarding the availability of class arbitration or consolidated arbitration, which is expressly waived below.~~ Disputes also include any dispute in which Medical Group is acting as the assignee of one or more Customer. ~~In such cases,~~ Medical Group agrees that the provisions of this Article VIII will apply, ~~including without limitation the requirement for arbitration.~~

~~If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the~~ policies and procedures set forth in that plan must be fully exhausted by Medical Group before Medical Group may invoke ~~any right to~~ arbitration ~~under this Article VIII~~.

For Disputes regarding payment of claims, a party must have timely initiated and completed the claim reconsideration and appeal process as set forth in the Administrative Guide in order to initiate the Dispute process.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it may do so only by submitting the Dispute to binding arbitration conducted by the American Arbitration Association ("AAA") in accordance with the AAA Healthcare Payor Provider Arbitration Rules, as they may be amended from time to time (see http://www.adr.org), except that, in any case involving a Dispute in which a party seeks an award of $1,000,000 or greater or seeks termination of this Agreement, a panel of three arbitrators will be used; a single arbitrator cannot award $1,000,000 or more or order that this Agreement is terminated. The arbitrator(s) will be selected from the AAA National Healthcare Roster (as described in the AAA Healthcare Payor Provider Arbitration Rules) or the AAA's National Roster of Arbitrators (as described the AAA Commercial Arbitration Rules and Mediation Procedures). Unless otherwise agreed to in writing by the parties, if the party wishing to pursue the Dispute does not initiate the arbitration within one year after the date on which written notice of the Dispute was given, or, for Disputes subject to the procedures or processes described in the previous paragraph, within one year after the completion of the applicable procedure or process, it will have waived its right to pursue the Dispute in any forum.

Any arbitration proceeding under this Agreement will be conducted in Guilford County, NC. The arbitrator(s) may construe or interpret but must not vary or ignore the terms of this Agreement and will be bound by controlling law. The arbitrator(s) have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for that relief.

Except as may be required by law, neither a party, including without limitation, the parties' representatives, consultants and counsel of record in the arbitration, nor an arbitrator may disclose the existence, content, or results of any arbitration hereunder, or any Confidential Arbitration Information, without the prior written consent of all parties. "Confidential Arbitration Information" means any written submissions in an arbitration by either party, discovery exchanged, evidence submitted, transcriptions or other records of hearings in the matter and any orders and awards issued, and any reference to whether

either party won, lost, prevailed, or did not prevail against the other party in any arbitration proceeding, as well as any settlement agreement related to an arbitration. However, judgment on the award may be entered under seal in any court having jurisdiction thereof, by either party.

The parties expressly intend that any arbitration be conducted on an individual basis, so that no third parties may be consolidated or joined or allowed to proceed with class arbitration. The parties agree that any arbitration ruling allowing class arbitration, or requiring consolidated arbitration involving any third party(ies), would be contrary to the terms of this Agreement and require immediate judicial review. Notwithstanding anything in this Agreement to the contrary, this paragraph may not be severed from Article VIII of the Agreement under any circumstances, including but not limited to unlawfulness, invalidity or unenforceability.

The decision of the arbitrator(s) on the points in dispute will be binding. The parties acknowledge that because this Agreement affects interstate commerce, the Federal Arbitration Act applies.

In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, the litigation. The litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for the termination exist, the matter will be resolved through arbitration under this Article VIII. While the arbitration remains pending, the termination for breach will not take effect.

This Article VIII will survive any termination of this Agreement.

Article IX.
Term and Termination

9.1 **Term.** This Agreement will take effect on the Effective Date. This Agreement has an initial term of three years and renews automatically for renewal terms of one year, until terminated pursuant to section 9.2 of this Agreement.

9.2 **Termination.** This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;

ii) by either party, upon at least 180 days' prior written notice, effective at the end of the initial term or effective at the end of any renewal term;

iii) by either party upon 60 days' prior written notice in the event of a material breach of this Agreement by the other party, which notice will include a specific description of the alleged breach; however, the termination will not take effect if the breach is cured within 60 days after notice of the termination or if the termination is deferred under Article VIII of this Agreement;

iv) by either party upon 10 days' prior written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement or fails to have insurance as required under section 5.6 or section 6.2 of this Agreement; or

v) by Medical Group, as described in section 7.4 of this Agreement, in the event of a non-routine fee schedule change.

9.3 Ongoing services to certain Customers after termination takes effect. In the event a Customer is receiving any of the Covered Services listed below, as of the effective date the termination of this Agreement or the effective date that a Benefit Plan is added to the list in Appendix 2 of Benefit Plans excluded from this Agreement, Medical Group will continue to render those Covered Services to that Customer and this Agreement will continue to apply to those Covered Services, after the termination/exclusion takes effect, for the length of time indicated below:

Covered Service	Continuity of Care Period
Inpatient Covered Services	30 days or until discharge, whichever comes first
Pregnancy, Third Trimester – Low Risk	Through postpartum follow up visit
Pregnancy, First, Second or Third Trimester – Moderate Risk and High Risk	Through postpartum follow up visit
Non-Surgical Cancer Treatment	30 days or a complete cycle of radiation or chemotherapy, whichever is greater
End Stage Kidney Disease and Dialysis	30 days
Symptomatic AIDS undergoing active treatment	30 days
Any circumstance where Payer is required by applicable law to provide transition coverage of services rendered by Medical Group after Medical Group leaves the provider network accessed by Payer.	As required by applicable law

Article X.
Miscellaneous Provisions

10.1 Entire Agreement. In order for this Agreement to be binding, it must be executed by all parties through written or electronic signature. This Agreement is the entire agreement between the parties with regard to its subject matter, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

10.2 Amendment. United may amend this Agreement or any of the appendices on 90 days' written or electronic notice by sending Medical Group a copy of the amendment, except United may provide less notice to Medical Group if an amendment is necessary in order to comply with applicable law or regulatory requirements. ~~Medical Group's signature is not required to make the amendment effective~~. However, if the amendment is not required by law or regulation and would impose a material adverse impact on Medical Group, then Medical Group may terminate this Agreement on 60 days' written notice to United by sending a termination notice within 30 days after receipt of the amendment. Notwithstanding, all amendments must be in writing

10.3 Non-waiver. The waiver by either party of any breach of any provision of this Agreement will not operate as a waiver of any subsequent breach of the same or any other provision.

10.4 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by United to any United Affiliates. Signed by both party

Additionally, if United transfers to a third party all of its business described in a given line item in Appendix 2, section 1, or other line of business, United may assign this Agreement, only as it relates to that transferred business, to that third party. Such an assignment will not impact the relationship of the parties under this Agreement with regard to the remainder of United's business.

10.5 Relationship of the parties. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

10.6 No third-party beneficiaries. United and Medical Group are the only entities with rights and remedies under this Agreement.

10.7 Calendar days. Unless this Agreement specifically provides otherwise, all references in this Agreement to a period of days refers to calendar days.

10.8 Notice procedures. Any notice required to be given under this Agreement must be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. Acceptable forms of written notice include facsimile, first class mail, certified mail, or overnight delivery by a national, recognized delivery service. All notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested, addressed to the appropriate party at the address set forth on the signature portion of this Agreement. Each party will provide the other with proper addresses, facsimile numbers and electronic mail addresses. All notices will be deemed received upon receipt by the party to which notice is given or on the 5th business day following mailing, whichever occurs first.

Subject to applicable law

10.9 Confidentiality. Neither party may disclose to a Customer, other health care provider, or other third party any of the following information (except as required by an agency of the government):

i) any proprietary business information, not available to the general public, obtained by the party from the other party;

ii) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits, including informing Customers, Benefit Plan sponsors and/or referring providers about the cost of a particular Covered Service or set of Covered Services; or

iii) any customer list of the other party regardless of how such customer list was generated.

This section 10.9 does not preclude the disclosure of information by United to a third party as part of the process by which the third party is considering whether to purchase services from United.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

10.10 Governing law. This Agreement will be governed by and construed in accordance with the laws of the state in which Medical Group renders Covered Services, and any other applicable law.

10.11 Regulatory appendices. One or more regulatory appendices may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

10.12 Severability. Except as otherwise set forth in this Agreement, any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction will not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

10.13 Survival. Notwithstanding the termination of this Agreement, this Agreement will continue to apply to Covered Services rendered while this Agreement was in effect. Additionally, section 10.9 of this Agreement, (except for the last paragraph) will survive the termination of this Agreement.

~~THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.~~

Forsyth County Department of Public Health	*Address to be used to give notice to Medical Group under this Agreement.*
Signature: _____	Street: 799 Highland Avenue
Print Name: _____	City: Winston-Salem
Title: _____	State: NC Zip Code: 27102
D/B/A: _____	Phone: _____ Fax: _____
Date: _____	E-mail: _____

UnitedHealthcare of North Carolina, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare Insurance Company, on behalf of itself and its other affiliates, as signed by its authorized representative:

Signature: _____
Print Name: _____
Title: _____
Date: _____

Address to be used for giving notice to United under this Agreement:
UnitedHealthcare Insurance Company
Street: 107 Westpark Blvd #110
City: Columbia
State: South Carolina Zip Code: 29210
Fax: _____
Email: _____

For office use only: _____
1475403
Month, day and year in which Agreement is first effective: _____

Appendix 1
Medical Group Service Locations

Medical Group attests that this Appendix identifies all services and locations covered under this Agreement.

IMPORTANT NOTE: Medical Group acknowledges its obligation under Section 5.7 to promptly report any change in Medical Group's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

Practice Name: Forsyth County Department of Public Health
Street Address: 799 Highland Avenue
City: Winston-Salem State: NC Zip: 27102
Taxpayer Identification Number(s) (TIN): _____
National Provider ID (NPI): _____

MEDICAL GROUP LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Medical Group Name	**Medical Group Name**
	Forsyth County Department of Public Health
Street Address	**Street Address**
	799 Highland Avenue
City	**City**
	Winston-Salem
State and Zip Code	**State and Zip Code**
	27102
Phone Number	**Phone Number**
	(336)-703-3100
TIN ***(If different from above)***	
National Provider ID (NPI)	

ADDITIONAL MEDICAL GROUP LOCATIONS - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Medical Group Name	**Medical Group Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN ***(If different from above)***	

National Provider ID (NPI)	
_____	

MEDICAL GROUP LOCATION - List BOTH the Service Location and the Billing Address for the Service Location	
Service Location	**Billing Address for the Service Location**
Medical Group Name	**Medical Group Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN *(If different from above)*	
National Provider ID (NPI)	
_____	

Medical Group Name	**Medical Group Name**
Street Address	**Street Address**
City	**City**
State and Zip Code	**State and Zip Code**
Phone Number	**Phone Number**
TIN *(If different from above)*	
National Provider ID (NPI)	
_____	

Appendix 2
Benefit Plan Descriptions

Section 1. United may allow Payers to access Medical Group's services under this Agreement for the Benefit Plan types described in each line item below, unless otherwise specified in section 2 of this Appendix 2:

- Benefit Plans where Customers are offered a network of participating providers and must select a primary physician, who in some cases must approve any care provided by other health care providers. Such Benefit Plans may or may not include an out-of-network benefit.

- Benefit Plans where Customers are offered a network of participating providers but are not required to select a primary physician. Such Benefit Plans may or may not include an out-of-network benefit.

- Medicare Advantage Benefit Plans.

- Benefit Plans for workers' compensation programs accessing a network administered by OneNet PPO, LLC.

Section 2. Notwithstanding the above section 1 of this Appendix 2, this Agreement will not apply to the Benefit Plan types described in the following line items:

- Benefit Plans where Customers are not offered a network of participating providers from which they may receive Covered Services.

- Medicare and Medicaid Enrollees (MME) Benefit Plans.

- Medicaid Benefit Plans.

- CHIP Benefit Plans.

- Benefit Plans for Medicare Select.

- Benefit Plans for workers' compensation benefit programs other than those accessing a network administered by OneNet PPO, LLC.

- Medicare Advantage Private Fee-For-Service Benefit Plans and Medicare Advantage Medical Savings Account Benefit Plans.

- Other Governmental Benefit Plans.
- TRICARE Benefit Plans.

_____

_____

_____

Note: Excluding certain Benefit Plans or programs from this Agreement does not preclude the parties or their affiliates from having or entering into a separate agreement providing for Medical Group's participation in a network for such Benefit Plans or Programs.

Section 3. Definitions:

Note: United may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions in this Appendix 2 regarding Customer identification cards. If that happens, section 1 or section 2 of this Appendix 2 will continue to apply to those Benefit Plans as it did previously, and United will provide Medical Group with the updated information. Additionally, United may revise the definitions in this Appendix 2 to reflect changes in the names or roles of United's business units, provided that doing so does not change Medical Group's participation status in Benefit Plans impacted by that change, and further provided that United provides Medical Group with the updated information.

MEDICARE:

- **Medicare Advantage Benefit Plans** means Benefit Plans sponsored, issued or administered by a Medicare Advantage organization as part of:
  i) the Medicare Advantage program under Title XVIII, Part C of the Social Security Act, or
  ii) the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act,
  as those program names may change from time to time.

_____ _____

_____ _____

- **Medicare and Medicaid Enrollees (MME) Benefit Plan** means the CMS sponsored Financial Alignment Demonstration Plan providing integrated care benefits for individuals eligible for both the state Medicaid program and the Medicare program (Parts A, B, C and D). At such time as this Benefit Plan is no longer a demonstration project and is fully implemented in the state, this definition will be interpreted to refer to the fully implemented plan.

MEDICAID, CHIP AND OTHER STATE PROGRAMS:

- **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program that is authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

- **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that is jointly financed by the federal and state governments and administered by the state.

- **Other Governmental Benefit Plans** means Benefit Plans that are funded wholly or substantially by a state or district government or a subdivision of a state (such as a city or county), but do not include Benefit Plans for:
  i) employees of a state government or a subdivision of a state and their dependents;
  ii) students at a public university, college or school;
  iii) employer-based coverage of private sector employees, even if the employer receives a government subsidy to help fund the coverage;
  iv) Medicaid beneficiaries;
  v) Children's Health Insurance Program (CHIP) beneficiaries; and
  vi) Medicare and Medicaid Enrollees (MME).

Additional Manuals Appendix

For some of the Benefit Plans for which Medical Group may provide Covered Services under this Agreement, Medical Group is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide ("UnitedHealthcare Administrative Guide").

For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the UnitedHealthcare Administrative Guide; or (2) a United Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

The Additional Manuals will be made available to Medical Group on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. United may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if United does so, United will inform Medical Group.

United may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1

Benefit Plan(s)	Description of Applicable Additional Manual	Website
No Additional Manuals Apply		
This row intentionally left blank	_____	_____

Medical Group Professional Roster

IMPORTANT NOTE: Medical Group acknowledges its obligation to notify United of any change in Medical Group Professionals in accordance with Article IV and Section 5.7. Failure to do so may result in denial of claims or incorrect payment.

Medical Group represents that it has provided United with a Medical Group Professional Roster that includes all of the following data elements for each Medical Group Professional:

- Name of Professional (first name, middle initial, last name)
- Degree (MD, DO, NP, PA, other)
- Gender (M/F)
- Provider Specialty(ies) (primary, secondary, additional specialties)
- Operates as and willing to be listed/assigned as a Primary Care Professional "PCP" (Y/N)
- State License Number
- Medicaid ID Number
- NPI Number
- Foreign Language(s)
- Admitting Hospital(s)

If any data element is not applicable to a specific Medical Group Professional, Medical Group will indicate "not applicable" in the appropriate field. Acceptable formats include in writing, electronically in Excel, ANSI, or text (comma delineated) formats.

Payment Appendix - All Payer

All Payer Fee Information Document: 13131 / 13132

Unless another Payment Appendix to this Agreement applies specifically to a particular Benefit Plan as it covers a particular Customer, the provisions of this Payment Appendix apply to Covered Services rendered by Medical Group to Customers covered by Benefit Plans sponsored, issued or administered by all Payers.

However, reimbursement to Medical Group by the applicable Payer for Covered Services rendered to Customers covered by Benefit Plans for workers' compensation programs accessing a network administered by OneNet PPO, LLC will be the least of: (i) this All Payer fee schedule; (ii) Medical Group's Customary Charge for such services; or (iii) (a) the applicable state's workers' compensation fee schedule, (b) the applicable federal workers' compensation fee schedule or (c) other state, federal, or government authorized methodology or schedule.

Payment Appendix - Medicare Advantage

Medicare Advantage Fee Information Document: 25492 / 25493

Unless another Payment Appendix to this Agreement applies specifically to a particular Medicare Advantage Benefit Plan as it covers a particular Customer, the provisions of this Payment Appendix apply to Covered Services rendered by Medical Group to Customers covered by all Medicare Advantage Benefit Plans, as described in this Agreement.

AMENDMENT

Forsyth County Health Department ("Provider") is party to an agreement (the "Agreement") with UnitedHealthcare of North Carolina, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare Insurance Company, contracting on behalf of itself and the other entities that are United's Affiliates (collectively "United"), under which Provider participates in United's network of contracted participating providers.

This Amendment is effective on the later of (a)_____; or (b) the first day that United begins providing coverage to Customers enrolled in North Carolina Medicaid and CHIP Benefit Plans, (the "Amendment Effective Date").

The parties hereby amend the Agreement as follows:

1. If any of the terms in this Amendment are defined (or the equivalent terms are defined) in the Agreement, then such terms have the same meaning in the Amendment as such defined terms or the equivalent terms. For example, "Benefit Plans," as used in this Amendment, will have the same meaning as any defined term in the Agreement for "Benefit Contracts"; "Customer," as used in this Amendment, will have the same meaning as any defined term in the Agreement for "Member," or "Enrollee;" and "Payer," as used in this Amendment, will have the same meaning as any defined term in the Agreement for "Payor." For purposes of this Amendment, the following additional definitions will apply:

   - **Benefit Plan Descriptions Provision** means Appendix 2, or any provision of the Agreement that describes or lists the products, Benefit Plans or networks that may be included or excluded under the Agreement.

   - **Inclusion List** means the portion of the Benefit Plan Description Provision that lists the applicable products, benefit plans or networks for which United may allow Payers to access Provider's services through the Agreement.

   - **Exclusion List** means the portion of the Benefit Plan Description Provision that lists the applicable products, benefit plans or networks in which Provider does not participate through the Agreement.

2. The Benefit Plan Descriptions Provision is amended by adding the following terms and definitions. These terms and definitions will supersede and replace any existing similar terms and definitions in the Agreement to the extent there is a conflict. United may adopt a different name for a particular Benefit Plan, and/or may modify information referenced in the definitions regarding Customer identification cards. If that happens, this Amendment will continue to apply to those Benefit Plans as it did previously, and United will provide Provider with the updated information.

   - **Medicaid Benefit Plans** means Benefit Plans that offer coverage to beneficiaries of a program authorized by Title XIX of the federal Social Security Act, and jointly financed by the federal and state governments and administered by the state.

   - **Children's Health Insurance Program ("CHIP") Benefit Plans** means Benefit Plans under the program authorized by Title XXI of the federal Social Security Act that are jointly financed by the federal and state governments and administered by the state.

UnitedHealthcare
Confidential and Proprietary

- **North Carolina Medicaid and CHIP Benefit Plans** means Medicaid Benefit Plans, CHIP Benefit Plans, and Benefit Plans for other state-based healthcare programs for low income individuals, issued in North Carolina that include a reference to "UnitedHealthcare Community Plan" on the valid identification card of any Customer eligible for and enrolled in that Benefit Plan.

1. The Benefit Plan Descriptions Provision is hereby amended by adding the following line item(s) to the Inclusion List:

   - North Carolina Medicaid and CHIP Benefit Plans.

   _____

   _____

   _____

2. The Benefit Plan Descriptions Provision is hereby amended by adding the following line item(s) to the Exclusion List:

   - Medicaid and CHIP Benefit Plans other than those separately addressed in the Benefit Plan Description Provisions.

   _____

   _____

   The Exclusion List is further amended by deleting any other line item for Medicaid or CHIP Benefit Plans.

3. The following is added to the Agreement:

   For some of the Benefit Plans for which Provider may provide Covered Services under this Agreement, Provider is subject to additional requirements of one or more additional provider manuals ("Additional Manuals"). When this Agreement refers to Protocols or Payment Policies, it is also referring to the Additional Manuals. An Additional Manual may be a separate document or it may be a supplement to the UnitedHealthcare Care Provider Administrative Guide ("UnitedHealthcare Administrative Guide").

   For Benefit Plans subject to an Additional Manual, the Additional Manual controls if it conflicts with any of the following: (1) a provision of this Agreement or of the UnitedHealthcare Administrative Guide; or (2) a United Protocol or Payment Policy. However, the Additional Manual does not control where it conflicts with applicable statutes or regulations.

   The Additional Manuals will be made available to Provider on a designated website and upon request. The names of the Additional Manuals, the websites to view and download them, and the Benefit Plans to which they apply, are listed in Table 1 below. United may change the location of a website or the Customer identification card identifier used to identify Customers subject to a given Additional Manual; if United does so, United will inform Provider.

   United may make changes to the Additional Manuals subject to this Appendix in accordance with the provisions of this Agreement relating to Protocol and Payment Policy changes.

Table 1:

Benefit Plan	Description of Applicable Additional Manual	Website
North Carolina Medicaid and CHIP Benefit Plans	UnitedHealthcare Physician, Health Care Professional, Facility and Ancillary Provider Administrative Guide for North Carolina Medicaid and CHIP	www.uhccommunityplan.com

1. The following paragraph is added to the Agreement and will replace any provision in the Agreement to the extent such provision directly conflicts with it:

   "Payment may be denied for services provided that are determined by United to be medically unnecessary, and Provider may not bill the customer for such services unless the customer has, with knowledge of United's determination of a lack of medical necessity, agreed in writing to be responsible for payment of those charges".

2. The attached Payment Appendix is added to the Agreement:

   - Payment Appendix for North Carolina Medicaid and CHIP Benefit Plans.

3. The attached Regulatory Appendix is added to the Agreement and will supersede and replace any existing applicable regulatory appendix or similar regulatory requirements appendix, addendum or provision in the Agreement.

   - Regulatory Requirements Appendix applicable to North Carolina Medicaid and CHIP Benefit Plans.

All other provisions of the Agreement shall remain in full force and effect. In the event of a conflict between this Amendment and the Agreement, this Amendment will control.

The undersigned have executed this Amendment to be effective as of the Amendment Effective Date.

UnitedHealthcare of North Carolina, Inc., UnitedHealthcare Insurance Company of the River Valley, and UnitedHealthcare Insurance Company, contracting on behalf of itself and the other entities that are United's Affiliates, as signed by its authorized representative	**Forsyth County Health Department**, as signed by its authorized representative
Signature:	Signature:
Print Name: _____	Print Name: _____
Title: _____	Title: _____
Date: _____	Medicaid ID number: _____
	National Provider Identification (NPI) Number:
	Tax Identification Number: 566000450
	Date: _____

Not signed

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 Forsyth County ("**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 this Agreement becomes effective as determined by Health Plan and set forth on the signature page of this Agreement. Federal law prohibits Health Plan from contracting with individuals or entities that are barred from participation in Federal Health Care Programs. Accordingly, the Effective Date is subject to Health Plan's completion of credentialing and determination that Contracted Provider meets the Credentialing Criteria.

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. 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.

Do we need to do this again?

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

(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. 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. "Any confidential material shall be marked and provide basis for exclusion from public records law

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.~~ Parties shall comply with all applicable law.

~~8.1 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 Raleigh, 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 ~~Wake County~~ Forsyth County, 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.

Notwithstanding, no amendments will be effective unless in writing signed by both parties

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	Forsyth County
By: _____	By: _____
Print Name: Lisa Wright	Print Name: _____
Title: Medicare Region President	Title: _____
Date: _____	Date: _____
	Fed Tax ID: 566000450
WellCare and Health Plan Notice Address:	Contracted Provider Notice Address:
8735 Henderson Rd.	799 Highland Ave
Tampa, FL 33634	Winston-Salem, NC 27101
ATTN: Director, Network Management	ATTN: Joshua Swift
Fax: (813) 981-5478	Fax: _____
	Revision # 2015.1

FOR HEALTH PLAN USE ONLY

Effective Date: _____

(To be completed by WellCare following approval of Contracted Provider as a Health Plan participating provider, which approval is subject to credentialing but not limited thereto. Any attempt by Contracted Provider to fill in an effective date shall have no force or effect.)

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

   b. 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.

   c. 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.

   d. 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.

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

   f. 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.

   g. 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.

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

   i. 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).

j. 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.

k. 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.

l. 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.

m. 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.

n. 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.

o. 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.

p. 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.

q. 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.

r. 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.

s. 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.

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

u. 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.

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

w. 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.

x. 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. Notwithstanding, no contract will be effective unless in writing signed by both parties

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

      viii. 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. 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.

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

iii. 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.

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

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

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

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

viii. 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.

ix. 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.

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

xi. 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.

xii. 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

1. The compensation rates set forth in this Attachment apply for Covered Services rendered by a local health department (LHD) Provider to Members with 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 LHD Providers rendering Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses:

   a. Laboratory Services: 100 percent of the applicable CMS Medicare fee schedule for the applicable locality published on CMS's website on the date the Covered Services are rendered. For laboratory Covered Services that are not listed on the CMS Medicare Fee Schedule, Health Plan will compensate Provider at 100 percent of the applicable North Carolina Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered.

   b. All Other Covered Services: 100 percent of the applicable North Carolina Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered.

3. Notwithstanding the foregoing, to the extent Health Plan is required by the Department to reimburse LHD Providers at an enhanced rate for their Covered Services rendered to Members, Health Plan's reimbursement will be 100% of the applicable Department enhanced fee schedule.

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. Unless prohibited by Laws or Department, 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. Health Plan will implement and apply changes to the applicable CMS Medicare and 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 the Governmental Authority's website, or (c) 45 days after a proposed fee schedule or rate change has received all necessary regulatory approvals. Unless prohibited by Laws or the 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 CMS's Medicare or Department's Medicaid, as applicable, fee schedules and payment systems published on their respective websites.

9. Additional, Utilization-based, Directed LHD Payments.

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

   b. Directed LHD Overpayments. Notwithstanding anything in the Agreement to the contrary, if any Additional Utilization-based Payment paid to an LHD Provider is recouped by the Department from Health Plan, the LHD Provider must refund the Additional Utilization-based Payment it received that was paid with the recouped Additional Utilization-based Payment to Health Plan within 10 business days of notice by Health Plan of the recoupment. If Health Plan is unable to collect the Additional Utilization-based Payment from the LHD Provider for any reason, then Health Plan may withhold from or offset against any other funds owed to the LHD Provider, whether they are Additional Utilization-based Payments or other funds, until Health Plan has collected the total amount of the Additional Utilization-based Payment to be refunded. Nothing in this paragraph prohibits Health Plan from pursuing any other remedy available to it under the law to recover funds owed by the LHD Provider to Health Plan under this Agreement.

ATTACHMENT C-2
NORTH CAROLINA MEDICAID COMPENSATION
LOCAL HEALTH DEPARTMENTS
(CARE MANAGEMENT SERVICES)

1. The compensation rates set forth in this Attachment apply to Local Health Department ("LHD") Providers rendering Care Management Services to High Risk Pregnancy or At-risk Children North Carolina Medicaid Members. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Local Health Department Compensation.

   a. Care Management.

      i. LHD Providers carrying out care management for High-Risk Pregnancy or At-Risk Children (the "Care Management Services") qualify for compensation in addition to the fee-for-service payments described in this Agreement (collectively, "Care Management Fees"). These payments are dependent on the LHD Provider's compliance with the Department's Care Management for High-Risk Pregnancy and Care Management for At-Risk Children Policies and shall be calculated using the applicable following rates:

         A. At- Risk Children. For the period commencing on the Effective Date and ending June 30, 2022, LHD Providers performing Care Management for At-Risk Children services shall receive $4.56 Per Member Per Month (PMPM) for all enrolled children, ages 0 to 5 residing in the LHD Provider's published service area as approved by Health Plan and subject to modification by the Department.

         B. High Risk Pregnant Women. For the period commencing on the Effective Date and ending June 30, 2022, LHD Providers performing Care Management for High Risk Pregnant Women services shall receive $4.96 Per Member Per Month (PMPM) for all enrolled women, ages 14 to 44 residing in the LHD Provider's published service area as approved by Health Plan and subject to modification by the Department.

         C. Period after July 1, 2022. The Department will provide Health Plan guidance regarding any continued Care Management Fees in the period beginning July 1, 2022.

      ii. Payment Frequency. The Care Management Fees shall each be paid on or about the 20th day of each month throughout the term of this Agreement, subject to adjustment as set forth herein. For a partial month, if any, Care Management Fees will be prorated based on the number of days in the month.

      iii. Calculating Assigned Membership. Health Plan will measure the number of Members attributed to LHD Provider on a monthly basis for the purpose of attribution for Care Management Fees. Each month, Health Plan will review the Monthly Payments for preceding months and reconcile such payments against the Department's member enrollment data. If Health Plan determines there were enrollment changes in any preceding month(s), Health Plan may adjust its Care Management Fees to LHD Provider in any subsequent month(s) by the amount of any underpayment or overpayment due to changes in enrollment to reflect the actual number of Members or to account for Members who enrolled or disenrolled retroactively with Health Plan.

iv. Corrective Action Plan. LHD Providers must meet the Program Requirements outlined in Attachment B to remain eligible for the Care Management Fees. Health Plan, in compliance with the North Carolina Contract and in conjunction with the Department, shall monitor LHD Providers' performance of the Care Management Services. LHD Provider agrees that Health Plan may require a corrective action plan ("CAP") if LHD Provider's performance is unsatisfactory. LHD Provider shall cooperate to develop a CAP with Health Plan. LHD Provider shall implement the CAP and timely comply with all of its obligations to the satisfaction of Health Plan.

v. Termination of Care Management Fee. In the event that LHD Provider is unable or unwilling to resolve any CAP in a timely manner or to the satisfaction of Health Plan, Health Plan reserves the right to cease payment of the Care Management Fees upon 30 days' prior written notice to LHD Provider until such time as Health Plan determines that LHD Provider has come into compliance with the Program Requirements.