AGENDA – MEETING
GREENE COUNTY BOARD OF COUNTY COMMISSIONERS
10:00 AM – THE WELLNESS CENTER MONDAY, JUNE 28, 2021

A. CALL TO ORDER

Invocation/Pledge to the Flag

B. APPROVAL OF AGENDA

C. PUBLIC COMMENTS

D. COUNTY MANAGERS REPORT

1. Participating Provider Agreements
2. FY 20/21 End of Year Budget Amendment

E. COUNTY ATTORNEY COMMENTS

F. COMMISSIONER'S REPORT AND RECOMMENDATION

G. ADJOURN

Commissioners
Bennie Heath - Chairman
James T. Shackleford-Vice Chair
Jerry Jones
Susan Blizzard
Derek Burress

GREENE COUNTY
A Place To Grow. The Way To Live.

County Manager
Kyle J. DeHaven

Finance Officer
Beverly T. Stroud

County Attorney
Gay Stanley

From: Kyle J. DeHaven, County Manager

Re: Participating Provider Agreements

Date: June 28, 2021

With Medicaid transformation taking place. Medicaid recipients are required to choose 1 of 5 Primary Health Providers. They are AmeriHealth Cantas, BCBS, United, Carolina Complete, and Wellcare. Depending on who the individual chooses for service, is who our billing company, Colleton will request payment from. We need contracts with each to be recognized as a provider with billable authority.

This new system and process takes effect July 1. Failure to have the appropriate contract in place will result in the inability to bill for services provided.

Action Recommended:

Motion to approve the BA as presented

Board Action is Needed

"Greene County is an equal opportunity provider, employer and lender."
To file a complaint of discrimination write USDA, Director, Office of Civil Rights, 1400 Independence Ave., SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TDD)

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "***Agreement***") is made and entered by and between Greene County ("***Provider***") and WellCare Health Plans, Inc. ("***WellCare***"). This Agreement is effective as of the date designated by WellCare on the signature page of this Agreement ("***Effective Date***"). For purposes of this Agreement, each of Provider and WellCare may be referred to herein as a "***Party***" and collectively as the "***Parties***."

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth; and

WHEREAS, WellCare desires for Provider to provide such health care services to individuals in such products, and WellCare desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

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

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means a person or entity directly or indirectly controlling, controlled by, or under common control with such entity.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.8, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means, as appropriate in the context, WellCare and/or one or more of its Affiliates listed on Schedule D of this Agreement, except those specifically excluded by WellCare.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by WellCare.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with WellCare to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by WellCare. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by WellCare (e.g., WellCare Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by WellCare).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II - PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and

the Provider Manual, in each case, to the same extent as if the Contracted Providers were parties hereto. Provider shall be responsible for any breach of this Agreement by any Contracted Provider.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Contracted Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Provider shall provide WellCare with the information listed on Schedule C entitled "Information for Contracted Providers" for itself and the Contracted Providers as of the Effective Date. Provider shall provide WellCare, from time to time or on a periodic basis as requested by WellCare, with a complete and accurate list of Information for Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide WellCare with a list of modifications to such list at least 30 days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. The effective date of any Contracted Provider added under this Agreement shall be the later of the Agreement Effective Date or date by which the Contracted Provider's enrollment as a Medicaid enrolled provider is effective within NC Tracks. In such case, Provider shall provide written notice to WellCare of the prospective addition(s), and shall use best efforts to provide such notice at least 60 days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within 30 days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. WellCare shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means as promptly as possible following WellCare's receipt of any and all necessary regulatory review and approval thereof (whether by the North Carolina Department of Health and Human Services, the North Carolina Division of Health Benefits or otherwise); provided, however, that in no event shall WellCare be required to make the Provider Manual available earlier than one hundred and twenty (120) days prior to North Carolina's effective date of the Medicaid managed care program. Upon Provider's reasonable request, WellCare shall provide Provider with a written copy of the Provider Manual. In the event of a material change to the Provider Manual, WellCare will provide Provider with at least sixty (60) days' advance written notice of such change. Such notice may be given by WellCare through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program or eligible to enroll as a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred.

2.8. Treatment Decisions. No Company or Payor shall be liable for, or exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted

Providers understand that determinations of Company or Payor that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company (each a "Non-Disparagement Party") shall not disparage any other Non-Disparagement Party during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of WellCare, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other WellCares consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting any Non-Disparagement Party's ability to use and disclose information and data obtained from or about another Non-Disparagement Party, including this Agreement, to the extent determined reasonably necessary or appropriate by such Non-Disparagement Party in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to WellCare and Payor of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any final adverse determinations in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify WellCare and Payor in writing within 10 days, and in any instance described in subsection (iv) above, Provider must notify WellCare and Payor in writing within 30 days, from the date it first obtains knowledge of any such final adverse determination.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company and/or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they

participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to WellCare complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III - CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain patient data and identifying information, diagnosis and service codes, and provider identifiers, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. Unless Company provides prior written approval to Provider, Provider shall make arrangements for and only accept Compensation Amounts by way of electronic funds transfer via the automated clearing house network (EFT-ACH).

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage

Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider following not less than thirty (30) days' advance written notice to Provider. Such notice will be accompanied by adequate specific information to identify the specific claim and the specific reason for the offset or recoupment. All offsets or recoupments will be made within the two (2) years after the date of the original claim payment unless Payor has a reasonable belief of fraud or other intentional misconduct by Provider, Contracted Provider or their respective agents or the claim involves the receipt of payment for the same service from a government payor. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider. If the recoupment is standard in scope, then Payor or its delegate may immediately offset any and all overpayments or payments made in error without prior notice to Provider. "Standard" means those overpayments or payments made in error that are discovered by Payor or its delegate on an individual account review basis. If the recoupment is non-standard in scope, then Payor or its delegate will provide written or electronic notice to Provider before using an offset as a means to recover an overpayment, and will not implement the offset if, within thirty (30) days after the date of the notice, Provider refunds the overpayment or initiates an appeal. The written or electronic notice from the Payor or its delegate shall explain the reason and calculation of the overpayment or payment made in error. "Non-standard" means those overpayments or payments made in error that are discovered by Payor or its delegate during an audit that is being conducted to correct a systemic error. Appeals shall be made pursuant to procedures set forth in the Policies and/or Provider Manual.

ARTICLE IV - RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii) appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations, to the extent such access is necessary for WellCare to maintain or apply for certain accreditations, as applicable. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Company and Payor agree to limit the number of copies of records requested of Provider and each Contracted Provider to the minimum necessary to satisfy the applicable obligation. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V - INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to WellCare, and in a minimum amount of $1,000,000 per occurrence, and $3,000,000 annual aggregate unless a lesser amount is accepted by WellCare or where State law mandates otherwise. Provider and each Contracted Provider will provide WellCare with at least 15 days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon WellCare's request, Provider and each Contracted Provider will furnish WellCare with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at WellCare's request defend) Company, Payor and each of their respective officers, directors, agents, and employees from and against any and all claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations (collectively, "Losses") arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by WellCare. WellCare agrees to indemnify and hold harmless (and at Provider's request (as applicable) defend) Provider, Contracted Providers, and each of their respective officers, directors, agents and employees from and against any and all Losses arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

ARTICLE VI - DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and WellCare and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the Dispute is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within 1 year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the Dispute has not been resolved within 60 days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than 1 year following, as applicable, the end of the 60 day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any

proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII - TERM AND TERMINATION

7.1. Term. This Agreement is effective as of the Effective Date, and will, subject to Section 7.1.2 of this Agreement, remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred eighty (180) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred eighty (180) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least 120 days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least 120 days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least 90 days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the 60 day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, WellCare has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when WellCare determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by WellCare, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by WellCare giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the 90 day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 5.4, 6.1, 6.2, 7.3, 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Relationship of Parties. The relationship between or among WellCare, Company, Provider, and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any "Company" under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to WellCare. Each Company (each an "Unaffiliated Party" and collectively, the "Unaffiliated Parties") acknowledge that references herein to their respective rights and obligations under this Agreement are references to the rights and obligations of each such Unaffiliated Party individually and not of the Unaffiliated Parties collectively. Notwithstanding anything that may be construed herein to the contrary, all such rights and obligations are individual and specific to each Unaffiliated Party and the reference to one Unaffiliated Party herein in no way imposes any cross-guarantees or joint responsibility or liability on the other Unaffiliated Party. A breach or default hereunder by an Unaffiliated Party shall not constitute a breach or default by the other Unaffiliated Party.

8.2. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.3. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without the WellCare's prior written consent; provided, however, WellCare shall, in addition to the rights provided under Section 8.2, have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of WellCare, or purchaser of the assets or stock of WellCare, or the line of business or business unit primarily responsible for carrying out WellCare's obligations under this Agreement. Any attempted assignment or delegation in violation of this Section 8.3 shall be void.

8.4. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.5. Governing Law. The interpretation of this Agreement and the rights and obligations of WellCare, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.6. Third Party Beneficiary. This Agreement is entered into by the Parties for their benefit, as well as, in the case of WellCare, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4, Section 5.2, Section 5.3 and/or Section 5.4 hereof, no Covered Person or any other third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.7. Amendment. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties.

8.7.1. WellCare may amend this Agreement by giving the Parties written notice of the amendment to the extent such amendment is deemed necessary or appropriate by WellCare to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by the Parties upon the giving of such notice.

8.7.2. WellCare may amend this Agreement by giving Provider written notice (electronic or paper) of the proposed amendment. When such an amendment proposes to modify Provider's reimbursement or addresses Covered Services routinely rendered by Provider to Covered Persons, the amendment will be evaluated by WellCare's Medical Affairs and Financial Matters Committees prior to WellCare giving written notice to Provider. Unless Provider notifies WellCare in writing of its objection to such amendment during the 30 day period following the giving of such notice by WellCare, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to this Agreement, WellCare may exclude one or more of the Contracted Providers from being Participating Providers in the Product (or any component program of, or Coverage Agreement in connection with, such Product) to which such amendment relates.

8.8. Entire Agreement. This Agreement, together with any attached or incorporated amendments, schedules, exhibits, attachments and appendices, constitute the entire understanding and agreement of the parties with respect to the subject matter hereof and supersedes all prior oral and written and all contemporaneous oral negotiations, commitments and understandings between them. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between WellCare and Provider relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.9. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.10. Waiver. Any term or condition of this Agreement may be waived at any time by the Party that is entitled to the benefit thereof, but no such waiver shall be effective, unless set forth in a written instrument duly executed by or on behalf of the Party waiving such term or condition; provided, however, that no Party shall be permitted to make any such waiver by or on behalf of any other Party. The waiver by any Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.11. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To WellCare at:	To Provider at:
Attn: President	Attn:
WellCare Health Plans, Inc.	Greene County
3128 Highwoods Blvd	229 Kingold Blvd Ste D
Raleigh, NC 27604	Snow Hill, NC 28580

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, WellCare may provide notices to Provider by electronic mail, through its provider newsletter or on its provider website.

8.12. Force Majeure. No Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by the employees of such Party, or any other similar cause beyond the reasonable control of such Party.

8.13. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information, and except for such disclosures as are required by Regulatory Requirements, Provider shall not disclose such information to any person or entity without WellCare's express written consent.

8.14. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of this Agreement. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to WellCare.

8.15. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement. Upon Provider's reasonable written request, WellCare shall provide Provider with a fully executed copy of this Agreement.

* * * * *

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

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

WELLCARE:	**PROVIDER:**
WellCare Health Plans, Inc.	Greene County (Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name: Troy Hildreth	Print Name: {{*Name_es_:Signer1 }}
Title: State President	Title: {{*Ttl1_es_:Signer1:title }}
Signature Date: {{$IntDate }}	Signature Date: {{$ExtDate }}
ICM #: ICMProviderAgreement_52604	Tax Identification Number: 56-6000304
	State Medicaid Number:
To be completed by WellCare only: Effective Date: {{$IntDate }}	National Provider Identifier:

{{#ExtDate=ExtSignDate_es_:signer1:date }}
{{#IntDate=IntSignDate_es_:signer2:date }}

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1 Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within 24 hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each Hospital agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Hospital's performance data.

2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a written statement from another Participating Provider who has such admitting privileges, in good standing, certifying

that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing 45 days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each Practitioner agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Practitioner's performance data.

3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing 45 days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each ancillary provider agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use ancillary provider's performance data.

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

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and WellCare has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to WellCare at any time upon request. FQHC shall promptly notify WellCare if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5 Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of WellCare's Standards. Each facility agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use facility's performance data.

6 Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community. Long-term care ("LTC") is another subset of LTSS which provides benefits as specified through the SMMC LTC Program.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of WellCare. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. WellCare acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to WellCare, via written notice or via telephone contact at a number to be provided by WellCare, within the following time frames:

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

6.5.2 Provider or the applicable Contracted Provider shall notify WellCare of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify WellCare if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

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

6.5.5 Provider or the applicable Contracted Provider shall notify WellCare of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify WellCare of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to WellCare or its designee the Minimum Data Set as defined by CMS and required under federal law and WellCare policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by WellCare.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in WellCare's LTSS quality improvement plan. Each Contracted Provider shall permit WellCare to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and WellCare's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by WellCare thereafter. Provider shall provide the results of such background checks to WellCare and member, if self-directed, upon request. WellCare within a reasonable time period following the completion thereof. Contracted Provider agrees to immediately notify WellCare of any criminal convictions of any Contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7 Person-Centered Planning, Care/Service Plan, and Services. Provider and Contracted Providers shall comply with all State and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by State and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Person.

7.3 LTSS providers shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 WellCare agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if State requirements differ) and provide a copy to LTSS provider(s) responsible for implementation.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid
Attachment B: Medicare
Attachment C: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
INFORMATION FOR CONTRACTED PROVIDERS

Provider shall provide WellCare with the information set forth below with respect to: (i) Provider; (ii) each Contracted Provider; and (iii) if applicable, each Contracted Provider's locations and/or professionals. To the extent Provider provides the name of any Contracted Provider to WellCare hereunder, such entity and/or individual will be considered a Contracted Provider under this Agreement regardless of whether the complete list of information set forth below relating to such Contracted Provider is provided by Provider.

1. Name
2. Address
3. E-mail address
4. Telephone and facsimile numbers
5. Professional license numbers
6. Medicare/Medicaid ID numbers
7. Federal tax ID numbers
8. Completed W-9 form
9. National Provider Identifier (NPI) numbers
10. Provider Taxonomy Codes
11. Area of medical specialty
12. Age restrictions (if any)
13. Area hospitals with admitting privileges (where applicable)
14. Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
15. 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.
16. Office contact person
17. Office hours
18. Billing office
19. Billing office address
20. Billing office telephone and facsimile numbers
21. Billing office e-mail address
22. Billing office contact person
23. Ownership Disclosure Form, as required to comply with Laws, Program Requirements, and Government Contract

NOTE: For a complete listing of the information and additional documentation required, please refer to the enrollment application

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE D
COMPANY AFFILIATES

As of the Effective Date, the Affiliates of WellCare included as the "Company" are listed below.

Affiliates	State
Celtic Insurance Company	Multiple States
Health Net Community Solutions, Inc.	Multiple States
Health Net Life Insurance Company	Multiple States
WellCare Health Plans, Inc.	Multiple States
WellCare of Alabama, Inc.	Alabama
Bridgeway Health Solutions of Arizona, Inc. Care1st Health Plan of Arizona Inc. Health Net of Arizona, Inc., d/b/a Arizona Complete Health One Care by Care1st Health Plan of Arizona Inc. WellCare Health Insurance of the Southwest, Inc. WellCare Health Plans of Arizona, Inc.	Arizona
Arkansas Health & Wellness Health Plan, Inc. Arkansas Total Care, Inc. NovaSys Health, Inc. WellCare Health Insurance Company of America	Arkansas
Harmony Health Plan, Inc.	Arkansas, Illinois, Mississippi, South Carolina, Tennessee
California Health and Wellness Plan Health Net of California, Inc. WellCare of California, Inc., f/k/a Easy Choice Health Plan, Inc.	California
WellCare Health Insurance of Connecticut, Inc.	Connecticut
WellCare of Connecticut, Inc.	Connecticut, North Carolina
Sunshine Health Plan Community Solutions, Inc. Sunshine State Health Plan, Inc. WellCare Health Insurance of Arizona, Inc.WellCare of Florida, Inc.	Florida
Ambetter of Peach State, Inc. Peach State Health Plan, Inc. WellCare of Georgia, Inc.	Georgia
WellCare Health Insurance of Arizona, Inc., d/b/a 'Ohana Health Plan, Inc. WellCare Health Insurance of Hawaii, Inc.	Hawaii
IlliniCare Health Plan, Inc. Meridian Health Plan of Illinois, Inc. WellCare of Illinois, Inc.	Illinois
Meridian Health Plan of Michigan, Inc.	Illinois, Indiana, Michigan, Ohio
Coordinated Care Corporation, d/b/a Managed Health Services - IN	Indiana
Iowa Total Care, Inc.	Iowa
Sunflower State Health Plan, Inc.	Kansas
WellCare Health Insurance Company of Kentucky, Inc., d/b/a WellCare of Kentucky, Inc.	Kentucky
Louisiana Healthcare Connections, Inc. WellCare Health Insurance Company of Louisiana, Inc.	Louisiana
WellCare of Maine, Inc.	Maine
CeltiCare Health Plan of Massachusetts, Inc. WellCare Health Plans of Massachusetts, Inc.	Massachusetts
Meridian Health Plan of Michigan, Inc. Michigan Complete Health, Inc.	Michigan
Ambetter of Magnolia, Inc.	Mississippi

Affiliates	State
Magnolia Health Plan, Inc. WellCare of Mississippi, Inc.	
Home State Health Plan, Inc.	Missouri
Nebraska Total Care, Inc.	Nebraska
SilverSummit Healthplan, Inc.	Nevada
Granite State Health Plan, Inc. WellCare Health Insurance Company of New Hampshire, Inc. WellCare of New Hampshire, Inc.	New Hampshire
WellCare Health Insurance Company of New Jersey, Inc. WellCare Health Plans of New Jersey, Inc.	New Jersey
Western Sky Community Care, Inc.	New Mexico
New York Quality Healthcare Corporation, d/b/a Fidelis Care WellCare Health Insurance of New York, Inc. WellCare of New York, Inc.	New York
American Progressive Life and Health Insurance Company of New York	New York, Maine
WellCare Health Insurance of North Carolina, Inc. WellCare of North Carolina, Inc.	North Carolina
Buckeye Community Health Plan, Inc. Buckeye Health Plan Community Solutions, Inc.	Ohio
WellCare Health Insurance Company of Oklahoma, Inc. WellCare of Oklahoma, Inc.	Oklahoma
Health Net Health Plan of Oregon, Inc. Trillium Community Health Plan, Inc.	Oregon
Pennsylvania Health & Wellness, Inc.	Pennsylvania
WellCare Health Plans of Rhode Island, Inc.	Rhode Island
Absolute Total Care, Inc. WellCare of South Carolina, Inc.	South Carolina
WellCare Health Insurance of Tennessee, Inc.	Tennessee
SelectCare Health Plans, Inc. SelectCare of Texas, Inc. Superior HealthPlan Community Solutions, Inc. Superior Healthplan, Inc. WellCare National Health Insurance Company WellCare of Texas, Inc.	Texas
WellCare Health Plans of Vermont, Inc.	Vermont
WellCare of Virginia, Inc.	Virginia
Coordinated Care of Washington, Inc. WellCare Health Insurance Company of Washington, Inc. WellCare of Washington, Inc.	Washington
Managed Health Services Insurance Corporation	Wisconsin

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

This PRODUCT ATTACHMENT ("***Attachment***") is made and entered between WellCare Health Plans, Inc., a North Carolina corporation ("***WellCare***") and Greene County ("***Provider***").

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

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

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

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

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement, or, if not defined there, in the State Contract (as herein defined). All technical managed care terms used in this Attachment are defined in the Agreement or this Attachment, and are consistent with definitions included in Covered Person materials issued in conjunction with the Medicaid managed care program.

1.1. "***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 state law, rule, regulation, administrative hearing, or court order is not an amendment.

1.2. "***Clean Claim***" means a claim for services submitted to WellCare by a Medicaid managed care medical or pharmacy services provider that can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

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

1.4. "***Emergency Services***" means inpatient and outpatient services furnished by a qualified provider needed to evaluate or stabilize an Emergency Medical Condition.

1.5. "***Health Care Provider***" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes of North Carolina 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 of North Carolina or is owned or operated by the State of North Carolina in which health care services are provided to patients.

1.6. ***"Medicaid Product"*** refers to those programs and health benefit arrangements offered by WellCare or other Company pursuant to a State Contract. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.7. "***Medically Necessary Service***" or "***Medically Necessary***" means definition as found in Section III.A.78.

1.8. "***Objective Quality Standards***" means the objective standards for quality determinations identified by WellCare that assess a provider's ability to deliver care; include specific defined thresholds for adverse quality determinations; meet standards established by the National Committee on Quality Assurance (NCQA); and are not discriminatory.

1.9. "***Primary Care Provider***" or "***PCP***" means the participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Covered Person to provide and coordinate the Covered Person's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.

1.10. "***State***" means North Carolina.

1.11. "***State Contract***" means a contract between WellCare or other Company and one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded program(s) and to meet certain performance standards while doing so.

2. Medicaid Product.

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

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

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

2.4. Construction. This Product Attachment supplements and forms a part of the Agreement. Except as otherwise provided herein or in the terms of the Agreement, the terms and conditions of the Agreement will remain unchanged and in full force and effect as a result of this Product Attachment. In the event of a conflict between the provisions of the Agreement and the provisions of this Product Attachment, this Product Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in or covered by a Medicaid Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from WellCare. To the extent any provision of this Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

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

4. Governmental Program Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the applicable State Contract to be included in the Agreement with respect to the Medicaid Product. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

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

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the North Carolina Medicaid Product under the State Contract.

1. Compliance.

1.1 Compliance with State and Federal Laws. Participating Provider understands and agrees that it, he or she 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 State Contract, and all persons or entities receiving state and federal funds. Participating 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 State Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. *(Section VII, Section G(3)(a)).*

1.2 Department Authority Related to the Medicaid Program. Participating Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services ("***NC DHHS***") 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. *(Section VII, G(3)(e)).*

1.3 Credentialing. Each Participating Provider shall be enrolled as a Medicaid provider as required by 45 C.F.R. § 455.410 and maintain enrollment for the term of the Agreement. Participating Provider shall maintain licensure, accreditation, and credentials sufficient to meet WellCare's network participation requirements, as outlined in WellCare's Provider Manual and its Credentialing and Re-credentialing Policy. Participating Provider shall notify WellCare of changes in the status of any information relating to Participating Provider's professional credentials. Participating Provider shall complete reenrollment or re-credentialing before renewal of the Agreement as set forth below:

(a) during the provider credentialing transition period, no less frequently than every five (5) years; and

(b) during the provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the NC DHHS. *(Section VII, G(1)(f))*

1.4 Liability Insurance. Participating Provider shall maintain professional liability insurance coverage in an amount acceptable to WellCare. Participating Provider shall notify WellCare of subsequent changes in the status of Participating Provider's professional liability insurance on a timely basis. *(Section VII, G(1)(g)).*

1.5 Utilization Management. Participating Provider shall comply with WellCare's utilization management programs, quality management programs, and provider sanction programs, except to the extent that any of these programs conflict with Participating Provider's professional or ethical responsibility or interfere with Participating Provider's ability to provide information or assistance to patients. WellCare utilizes only NC Medicaid's Clinical Coverage Policies for utilization management/clinical guidelines and other NC DHHS-approved utilization management/clinical guidelines. *(Section VII, G(1)(o)).*

1.6 Dispute Resolution. Participating Provider shall utilize the applicable dispute resolution procedures outlined in the Agreement to resolve disputes between WellCare and Participating Provider. *(Section VII, G(1)(q)).*

1.7 Reporting Requirements. Participating Provider shall promptly provide WellCare with the data and information that WellCare requests in order to meet its reporting requirements under the State Contract. *(Section VII, J. Table 1).*

1.8 Hours of Operation. Participating Provider will offer hours of operation to Covered Persons that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if Participating Provider serves only Medicaid or NC Health Choice members. *(Section V, D(1)(d)(iii)).*

2. Entire Agreement. The Agreement identifies the documents that constitute the entire contract between the parties. *(Section VII, G(1)(a)).*

3. Hold Harmless. Participating Provider agrees to hold the Covered Person harmless for charges for any Covered Service. Participating Provider agrees not to bill a Covered Person for Medically Necessary Services covered by WellCare so long as the Covered Person is eligible for coverage. *(Section VII, G(3)(b))*. Participating Provider will not hold Covered Person's responsible for any of the following: (a) WellCare's debts in the event of its insolvency; (b) Covered Services provided to the Covered Person for which: (i) NC DHHS does not pay WellCare, or (ii) NC DHHS, or WellCare, does not pay the Participating Provider; (c) payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Covered Person would owe if WellCare covered the services directly. 42 C.F.R. § 438.106. *(Section V, C(1)(i)(iii) and Section V, C(2)(r)(iii))*.

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

5. Non-Discrimination.

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

5.2 Interpreting and Translation Services. Participating Provider shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Covered Person. Participating Provider shall ensure that Participating Provider's staff are trained to appropriately communicate with patients with various types of hearing loss. Participating Provider shall report to WellCare, in a format and frequency determined by WellCare, whether hearing loss accommodations are needed and provided and the type of accommodation provided. *(Section VII, G(1)(t)).*

6. Term; Termination.

6.1 Term. This Attachment is coterminous with the Agreement, unless otherwise agreement by the parties, but in no event will the term of this Attachment exceed the term of the State Contract (including, for avoidance of doubt, any renewals of the State Contract) *(Section VII, G(1)(c))*.

6.2 Termination. The Agreement sets forth the basis for termination of the Agreement by either party and the related notice requirements. Notwithstanding anything in the Agreement or this Attachment to the contrary, WellCare may immediately terminate the Agreement or this Attachment and a Participating Provider's participation thereunder upon: (1) a confirmed finding of fraud, waste or abuse by the NC DHHS or the North Carolina Department

of Justice Medicaid Investigations Division, or (2) failure of the Participating Provider to maintain enrollment as a Medicaid provider. *(Sections VII, G(1)(d) and G(1)(f)(i))*.

6.3 Insolvency. If the Agreement or this Attachment terminates as a result of WellCare's or Payor's insolvency, Participating Provider will cooperate in the transition of administrative duties and records and ensure the continuation of care when inpatient care is on-going in accordance with the requirements of the Agreement, this Attachment and the State Contract. If WellCare or Payor provides for or arranges for the delivery of health care services on a prepaid basis, Participating Provider will continue inpatient care until the patient is ready for discharge. *(Section VII, G(1)(e))*.

7. Covered Person Services.

7.1 Covered Person Billing. Participating Provider shall not bill any Medicaid Managed Care Covered Person for Covered Services, except for specified coinsurance, copayments, and applicable deductibles. Participating Provider is responsible for collecting applicable deductibles, copayments, coinsurance and fees for non-Covered Services. This provision does not prohibit a Participating Provider and Covered Person from agreeing to continue non-Covered Services at the Covered Person's own expense, as long as the Participating Provider has notified the Covered Person in advance that a Payor may not cover or continue to cover specific services and the Covered Person to receive the services *(Section VII, G(1)(h))*.

7.2 Provider Accessibility. Participating Provider shall provide call coverage or other back-up to provide service in accordance with WellCare's standards for provider accessibility addressed set forth herein, in the Provider Manual and/or in the State Contract. *(Section VII, G(1)(i))*. Participating Provider agrees to meet the NC DHHS standards for timely access to care and services, taking into account the urgency of need for services. *(Section V, D(1)(d)(ii))*. Participating Provider shall provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for Medicaid Covered Persons with physical or mental disabilities. *(Section V, (1)(d)(vi))*.

7.3 Eligibility Verification. WellCare or Payor shall provide a mechanism that allows Participating Provider to verify Covered Person eligibility, based on current information held by WellCare or Payor, as applicable, before rendering Covered Services. *(Section VII, G(1)(j))*.

7.4 Covered Person Appeals and Grievances. Participating Provider shall cooperate with Covered Person in regard to Covered Person appeals and grievance procedures. *(Section VII, G(1)(l))*. Participating Provider has the right to file a grievance or appeal. WellCare's internal appeal processes must be completed before seeking other legal or administrative remedies under state or federal law. *(Section V, D(2)(c)(xi))*.

7.5 Appointment Wait Times. Participating Provider shall cooperate with WellCare to ensure that appointment wait times for Covered Persons do not exceed the requirements set forth below, to the extent applicable. *(Section VII, F. Table 3)*.

(a) If Participating Provider is a PCP providing preventative care services, appointment wait time shall not exceed thirty (30) calendar days for adults (21 years of age and older) and children ages six (6) months to twenty (20) years of age, and fourteen (14) calendar days for children less than six (6) months of age.

(b) If Participating Provider is a PCP providing urgent care services, appointment wait time shall not exceed twenty-four (24) hours.

(c) If Participating Provider is a PCP providing services for routine/check-up without symptoms, appointment wait time shall not exceed thirty (30) calendar days.

(d) If Participating Provider is a PCP providing after-hours access for emergent and urgent care, care shall be administered immediately upon presentation at a service delivery site.

(e) If Participating Provider provides prenatal care, appointment wait time for initial appointments within the first or second trimester shall not exceed fourteen (14) calendar days and appointment wait time for initial appointments within the third trimester or for a high-risk pregnancy shall not exceed five (5) calendar days.

(f) If Participating Provider provides specialty care, appointment wait time shall not exceed twenty-four (24) hours for urgent care services or thirty (30) calendar days for routine/check-up without symptoms services. For after-hours access for emergent and urgent care, care shall be administered immediately upon immediately upon presentation at a service delivery site.

(g) If Participating Provider provides behavioral health care, appointment wait time shall not exceed thirty (30) minutes for Mobile Crisis Management Services; twenty-four (24) hours for Urgent Care Services for Mental Health or Urgent Care Services for SUDs; and fourteen (14) calendar days for Routine Services for Mental Health or Routine Services for SUDs. For Emergency Services for Mental Health or SUDs, care should administered immediately upon presentation at a service delivery site.

(h) To the extent Participating Provider performs Emergency Services, Participating Provider shall make Emergency Services available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.

8. Records.

8.1 Medical Records. Participating Provider shall maintain confidentiality of Covered Person medical records and personal information and other health records as required by law. Participating Provider shall maintain adequate medical and other health records according to industry and WellCare standards. Participating Provider shall make copies of such records available to WellCare, Payor and NC DHHS in conjunction with its regulation of WellCare. Participating Provider shall make available and furnish the records immediately upon request in either paper or electronic form, at no cost to the requesting party. *(Section VII, G(1)(k))*.

8.2 Access to Provider Records.

(a) Participating Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to WellCare or Payor and the Agreement and any records, books, documents, and papers that relate to WellCare or Payor and the Agreement and/or Participating 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: (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) 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; and (ix) any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

(c) 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. *(Section VII, G(3)(f))*.

9. Provider Ownership Disclosure. Participating 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. Participating Provider agrees to notify, in writing, WellCare and the NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction. *(Section VII, G(3)(g)).*

10. Provider Payment.

10.1 Methodology. The Agreement includes a provider payment provision that describes the methodology to be used as a basis for payment. Such provision does not include a rate methodology that provides for automatic increases in rates, consistent with N.C. Gen. Stat. 58-3-227(a)(5). *(Section VII, G(1)(m)).*

10.2 G.S. 58-3-225, Prompt Claim Payments under Health Benefit Plans. Unless otherwise provided by the NC DHHS's Advanced Medical Home Program Policy, Pregnancy Management Program Policy, Care Management for High-Risk Pregnancy Policy, or Care Management for At-Risk Children Policy, Participating Provider shall submit all claims to the Payor for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Participating Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Participating 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. *(Section VII, G(3)(h)).*

(a) For medical claims (including behavioral health), Payor shall comply with the requirements set forth below.

(i) The Payor shall within eighteen (18) calendar days of receiving a Medical Claim notify Participating Provider whether the claim is a Clean Claim, or pend the claim and request from Participating Provider all additional information needed to process the claim.

(ii) The Payor 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.

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

(b) For pharmacy claims, Payor shall comply with the requirements set forth below.

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

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

(c) 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 Payor shall deny the claim per § 58-3-225 (d). The Payor shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

(d) If the Payor fails to pay a Clean Claim in full pursuant to this provision, the Payor shall pay 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.

(e) Failure to pay a Clean Claim within thirty (30) days of receipt will result in the Payor paying 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.

(f) The Payor shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require Provider to requests the interest or the penalty.

10.3 Government Funds. Participating Provider and WellCare acknowledge that funds used for provider payments are government funds. (Section VII, G (1)(s)).

11. Data to Provider. WellCare will provide certain data and information to the Provider, and changes to such information, which may include performance feedback report if compensation is related to efficiency criteria, information on benefit exclusions, administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies *(Section VII, G(1)(n))*.

12. Provider Directory. Participating Provider authorizes WellCare and/or Payor to include, and WellCare and/or Payor shall include, the name of Participating Provider and/or Participating Provider's group in the provider directory distributed to Covered Persons. *(Section VII, G (1)(p))*.

13. Assignment. Participating Provider shall not assign, delegate, or transfer any of its duties and/or responsibilities under the Agreement without prior written consent of WellCare. WellCare shall notify Provider in writing of any duties or obligations that are to be delegated or transferred, before the delegation or transfer. (Section VII, G (1)(r)).

14. Providers of Perinatal Care. To the extent that Participating Provider offers prenatal, perinatal, and postpartum services or is an obstetrician, Participating Provider shall comply with NC DHHS's Pregnancy Management Program. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes and reducing health care costs among participating providers. Participating Provider shall: (a) complete the standardized risk-screening tool at each initial visit; (b) allow WellCare or WellCare's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators; (c) commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation; (d) commit to decreasing the cesarean section rate among nulliparous women; (e) 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; (f) complete a high-risk screening on each pregnant Medicaid Managed Care Covered Person in the program and integrate the plan of care with local pregnancy care management; (g) decrease the primary cesarean delivery rate if the rate is over NC DHHS's designated cesarean rate (NC DHHS will set the rate annually at or below 20%); and (h) ensure comprehensive post-partum visits occur within fifty-six (56) days of delivery *(Section VII, G(1)(u)) and M(3))*.

14.1 High-Risk Pregnancies Information Requirement. Participating Provider shall send all screening information and applicable medical record information for Covered Persons in the Care Management of High-Risk Pregnancies to WellCare and the Local Health Departments or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancy within one business day of the provider completing the screening (Section VII, M(3.3.i.)).

15. Advanced Medical Homes. To the extent Participating Provider is an Advanced Medical Home (AMH), Participating Provider shall comply with NC DHHS' Advanced Medical Home Program, including the requirements set forth below. *(Section VII, G(1)(v))*.

15.1 Identified as PCP. Participating Provider shall accept Covered Persons and be listed as a PCP in WellCare's Covered Person-facing materials for the purpose of providing care to Covered Persons and managing their health care needs.

15.2 Care Coordination Services. Participating Provider shall provide primary care and patient care coordination services to each Covered Person, in accordance with WellCare policies. *(Section VII, G(1)(v)(i))*

15.3 Primary Care Coverage. Participating 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.

15.4 Minimum Office Hours. Participating Provider shall provide direct patient care a minimum of 30 office hours per week.

15.5 Preventive Services. Participating Provider shall provide preventive services, in accordance with Section VII. Attachment M. Table 1: Required Preventive Services of the State Contract as set forth on Attachment A: Medicaid, Appendix A to Schedule A, Governmental Program Requirements to the Agreement.

15.6 Unified Medical Record. Participating Provider shall maintain a unified patient medical record for each Covered Person following the WellCare's medical record documentation guidelines.

15.7 Referrals. Participating Provider shall promptly arrange referrals for Medically Necessary health care services that are not provided directly and document referrals for specialty care in the medical record.

15.8 Medical Record Transfer. Participating Provider shall transfer the Covered Person medical record to the receiving provider upon the change of PCP at the request of the new PCP or WellCare (if applicable) and as authorized by the Covered Person within thirty (30) days of the date of the request, free of charge.

15.9 Appointments. Participating Provider shall authorize care for the Covered Person or provide care for the Covered Person based on the standards of appointment availability as defined by the WellCare's network adequacy standards.

15.10 Second Opinion. Participating Provider shall refer for a second opinion as requested by the Covered Person, based on NC DHHS guidelines and WellCare standards.

15.11 Utilization Management.

15.11.1.Participating Provider shall review and use Covered Person utilization and cost reports provided by WellCare for the purpose of AMH level utilization management and advise WellCare of errors, omissions, or discrepancies if they are discovered.

15.11.2.Prepaid Health Plans utilizes only North Carolina Medicaid's Clinical Coverage Policies for utilization management/clinical guidelines and other Department-approved utilization management/clinical guidelines.

15.12 Enrollment Report. Participating Provider shall review and use the monthly enrollment report provided by WellCare for the purpose of participating in WellCare or practice-based population health or care management activities. *(Section VII, M(2))*

15.13 Advanced Medical Home Tier 3 Standard Terms and Conditions. If Provider or a Contracted Provider is a Tier 3 Advanced Medical Home ("AMH") Participating Provider, the Agreement must include provisions that outline the AMH Tier 3 care management model and requirements consistent with the State Contract as set forth below. *(Section VII, M(2 - 4 (a-e))*

(a) (The AMH has primary responsibility for care management, and when the Prepaid Health Plan ("PHP") and AMH offer the same or similar disease management programs, the PHP will defer to the AMH

program when the member's AMH is contracted as an Tier 3 AMH ("AMH3" or "AMH Level 3") except where the AMH is not performing to the operational or quality levels contractually required; and

(b) The PHP's disease management and care coordination program shall coordinate and work with the member's Advanced Medical Home's care coordination when the member's AMH is contracted as a Tier 3 AMH.

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. The WellCare shall maintain a contractual relationship with the AMH (not the CIN).

15.13.1. Tier 3 AMH practices must be able to risk stratify all empaneled patients.

(a) The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the WellCare are reconciled with the practice's panel list and up to date in the clinical system of record.

(b) The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.

(c) The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from the WellCare with clinical information to score and stratify the patient panel.

(d) The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Contract of identifying "priority populations" for care management.

(e) The Tier 3 AMH practice 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.

(f) The Tier 3 AMH practice must define the process and frequency of risk score review and validation.

15.13.2. Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.

(a) The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.

(b) The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient 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:

i) Patients immediate care needs and current services;

ii) Other state or local services currently used;

iii) Physical health conditions, including dental;

iv) Current and past behavioral and mental health and substance use status and/or disorders;

v) Physical, intellectual developmental disabilities;

vi) Medications — prescribed and taken;

vii) Priority domains of social determinants of health (housing, food, transportation; and interpersonal safety);

viii) Available informal, caregiver, or social supports, including peer supports.

(c) The Tier 3 AMH practice 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 patients.

(d) For each high-need patient, the Tier 3 AMH practice 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.

15.13.3. Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.

(a) The Tier 3 AMH practice must develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.

(b) The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.

(c) The Tier 3 AMH practice must incorporate findings from the WellCare Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.

(d) The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:

i) Measurable patient (or patient and caregiver) goals;

ii) Medical needs including any behavioral health and dental needs;

iii) Interventions, including medication management and adherence;

iv) Intended outcomes; and

v) Social, educational, and other services needed by the patient.

(e) The Tier 3 AMH practice must have a process to update each Care Plan as Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.

(f) The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.

(g) The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.

(h) The Tier 3 AMH practice must track empaneled patients' 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 patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.

(i) The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).

i) Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.

ii) 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; and

iii) Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)

15.13.4. Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.

(a) The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:

i) Frequency, duration and acuity of inpatient, SNF and LTSS admissions or ED visits;

ii) Discharges from inpatient behavioral health services, facility-based crisis services, non-hospital medical detoxification, medically supervised or alcohol drug abuse treatment center;

iii) NICU discharges; and

iv) Clinical complexity, severity of condition, medications, risk score.

(b) For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice 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.

(c) The Tier 3 AMH practice must include the following elements in transitional care management:

i) Ensuring that a care manager is assigned to manage the transition
ii) Facilitating clinical handoffs;
iii) Obtaining a copy of the discharge plan/summary;
iv) Conducting medication reconciliation;
v) Following-up by the assigned care manager rapidly following discharge;
vi) Ensuring that a follow-up outpatient, home visit or face to face encounter occurs; and
vii) Developing a protocol for determining the appropriate timing and format of such outreach.

15.13.5. Tier 3 AMH practices must use electronic data to promote care management.

(a) The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet state-designated security standards for their storage and use.

16. Care Management for High-Risk Pregnancy. To the extent Participating Provider is a Local Health Department ("***LHD***") offering care management for high-risk pregnancy, this Section applies. Care Management for High-Risk Pregnancy refers to care management services provided to a subset of high-risk pregnant women by LHDs *(Section VII, M(4))*.

16.1 General Contracting Requirement. Participating Provider shall accept referrals from WellCare for Care Management for High-Risk Pregnancy Services. Participating Provider shall comply with the requirements NC DHHS' Care Management for High-Risk Pregnancy Policy.

16.2 Care Management for High-Risk Pregnancy: Outreach. Participating Provider 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. Participating Provider 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.

16.3 Care Management for High-Risk Pregnancy: Population Identification and Engagement. Participating Provider 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 (5) calendar days of receipt of risk screening forms. Participating Provider 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. Participating Provider 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. Participating Provider shall review available WellCare 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 Participating Provider. Participating Provider 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.

16.4 Care Management for High-Risk Pregnancy: Assessment and Risk Stratification. Participating Provider 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. Participating Provider shall utilize assessment findings, including those conducted by WellCare to determine level of need for care management support. Participating Provider shall document assessment findings in the care management documentation system. Participating Provider 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. Participating Provider shall assign case status based on level of patient need.

16.5 Care Management for High-Risk Pregnancy: Interventions. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients 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. Participating Provider shall provide care management services based upon level of patient need as determined through ongoing assessment. Participating Provider shall develop patient-centered care plans, including appropriate goals, interventions and tasks. Participating Provider shall utilize NC Resource Platform and identify additional community resources once NC DHHS has

certified it as fully functional. Participating Provider shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Covered Person's WellCare network. Participating Provider shall document all care management activity in the care management documentation system.

16.6 Care Management for High-Risk Pregnancy: Integration with WellCare and Providers. Participating Provider shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. Participating Provider shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program. Participating Provider shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers. Participating Provider 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. Participating Provider shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population. Participating Provider shall ensure awareness of WellCare Covered Persons' "in network" status with providers when organizing referrals. Participating Provider shall ensure understanding of WellCare's prior authorization processes relevant to referrals.

16.7 Care Management for High-Risk Pregnancy: Collaboration with WellCare. Participating Provider shall work with WellCare to ensure program goals are met. Participating Provider shall review and monitor WellCare reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk. Participating Provider shall communicate with WellCare regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers. Participating Provider shall participate in pregnancy care management and other relevant meetings hosted by WellCare.

16.8 Care Management for High-Risk Pregnancy: Training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by WellCare and/or NC DHHS, including webinars, new hire orientation or other programmatic training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by WellCare and/or NC DHHS. Participating Provider 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. Participating Provider shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

16.9 Care Management for High-Risk Pregnancy: Staffing.

(a) Participating Provider shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications: registered nurse; or social worker 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. Participating Provider 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. Participating Provider 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. If the Participating Provider only has a single Care Manager for High-Risk Pregnancy, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider 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 patients with both medically and socially complex conditions. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following WellCare /NC DHHS guidance about communication with WellCare about

any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by WellCare.

(b) Participating Provider 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.

(c) Participating Provider 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.

17. Care Management for At-Risk Children. To the extent Participating Provider is a LHD offering care management for at-risk children, this Section applies. Care Management for At-Risk Children is care management services provided by to a subset of the Medicaid population ages 0-5 identified as being "high-risk" *(Section VII, M(5))*.

17.1 Care Management for At-Risk Children: General Requirements. Participating Provider shall accept referrals from WellCare for children identified as requiring Care Management for At-Risk Children. Participating Providers shall comply with the requirements of NC DHHS' Care Management for At-Risk Children Policy.

17.2 Care Management for At-Risk Children: Outreach. Participating Provider 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. Participating Provider 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. Participating Provider shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county. Participating Provider shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population. Participating Provider 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 NC DHHS.

17.3 Care Management for At-Risk Children: Population Identification. Participating Provider shall use any claims-based reports and other information provided by WellCare, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations. Participating Provider shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population. Participating Provider 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.

17.4 Care Management for At-Risk Children: Family Engagement. Participating Provider shall involve families (or legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care. Participating Provider shall foster self-management skill building when working with families of children. Participating Provider shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

17.5 Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level. Participating Provider shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description. Participating Provider shall review and monitor WellCare reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk. Participating Provider shall use the information gained from the assessment to determine the need for and the level of service to be provided.

17.6 Care Management for At-Risk Children: Plan of Care. Participating Provider shall provide information and/or education to meet families' needs and encourage self-management using materials that meet literacy standards. Participating Provider shall ensure children/families are well-linked to the child's Advanced Medical Home or other practice; provide education about the importance of the medical home. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving care plan goals. Participating Provider shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally-developed resource list (including NC Resource Platform) to ensure families are well linked to resources to meet the identified need. Participating Provider shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

17.7 Care Management for At-Risk Children: Integration with WellCare and Providers. Participating Provider shall collaborate with Advanced Medical Home/PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet individual child's needs. Participating Provider shall ensure that changes in the care management level of care, need for patient 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. Where care management is being provided by WellCare and/or Advanced Medical Home practice in addition to the Care Management for At-Risk program, the WellCare/AMH practice must explicitly agree on the delineation of responsibility and document that agreement in the child's Plan of Care to avoid duplication of services Participating Provider shall ensure that changes in the care management level of care, need for patient 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 WellCare. Participating Provider shall ensure awareness of WellCare Covered Person's "in network" status with providers when organizing referrals. Participating Provider shall ensure understanding of WellCare's prior authorization processes relevant to referrals.

17.8 Care Management for At-Risk Children: Service Provision. Participating Provider shall document all care management activities in the care management documentation system in a timely manner. Participating Provider 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.

17.9 Care Management for At-Risk Children: Training. Participating Provider shall participate in NC DHHS/ WellCare-sponsored webinars, trainings and continuing education opportunities as provided. Participating Provider shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

17.10 Care Management for At-Risk Children: Staffing.

(a) Participating Provider shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications: registered nurse; or social worker 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. Participating Provider 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 patients with both medically and socially complex conditions. Participating Provider 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. If the Participating Provider has only has a single Care Management for At-Risk Children care manager, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall maintain services during the event of an extended vacancy. In the event of an extended vacancy, Participating Provider 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. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following NC DHHS guidance regarding vacancies or extended staff absences and adhering to NC DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight. Participating Provider shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications. Participating Provider 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.

(b) Participating Provider 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.

(c) Participating Provider 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.

18. N.C. Gen. Stat. Ch. 58 Requirements.

18.1 N.C. Gen. Stat. § 58-3-200(c), Coverage Determinations. If WellCare or Payor determines that services, supplies or other items are Covered Services, WellCare or Payor shall not subsequently retract its determination after such services have been provided, or reduce payments for such services furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Covered Person's health condition that was knowingly made by the Covered Person or the provider of the service, supply or other item. *(Section VII, G (1)(x)(i)).*

18.2 N.C. Gen. Stat. § 58-3-227(h), Contract Negotiations. When offering a contract to a Health Care Provider, WellCare or Payor shall make available to Health Care Provider its schedule of fees associated with the top 30 services or procedures most commonly billed by the class of Provider. Upon the request of the Health Care Provider, WellCare or Payor shall also make available the full schedule of fees for services or procedures billed by that class of provider(s). If Health Care Provider requests fees for more than 30 services and procedures, WellCare or Payor may require the Health Care Provider to specify the additional requested services and procedures and may limit the Health Care 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 such Health Care Provider. *(Section VII, G(1)(x)(ii)).*

18.3 N.C. Gen. Stat. § 58-50-275(a)-(b), Notice Contact. Provider and WellCare have set forth in the Agreement a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed Amendments and other notices, pertaining to the contractual relationship between the Parties shall be sent. Notwithstanding anything in the Agreement to the contrary, means for sending all notices provided under the Agreement is one or more of the following, calculated as (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 section prohibits the use of an electronic medium for a communication other than an Amendment if agreed to by WellCare and Provider (Section VII, G(1)(x)(iv)).

18.4 N.C. Gen. Stat. § 58-50-280(a)-(d), Proposed Amendment. WellCare shall date, label "Amendment," sign, include an effective date, and send any proposed Amendment to this Agreement or this Attachment to the notice contact of Provider. Provider will have sixty (60) days from the date of receipt to object to the proposed Amendment in writing. If Provider fails to object in writing within such sixty (60) days, the Amendment will be effective. If Provider timely objects to a proposed Amendment in writing, then WellCare may terminate the Agreement or this Attachment upon sixty (60) days' written notice to Provider. *(Section VII, G(1)(x)(v))*.

18.5 N.C. Gen. Stat. § 58-50-285 (a)-(b), Policies and Procedures. WellCare or Payor shall provide a Health Care Provider with a copy of its policies and procedures prior to execution of a new or amended contract and annually to all Participating Providers. Such policies and procedures may be provided in hard copy, CD or other electronic format, and may also be provided by posting the policies and procedures on the WellCare or Payor website. Such policies and procedures will 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. (Section VII, G(1)(x)(vi)).

18.6 N.C. Gen. Stat. § 58-51-37(d)-(e), Pharmacy Participation. To the extent Participating Provider is a pharmacy or pharmacist, this Section applies. Participating Provider shall not waive, discount, rebate, or distort a copayment or a Covered Person's portion of a prescription drug coverage or reimbursement. If Participating Provider provides a pharmacy service to a Covered Person that meets the terms and requirements of the Coverage Agreement, Participating Provider shall provide its pharmacy services to all Covered Persons covered by that Coverage Agreement on the same terms and requirements. A violation of the foregoing is a violation of the Pharmacy Practice Act subjecting the pharmacist to disciplinary authority of the North Carolina Board of Pharmacy. At least sixty (60) days before the effective date of a Payor providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, WellCare or Payor shall notify, in writing, all pharmacies within the geographical coverage area of the Coverage Agreement and offer to the pharmacies the opportunity to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. WellCare shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform the Covered Persons of the Coverage Agreement 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 their customers through a means acceptable to the pharmacy and WellCare. The pharmacy notification provisions of this section do not apply when an individual or group is enrolled, but when WellCare enters a particular county of the State. *(Section VII, G(1)(x)(vii))*.

19. Indian Health Care Providers. To the extent Participating Provider is an Indian Health Care Provider, Participating Provider shall execute and comply with the Medicaid Managed Care Addendum for Indian Health Care Providers. *(Section VII, H)*.

20. Conflict of Interest. Participating Provider will comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the Social Security Act, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C. Participating Provider agrees that financial considerations will not influence decisions to provide medically appropriate care. Participating Provider shall abide by his or her professional obligations to patients and Covered Persons and will not take any actions that conflict with such obligations. *(Section V, A.9.i)*

21. Vaccines for Children Program. If Participating Provider is a Primary Care Provider who services Covered Persons under age 19, Participating Provider is encouraged to participate in the Vaccines for Children Program. If Participating Provider is a Primary Care Provider, Participating Provider will administer vaccines consistent with the AAP/Bright Future periodicity schedule. *(Section V, C(1)(c)(ix)* and *Section V, C(2)(v)(vii))*.

22. PCPs. If Participating Provider is a Primary Care Provider, Participating Provider will: (a) perform, during preventive service visits, and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the NC DHHS's Oral Health Periodicity Schedule; (b) refer infant Medicaid Covered Persons to a dentist or a dental professional working under the supervision of a dentist at age one (1), per the requirements of the NC DHHS's Oral Health Periodicity Schedule; and (c) include all of the following components in each medical screening: (i) routine physical examinations as recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents", screening for developmental delay at each visit through the 5th year and screening for Autistic Spectrum Disorders per AAP guidelines, (ii) comprehensive, unclothed physical examination, (iii) all appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices, (iv) laboratory testing (including blood lead screening appropriate for age and risk factors); and (e) health education and anticipatory guidance for both the child and caregiver. *(Section V, C.2.i).*

23. Behavioral Health Providers. If Participating Provider is a behavioral health provider, Participating Provider will coordinate with Primary Care Providers and specialists conducting EPSDT screenings. *(Section V, C.2.j).*

24. 340B Covered Entities. If Participating Provider is a 340B covered entity, the Participating Provider will: (a) submit National Council for Prescription Drug Programs (NCPDP) code "08" in Basis of Cost Determination field 423-DN or in Compound Ingredient Basis of Cost Determination field 490-UE at the point of sale to identify claims submitted for drugs purchased through the 340B program; (b) identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the NC DHHS (42 C.F.R. § 438.3(s)(3)); (c) comply with the point of sale identification of drugs purchased through the 340B program (42 C.F.R. § 438.3(s)(3)); and (d) resubmit the claims with the appropriate NCPDP 340B claims identification codes when 340B claims are retroactively identified (42 C.F.R. § 438.3(s)(3)). *(Section V, C(3)(i)(v)).*

25. Exclusion. Participating Provider represents and warrants that he, she or it is not excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b). Participating Provider will immediately notify WellCare in writing upon any change regarding foregoing. *(Section V, D(2)(c)(iv)).*

26. High Level Clinical Setting Discharge. Participating Provider will notify WellCare when a Covered Person in a high level clinical setting is being discharged. For the purpose of this section, a High Level Clinical Setting includes but is not limited to:

(a) Hospital/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
(g) ADATC

(Section V, D(2)(c)(xiv)).

27. Claim Submission. Participating Provider will not submit claim or encounter data for services covered by Medicaid managed care and WellCare directly to the NC DHHS. *(Section V, D(2)(c)(xviii)).*

28. Provider Preventable Conditions. Participating Provider will comply with 42 C.F.R. § 438.3(g), which, at a minimun, means non-payment of provider-preventable conditions as well as appropriate reporting, as required by WellCare. *(Section V, D(2)(d)(ii)).*

29. Program Integrity. Participating Provider: (a) will 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; (b) will have policies and procedures that recognize and accept Medicaid as "the payer of last resort"; and (c) is prohibited from billing Covered Persons for Covered Services any amount greater than would be owed if the Participating Provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2). *(Section V, D(2)(f); Section V, J(2)(b)(iii)(c)).*

30. No Auto-Enrollment in Other Products. WellCare will not require individual practitioners, as a condition of contracting with it, to agree to participate or accept other products offered by the WellCare nor will WellCare automatically enroll the provider in any other product offered by it. This requirement does not apply to facility providers. *(Section V, D(2)(c) (viii))*

31. Grievance and Appeals. WellCare shall handle appeals and grievances raised by Provider in connection with the Medicaid Product promptly, consistently, fairly, and in compliance with state and federal law and Department requirements, through an appeals and grievance system that is distinct from that offered to Covered Persons. Such appeals and grievance system, additional information about which is set forth in the Provider Manual, shall meet the requirements set forth below:

(a) Grievances. WellCare will have a process in place to receive and resolve complaints or disputes with Provider, in a timely manner, where remedial action is not requested. WellCare will accept and resolve Provider's grievances regarding WellCare that are referred from the Department. WellCare will make available to Provider a method for submitting grievances through WellCare's provider portal.

(b) Appeals. WellCare will offer Provider appeal rights as described in the State Contract and Provider Manual. WellCare will provide written notice of Provider's right to appeal along with any notice of a decision giving rise to Provider's right to appeal. WellCare will make available to Provider a method for submitting appeals through WellCare's provider portal. WellCare will accept a written request for an appeal from Provider within thirty (30) calendar days of the date on which (i) Provider received written notice from WellCare of the decision giving rise to the right to appeal; or (ii) WellCare should have taken a required action and failed to take such actions. WellCare will acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request, and will extend such timeframe by thirty (30) calendar days if Provider's request is for an appeal for good cause shown, as determined by WellCare. WellCare will consider the voluminous nature of required evidence/supporting documentation, and the appeal of an adverse quality decision, as good cause reasons to extend such timeframe. Provider shall exhaust WellCare's internal appeals process before seeking recourse under any other process permitted by contract or law.

(c) Resolution of Appeal. WellCare will establish a committee to review and make decisions on Provider's appeals, which committee will consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal, as well as an external peer reviewer when the issue on appeal involves whether the provider met the Objective Quality Standards. WellCare will provide written notice of decision of the appeal (which notice shall include information regarding further appeal rights) within thirty (30) calendar days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all evidence is submitted to WellCare. Provider may be represented by an attorney during the appeals process.

(d) Appeals of Suspension or Withhold of Provider Payment. In cases of the suspension or withholding of Provider payments, WellCare will limit the issue on appeal to whether WellCare had good cause to commence the withholding or suspension of payments to Provider; WellCare will not address whether Provider has or has not committed fraud or abuse. WellCare will offer Provider an in-person or telephone hearing when Provider is appealing whether WellCare has good cause to withhold or suspend payments to Provider. WellCare will schedule such hearing and issue a written decision regarding whether WellCare had good cause to suspend or withhold payments within fifteen (15) business days of receiving Provider's appeal. Upon a finding that WellCare did not have good cause to suspend or withhold payments, WellCare will reinstate any payments that were withheld or suspended within five (5) business days. WellCare will pay interest and penalties for overturned denials, underpayments, or

findings that it did not have good cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial. *(Attachment G-1.q)*

32. Material Changes to Provider Manual, Reimbursement Policies or Clinical Policies. WellCare shall notify Participating Provider of updates to WellCare's clinical policies electronically no later than 30 calendar days prior to the effective date of the policy, or at a date defined by the NC DHHS, directed to Participating Provider's contact for notices under this Agreement via WellCare's provider portal. Participating Provider may request written notification, at no additional cost, to be mailed no later than 30 days prior to the effective date of the policy, or at a date defined by the NC DHHS, of the policy. WellCare shall not implement any material changes to the clinical policies without express approval from the NC DHHS. *(Section VII, Attachment G(3)(i))*

33. Contract Amendments with Individual Providers. For the purposes of this Section 33 only, the following terms shall have the following definitions:

(i) "***Amendment***" shall mean any change to the terms of this Medicaid Product Attachment, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an Amendment.

(ii) "***Contract***" shall mean this Agreement, which is an agreement between WellCare and Provider for the provision of health care services by the provider on a preferred or in-network basis.

(iii) "***Health Benefit Plan***" shall mean a policy, certificate, contract, or plan as defined in N.C. Gen. Stat. §58-3-167.

(iv) "***Health Care Provider***" shall mean Provider if Provider is 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.

(v) "***Insurer***" shall mean WellCare (as otherwise defined herein), which is an entity as defined in N.C. Gen. Stat. §58-3-227(a)(4).

Insurer shall send any proposed Contract Amendment to the notice contact of Health Care Provider pursuant to N.C. Gen. Stat. §58-50-275. The proposed Amendment shall be dated, labeled "Amendment," signed by the Insurer, and include an effective date for the proposed Amendment. Health Care Provider receiving a proposed Amendment shall be given at least sixty (60) days from the date of receipt to object to the proposed Amendment. The proposed Amendment shall be effective upon Health Care Provider failing to object in writing within sixty (60) days. If Health Care Provider objects to a proposed Amendment, then the proposed Amendment is not effective and the initiating Insurer shall be entitled to terminate the Contract upon sixty (60) days written notice to Health Care Provider. Nothing in this Part prohibits Health Care Provider and Insurer from negotiating Contract terms that provide for mutual consent to an Amendment, a process for reaching mutual consent, or alternative notice contacts. *(Attachment G-1.x.iii)*

34. Exemption from Notification of Emergent or Observation Admissions. For all contracts with a hospital who attests live in production status with North Carolina HealthConnex, the contract shall indicate the provider is exempted from reporting any emergent or observation admissions to the PHP, and that the PHP shall utilize NC*Notify for such admission information. Except the exemption from notification shall not apply when the hospital has technical or data quality issues, in which case the hospital shall notify the PHP directly.

35. Incident Reporting Procedures and Peer Review Process. Providers rendering Covered Services to Members or Covered Persons shall report critical incidents to Health Plan and to the Department in accordance with all applicable Laws and Governmental Authority's mandated requirements and procedures for reporting such incidents, and Providers shall cooperate with Health Plan in its investigation of critical incidents. Notwithstanding the foregoing,

nothing in this Agreement shall require Providers who participate in Health Plan's peer review, medical review, or quality review committees to take any actions that are contrary to the confidentiality and liability protections afforded such Providers under N.C. Gen. Stat. §§90-21.22A, 131E-76, or 131E-95, as applicable.

36. Patient Choice Counseling Limitations. Nothing in this Agreement shall be construed to limit the ability of Provider to inform its patients of Provider or its Contracted Provider's participation or non-participation in specific Medicaid Managed Care health plans. Provider may also inform its patients of the categories of Medicaid participants remaining in North Carolina Medicaid Direct.

APPENDIX A TO
SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

Section VII Attachment M.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (The age ranges are not displayed to the provider on this screen. The age ranges will be used in PEGA workflow for approval and verification purposes.)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Caccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
ANCILLARY SERVICES
PUBLIC AMBULANCE

Greene County

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The compensation for ambulance Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is 100% of the amount payable based on the Medicaid Managed Care Ambulance Fee Schedule set forth by the North Carolina Division of Health Benefits ("NCDHB") at the date of service.

Additional Directed Payments. WellCare shall make additional payments as directed and determined by NCDHB and approved by CMS.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

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

3. Billing Requirements. Contracted Provider must bill HCPCS codes in addition to revenue code for services specified within this Compensation Schedule. Failure to submit a HCPCS code may result in a claim denial.

4. Date of Service Requirements. Contracted Provider is required to identify each date of service on claims for multiple dates of service.

5. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

6. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claim processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

Attachment B: Medicare

MEDICARE PRODUCT ATTACHMENT
(INCLUDING REGULATORY REQUIREMENTS AND COMPENSATION SCHEDULE)

THIS PRODUCT ATTACHMENT (this "***Product Attachment***") is made and entered into as of the Effective Date of the Agreement by and between WellCare Health Plans, Inc. ("***Health Plan***") and Greene County ("***Provider***").

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

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

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

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

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

2. Product Participation.

2.1 Medicare Product. This Attachment addresses the participation of Provider and the applicable Contracted Providers in the following Product: Medicare Product (which is sometimes referred to in this Attachment as this "***Product***"). The term "***Medicare Product***" refers to those programs and health benefit arrangements offered by Health Plan or another Company in connection with one or more of the following Medicare product types that is administered, sponsored or regulated by the federal government (or any agency, department or division thereof) on its own or jointly with a State that administers or regulates such program or plan (each a "Medicare Product Type"): a non-Dual Eligible Special Needs Plan Medicare Advantage plan ("***MA Plan***"); a Medicare Advantage prescription drug plan ("***MA-PD Plan***"); a Dual Eligible Special Needs Plan ("***DSNP Plan***"); a Capitated Financial Alignment Demonstration ("***MMP Plan***") plan or program (e.g., a plan or program adopted or established under the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments); or other Medicare Product Types. The Medicare Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of a Medicare Product. The Medicare Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicare Product. Provider acknowledges that it will participate in each Medicare Product Type for which a Compensation Schedule(s) is attached to this Medicare Product Attachment.

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

delegated to a Company, a Payor or their delegates. Neither Health Plan, Company nor any Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels and/or Medicare Product Types, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Medicare Product Type.

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

2.4 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to health care services, supplies or accommodations (including Covered Services) rendered to Covered Persons enrolled in the Medicare Product. To the extent Provider or any Contracted Provider is unclear about its, his or her respective duties and obligations, Provider or the applicable Contracted Provider shall request clarification from the Company.

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

4. CMS Regulatory Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicare Product under a Governmental Contract.

5. Compensation Schedule. This Section sets forth or describes the Compensation Schedule applicable to the various Medicare Product Types.

5.1 Schedule. The Compensation Schedule for the Medicare Product at any given time is the lesser of (i) the Allowable Charges for the particular Covered Service, or (ii) the appropriate amount for such Covered Service under the Company's fee schedule in effect on the date of service for the Medicare Product. Upon Provider's reasonable written request from time to time the Company will provide Provider with a representative sample of the fees then in effect under the Company's fee schedule applicable to the Medicare Product.

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

Attachment B: Medicare

SCHEDULE A
CMS REGULATORY REQUIREMENTS

This Schedule sets forth required provisions that are applicable to all Medicare Product Types under this Medicare Product Attachment.

1. **DEFINITIONS**. The following terms shall be defined as set forth below as used in this Medicare Product Attachment. Capitalized terms not otherwise defined in this Schedule shall be defined as set forth in the Agreement or elsewhere in the Medicare Product Attachment.

1.1 ***Capitated Financial Alignment Demonstration Program*** means the program, created by Congress in the Affordable Care Act of 2010, to test new service delivery and payment models for people dually eligible for Medicare and Medicaid, including any regulations or CMS pronouncements and any future Attachments.

1.2 ***Clean Claim*** means a claim that has no defect, impropriety, lack of any required substantiating documentation – including the substantiating documentation needed to meet the requirements for encounter data – or particular circumstance requiring special treatment that prevents timely payment; and a claim that otherwise conforms to the Clean Claim requirements under original Medicare.

1.3 ***CMS*** means Centers for Medicare and Medicaid Services.

1.4 ***CMS Contract*** means the contract between Health Plan or a Payor and CMS, or among Health Plan or a Payor, CMS and the State, that governs the terms of Health Plan's or Payor's participation in a Medicare Plan.

1.5 ***Completion of Audit*** means completion of audit by HHS, the Government Accountability Office, or their designees of a Medicare Advantage Organization, First Tier, Downstream or Related Entity.

1.6 ***Covered Persons*** means those individuals who are enrolled in a Medicare Plan.

1.7 ***Covered Services*** means those services which are covered under a Medicare Plan.

1.8 ***Downstream Entity*** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between Health Plan and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

1.9 ***First Tier Entity*** means any party that enters into a written arrangement, acceptable to CMS, with Health Plan to provide administrative services or health care services for a Medicare eligible individual under a Medicare Plan.

1.10 ***HHS*** means the United States Department of Health and Human Services.

1.11 ***Medicare Advantage Program*** means the program created by Congress in the Medicare Modernization Act of 2003 to replace the Medicare+Choice Program established under Part C of Title XVIII of the Social Security Act, including any regulations or CMS pronouncements and any future Attachments.

1.12 ***Preclusion List*** means the CMS-compiled list of individuals and entities that -

a. Meet all of the following requirements: (i) The individual or entity is currently revoked from Medicare under 42 § 424.535. (ii) The individual or entity is currently under a reenrollment bar under 42 § 424.535(c). (iii) CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under (iii), CMS considers the following factors: (A) The

seriousness of the conduct underlying the individual's or entity's revocation. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program. (C) Any other evidence that CMS deems relevant to its determination; or

b. Meet both of the following requirements: (i) The individual or entity has engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable had they been enrolled in Medicare. (ii) CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. In making this determination under (ii), CMS considers the following factors: (A) The seriousness of the conduct involved. (B) The degree to which the individual's or entity's conduct could affect the integrity of the Medicare program; and (C) Any other evidence that CMS deems relevant to its determination. *42 C.F.R. § 422.2*

1.13 ***Related Entity*** means any entity that is related to Health Plan by common ownership or control and (1) performs some of Health Plan's management functions under contract or delegation; (2) furnishes services to Covered Persons under an oral or written agreement; or (3) leases real property or sells materials to Health Plan at a cost of more than $2,500 during a contract period.

1.14 ***State*** means one or more applicable state governmental agencies of the State of North Carolina, unless otherwise defined in an Attachment for the purposes of that Attachment.

2. **COVERED SERVICES**. Provider shall furnish Covered Services to Covered Persons as set forth in the Agreement and this Medicare Product Attachment.

3. **SUBCONTRACTOR OBLIGATIONS**. To the extent that Provider engages any other person (excluding an employee) or entity to perform services in connection with a Medicare Product, including any Downstream or Related Entity, Provider agrees that such engagement shall be set forth in a written agreement that requires such other person or entity to assume the same obligations that Provider assumes under this Medicare Product Attachment.

4. **GOVERNMENT RIGHT TO INSPECT**.

4.1 Provider agrees that HHS, the Comptroller General or their designees have the right to audit evaluate, collect and inspect any books, contracts, computer or other electronic systems, (including medical records and documentation of Provider relating to the CMS Contract through ten (10) years from the termination date of this Medicare Product Attachment or from the date of Completion of Audit, whichever is later. *42 C.F.R. §§ 422.504 (i)(2)(i) and (ii), 423.505(i)(2)(i) and (iv).*

4.2 Provider agrees that HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 4.1 of this Medicare Product Attachment directly from Provider or any other First Tier, Downstream or Related Entity. For records subject to review under this Section 4.2, except in exceptional circumstances, CMS will provide notification to Health Plan that a direct request for information has been initiated. *42 C.F.R. §§ 422.504(i)(2)(ii) and (iii), 423.505(i)(2)(ii) and (iii).*

5. **PRIVACY, CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS**. Provider shall comply with all privacy, confidentiality and accuracy requirements with respect to Covered Person record accuracy requirements, including: (1) abiding by all federal and State laws regarding the confidentiality and disclosure of medical records or other health and enrollment information; (2) safeguarding the privacy of any information that identifies a particular Covered Person and, as applicable, having procedures that specify (i) for what purposes the information is used within the organization; and (ii) to whom and for what purposes it discloses the information outside the organization; (3) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoena; (4) maintaining the records and information in an accurate and timely manner; and (5) ensuring timely access by Covered Persons to the records and information that pertains to them. *42 C.F.R. §§422.504(a)(13). 422.118 and 423.136*

6. **HOLD HARMLESS.**

6.1 Provider hereby agrees that Covered Persons shall not be held liable for payment of any fees that are the legal obligation of Payor. *42 C.F.R. §§422.504(i)(3)(i), 422.504(g)(1)(i), 423.505(i)(3)(i) and 423.505(g)(1)(i).*

6.2 With respect to MA Plans and MA-PD Plans, Provider hereby acknowledges and agrees that for Covered Persons eligible for both Medicare and Medicaid, such Covered Persons shall not be held liable for Medicare Part A and Part B cost-sharing when the State is responsible for paying such amounts. With respect to Medicare-Medicaid Plans, Provider hereby acknowledges and agrees that Covered Persons eligible for both Medicare and Medicaid shall not be held liable for Medicare Part A and Part B cost-sharing; in addition, Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. *42 C.F.R. §§422.504(g)(1)(iii); March 29, 2012 CMS Issued Guidance*

With respect to all Medicare Plans, Provider will be informed of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. If Provider contracts with Contracted Providers to provide Covered Services to Covered Persons, Provider will inform Contracted Providers of Medicare and Medicaid benefits and rules for Covered Persons eligible for Medicare and Medicaid. Provider may not impose, and must prohibit any Downstream Entities from imposing, cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Covered Person under title XIX if such Covered Person were not enrolled with Health Plan or Payor. Provider shall accept payment from Payor as payment in full, or bill the appropriate State source. *42 C.F.R. §§422.504(i)(3)(i) and 422.504(g)(1)(iii)*

7. **COMPLIANCE WITH CMS CONTRACT.** Provider shall perform its obligations under this Medicare Product Attachment in a manner consistent with and in compliance with Health Plan's and Payor's contractual obligations under the CMS Contract. *42 C.F.R. §§422.504(i)(3)(iii), 423.505(i)(3)(iii).*

8. **PROMPT PAYMENT.** Payor shall pay, or arrange to pay, Provider for Covered Services rendered to Covered Persons in accordance with Exhibit 1 to this Medicare Product Attachment. Any Clean Claim shall be paid within thirty (30) days of receipt by Health Plan, Payor or (if Provider contracts with Downstream Entities) Provider, as applicable, as designated by Provider or such Downstream Entity, as applicable. *42 C.F.R. §422.520(b)(1) and (2)*

9. **EFFECT OF PRECLUSION LIST.** Provider acknowledges and agrees that Payor may not pay, directly or indirectly, on any basis, for items or services furnished to a Covered Person by any individual or entity that is excluded by the HHS Office of the Inspector General or is included on the Preclusion List. Provider acknowledges and agrees that, after the expiration of the 60-day period specified in 42 C.F.R. § 422.222: (i) Provider will no longer be eligible for payment from Payor and will be prohibited from pursuing payment from the Covered Person as stipulated by the terms of the contract between CMS and the Payor per 42 C.F.R. § 422.504(g)(1)(iv); and (ii) Provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point Provider will have already received notification of the preclusion. *42 C.F.R. §§422.224; 422.504(g)(1)(v)*

10. **COMPLIANCE WITH FEDERAL AND STATE LAWS.** Health Plan, Provider, Payor, and any Downstream or Related Entity shall comply with all applicable laws including Medicare laws, regulations and CMS and/or State instructions. *42 C.F.R. §§422.504(i)(4)(v), 423.505(i)(4)(iv)*

11. **DELEGATION OF DUTIES.** In the event that Health Plan delegates to Provider any function or responsibility imposed pursuant to the CMS Contract, such delegation shall be subject to the applicable requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and 423.505(i), as they may be amended over time. Any delegation by Provider of functions or responsibilities imposed pursuant to this Medicare Product Attachment shall be subject to the prior written approval of Health Plan or Payor and shall also be subject to the requirements set forth in 42 C.F.R. §§ 422.504(i)(4) and (5) and 423.505(i), as they may be amended over time.

11.1 Provider's delegated activities and reporting responsibilities, if any, are specified in the Agreement or applicable attachment to the Agreement (e.g., Delegated Credentialing Agreement, Delegated Services Agreement,

Statement of Work, or other scope of services attachment). If such attachment is not executed, no administrative functions shall be deemed as delegated.

11.2 CMS, Health Plan and Payor reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS, Health Plan or Payor determine that such parties have not performed satisfactorily.

11.3 Health Plan or Payor will monitor the performance of the parties on an ongoing basis.

11.4 As specified in the attached Delegated Credentialing Agreement or Delegated Services Agreement to this Agreement, the credentials of medical professionals affiliated with Provider will be either reviewed by Health Plan, or the credentialing process will be reviewed and approved by Health Plan and Health Plan must audit the credentialing process on an ongoing basis.

11.5 If Health Plan or Payor delegates the selection of providers, contractors, or subcontractors, Health Plan or Payor retains the right to approve, suspend, or terminate any such arrangement. *42 C.F.R. §§ 422.504(i)(4) and (5), and 423.505(i).*

12. **NON-DISCRIMINATION BASED ON HEALTH OR OTHER STATUS**. Provider shall not deny, limit, or condition coverage or the furnishing of health care services or benefits to Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental as well as physical illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), race, ethnicity, national origin, religion, sex, age, sexual orientation, source of payment and mental or physical disability. *42 C.F.R. §422.110(a)*

13. **SERVICE AVAILABILITY**. Provider shall ensure that its hours of operation are convenient to Covered Persons and do not discriminate against Covered Persons; and that Covered Services are available twenty-four (24) hours a day, seven (7) days a week, when medically necessary. *42 C.F.R. §422.112(a)(7).*

14. **CULTURAL COMPETENCE**. Provider must provide all services in a culturally competent manner to all Covered Persons, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. *42 C.F.R. §422.112(a)(8).*

15. **FOLLOW-UP CARE**. Provider shall ensure that Covered Persons are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health. *42 C.F.R. §422.112(b)(5).*

16. **ADVANCE DIRECTIVES**. Provider shall comply with Health Plan's and Payor's policies and procedures concerning advance directives. *42 C.F.R. §422.128(b)(1)(ii)(E).*

17. **PROFESSIONALLY RECOGNIZED STANDARDS OF CARE**. Provider agrees to provide Covered Services under the Agreement to Medicare beneficiaries in a manner consistent with professionally recognized standards of health care. *42 C.F.R. §422.504(a)(3)(iii).*

18. **CONTINUATION OF BENEFITS**. Provider shall provide Covered Services as provided in the Agreement and this Medicare Product Attachment: (a) for all Covered Persons, for the duration of the contract period for which CMS payments have been made; and (b) for Covered Persons who are hospitalized on the date the CMS Contract terminates, or, in the event of an insolvency, through discharge. This continuation of benefits provision shall survive termination of this Medicare Product Attachment. *42 C.F.R. §§422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)*

19. **PHYSICIAN INCENTIVE ARRANGEMENTS**. If Provider is a physician or physician group, neither Payor nor Health Plan shall make any specific payment, directly or indirectly, to Provider as an inducement to reduce or limit medically necessary services furnished to any particular Covered Person. Indirect payments may include offerings of monetary value (such as stock options or waivers of debt) measured in the present or future. Provider

agrees that, if Health Plan or Payor has a physician incentive plan that places Provider at substantial financial risk (as determined under 42 C.F.R § 422.208(d)) for services that Provider does not furnish itself, Provider shall obtain and maintain either aggregate or per-patient stop-loss protection in accordance with the requirements at 42 C.F.R. § 422.208(f). *42 C.F.R. §422.208.*

20. **INFORMATION DISCLOSURES TO CMS.** Provider shall cooperate with Health Plan and Payor in providing any information to CMS deemed necessary by CMS for the administration or evaluation of the Medicare program. *42 C.F.R. §422.504(f)(2).*

21. **NOTICE OF PROVIDER TERMINATIONS.** Health Plan shall make a good faith effort to provide written notice of a termination of a contracted provider at least 30 calendar days before the termination effective date to all Covered Persons who are patients seen on a regular basis by the provider whose contract is terminating, irrespective of whether the termination was for cause or without cause. If Provider is a primary care professional, all Covered Persons who are patients of that primary care professional must be notified. *42 C.F.R. §422.111(e).*

22. **RISK ADJUSTMENT DATA.** Provider shall provide to Health Plan risk adjustment data as required by CMS. *42 C.F.R. §§ 422.310(d)(3), (4).* Upon Health Plan's or CMS's request, Provider shall submit a sample of medical records for the validation of risk adjustment data, as required by CMS. Provider acknowledges that penalties may apply for submission of false data. Provider certifies based on best knowledge, information and belief that the data it submits under 42 C.F.R. § 422.310 are accurate, complete and truthful. *42 C.F.R. §§ 422.310(e) and 422.504(l)(3).*

23. **COMPLIANCE WITH HEALTH PLAN POLICIES AND PROCEDURES.** Provider shall comply with Health Plan's and Payor's policies and procedures. In addition, if Provider is a physician or physician group, Provider shall, or shall require the physician members of the group to, upon Health Plan's request, consult with Health Plan regarding Health Plan's medical policy, quality improvement programs and medical management procedures and ensure that the following standards are met: (a) practice guidelines and utilization management guidelines (i) are based on reasonable medical evidence or a consensus of health care professionals in the particular field; (ii) consider the needs of the enrolled population; (iii) are developed in consultation with contracting physicians; and (iv) are reviewed and updated periodically; (b) the guidelines are communicated to providers and, as appropriate, to Covered Persons; and (c) decisions with respect to utilization management, Covered Person education, coverage of services, and other areas in which the guidelines apply are consistent with the guidelines. *42 C.F.R. §422.202(b).* Provider shall comply with Health Plan's quality assurance and performance improvement programs. *42 C.F.R.§422.504(a)(5).*

24. **WRITTEN NOTICE FOR REASON FOR SUSPENSION AND TERMINATION.** In the event Health Plan suspends or terminates this Medicare Product Attachment with respect to Provider or any physicians employed or contracted with Provider, Health Plan shall give Provider or such physician written notice of the following: (a) the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the affected physician, and the numbers and mix of physicians needed by Health Plan, and (b) the affected physician's right to appeal the action and the process and timing for requesting a hearing. *42 C.F.R. §422.202(d)(1)*

25. **NOTICE OF WITHOUT CAUSE TERMINATION.** Health Plan and Provider must provide a minimum of sixty (60) days written notice, or such longer period specified in this Agreement, to each other before terminating this Medicare Product Attachment without cause. *42 C.F.R. §422.202(d)(4).*

26. **COMPLIANCE WITH FEDERAL LAWS AND REGULATIONS.** Health Plan and Provider agree to comply with (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (section 1128B(b)) of the Act); and (b) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. *42 C.F.R. §422.504(h)(1).*

27. **FEDERAL FUNDS.** Provider acknowledges that payments Provider receives from Health Plan or Payor to pursuant to this Medicare Product Attachment are, in whole or part, from Federal funds. Therefore, Provider and any

of its Downstream or Related Entities are subject to certain laws that are applicable to individuals and entities receiving Federal funds, which may include but is not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 C.F.R. Part 84; the Age Discrimination Act of 1975 as implemented by 45 C.F.R. Part 91; the Americans with Disabilities Act; the Rehabilitation Act of 1973 and any other regulations applicable to recipients of Federal Funds. *Medicare Managed Care Manual, Ch. 11 § 120.*

28. **EXCLUDED PERSONS/PROGRAM INTEGRITY**. Provider warrants to Health Plan and each Payor that it is not excluded and shall not employ or contract for the provision of health care, utilization review, medical social work, or any administrative services pursuant to this Agreement with any individual or entity (hereafter, "person") whom Provider knows or reasonably should have known is excluded from participation in the Medicare and Medicaid program under Section 1128 or 1128A of the Social Security Act. Provider hereby certifies that no such excluded person currently is employed by or under contract with Provider. Provider shall review the Office of Inspector List of Excluded Individuals and Entities and the System for Award Management exclusion list and verify on a monthly basis or as often as required by CMS guidelines, that the persons it employs or contracts for the provision of such services pursuant to this Agreement are in good standing. Provider shall promptly disclose to Health Plan and Payor any exclusion, or other event that makes a Provider employee or Downstream or Related Entity ineligible to perform work related to Medicare or Medicaid. *42 C.F.R. § 422.752(a)(8)*. Provider shall promptly notify Health Plan and Payor in writing in the event that Provider is criminally convicted or has a civil judgment entered against Provider for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services. Provider agrees to be bound by the provisions set forth at 2 C.F.R. Part 376.

29. **COMPLIANCE WITH GRIEVANCE AND APPEALS REQUIREMENTS**. Provider shall cooperate and comply with all applicable State, federal Health Plan and Payor requirements regarding Covered Persons grievances and appeals, as well as enrollment and disenrollment determinations, including the obligation to provide information (including medical records and other pertinent information) to Health Plan and Payor within the time frame required by regulation or, if not so required, reasonably requested for such purpose.

30. **OFFSHORE SUBCONTRACTORS**. In addition to the applicable requirements of Section 11 of this Medicare Product Attachment, Provider shall disclose to Health Plan in writing, 30 days prior to signing an offshore contract, all offshore contractor information and an attestation for each such offshore contractor, in a format required or permitted by CMS. *CMS Health Plan Management System Memos 7/23/2007, 9/20/2007, and 8/26/2008.*

31. **SCOPE AND CONFLICTS**. Nothing in this Medicare Product Attachment shall be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the Agreement, including the Provider Manual, except as stated in this Medicare Product Attachment. In the event of any conflict between this Medicare Product Attachment and any provision of the Agreement, the provisions of this Medicare Product Attachment shall govern. In the event that any provision of this Medicare Product Attachment conflicts with the provisions of any statute or regulation applicable to Health Plan, the provisions of the statute or regulation shall have full force and effect unless such statute or regulation is preempted by federal law.

32. **TERMINATION**. This Medicare Product Attachment shall terminate upon the termination of the Agreement and under the same terms and conditions specified in the Agreement. This Medicare Product Attachment may be further terminated by Health Plan immediately upon written notice to Provider if a CMS Contract is terminated, or if Provider is listed on the GSA List or SAM as excluded or is otherwise suspended or excluded from participation in Medicare or Medicaid or is listed on the Preclusion List.

33. **PART D**. If Subcontractor provides pharmacy benefit services, the following provisions shall apply.

33.1 Prompt Payment. Subcontractor shall issue, mail, or otherwise transmit payment with respect to all Clean Claims submitted by Participating Providers that are network pharmacies ("***Participating Pharmacies***") (other than mail-order and long-term care pharmacies) within the following timeframes:

a. Fourteen (14) days after the date on which the Clean Claim is received, as defined in paragraph (a)(2)(i) of this section, for an electronic claim; or

b. Thirty (30) days after the date on which the Clean Claim is received, as defined in paragraph (a)(2)(ii) of this section, for any other claim.

33.2 Access to Covered Part D Drugs. Subcontractor shall comply with the following requirements:

a. *Use of Standardized Technology*. Subcontractor shall issue and reissue, as necessary, a card or other type of technology that Covered Persons may use to access negotiated prices for covered Part D drugs as provided under § 423.104(g). The card or other technology must comply with standards CMS establishes.

b. *Submission of Claims*. Subcontractor shall require its Participating Pharmacies to submit claims unless the Covered Person expressly requests that a particular claim not be submitted to the Health Plan or its intermediary.

33.3 Disclosing Drug Pricing. Subcontractor shall (i) update any prescription drug pricing standard (as defined in 42 C.F.R. §423.501) based on the cost of the drug used for reimbursement of Participating Pharmacies by January 1st of each contract year and not less frequently than once every seven (7) days thereafter; (ii) indicate the source used for making any such updates; and (iii) disclose all individual drug prices to be updated to the applicable pharmacies in advance of their use for reimbursement of claims, if the source for any prescription drug pricing standard is not publicly available.

33.4 Validation of Part D Reporting Requirements. Subcontractor shall comply with the following reporting requirements:

a. *Required Information*. Subcontractor shall have an effective procedure to develop, compile, evaluate, and report to Health Plan, to Covered Persons, and to the general public, at the times and in the manner that CMS requires, statistics indicating the following:

i. The cost of its operations.

ii. The patterns of utilization of its services.

iii. The availability, accessibility, and acceptability of its services.

iv. Information demonstrating that Health Plan has a fiscally sound operation.

v. Other matters that CMS may require.

b. *Reporting Requirements*. Subcontractor must provide upon request to Health Plan, and Health Plan must provide to CMS, in a manner specified by CMS, the following with respect to Covered Persons:

i. The total number of prescriptions that were dispensed.

ii. The percentage of all prescriptions that were provided through retail pharmacies compared to mail order pharmacies.

iii. The percentage of prescriptions for which a generic drug was available and dispensed (generic dispensing rate), by pharmacy type (which includes an independent pharmacy, chain pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public), that is paid by Health Plan.

iv. The aggregate amount and type of rebates, discounts, or price concessions (excluding bona fide service fees as defined in 42 C.F.R. §423.501) that the Subcontractor negotiates that are attributable to patient utilization under the plan.

v. The aggregate amount of the rebates, discounts, or price concessions that are passed through to the Health Plan, and the total number of prescriptions that were dispensed.

vi. The aggregate amount of the difference between the amount the Health Plan pays Subcontractor and the amount that the Subcontractor pays retail pharmacies, and mail order pharmacies.

c. *Confidentiality of Subcontractor Data.* Information disclosed by Subcontractor is confidential and must not be disclosed by Health Plan, except that the Secretary may disclose the information in a form which does not disclose the identity of Subcontractor or Health Plan, or prices charged for drugs, for the following purposes:

i. As the Secretary determines necessary to carry out section 1150A of the Act or Part D of Title XVIII.

ii. To permit the Comptroller General to review the information provided.

iii. To permit the Director of the Congressional Budget Office to review the information provided.

42 CFR §423.514(d) and (e)

Attachment B: Medicare

EXHIBIT 1
COMPENSATION SCHEDULE
MA PLAN/MA-PD PLAN/DSNP PLAN
ANCILLARY SERVICES
AMBULANCE

Greene County

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicare Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The maximum compensation for ambulance Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for ambulance Covered Services is the lesser of: (i) Allowable Charges; or (ii) 100% of the Medicare fee schedule in effect on the date of service.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

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

3. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

4. Payment under this Compensation Schedule. Claims should be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative (CCI) Policy Manual, CCI table edits and other CMS

guidelines). All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual, and any applicable billing manual and claims processing policies.

Definitions:

1. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

2. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

PARTICIPATING PROVIDER AGREEMENT

This Participating Provider Agreement (together with all Attachments and amendments, this "Agreement") is made and entered by and among _____ ("Provider"), Carolina Complete Health, Inc., a North Carolina corporation ("Carolina Complete") and Carolina Complete Health Network, Inc., a Delaware corporation ("CCHN") and subsidiary of the North Carolina Medical Society. This Agreement is effective as of the date designated by Carolina Complete on the signature page of this Agreement ("Effective Date"). For purposes of this Agreement, each of Provider and Carolina Complete (and, solely for purposes of Article VIII, CCHN) may be referred to herein as a "Party" and collectively as the "Parties."

WHEREAS, Provider desires to provide certain health care services to individuals in products offered by or available from or through a Company or Payor (as hereafter defined), and Provider desires to participate in such products as a Participating Provider (as defined herein), all as hereinafter set forth.

WHEREAS, Carolina Complete desires for Provider to provide such health care services to individuals in such products, and Carolina Complete desires to have Provider participate in certain of such products as a Participating Provider, all as hereinafter set forth.

WHEREAS, CCHN has agreed to assist the Carolina Complete in connection with its efforts to create, recruit, build, develop, manage, operate and maintain a network of health care providers and, in connection therewith, desires to support Carolina Complete on an as-needed basis in the performance of certain functions under this Agreement.

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

ARTICLE I - DEFINITIONS

When appearing with initial capital letters in this Agreement (including an Attachment), the following quoted and underlined terms (and the plural thereof, when appropriate) have the meanings set forth below.

1.1. "Affiliate" means, with respect to any entity, a person or entity directly or indirectly controlling, controlled by, or under common control with such entity, provided that, notwithstanding the foregoing, CCHN shall not be deemed to be an Affiliate of Company.

1.2. "Attachment" means any document, including an addendum, schedule or exhibit, attached to this Agreement as of the Effective Date or that becomes attached pursuant to Section 2.2 or Section 8.8, all of which are incorporated herein by reference and may be amended from time to time as provided in this Agreement.

1.3. "Clean Claim" has, as to each particular Product, the meaning set forth in the applicable Product Attachment or, if no such definition exists, the Provider Manual.

1.4. "Company" means, as appropriate in the context, Carolina Complete and/or one or more of its Affiliates listed on Schedule D of this Agreement, except those specifically excluded by Carolina Complete.

1.5. "Compensation Schedule" means at any given time the then effective schedule(s) of maximum rates applicable to a particular Product under which Provider and Contracted Providers will be compensated for the provision of Covered Services to Covered Persons. Such Compensation Schedule(s) will be set forth or described in one or more Attachments to this Agreement, and may be included within a Product Attachment.

1.6. "Contracted Provider" means a physician, hospital, health care professional or any other provider of items or services that is employed by or has a contractual relationship with Provider. The term "Contracted Provider" includes Provider for those Covered Services provided by Provider.

1.7. "Coverage Agreement" means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Carolina Complete.

1.8. "Covered Person" means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.9. "Covered Services" means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be Medically Necessary.

1.10. "Medically Necessary" or "Medical Necessity" shall have the meaning defined in the applicable Coverage Agreement or applicable Regulatory Requirements.

1.11. "Participating Provider" means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Carolina Complete to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.12. "Payor" means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.13. "Payor Contract" means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Carolina Complete. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "Governmental Contract") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.14. "Product" means any program or health benefit arrangement designated as a "product" by Carolina Complete (e.g., Carolina Complete Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Carolina Complete).

1.15. "Product Attachment" means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.16. "Provider Manual" means the provider manual and any billing manuals, adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.17. "Regulatory Requirements" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements

of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.18. "State" is defined as the state identified in the applicable Attachment.

ARTICLE II – PRODUCTS AND SERVICES

2.1. Contracted Providers. Provider shall, and shall cause each Contracted Provider, to comply with and abide by the agreements, representations, warranties, acknowledgements, certifications, terms and conditions of this Agreement (including the provisions of Schedule A that are applicable to Provider, a Contracted Provider, or their services, and any other Attachments), and the Provider Manual, and fulfill all of the duties, responsibilities and obligations imposed on Provider and Contracted Providers under this Agreement (including each Attachment), and the Provider Manual, in each case, to the same extent as if the Contracted Providers were parties hereto. Provider shall be responsible for any breach of this Agreement by any Contracted Provider.

2.2. Participation in Products. Subject to the other provisions of this Agreement, each Contracted Provider may be identified as a Participating Provider in each Product identified in a Product Attachment designated on Schedule B of this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.1. Provider shall, at all times during the term of this Agreement, require each of its Contracted Providers to, subject to Company's approval, participate as Participating Providers in each Product identified in a Product Attachment that is designated on Schedule B to this Agreement or added to this Agreement in accordance with Section 2.2 hereof.

2.2.2. A Contracted Provider may only identify itself as a Contracted Provider for those Products in which the Contracted Provider actually participates as provided in this Agreement. Provider acknowledges that Company or Payor may have, develop or contract to develop various Products or provider networks that have a variety of provider panels, program components and other requirements. No Company or Payor warrants or guarantees that any Contracted Provider: (i) will participate in all or a minimum number of provider panels, (ii) will be utilized by a minimum number of Covered Persons, or (iii) will indefinitely remain a Participating Provider or member of the provider panel for a particular network or Product.

2.2.3. Attached hereto as Schedule C is the initial list of the Contracted Providers as of the Effective Date. Provider shall provide Carolina Complete, from time to time or on a periodic basis as requested by Carolina Complete, with a complete and accurate list containing the names, office telephone numbers, addresses, tax identification numbers, hospital affiliations, specialties and board status (if applicable), State license number, and National Provider Identifier of Contracted Providers and such other information as mutually agreed upon by the Parties, and shall provide Carolina Complete with a list of modifications to such list at least thirty (30) days prior to the effective date of such changes, when possible. Provider shall provide such lists in a manner and format mutually acceptable to the Parties.

2.2.4. Provider may add new providers to this Agreement as Contracted Providers. In such case, Provider shall provide written notice to Carolina Complete of the prospective addition(s), and shall use best efforts to provide such notice at least sixty (60) days in advance of such addition. Provider shall maintain written agreements with each of its Contracted Providers (other than Provider) that require the Contracted Providers to comply with the terms and conditions of this Agreement and that address and comply with the Regulatory Requirements.

2.2.5. If Company desires to add one or more Contracted Providers to an additional Product, Company or Payor, as applicable, will provide advance written notice (electronic or paper) thereof to Provider, along with the applicable Product Attachment and the new Compensation Schedule, if any. The applicable Contracted Providers will not be designated as Participating Providers in such additional Product if Provider opts out of such additional Product by giving Company or Payor, as applicable, written notice of its decision to opt-out within thirty (30) days of Company's or Payor's, as applicable, giving of written notice. If Provider timely provides such opt-out

notice, the applicable Contracted Providers will not be considered Participating Providers in such Product. If Provider does not timely provide such opt-out notice, then each applicable Contracted Provider shall be a Participating Provider in such additional Product on the terms and conditions set forth in this Agreement and the applicable Product Attachment.

2.3. Covered Services. Each Contracted Provider shall provide Covered Services described or referenced in the applicable Product Attachment(s) to Covered Persons in those Products in which the Contracted Provider is a Participating Provider, in accordance with this Agreement. Each Contracted Provider shall provide Covered Services to Covered Persons with the same degree of care and skill as customarily provided to patients who are not Covered Persons, within the scope of the Contracted Provider's license and in accordance with generally accepted standards of the Contracted Provider's practice and business and in accordance with the provisions of this Agreement, the Provider Manual, and Regulatory Requirements.

2.4. Provider Manual; Policies and Procedures. Provider and Contracted Providers shall at all times cooperate and comply with the requirements, policies, programs and procedures ("Policies") of Company and Payor, which may be described in the Provider Manual and include, but are not limited to, the following: credentialing criteria and requirements; notification requirements; medical management programs; claims and billing, quality assessment and improvement, utilization review and management, disease management, case management, on-site reviews, referral and prior authorization, and grievance and appeal procedures; coordination of benefits and third party liability policies; carve-out and third party vendor programs; and data reporting requirements. The failure to comply with such Policies could result in a denial or reduction of payment to the Provider or Contracted Provider or a denial or reduction of the Covered Person's benefits. Such Policies do not in any way affect or remove the obligation of Contracted Providers to render care. Carolina Complete shall make the Provider Manual available to Provider and Contracted Providers via one or more designated websites or alternative means as promptly as possible following Carolina Complete's receipt of any and all necessary regulatory review and approval thereof (whether by the North Carolina Department of Health and Human Services, the North Carolina Division of Health Benefits or otherwise); provided, however, that in no event shall Carolina Complete be required to make the Provider Manual available earlier than one hundred and twenty (120) days prior to North Carolina's effective date of the Medicaid managed care program. Upon Provider's reasonable request, Carolina Complete shall provide Provider with a written copy of the Provider Manual. In the event of a material change to the Provider Manual, Carolina Complete will provide Provider with at least sixty (60) days' advance written notice of such change. Such notice may be given by Carolina Complete through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.5. Credentialing Criteria. Provider and each Contracted Provider shall complete Company's and/or Payor's credentialing and/or recredentialing process as required by Company's and/or Payor's credentialing Policies, and shall at all times during the term of this Agreement meet all of Company's and/or Payor's credentialing criteria. Provider and each Contracted Provider represents, warrants and agrees: (a) that it is currently, and for the duration of this Agreement shall remain: (i) in compliance with all applicable Regulatory Requirements, including licensing laws; (ii) if applicable, accredited by The Joint Commission or the American Osteopathic Association; and (iii) a Medicare participating provider under the federal Medicare program or eligible to enroll as a Medicare participating provider under the federal Medicare program and a Medicaid participating provider under applicable federal and State laws; and (b) that all Contracted Providers and all employees and contractors thereof will perform their duties in accordance with all Regulatory Requirements, as well as applicable national, State and local standards of professional ethics and practice. No Contracted Provider shall provide Covered Services to Covered Persons or identify itself as a Participating Provider unless and until the Contracted Provider has been notified, in writing, by Company that such Contracted Provider has successfully completed Company's credentialing process.

2.6. Eligibility Determinations. Provider or Contracted Provider shall timely verify whether an individual seeking Covered Services is a Covered Person. Company or Payor, as applicable, will make available to Provider and Contracted Providers a method, whereby Provider and Contracted Providers can obtain, in a timely manner, general information about eligibility and coverage. Company or Payor, as applicable, does not guarantee that persons identified as Covered Persons are eligible for benefits or that all services or supplies are Covered Services. If

Company, Payor or its delegate determines that an individual was not a Covered Person at the time services were rendered, such services shall not be eligible for payment under this Agreement. In addition, Company will use reasonable efforts to include or contractually require Payors to clearly display Company's name, logo or mailing address (or other identifier(s) designated from time to time by Company) on each membership card.

2.7. Referral and Preauthorization Procedures. Provider and Contracted Providers shall comply with referral and preauthorization procedures adopted by Company and or Payor, as applicable, prior to referring a Covered Person to any individual, institutional or ancillary health care provider. Except as required by applicable law, failure of Provider and Contracted Providers to follow such procedures may result in denial of payment for unauthorized treatment. Unless otherwise expressly authorized in writing by Company or Payor, Provider and Contracted Providers shall refer Covered Persons only to Participating Providers to provide the Covered Service for which the Covered Person is referred.

2.8. Treatment Decisions. Neither Company, Payor, nor CCHN shall be liable for, or exercise control over, the manner or method by which a Contracted Provider provides items or services under this Agreement. Provider and Contracted Providers understand that determinations of Company, Payor, or CCHN that certain items or services are not Covered Services or have not been provided or billed in accordance with the requirements of this Agreement or the Provider Manual are administrative decisions only. Such decisions do not absolve the Contracted Provider of its responsibility to exercise independent judgment in treatment decisions relating to Covered Persons. Nothing in this Agreement (i) is intended to interfere with Contracted Provider's relationship with Covered Persons, or (ii) prohibits or restricts a Contracted Provider from disclosing to any Covered Person any information that the Contracted Provider deems appropriate regarding health care quality, medical treatment decisions or alternatives.

2.9. Carve-Out Vendors. Provider acknowledges that Company may, during the term of this Agreement, carve-out certain Covered Services from its general provider contracts, including this Agreement, for one or more Products as Company deems necessary or appropriate. Provider and Contracted Providers shall cooperate with and, when medically appropriate, utilize all third party vendors designated by Company for those Covered Services identified by Company from time to time for a particular Product.

2.10. Disparagement Prohibition. Provider, each Contracted Provider and the officers of Company and CCHN (each a "Non-Disparagement Party") shall not disparage any other Non-Disparagement Party during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Neither Provider nor Contracted Provider shall interfere with Company's and/or CCHN's direct or indirect contractual relationships including, but not limited to, those with Covered Persons or other Participating Providers. Nothing in this Agreement should be construed as limiting the ability of Carolina Complete, Company, Provider or a Contracted Provider to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Provider, to promote Provider to the general public or to post information regarding other health plans consistent with Provider's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting any Non-Disparagement Party's ability to use and disclose information and data obtained from or about another Non-Disparagement Party, including this Agreement, to the extent determined reasonably necessary or appropriate by such Non-Disparagement Party in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

2.11. Nondiscrimination. Provider and each Contracted Provider will provide Covered Services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of Payor, source of payment (e.g., Medicaid generally or a State-specific health care program), physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991. Provider and Contracted Providers recognize that, as a governmental contractor, Company or Payor may be subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors, and Provider and each Contracted Provider agree to comply with such requirements as described in any applicable Attachment.

2.12. Notice of Certain Events. Provider shall give written notice to Carolina Complete and Payor of: (i) any event of which notice must be given to a licensing or accreditation agency or board; (ii) any change in the status of Provider's or a Contracted Provider's license; (iii) termination, suspension, exclusion or voluntary withdrawal of Provider or a Contracted Provider from any state or federal health care program, including but not limited to Medicaid; or (iv) any final adverse determinations in connection with a lawsuit or claim filed or asserted against Provider or a Contracted Provider alleging professional malpractice involving a Covered Person. In any instance described in subsection (i)-(iii) above, Provider must notify Carolina Complete and Payor in writing within ten (10) days, and in any instance described in subsection (iv) above, Provider must notify Carolina Complete and Payor in writing within thirty (30) days, from the date it first obtains knowledge of any such final adverse determination.

2.13. Use of Name. Provider and each Contracted Provider hereby authorizes each Company and/or Payor to use their respective names, telephone numbers, addresses, specialties, certifications, hospital affiliations (if any), and other descriptive characteristics of their facilities, practices and services for the purpose of identifying the Contracted Providers as "Participating Providers" in the applicable Products. Provider and Contracted Providers may only use the name of the applicable Company or Payor for purposes of identifying the Products in which they participate, and may not use the registered trademark or service mark of Company or Payor without prior written consent.

2.14. Compliance with Regulatory Requirements. Provider, each Contracted Provider and Company agree to carry out their respective obligations under this Agreement and the Provider Manual in accordance with all applicable Regulatory Requirements, including, but not limited to, the requirements of the Health Insurance Portability and Accountability Act, as amended, and any regulations promulgated thereunder. If, due to Provider's or Contracted Provider's noncompliance with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company, Company may, in its sole discretion, offset such amounts against any amounts due Provider or Contracted Providers from any Company or require Provider or the Contracted Provider to reimburse Company for such amounts.

2.15. Program Integrity Required Disclosures. Provider agrees to furnish to Carolina Complete complete and accurate information necessary to permit Company to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Company to comply with such requirements. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Provider and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Provider; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Provider, or who are managing employees of Provider, who have been convicted of a crime.

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

3.1. Claims or Encounter Data Submission. As provided in the Provider Manual and/or Policies, Contracted Providers shall submit to Payor or its delegate claims for payment for Covered Services rendered to Covered Persons. Contracted Provider shall submit encounter data to Payor or its delegate in a timely fashion, which must contain patient data and identifying information, diagnosis and service codes, and provider identifiers, if and as required in the Provider Manual. Payor or its delegate reserves the right to deny payment to the Contracted Provider if the Contracted Provider fails to submit claims for payment or encounter data in accordance with the Provider Manual and/or Policies.

3.2. Compensation. The compensation for Covered Services provided to a Covered Person ("Compensation Amount") will be the appropriate amount under the applicable Compensation Schedule in effect on the date of service for the Product in which the Covered Person participates. Subject to the terms of this Agreement

and the Provider Manual, Provider and Contracted Providers shall accept the Compensation Amount as payment in full for the provision of Covered Services. Subject to the terms of this Agreement, Payor shall pay or arrange for payment of each Clean Claim received from a Contracted Provider for Covered Services provided to a Covered Person in accordance with the applicable Compensation Amount less any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. Unless Company provides prior written approval to Provider, Provider shall make arrangements for and only accept Compensation Amounts by way of electronic funds transfer via the automated clearing house network (EFT-ACH).

3.3. Financial Incentives. The Parties acknowledge and agree that nothing in this Agreement shall be construed to create any financial incentive for Provider or a Contracted Provider to withhold Covered Services.

3.4. Hold Harmless. Provider and each Contracted Provider agree that in no event, including but not limited to non-payment by a Payor, a Payor's insolvency, or breach of this Agreement, shall Provider or a Contracted Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Covered Person or person acting on the Covered Person's behalf, other than Payor, for Covered Services provided under this Agreement. This provision shall not prohibit collection of any applicable copayments, cost-sharing or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement. This provision survives termination or expiration of this Agreement for any reason, will be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between Provider or a Contracted Provider and a Covered Person.

3.5. Recovery Rights. Payor or its delegate shall have the right to immediately offset or recoup any and all amounts owed by Provider or a Contracted Provider to Payor or Company against amounts owed by the Payor or Company to the Provider or Contracted Provider following not less than thirty (30) days' advance written notice to Provider. Such notice will be accompanied by adequate specific information to identify the specific claim and the specific reason for the offset or recoupment. All offsets or recoupments will be made within the two (2) years after the date of the original claim payment unless Payor has a reasonable belief of fraud or other intentional misconduct by Provider, Contracted Provider or their respective agents or the claim involves the receipt of payment for the same service from a government payor. Provider and Contracted Providers agree that all recoupment and any offset rights under this Agreement will constitute rights of recoupment authorized under State or federal law and that such rights will not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Provider or a Contracted Provider. If the recoupment is standard in scope, then Payor or its delegate may immediately offset any and all overpayments or payments made in error without prior notice to Provider. "Standard" means those overpayments or payments made in error that are discovered by Payor or its delegate on an individual account review basis. If the recoupment is non-standard in scope, then Payor or its delegate will provide written or electronic notice to Provider before using an offset as a means to recover an overpayment, and will not implement the offset if, within thirty (30) days after the date of the notice, Provider refunds the overpayment or initiates an appeal. The written or electronic notice from the Payor or its delegate shall explain the reason and calculation of the overpayment or payment made in error. "Non-standard" means those overpayments or payments made in error that are discovered by Payor or its delegate during an audit that is being conducted to correct a systemic error. Appeals shall be made pursuant to procedures set forth in the Policies and/or Provider Manual.

ARTICLE IV – RECORDS AND INSPECTIONS

4.1. Records. Each Contracted Provider shall maintain medical, financial and administrative records related to items or services provided to Covered Persons, including but not limited to a complete and accurate permanent medical record for each such Covered Person, in such form and detail as are required by applicable Regulatory Requirements and consistent with generally accepted medical standards.

4.2. Access. Provider and each Contracted Provider shall provide access to their respective books and records to each of the following, including any delegate or duly authorized agent thereof, subject to applicable Regulatory Requirements: (i) Company and Payor, during regular business hours and upon prior notice; (ii)

appropriate State and federal authorities, to the extent such access is necessary to comply with Regulatory Requirements; and (iii) accreditation organizations, to the extent such access is necessary for Carolina Complete to maintain or apply for certain accreditations, as applicable. Provider and each Contracted Provider shall provide copies of such records at no expense to any of the foregoing that may make such request. Each Contracted Provider also shall obtain any authorization or consent that may be required from a Covered Person in order to release medical records and information to Company or Payor or any of their delegates. Company and Payor agree to limit the number of copies of records requested of Provider and each Contracted Provider to the minimum necessary to satisfy the applicable obligation. Provider and each Contracted Provider shall cooperate in and allow on-site inspections of its, his or her facilities and records by any Company, Payor, their delegates, any authorized government officials, and accreditation organizations. Provider and each Contracted Provider shall compile information necessary for the expeditious completion of such on-site inspection in a timely manner.

4.3. Record Transfer. Subject to applicable Regulatory Requirements, each Contracted Provider shall cooperate in the timely transfer of Covered Persons' medical records to any other health care provider, at no charge and when required.

ARTICLE V – INSURANCE AND INDEMNIFICATION

5.1. Insurance. During the term of this Agreement and for any applicable continuation period as set forth in Section 7.3 of this Agreement, Provider and each Contracted Provider shall maintain policies of general and professional liability insurance and other insurance necessary to insure Provider and such Contracted Provider, respectively; their respective employees; and any other person providing services hereunder on behalf of Provider or such Contracted Provider, as applicable, against any claim(s) of personal injuries or death alleged to have been caused or caused by their performance under this Agreement. Such insurance shall include, but not be limited to, any "tail" or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier acceptable to Carolina Complete, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) annual aggregate unless a lesser amount is accepted by Carolina Complete or where State law mandates otherwise. Provider and each Contracted Provider will provide Carolina Complete with at least fifteen (15) days prior written notice of cancellation, non-renewal, lapse, or adverse material modification of such coverage. Upon Carolina Complete's request, Provider and each Contracted Provider will furnish Carolina Complete with evidence of such insurance.

5.2. Indemnification by Provider and Contracted Provider. Provider and each Contracted Provider shall indemnify and hold harmless (and at Carolina Complete's request defend) Company, Payor and CCHN and each of their respective officers, directors, agents, and employees from and against any and all claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations (collectively, "Losses") arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Provider, a Contracted Provider, or any of their respective officers, directors, agents or employees.

5.3. Indemnification by Carolina Complete. Carolina Complete agrees to indemnify and hold harmless (and at Provider's or CCHN's request (as applicable) defend) Provider, Contracted Providers, CCHN and each of their respective officers, directors, agents and employees from and against any and all Losses arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

5.4. Indemnification by CCHN. CCHN agrees to indemnify and hold harmless (and at Provider's or Carolina Complete's request (as applicable) defend) Company, Provider, Contracted Providers and each of their respective officers, directors, agents and employees from and against any and all Losses arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by CCHN or its directors, officers, agents or employees, whether in connection with the performance of its obligations under Section 8.2 or otherwise.

ARTICLE VI – DISPUTE RESOLUTION

6.1. Informal Dispute Resolution. Any dispute between Provider and/or a Contracted Provider, as applicable (the "Provider Party"), and CCHN, Carolina Complete and/or Company, as applicable (including any Company acting as Payor) (the "Administrator Party"), with respect to or involving the performance under, termination of, or interpretation of this Agreement, or any other claim or cause of action hereunder, whether sounding in tort, contract or under statute (a "Dispute") shall first be addressed by exhausting the applicable procedures in the Provider Manual pertaining to claims payment, credentialing, utilization management, or other programs. If, at the conclusion of these applicable procedures, the Dispute is not resolved to satisfaction of the Provider Party and the Administrator Party, or if there are no applicable procedures in the Provider Manual, then the Provider Party and the Administrator Party shall engage in a period of good faith negotiations between their designated representatives who have authority to settle the Dispute, which negotiations may be initiated by either the Provider Party or the Administrator Party upon written request to the other, provided such request takes place within one year of the date on which the requesting party first had, or reasonably should have had, knowledge of the event(s) giving rise to the Dispute. If the Dispute has not been resolved within sixty (60) days of such request, either the Provider Party or the Administrator Party may, as its sole and exclusive forum for the litigation of the Dispute or any part thereof, initiate arbitration pursuant to Section 6.2 below by providing written notice to the other party.

6.2. Arbitration. If either the Provider Party or the Administrator Party wishes to pursue the Dispute as provided in Section 6.1, such party shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("AAA"). In no event may any arbitration be initiated more than one (1) year following, as applicable, the end of the sixty (60) day negotiation period set forth in Section 6.1, or the date of notice of termination. Arbitration proceedings shall be conducted by an arbitrator chosen from the National Healthcare Panel at a mutually agreed upon location within the State. The arbitrator shall not award any punitive or exemplary damages of any kind, shall not vary or ignore the provisions of this Agreement, and shall be bound by controlling law. The Parties, CCHN and the Contracted Providers, on behalf of themselves and those that they may now or hereafter represent, agree to and do hereby waive any right to pursue, on a class basis, any Dispute. Each of the Provider Party and the Administrator Party shall bear its own costs and attorneys' fees related to the arbitration except that the AAA's Administrative Fees, all Arbitrator Compensation and travel and other expenses, and all costs of any proof produced at the direct request of the arbitrator shall be borne equally by the applicable parties, and the arbitrator shall not have the authority to order otherwise. The existence of a Dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Except as hereafter provided, during an arbitration proceeding, each of the Provider Party and the Administrator Party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. Nothing herein shall bar either the Provider Party or the Administrator Party from seeking emergency injunctive relief to preclude any actual or perceived breach of this Agreement, although such party shall be obligated to file and pursue arbitration at the earliest reasonable opportunity. Judgment on the award rendered may be entered in any court having jurisdiction thereof. Nothing contained in this Article VI shall limit a Party's right to terminate this Agreement with or without cause in accordance with Section 7.2.

ARTICLE VII – TERM AND TERMINATION

7.1. Term.

7.1.1. This Agreement is effective as of the Effective Date, and will, subject to Section 7.1.2 of this Agreement, remain in effect for an initial term ("Initial Term") of three (3) year(s), after which it will automatically renew for successive terms of one (1) year each (each a "Renewal Term"), unless this Agreement is sooner terminated as provided in this Agreement or either Party gives the other Party written notice of non-renewal of this Agreement not less than one hundred eighty (180) days prior to the end of the then-current term. In addition, either Party may elect to not renew a Contracted Provider's participation as a Participating Provider in a particular Product for the next Renewal Term, by giving Provider written notice of such non-renewal not less than one hundred eighty (180) days prior to the, as applicable, last day of the Initial Term or applicable Renewal Term; in such event, Provider shall immediately notify the affected Contracted Provider of such non-renewal. Termination of any Contracted Provider's participation in a particular Product will not have the effect of terminating either this Agreement or the Contracted Provider's participation in any other Product in which the Contract Provider participates under this Agreement.

7.1.2. The Parties and CCHN acknowledge that CCHN has contractually agreed (the " CCHN Agreement") to provide services to Carolina Complete and assist Carolina Complete by facilitating and coordinating the participation of Provider in Carolina Complete as a Participating Provider and performing such obligations as may be delegated to CCHN pursuant to Section 8.2 of this Agreement. In the event that the CCHN Agreement shall be terminated for any reason, the Parties hereby acknowledge and agree that this Agreement shall remain in full force and effect, and without any further action or notice required by or on behalf of any Party, (a) the then current Term of this Agreement shall automatically be extended to continue until the date that is five (5) years from and after the date on which the CCHN Agreement is terminated, after which it will automatically renew for successive terms of one (1) year each in accordance with the provisions set forth in Section 7.1.1 of this Agreement with respect to Renewal Terms; (b) this Agreement shall be deemed to have been amended to remove CCHN as a party hereto and all references to CCHN herein; and (c) in no event shall the termination of the CCHN Agreement modify, amend or otherwise release Provider from its obligation to perform under and comply with the provisions of this Agreement.

7.2. Termination. This Agreement, or the participation of Provider or a Contracted Provider as a Participating Provider in one or more Products, may be terminated or suspended as set forth below. Notwithstanding anything contained herein to the contrary, in no event shall CCHN, whether individually or on behalf of Carolina Complete, have the ability or authority to terminate this Agreement for any reason, whether pursuant to Section 7.1, this Section 7.2 or otherwise.

7.2.1. Upon Notice. This Agreement may be terminated by either Party giving the other Party at least one hundred twenty (120) days prior written notice of such termination. The participation of any Contracted Provider as a Participating Provider in a Product may be terminated by either Party giving the other Party at least one hundred twenty (120) days prior written notice of such termination; in such event, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.2. With Cause. This Agreement, or the participation of any Contracted Provider as a Participating Provider in one or more Products under this Agreement, may be terminated by either Party giving at least ninety (90) days prior written notice of termination to the other Party if such other Party (or the applicable Contracted Provider) is in breach of any material term or condition of this Agreement and such other Party (or the Contracted Provider) fails to cure the breach within the sixty (60) day period immediately following the giving of written notice of such breach. Any notice given pursuant to this Section 7.2.2 must describe the specific breach. In the case of a termination of a Contracted Provider, Provider shall immediately notify the affected Contracted Provider of such termination.

7.2.3. Suspension of Participation. Unless expressly prohibited by applicable Regulatory Requirements, Carolina Complete has the right to immediately suspend or terminate the participation of a Contracted Provider in any or all Products by giving written notice thereof to Provider when Carolina Complete determines that (i) based upon available information, the continued participation of the Contracted Provider appears to constitute an immediate threat or risk to the health, safety or welfare of Covered Persons, or (ii) the Contracted Provider's fraud, malfeasance or non-compliance with Regulatory Requirements is reasonably suspected. Provider shall immediately notify the affected Contracted Provider of such suspension. During such suspension, the Contracted Provider shall, as directed by Carolina Complete, discontinue the provision of all or a particular Covered Service to Covered Persons. During the term of any suspension, the Contracted Provider shall notify Covered Persons that his or her status as a Participating Provider has been suspended. Such suspension will continue until the Contracted Provider's participation is reinstated or terminated.

7.2.4. Insolvency. This Agreement may be terminated immediately by a Party giving written notice thereof to the other Party if the other Party is insolvent or has bankruptcy proceedings initiated against it.

7.2.5. Credentialing. The status of a Contracted Provider as a Participating Provider in one or more Products may be terminated immediately by Carolina Complete giving written notice thereof to Provider if the Contracted Provider fails to adhere to Company's or Payor's credentialing criteria, including, but not limited to, if

the Contracted Provider (i) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (ii) fails to comply with the insurance requirements set forth in this Agreement; or (iii) is convicted of a criminal offense related to involvement in any state or federal health care program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any state or federal health care program. Provider shall immediately notify the affected Contracted Provider of such termination.

7.3. Effect of Termination. After the effective date of termination of this Agreement or a Contracted Provider's participation in a Product, this Agreement shall remain in effect for purposes of those obligations and rights arising prior to the effective date of termination. Upon such a termination, each affected Contracted Provider (including Provider, if applicable) shall (i) continue to provide Covered Services to Covered Persons in the applicable Product(s) during the longer of the ninety (90) day period following the date of such termination or such other period as may be required under any Regulatory Requirements, and, if requested by Company, each affected Contracted Provider (including Provider, if applicable) shall continue to provide, as a Participating Provider, Covered Services to Covered Persons until such Covered Persons are assigned or transferred to another Participating Provider in the applicable Product(s), and (ii) continue to comply with and abide by all of the applicable terms and conditions of this Agreement, including, but not limited to, Section 3.4 (Hold Harmless) hereof, in connection with the provision of such Covered Services during such continuation period. During such continuation period, each affected Contracted Provider (including Provider, if applicable) will be compensated in accordance with this Agreement and shall accept such compensation as payment in full.

7.4. Survival of Obligations. All provisions hereof that by their nature are to be performed or complied with following the expiration or termination of this Agreement, including without limitation Sections 2.8, 2.10, 3.2, 3.4, 3.5, 4.2, 5.1, 5.2, 5.3, 5.4, 6.1, 6.2, 7.3, 7.4 and Article VIII, survive the expiration or termination of this Agreement.

ARTICLE VIII - MISCELLANEOUS

8.1. Delegation of Obligations. Upon the mutual written agreement of Carolina Complete and CCHN, Carolina Complete may delegate performance of all or any part of its obligations under this Agreement (other than and excluding any of its obligations arising under Article III of this Agreement) to CCHN (each such obligation, a "Delegated Obligation") without notice to or consent of Provider and no such delegation by Carolina Complete shall in any way affect Carolina Complete's rights or relieve Provider of any of its obligations under this Agreement. CCHN hereby acknowledges and agrees that it shall, in connection with the performance of any such Delegated Obligation, be bound by and strictly comply with the terms of this Agreement and shall perform any such Delegated Obligation in good faith. Notwithstanding anything contained herein to the contrary, CCHN shall not perform any obligation on behalf of Carolina Complete unless, and then, only to the extent, such obligation has been expressly delegated to CCHN as provided by this Section 8.1.

8.2. Relationship of Parties. The relationship between or among CCHN, Carolina Complete, Company, Provider, and any Contracted Provider hereunder is that of independent contractors. None of the provisions of this Agreement will be construed as creating any agency, partnership, joint venture, employee-employer, or other relationship. References herein to the rights and obligations of any "Company" under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach or default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Carolina Complete. Each of Company and CCHN (each an "Unaffiliated Party" and collectively, the "Unaffiliated Parties") acknowledge that references herein to their respective rights and obligations under this Agreement are references to the rights and obligations of each such Unaffiliated Party individually and not of the Unaffiliated Parties collectively. Notwithstanding anything that may be construed herein to the contrary, all such rights and obligations are individual and specific to each Unaffiliated Party and the reference to one Unaffiliated Party herein in no way imposes any cross-guarantees or joint responsibility or liability on the other Unaffiliated Party. A breach or default hereunder by an Unaffiliated Party shall not constitute a breach or default by the other Unaffiliated Party. CCHN acknowledges and agrees that nothing in this Agreement

is intended to supersede, disrupt, interfere or conflict with the CCHN Agreement or any other arrangement or agreement to which CCHN or any of its Affiliates are a party relating to the governance, management and day-to-day operations of Carolina Complete or any of its Affiliates.

8.3. Conflicts Between Certain Documents. If there is any conflict between this Agreement and the Provider Manual, this Agreement will control. In the event of any conflict between this Agreement and any Product Attachment, the Product Attachment will control as to such Product.

8.4. Assignment. This Agreement is intended to secure the services of and be personal to Provider and may not be assigned, sublet, delegated, subcontracted or transferred by Provider without the Carolina Complete's prior written consent; provided, however, Carolina Complete shall, in addition to the rights provided under Section 8.2, have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Carolina Complete, or purchaser of the assets or stock of Carolina Complete, or the line of business or business unit primarily responsible for carrying out Carolina Complete's obligations under this Agreement. CCHN shall not, directly or indirectly, assign, transfer or delegate this Agreement and/or any of its rights or obligations under this Agreement, voluntarily or involuntarily, including by change of control, merger (whether or not CCHN is the surviving corporation), operation of law or any other manner, without the prior written consent of Carolina Complete. Any attempted assignment or delegation in violation of this Section 8.5 shall be void.

8.5. Headings. The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not limit, define, or extend the specific terms of the section so designated.

8.6. Governing Law. The interpretation of this Agreement and the rights and obligations of Carolina Complete, CCHN, Company, Provider and any Contracted Providers hereunder will be governed by and construed in accordance with applicable federal and State laws.

8.7. Third Party Beneficiary. This Agreement is entered into by the Parties for their benefit, as well as, in the case of Carolina Complete, the benefit of Company, and in the case of Provider, the benefit of each Contracted Provider. Except as specifically provided in Section 3.4, Section 5.2, Section 5.3 and/or Section 5.4 hereof, no Covered Person or any other third party, other than Company, will be considered a third party beneficiary of this Agreement.

8.8. Amendment. Except as set forth in Section 7.1.2 and this Section 8.8, this Agreement may be amended only by written agreement of the applicable Parties to whom such amendment directly relates, as determined by Carolina Complete.

8.8.1 Carolina Complete may amend this Agreement by giving the Parties written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Carolina Complete to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by the Parties upon the giving of such notice.

8.8.2 Excluding any amendment to this Agreement contemplated by Section 8.8.1, Carolina Complete may amend this Agreement at any time by giving Provider written notice (electronic or paper) of the proposed amendment. When such an amendment proposes to modify Provider's reimbursement or addresses Covered Services routinely rendered by Provider to Covered Persons, the amendment will be evaluated by Carolina Complete's Medical Affairs and Financial Matters Committees prior to Carolina Complete giving written notice to Provider. Unless Provider notifies Carolina Complete in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Carolina Complete, Provider shall be deemed to have accepted the amendment. If Provider objects to any proposed amendment to this Agreement, Carolina Complete may exclude one or more of the Contracted Providers from being Participating Providers in the Product (or any component program of, or Coverage Agreement in connection with, such Product) to which such amendment relates.

8.9. Entire Agreement. This Agreement, together with any attached or incorporated amendments, schedules, exhibits, attachments and appendices, constitute the entire understanding and agreement of the parties with respect to the subject matter hereof and supersedes all prior oral and written and all contemporaneous oral negotiations, commitments and understandings between them. All prior or concurrent agreements, promises, negotiations or representations either oral or written, between Carolina Complete and Provider and/or CCHN and Provider, relating to the subject matter of this Agreement, which are not expressly set forth in this Agreement, are of no force or effect.

8.10. Severability. The invalidity or unenforceability of any terms or provisions hereof will in no way affect the validity or enforceability of any other terms or provisions.

8.11. Waiver. Any term or condition of this Agreement may be waived at any time by the Party that is entitled to the benefit thereof, but no such waiver shall be effective, unless set forth in a written instrument duly executed by or on behalf of the Party waiving such term or condition; provided, however, that (i) no Party shall be permitted to make any such waiver by or on behalf of any other Party; and (ii) CCHN shall not be permitted to waive any term or condition of this Agreement as it relates to any obligation (or the performance thereof) of Provider. The waiver by any Party of the violation of any provision or obligation of this Agreement will not constitute the waiver of any subsequent violation of the same or other provision or obligation.

8.12. Notices. Except as otherwise provided in this Agreement, any notice required or permitted to be given hereunder is deemed to have been given when such written notice has been personally delivered or deposited in the United States mail, postage paid, or delivered by a service that provides written receipt of delivery, addressed as follows:

To Carolina Complete at:

Attn: President

Carolina Complete Health, Inc.

3120 Highwoods Blvd., Suite 212

Raleigh, NC 27604

To Provider at:

Attn: _____

_____

_____

_____, _____ _____

_____

To CCHN at:

Attn:

Carolina Complete Health Network, Inc.

222 N. Person Street, Suite 010

Raleigh, NC 27601

or to such other address as such Party may designate in writing. Notwithstanding the previous paragraph, Carolina Complete and CCHN may provide notices to Provider by electronic mail, through its provider newsletter or on its provider website.

8.13. Force Majeure. No Party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by the employees of such Party, or any other similar cause beyond the reasonable control of such Party.

8.14. Proprietary Information. Each Party is prohibited from, and shall prohibit its Affiliates and Contracted Providers from, disclosing to a third party the substance of this Agreement, or any information of a confidential nature acquired from the other Party (or Affiliate or Contracted Provider thereof) during the course of this Agreement, except to agents of such Party as necessary for such Party's performance under this Agreement, or as required by a Payor Contract or applicable Regulatory Requirements. Provider acknowledges and agrees that all information relating to Company's programs, policies, protocols and procedures is proprietary information, and except for such disclosures as are required by Regulatory Requirements, Provider shall not disclose such information to any person or entity without Carolina Complete's express written consent.

8.15. Authority. The individuals whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement. Provider represents and warrants that it has all legal authority to contract on behalf of and to bind all Contracted Providers to the terms of this Agreement. Provider and each Contracted Provider acknowledges that references herein to the rights and obligations of any "Company" or a "Payor" under this Agreement are references to the rights and obligations of each Company and each Payor individually and not of the Companies or Payors collectively. Notwithstanding anything herein to the contrary, all such rights and obligations are individual and specific to each such Company and each such Payor and the reference to Company or Payor herein in no way imposes any cross-guarantees or joint responsibility or liability by, between or among such individual Companies or Payors. A breach or default by an individual Company or Payor shall not constitute a breach or default by any other Company or Payor, including but not limited to Carolina Complete.

8.16. Counterparts. This Agreement may be executed in counterparts, each of which shall be deemed an original, but all of which together shall be deemed to be one and the same agreement. A signed copy of this Agreement delivered by facsimile, e-mail or other means of electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this Agreement. Upon Provider's reasonable written request, Carolina Complete shall provide Provider with a fully executed copy of this Agreement.

* * * * *

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

IN WITNESS WHEREOF, the Parties hereto have executed this Agreement, including all Product Attachments noted on Schedule B, effective as of the date set forth beneath their respective signatures.

CAROLINA COMPLETE:

Carolina Complete Health, Inc.

Authorized Signature: _____

Print Name: _____

Title: _____

Signature Date: _____

ECM #: _____

To be completed by Carolina Complete only:
Effective Date: _____, 20

PROVIDER:

_____
(Legibly Print Name of Provider)

Authorized Signature: _____

Print Name: _____

Title: _____

Signature Date: _____

Tax Identification Number: _____

State Medicaid Number: _____

National Provider Identifier: _____

CCHN:

Carolina Complete Health Network, Inc.

Authorized Signature: _____

Print Name: _____

Title: _____

Signature Date: _____

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

Provider and Contracted Providers shall comply with the applicable provisions of this Schedule A.

1 Hospitals. If Provider or a Contracted Provider is a hospital ("Hospital"), the following provisions apply.

1.1 24 Hour Coverage. Each Hospital shall be available to provide Covered Services to Covered Persons twenty-four (24) hours per day, seven (7) days per week.

1.2 Emergency Care. Each Hospital shall provide Emergency Care (as hereafter defined) in accordance with Regulatory Requirements. The Contracted Provider shall notify Company's medical management department of any emergency room admissions by electronic file sent within twenty-four (24) hours or by the next business day of such admission. "Emergency Care" (or derivative thereof) has, as to each particular Product, the meaning set forth in the applicable Coverage Agreement or Product Attachment. If there is no definition in such documents, "Emergency Care" means inpatient and/or outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition. "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

1.3 Staff Privileges. Each Hospital shall assist in granting staff privileges or other appropriate access to Company's Participating Providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standards of practice and credentialing standards established by the Hospital's medical staff and bylaws, rules, and regulations.

1.4 Discharge Planning. Each Hospital agrees to cooperate with Company's system for the coordinated discharge planning of Covered Persons, including the planning of any necessary continuing care.

1.5 Credentialing Criteria. Each Hospital shall (a) currently, and for the duration of this Agreement, remain accredited by the Joint Commission or American Osteopathic Association, as applicable; and (b) ensure that all employees of Hospital perform their duties in accordance with all applicable local, State and federal licensing requirements and standards of professional ethics and practice.

1.6 National Committee for Quality Assurance ("NCQA") Accreditation of Carolina Completes Standards. Each Hospital agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Hospital's performance data.

2 Practitioners. If Provider or Contracted Provider is a physician or other health care practitioner (including physician extenders) ("Practitioner"), the following provisions apply.

2.1 Contracted Professional Qualifications. At all times during the term of this Agreement, Practitioner shall, as applicable, maintain medical staff membership and admitting privileges with at least one hospital that is a Participating Provider ("Participating Hospital") with respect to each Product in which the Practitioner participates. Upon Company's request, Practitioner shall furnish evidence of the foregoing to Company. If Practitioner does not have such admitting privileges, Provider or the Practitioner shall provide Company with a

written statement from another Participating Provider who has such admitting privileges, in good standing, certifying that such individual agrees to assume responsibility for providing inpatient Covered Services to Covered Persons who are patients of the applicable Practitioner.

2.2 Acceptance of New Patients. To the extent that Practitioner is accepting new patients, such Practitioner must also accept new patients who are Covered Persons with respect to the Products in which such Practitioner participates. Practitioner shall notify Company in writing forty-five (45) days prior to such Practitioner's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Practitioner be considered a new patient.

2.3 Preferred Drug List/Drug Formulary. If applicable to the Covered Person's coverage, Practitioners shall use commercially reasonable efforts, when medically appropriate under the circumstances, to comply with formulary or preferred drug list when prescribing medications for Covered Persons.

2.4 National Committee for Quality Assurance ("NCQA") Accreditation of Carolina Completes Standards. Each Practitioner agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use Practitioner's performance data.

3 Ancillary Providers. If Provider or Contracted Provider is an ancillary provider (including but not limited to a home health agency, durable medical equipment provider, sleep center, pharmacy, ambulatory surgery center, nursing facility, laboratory or urgent care center)("Ancillary Provider"), the following provisions apply.

3.1 Acceptance of New Patients. To the extent that Ancillary Provider is accepting new patients, such Ancillary Provider must also accept new patients who are Covered Persons with respect to the Products in which such Ancillary Provider participates. Ancillary Provider shall notify Company in writing forty-five (45) days prior to such Ancillary Provider's decision to no longer accept Covered Persons with respect to a particular Product. In no event will an established patient of any Ancillary Provider be considered a new patient.

3.2 National Committee for Quality Assurance ("NCQA") Accreditation of Carolina Completes Standards. Each ancillary provider agrees to: i) cooperate with Quality Management and Improvement ("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use ancillary provider's performance data.

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

4.1 FQHC Insurance. To the extent FQHC's employees are deemed to be federal employees qualified for protection under the Federal Tort Claims Act ("FTCA") and Carolina Complete has been provided with documentation of such status issued by the U.S. Department of Health and Human Services (such status to be referred to as "FTCA Coverage"), Section 5.1 of this Agreement will not apply to those Contracted Providers with FTCA Coverage. FQHC shall provide evidence of such FTCA Coverage to Carolina Complete at any time upon request. FQHC shall promptly notify Carolina Complete if, any time during the term of this Agreement, any Contracted Provider is no longer eligible for, or if FQHC becomes aware of any fact or circumstance that would jeopardize, FTCA Coverage. Section 5.1 of this Agreement will apply to a Contracted Provider immediately upon such Contracted Provider's loss of FTCA Coverage for any reason.

5 Facility Providers. If Provider or a Contracted Provider is a facility (including but not limited to Clinic, FQHC, LTAC, Nursing Home, Rehab, Rural Health Clinic, Skilled Nursing) ("Facility Provider") the following provision applies.

5.1 National Committee for Quality Assurance ("NCQA") Accreditation of Carolina Completes Standards. Each facility agrees to: i) cooperate with Quality Management and Improvement

("QI") activities; ii) maintain the confidentiality of a Covered Persons information and records pursuant to the Agreement; and iii) allow the Company to use facility's performance data.

6 Long Term Services and Supports ("LTSS") and Home and Community-Based Services ("HCBS") Providers. If Provider or a Contracted Provider is a provider of LTSS and/or HCBS services, the following provisions apply.

6.1 Definition. LTSS generally includes assistance with daily self-care activities (e.g., walking, toileting, bathing, and dressing) and activities that support an independent lifestyle (e.g., food preparation, transportation, and managing medications). The broad category of LTSS also includes care and service coordination for people who live in their own home, a residential setting, a nursing facility, or other institutional setting. Home and community-based services ("HCBS") are a subset of LTSS that functions outside of institutional care to maximize independence in the community. Long-term care ("LTC") is another subset of LTSS which provides benefits as specified through the SMMC LTC Program.

6.2 HCBS Waiver Authorization. Provider shall not provide HCBS Covered Services to Covered Person without the required HCBS waiver authorization.

6.3 Conditions for Reimbursement. No payment shall be made to the Provider unless the Provider has strictly conformed to the policies and procedures of the HCBS Waiver Program, including but not limited to not providing HCBS Covered Services without prior authorization of Carolina Complete. For the purposes of this Exhibit, "HCBS Waiver Program" shall mean any special Medicaid program operated under a waiver approved by the Centers for Medicare and Medicaid Services which allows the provision of a special package of approved services to Covered Person.

6.4 Acknowledgement. Carolina Complete acknowledges that Provider is a provider of LTSS and is not necessarily a provider of medical or health care services. Nothing in this Agreement is intended to require Provider to provide medical or health care services that Provider does not routinely provide, but would not prohibit providers from offering these services, as appropriate.

6.5 Notification Requirements. Provider or the applicable Contracted Provider shall provide the following notifications to Carolina Complete, via written notice or via telephone contact at a number to be provided by Carolina Complete, within the following time frames:

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

6.5.2 Provider or the applicable Contracted Provider shall notify Carolina Complete of any change to the designated/assigned services being provided under a Covered Person's plan of care and/or service plan, within 24 hours of becoming aware of such change.

6.5.3 Provider or the applicable Contracted Provider shall notify Carolina Complete if a Covered Person misses an appointment with Provider, within 24 hours of becoming aware of such missed appointment.

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

6.5.5 Provider or the applicable Contracted Provider shall notify Carolina Complete of any safety issue identified by Provider or Contracted Provider or its agent or subcontractor, within 24 hours of the identification of such safety issue. (Examples of safety issues are set forth in the Provider Manual.)

6.5.6 Provider or the applicable Contracted Provider shall notify Carolina Complete of any change in Provider's or Contracted Provider's key personnel, within 24 hours of such change.

6.6 Minimum Data Set. If Contracted Provider is a nursing facility, Provider or such Contracted Provider shall submit to Carolina Complete or its designee the Minimum Data Set as defined by CMS and required under federal law and Carolina Complete policy as it relates to all Covered Persons who are residents in Contracted Provider's facility. Such submission shall be via electronic mail, facsimile transmission, or other manner and format reasonably requested by Carolina Complete.

6.7 Quality Improvement Plan. Each Contracted Provider shall participate in Carolina Complete's LTSS quality improvement plan. Each Contracted Provider shall permit Carolina Complete to access such Contracted Providers' assessment and quality data upon reasonable advance notice, which may be given by electronic mail.

6.8 Electronic Visit Verification. If Contracted Provider provides in-home services, Contracted Provider shall comply with 21st Century Cures Act and Carolina Complete's electronic visit verification system requirements where applicable and accessible.

6.9 Criminal Background Checks. Provider shall conduct a criminal background check on each Contracted Provider prior to the commencement of services under this Agreement and as requested by Carolina Complete thereafter. Provider shall provide the results of such background checks to Carolina Complete and member, if self-directed, upon request. Carolina Complete within a reasonable time period following the completion thereof. Contracted Provider agrees to immediately notify Carolina Complete of any criminal convictions of any Contracted Provider. Provider shall pay any costs associated with such criminal background checks.

7 Person-Centered Planning, Care/Service Plan, and Services. Provider and Contracted Providers shall comply with all State and federal regulatory requirements related to person-centered planning, care/service plans, and services including, but not limited to:

7.1 Covered Persons shall lead the person-centered planning process and can elect to include, and/or consult with, any of their LTSS providers in the care/service plan development process.

7.2 The care/service plan must be finalized and agreed to, with the informed consent of the individual in writing, and signed by all individuals and providers responsible for its implementation through the mechanism required by State and federal requirements. Non-medical service providers (such as meals or assistive technology) can signify their agreement through this contract or written agreement in lieu of directly in the plan, if permitted by the Covered Person.

7.3 LTSS providers shall be aware of, respect, and adhere to a Covered Person's preferences for the delivery of services and supports.

7.4 LTSS providers shall ensure services and supports are culturally appropriate, provided in plain language (where applicable), and accessible to Covered Persons and the person(s) supporting them who have disabilities and/or are limited English proficient.

7.5 Carolina Complete agrees to complete the care/service plan in a timely manner (within at least 120 days of enrollment or annually, or less if State requirements differ) and provide a copy to LTSS provider(s) responsible for implementation.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

Provider will be designated as a "Participating Provider" in the Product Attachments listed below as of the date of successful completion of credentialing in accordance with this Agreement.

List of Product Attachments:

Attachment A: Medicaid
Attachment B: [Reserved]
Attachment C: [Reserved]

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
CONTRACTED PROVIDERS

ENTITY/GROUP/CLINIC/FACILITY NAME	TAX ID #	NPI #

NOTE: This Schedule is intended to capture all groups, clinics and facilities participating under the Agreement (i.e., are "Contracted Providers" under this Agreement) as of the Effective Date.

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE D
COMPANY AFFILIATES

As of the Effective Date, the Affiliates of Carolina Complete included as the "Company" are listed below.

Affiliates (Carolina Completes):
Absolute Total Care, Inc.
Ambetter of Magnolia, Inc.
Ambetter of North Carolina, Inc.
Ambetter of Peach State, Inc.
Arkansas Health & Wellness Health Plan, Inc.
Arkansas Total Care, Inc.
Bridgeway Health Solutions of Arizona, Inc.
Buckeye Community Health Plan, Inc.
Buckeye Health Plan Community Solutions, Inc.
California Health and Wellness Plan
Carolina Complete Health, Inc.
Celtic Insurance Company
CeltiCare Health Plan of Massachusetts, Inc.
Coordinated Care Corporation, d/b/a Managed Health Services - IN
Coordinated Care of Washington, Inc.
Michigan Complete Health, Inc.
Granite State Health Plan, Inc.
Health Net Community Solutions, Inc.
Health Net Health Plan of Oregon, Inc.
Health Net Life Insurance Company
Health Net of Arizona, Inc., d/b/a Arizona Complete Health
Health Net of California, Inc.
Home State Health Plan, Inc.
IlliniCare Health Plan, Inc.
Iowa Total Care, Inc.
Louisiana Healthcare Connections, Inc.
Magnolia Health Plan, Inc.
Managed Health Services Insurance Corporation
Nebraska Total Care, Inc.
New York Quality Healthcare Corporation, d/b/a Fidelis Care
NovaSys Health, Inc.
Peach State Health Plan, Inc.
Pennsylvania Health & Wellness, Inc.
SilverSummit Healthplan, Inc.
Sunflower State Health Plan, Inc.
Sunshine Health Plan Community Solutions, Inc.
Sunshine State Health Plan, Inc.
Superior HealthPlan Community Solutions, Inc.
Superior Healthplan, Inc.
Trillium Community Health Plan, Inc.
Western Sky Community Care, Inc.

Affiliates (Specialty Companies):
AcariaHealth, Inc.
Cenpatico Behavioral Health, LLC

Centurion, LLC
Envolve Benefits Options, Inc.
Envolve PeopleCare, Inc.
Envolve Pharmacy Solutions, Inc.
Envolve, Inc.
LifeShare Management Group LLC
U.S. Medical Management, LLC
VPA of Texas, PLLC, d/b/a Visiting Physicians Association
VPA, P.C., d/b/a Visiting Physicians Association

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

This PRODUCT ATTACHMENT ("***Attachment***") is made and entered between Carolina Complete Health, Inc., a North Carolina corporation ("Carolina Complete"), Carolina Complete Health Network, Inc., a Delaware corporation ("CCHN") and subsidiary of the North Carolina Medical Society and _____ ("***Provider***").

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

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

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

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

1. Defined Terms. For purposes of the Medicaid Product (as herein defined), the following terms have the meanings set forth below. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement, or, if not defined there, in the State Contract (as herein defined). All technical managed care terms used in this Attachment are defined in the Agreement or this Attachment, and are consistent with definitions included in Covered Person materials issued in conjunction with the Medicaid managed care program.

1.1 "***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 state law, rule, regulation, administrative hearing, or court order is not an amendment.

1.2 "***Clean Claim***" means a claim for services submitted to Carolina Complete by a Medicaid managed care medical or pharmacy services provider that can be processed without obtaining additional information from the submitter in order to adjudicate the claim.

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

1.4 "***Emergency Services***" means inpatient and outpatient services furnished by a qualified provider needed to evaluate or stabilize an Emergency Medical Condition.

1.5 "***Health Care Provider***" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes of North Carolina 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 of North Carolina or is owned or operated by the State of North Carolina in which health care services are provided to patients.

1.6 ***"Medicaid Product"*** refers to those programs and health benefit arrangements offered by Carolina Complete or other Company pursuant to a State Contract. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement.

1.7 "***Medically Necessary Service***" or "***Medically Necessary***" means those Covered Services that are within generally accepted standards of medical care in the State community, as verified by independent Medicaid consultants, and not experimental in nature.

1.8 "***Objective Quality Standards***" means the objective standards for quality determinations identified by Carolina Complete that assess a provider's ability to deliver care; include specific defined thresholds for adverse quality determinations; meet standards established by the National Committee on Quality Assurance (NCQA); and are not discriminatory.

1.9 "***Primary Care Provider***" or "***PCP***" means the participating physician, physician extender (e.g. physician assistant, nurse practitioner, certified nurse midwife) or group practice/center selected by or assigned to the Covered Person to provide and coordinate the Covered Person's health care needs and to initiate and monitor referrals for specialized services when required. Includes family practitioners, pediatricians, obstetricians, and internal medicine physicians.

1.10 "***State***" means North Carolina.

1.11 "***State Contract***" means a contract between Carolina Complete or other Company and one or more state Medicaid agency(ies), or any successors thereto, to provide specified services and goods to covered beneficiaries under state Medicaid-funded program(s) and to meet certain performance standards while doing so.

2. Medicaid Product.

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

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

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

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

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

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

4. State Mandated Program Requirements. Schedule A to this Product Attachment, which is incorporated herein by this reference, sets forth the provisions that are required by the applicable State Contract to be included in the Agreement with respect to the Medicaid Product. Any additional requirements that may apply to the Coverage Agreements or Covered Persons enrolled in or covered by this Product may be set forth in the Provider Manual or another Attachment and are incorporated herein by this reference.

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

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the North Carolina Medicaid Product under the State Contract.

1. Compliance.

1.1 Compliance with State and Federal Laws. Participating Provider understands and agrees that it, he or she 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 State Contract, and all persons or entities receiving state and federal funds. Participating 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 State Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. *(Section VII, Section G(3)(a)).*

1.2 Department Authority Related to the Medicaid Program. Participating Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services ("***NC DHHS***") 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. *(Section VII, G(3)(e)).*

1.3 Credentialing. Each Participating Provider shall be enrolled as a Medicaid provider as required by 45 C.F.R. § 455.410 and maintain enrollment for the term of the Agreement. Participating Provider shall maintain licensure, accreditation, and credentials sufficient to meet Carolina Complete's network participation requirements, as outlined in Carolina Complete's Provider Manual and its Credentialing and Re-credentialing Policy. Participating Provider shall notify Carolina Complete of changes in the status of any information relating to Participating Provider's professional credentials. Participating Provider shall complete reenrollment or re-credentialing before renewal of the Agreement as set forth below:

(a) during the provider credentialing transition period, no less frequently than every five (5) years; and

(b) during the provider credentialing under full implementation, no less frequently than every three (3) years, except as otherwise permitted by the NC DHHS. *(Section VII, G(1)(f))*

1.4 Liability Insurance. Participating Provider shall maintain professional liability insurance coverage in an amount acceptable to Carolina Complete. Participating Provider shall notify Carolina Complete of subsequent changes in the status of Participating Provider's professional liability insurance on a timely basis. *(Section VII, G(1)(g)).*

1.5 Utilization Management. Participating Provider shall comply with Carolina Complete's utilization management programs, quality management programs, and provider sanction programs, except to the extent that any of these programs conflict with Participating Provider's professional or ethical responsibility or interfere with Participating Provider's ability to provide information or assistance to patients. *(Section VII, G(1)(o)).*

1.6 Dispute Resolution. Participating Provider shall utilize the applicable dispute resolution procedures outlined in the Agreement to resolve disputes between Carolina Complete and Participating Provider. *(Section VII, G(1)(q)).*

1.7 Reporting Requirements. Participating Provider shall promptly provide Carolina Complete with the data and information that Carolina Complete requests in order to meet its reporting requirements under the State Contract. *(Section VII, J. Table 1).*

1.8 Hours of Operation. Participating Provider will offer hours of operation to Covered Persons that are not less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if Participating Provider serves only Medicaid or NC Health Choice members. *(Section V, D(1)(d)(iii)).*

2. Entire Agreement. The Agreement identifies the documents that constitute the entire contract between the parties. *(Section VII, G(1)(a)).*

3. Hold Harmless. Participating Provider agrees to hold the Covered Person harmless for charges for any Covered Service. Participating Provider agrees not to bill a Covered Person for Medically Necessary Services covered by Carolina Complete so long as the Covered Person is eligible for coverage. *(Section VII, G(3)(b)).* Participating Provider will not hold Covered Person's responsible for any of the following: (a) Carolina Complete's debts in the event of its insolvency; (b) Covered Services provided to the Covered Person for which: (i) NC DHHS does not pay Carolina Complete, or (ii) NC DHHS, or Carolina Complete, does not pay the Participating Provider; (c) payments for Covered Services furnished under a contract, referral or other arrangement, to the extent that those payments are in excess of the amount that the Covered Person would owe if Carolina Complete covered the services directly. 42 C.F.R. § 438.106. *(Section V, C(1)(i)(iii) and Section V, C(2)(r)(iii)).*

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

5. Non-Discrimination.

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

5.2 Interpreting and Translation Services. Participating Provider shall provide qualified sign language interpreters if closed captioning is not the appropriate auxiliary aid for the Covered Person. Participating Provider shall ensure that Participating Provider's staff are trained to appropriately communicate with patients with various types of hearing loss. Participating Provider shall report to Carolina Complete, in a format and frequency determined by Carolina Complete, whether hearing loss accommodations are needed and provided and the type of accommodation provided. *(Section VII, G(1)(t)).*

6. Term; Termination.

6.1 Term. This Attachment is coterminous with the Agreement, unless otherwise agreement by the parties, but in no event will the term of this Attachment exceed the term of the State Contract (including, for avoidance of doubt, any renewals of the State Contract) *(Section VII, G(1)(c)).*

6.2 Termination. The Agreement sets forth the basis for termination of the Agreement by either party and the related notice requirements. Notwithstanding anything in the Agreement or this Attachment to the contrary, Carolina Complete may immediately terminate the Agreement or this Attachment and a Participating Provider's participation thereunder upon: (1) a confirmed finding of fraud, waste or abuse by the NC DHHS or the North Carolina Department of Justice Medicaid Investigations Division, or (2) failure of the Participating Provider to maintain enrollment as a Medicaid provider. *(Sections VII, G(1)(d) and G(1)(f)(i))*.

6.3 Insolvency. If the Agreement or this Attachment terminates as a result of Carolina Complete's or Payor's insolvency, Participating Provider will cooperate in the transition of administrative duties and records and ensure the continuation of care when inpatient care is on-going in accordance with the requirements of the Agreement, this Attachment and the State Contract. If Carolina Complete or Payor provides for or arranges for the delivery of health care services on a prepaid basis, Participating Provider will continue inpatient care until the patient is ready for discharge. *(Section VII, G(1)(e))*.

7. Covered Person Services.

7.1 Covered Person Billing. Participating Provider shall not bill any Medicaid Managed Care Covered Person for Covered Services, except for specified coinsurance, copayments, and applicable deductibles. Participating Provider is responsible for collecting applicable deductibles, copayments, coinsurance and fees for non-Covered Services. This provision does not prohibit a Participating Provider and Covered Person from agreeing to continue non-Covered Services at the Covered Person's own expense, as long as the Participating Provider has notified the Covered Person in advance that a Payor may not cover or continue to cover specific services and the Covered Person to receive the services *(Section VII, G(1)(h))*.

7.2 Provider Accessibility. Participating Provider shall provide call coverage or other back-up to provide service in accordance with Carolina Complete's standards for provider accessibility addressed set forth herein, in the Provider Manual and/or in the State Contract. *(Section VII, G(1)(i))*. Participating Provider agrees to meet the NC DHHS standards for timely access to care and services, taking into account the urgency of need for services. *(Section V, D(1)(d)(ii))*. Participating Provider shall provide physical access, reasonable accommodations, including parking, exam and waiting rooms, and accessible equipment for Medicaid Covered Persons with physical or mental disabilities. *(Section V, (1)(d)(vi))*.

7.3 Eligibility Verification. Carolina Complete or Payor shall provide a mechanism that allows Participating Provider to verify Covered Person eligibility, based on current information held by Carolina Complete or Payor, as applicable, before rendering Covered Services. *(Section VII, G(1)(j))*.

7.4 Covered Person Appeals and Grievances. Participating Provider shall cooperate with Covered Person in regard to Covered Person appeals and grievance procedures. *(Section VII, G(1)(l))*. Participating Provider has the right to file a grievance or appeal. Carolina Complete's internal appeal processes must be completed before seeking other legal or administrative remedies under state or federal law. *(Section V, D(2)(c)(xi))*.

7.5 Appointment Wait Times. Participating Provider shall cooperate with Carolina Complete to ensure that appointment wait times for Covered Persons do not exceed the requirements set forth below, to the extent applicable. *(Section VII, F. Table 3)*.

(a) If Participating Provider is a PCP providing preventative care services, appointment wait time shall not exceed thirty (30) calendar days for adults (21 years of age and older) and children ages six (6) months to twenty (20) years of age, and fourteen (14) calendar days for children less than six (6) months of age.

(b) If Participating Provider is a PCP providing urgent care services, appointment wait time shall not exceed twenty-four (24) hours.

(c) If Participating Provider is a PCP providing services for routine/check-up without symptoms, appointment wait time shall not exceed thirty (30) calendar days.

(d) If Participating Provider is a PCP providing after-hours access for emergent and urgent care, care shall be administered immediately upon presentation at a service delivery site.

(e) If Participating Provider provides prenatal care, appointment wait time for initial appointments within the first or second trimester shall not exceed fourteen (14) calendar days and appointment wait time for initial appointments within the third trimester or for a high-risk pregnancy shall not exceed five (5) calendar days.

(f) If Participating Provider provides specialty care, appointment wait time shall not exceed twenty-four (24) hours for urgent care services or thirty (30) calendar days for routine/check-up without symptoms services. For after-hours access for emergent and urgent care, care shall be administered immediately upon immediately upon presentation at a service delivery site.

(g) If Participating Provider provides behavioral health care, appointment wait time shall not exceed thirty (30) minutes for Mobile Crisis Management Services; twenty-four (24) hours for Urgent Care Services for Mental Health or Urgent Care Services for SUDs; and fourteen (14) calendar days for Routine Services for Mental Health or Routine Services for SUDs. For Emergency Services for Mental Health or SUDs, care should administered immediately upon presentation at a service delivery site.

(h) To the extent Participating Provider performs Emergency Services, Participating Provider shall make Emergency Services available twenty-four (24) hours a day, three hundred sixty-five (365) days a year.

8. Records.

8.1 Medical Records. Participating Provider shall maintain confidentiality of Covered Person medical records and personal information and other health records as required by law. Participating Provider shall maintain adequate medical and other health records according to industry and Carolina Complete standards. Participating Provider shall make copies of such records available to Carolina Complete, Payor and NC DHHS in conjunction with its regulation of Carolina Complete. Participating Provider shall make available and furnish the records immediately upon request in either paper or electronic form, at no cost to the requesting party. *(Section VII, G(1)(k))*.

8.2 Access to Provider Records.

(a) Participating Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to Carolina Complete or Payor and the Agreement and any records, books, documents, and papers that relate to Carolina Complete or Payor and the Agreement and/or Participating 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: (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) 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; and (ix) any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

(c) 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. *(Section VII, G(3)(f))*.

9. Provider Ownership Disclosure. Participating 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. Participating Provider agrees to notify, in writing, Carolina Complete and the NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction. *(Section VII, G(3)(g))*.

10. Provider Payment.

10.1 Methodology. The Agreement includes a provider payment provision that describes the methodology to be used as a basis for payment. Such provision does not include a rate methodology that provides for automatic increases in rates, consistent with N.C. Gen. Stat. 58-3-227(a)(5). *(Section VII, G(1)(m))*.

10.2 G.S. 58-3-225, Prompt Claim Payments under Health Benefit Plans. Unless otherwise provided by the NC DHHS's Advanced Medical Home Program Policy, Pregnancy Management Program Policy, Care Management for High-Risk Pregnancy Policy, or Care Management for At-Risk Children Policy, Participating Provider shall submit all claims to the Payor for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Participating Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Participating 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. *(Section VII, G(3)(h))*.

(a) For medical claims (including behavioral health), Payor shall comply with the requirements set forth below.

(i) The Payor shall within eighteen (18) calendar days of receiving a Medical Claim notify Participating Provider whether the claim is a Clean Claim, or pend the claim and request from Participating Provider all additional information needed to process the claim.

(ii) The Payor 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.

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

(b) For pharmacy claims, Payor shall comply with the requirements set forth below.

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

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

(c) 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 Payor shall deny

the claim per § 58-3-225 (d). The Payor shall reprocess medical and pharmacy claims in a timely and accurate manner as described in this provision (including interest and penalties if applicable).

(d) If the Payor fails to pay a Clean Claim in full pursuant to this provision, the Payor shall pay 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.

(e) Failure to pay a Clean Claim within thirty (30) days of receipt will result in the Payor paying 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.

(f) The Payor shall pay the interest and penalty from subsections (e) and (f) as provided in that subsection, and shall not require Provider to requests the interest or the penalty.

10.3 Government Funds. Participating Provider and Carolina Complete acknowledge that funds used for provider payments are government funds. (Section VII, G (1)(s)).

11. Data to Provider. Carolina Complete will provide certain data and information to the Provider, and changes to such information, which may include performance feedback report if compensation is related to efficiency criteria, information on benefit exclusions, administrative and utilization management requirements; credential verification programs; quality assessment programs; and provider sanction policies *(Section VII, G(1)(n))*.

12. Provider Directory. Participating Provider authorizes Carolina Complete and/or Payor to include, and Carolina Complete and/or Payor shall include, the name of Participating Provider and/or Participating Provider's group in the provider directory distributed to Covered Persons. *(Section VII, G (1)(p))*.

13. Assignment. Participating Provider shall not assign, delegate, or transfer any of its duties and/or responsibilities under the Agreement without prior written consent of Carolina Complete. Carolina Complete shall notify Provider in writing of any duties or obligations that are to be delegated or transferred, before the delegation or transfer. (Section VII, G (1)(r)).

14. Providers of Perinatal Care: To the extent that Participating Provider offers prenatal, perinatal, and postpartum services or is an obstetrician, Participating Provider shall comply with NC DHHS's Pregnancy Management Program. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes and reducing health care costs among participating providers. Participating Provider shall: (a) complete the standardized risk-screening tool at each initial visit; (b) allow Carolina Complete or Carolina Complete's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators; (c) commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation; (d) commit to decreasing the cesarean section rate among nulliparous women; (e) 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; (f) complete a high-risk screening on each pregnant Medicaid Managed Care Covered Person in the program and integrate the plan of care with local pregnancy care management; (g) decrease the primary cesarean delivery rate if the rate is over NC DHHS's designated cesarean rate (NC DHHS will set the rate annually at or below twenty percent (20%)); and (h) ensure comprehensive post-partum visits occur within fifty-six (56) days of delivery *(Section VII, G(1)(u)) and M(3))*.

14.1 High-Risk Pregnancies Information Requirement. Participating Provider shall send all screening information and applicable medical record information for Covered Persons in the Care Management of High-Risk Pregnancies to Carolina Complete and the Local Health Departments or other applicable local care management entities that are contracted for the provision of providing care management services for high risk pregnancy within one business day of the provider completing the screening (Section VII, M(3.3.i.)).

15. Advanced Medical Homes. To the extent Participating Provider is an Advanced Medical Home (AMH), Participating Provider shall comply with NC DHHS' Advanced Medical Home Program, including the requirements set forth below. *(Section VII, G(1)(v))*.

15.1 Identified as PCP. Participating Provider shall accept Covered Persons and be listed as a PCP in Carolina Complete's Covered Person-facing materials for the purpose of providing care to Covered Persons and managing their health care needs.

15.2 Care Coordination Services. Participating Provider shall provide primary care and patient care coordination services to each Covered Person, in accordance with Carolina Complete policies.

15.3 Primary Care Coverage. Participating 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.

15.4 Minimum Office Hours. Participating Provider shall provide direct patient care a minimum of 30 office hours per week.

15.5 Preventive Services. Participating Provider shall provide preventive services, in accordance with Section VII. Attachment M. Table 1: Required Preventive Services of the State Contract as set forth on Attachment A: Medicaid, Appendix A to Schedule A, Governmental Program Requirements to the Agreement.

15.6 Unified Medical Record. Participating Provider shall maintain a unified patient medical record for each Covered Person following the Carolina Complete's medical record documentation guidelines.

15.7 Referrals. Participating Provider shall promptly arrange referrals for Medically Necessary health care services that are not provided directly and document referrals for specialty care in the medical record.

15.8 Medical Record Transfer. Participating Provider shall transfer the Covered Person medical record to the receiving provider upon the change of PCP at the request of the new PCP or Carolina Complete (if applicable) and as authorized by the Covered Person within thirty (30) days of the date of the request, free of charge.

15.9 Appointments. Participating Provider shall authorize care for the Covered Person or provide care for the Covered Person based on the standards of appointment availability as defined by the Carolina Complete's network adequacy standards.

15.10 Second Opinion. Participating Provider shall refer for a second opinion as requested by the Covered Person, based on NC DHHS guidelines and Carolina Complete standards.

15.11 Utilization Management. Participating Provider shall review and use Covered Person utilization and cost reports provided by Carolina Complete for the purpose of AMH level utilization management and advise Carolina Complete of errors, omissions, or discrepancies if they are discovered.

15.12 Enrollment Report. Participating Provider shall review and use the monthly enrollment report provided by Carolina Complete for the purpose of participating in Carolina Complete or practice-based population health or care management activities. *(Section VII, M(2))*

15.13 Advanced Medical Home Tier 3 Standard Terms and Conditions. If Provider or a Contracted Provider is a Tier 3 Advanced Medical Home ("AMH") Participating Provider, the Agreement must include provisions that outline the AMH Tier 3 care management model and requirements consistent with the State Contract as set forth below. *(Section VII, M(2 - 4 (a-e))*

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. The Carolina Complete shall maintain a contractual relationship with the AMH (not the CIN).

15.13.1 Tier 3 AMH practices must be able to risk stratify all empaneled patients.

(a) The Tier 3 AMH practice must ensure that assignment lists transmitted to the practice by the Carolina Complete are reconciled with the practice's panel list and up to date in the clinical system of record.

(b) The Tier 3 AMH practice must use a consistent method to assign and adjust risk status for each assigned patient.

(c) The Tier 3 AMH practice must use a consistent method to combine risk scoring information received from the Carolina Complete with clinical information to score and stratify the patient panel.

(d) The Tier 3 AMH practice must, to the greatest extent possible, ensure that the method is consistent with the Contract of identifying "priority populations" for care management.

(e) The Tier 3 AMH practice 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.

(f) The Tier 3 AMH practice must define the process and frequency of risk score review and validation.

15.13.2 Tier 3 AMH practices must be able to define the process and frequency of risk score review and validation.

(a) The Tier 3 AMH practice must use its risk stratification method to identify patients who may benefit from care management.

(b) The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient 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:

i) Patients immediate care needs and current services;
ii) Other state or local services currently used;
iii) Physical health conditions, including dental;
iv) Current and past behavioral and mental health and substance use status and/or disorders;
v) Physical, intellectual developmental disabilities;
vi) Medications — prescribed and taken;
vii) Priority domains of social determinants of health (housing, food, transportation, and interpersonal safety);
viii) Available informal, caregiver, or social supports, including peer supports.

(c) The Tier 3 AMH practice 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 patients.

(d) For each high-need patient, the Tier 3 AMH practice 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.

15.13.3 Tier 3 AMH practices must use a documented Care Plan for each high-need patient receiving care management.

(a) The Tier 3 AMH practice must develop the Care Plan within thirty (30) days of Comprehensive Assessment, or sooner if feasible, while ensuring that needed treatment is not delayed by the development of the Care Plan.

(b) The Tier 3 AMH practice must develop the Care Plan so that it is individualized and person-centered, using a collaborative approach including patient and family participation where possible.

(c) The Tier 3 AMH practice must incorporate findings from the Carolina Complete Care Needs Screening/risk scoring, practice-based risk stratification and Comprehensive Assessment with clinical knowledge of the patient into the Care Plan.

(d) The Tier 3 AMH practice must include, at a minimum, the following elements in the Care Plan:

i) Measurable patient (or patient and caregiver) goals
ii) Medical needs including any behavioral health and dental needs;
iii) Interventions, including medication management and adherence;
iv) Intended outcomes; and
Social, educational, and other services needed by the patient.

(e) The Tier 3 AMH practice must have a process to update each Care Plan as Member needs change and/or to address gaps in care; including, at a minimum, review and revision upon re-assessment.

(f) The Tier 3 AMH practice must have a process to document and store each Care Plan in the clinical system of record.

(g) The Tier 3 AMH practice must periodically evaluate the care management services provided to high-risk, high-need patients by the practice to ensure that services are meeting the needs of empaneled patients, and refine the care management services as necessary.

(h) The Tier 3 AMH practice must track empaneled patients' 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 patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.

(i) The Tier 3 AMH practice or CIN must implement a systematic, clinically appropriate care management process for responding to certain high-risk ADT alerts (indicated below).

i) Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
ii) 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;

iii) Within a several-day period to address outpatient needs or prevent future problems for high risk patients who have been discharged from a hospital or ED (e.g., to assist with scheduling appropriate follow-up visits or medication reconciliations post discharge)

15.13.4 Tier 3 AMHs must be able to provide short-term, transitional care management along with medication reconciliation to all empaneled patients who have an emergency department (ED) visit or hospital admission / discharge / transfer and who are at risk of readmissions and other poor outcomes.

(a) The Tier 3 AMH practice must have a methodology or system for identifying patients in transition who are at risk of readmissions and other poor outcomes that considers all of the following:

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

(b) For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice 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.

(c) The Tier 3 AMH practice must include the following elements in transitional care management:

i) Ensuring that a care manager is assigned to manage the transition
ii) Facilitating clinical handoffs;
iii) Obtaining a copy of the discharge plan/summary;
iv) Conducting medication reconciliation;
v) Following-up by the assigned care manager rapidly following discharge;
vi) Ensuring that a follow-up outpatient, home visit or face to face encounter occurs; and
vii) Developing a protocol for determining the appropriate timing and format of such outreach.

15.13.5 Tier 3 AMH practices must use electronic data to promote care management.

(a) The Tier 3 AMH practice must receive claims data feeds (directly or via a CIN) and meet state-designated security standards for their storage and use.

16. Care Management for High-Risk Pregnancy. To the extent Participating Provider is a Local Health Department ("***LHD***") offering care management for high-risk pregnancy, this Section applies. Care Management for High-Risk Pregnancy refers to care management services provided to a subset of high-risk pregnant women by LHDs *(Section VII, M(4))*.

16.1 General Contracting Requirement. Participating Provider shall accept referrals from Carolina Complete for Care Management for High-Risk Pregnancy Services. Participating Provider shall comply with the requirements NC DHHS' Care Management for High-Risk Pregnancy Policy.

16.2 Care Management for High-Risk Pregnancy: Outreach. Participating Provider 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. Participating Provider 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.

16.3 Care Management for High-Risk Pregnancy: Population Identification and Engagement. Participating Provider 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 (5) calendar days of receipt of risk screening forms. Participating Provider 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. Participating Provider 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. Participating Provider shall review available Carolina Complete 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 Participating Provider. Participating Provider 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.

16.4 Care Management for High-Risk Pregnancy: Assessment and Risk Stratification. Participating Provider 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. Participating Provider shall utilize assessment findings, including those conducted by Carolina Complete to determine level of need for care management support. Participating Provider shall document assessment findings in the care management documentation system. Participating Provider 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. Participating Provider shall assign case status based on level of patient need.

16.5 Care Management for High-Risk Pregnancy: Interventions. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients 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. Participating Provider shall provide care management services based upon level of patient need as determined through ongoing assessment. Participating Provider shall develop patient-centered care plans, including appropriate goals, interventions and tasks. Participating Provider shall utilize NC Resource Platform and identify additional community resources once NC DHHS has certified it as fully functional. Participating Provider shall refer identified population to childbirth education, oral health, behavioral health or other needed services included in the Covered Person's Carolina Complete network. Participating Provider shall document all care management activity in the care management documentation system.

16.6 Care Management for High-Risk Pregnancy: Integration with Carolina Complete and Providers. Participating Provider shall assign a specific care manager to cover each Pregnancy Management Program provider within the county or serving residents of the county. Participating Provider shall ensure that an embedded or otherwise designated care manager has an assigned schedule indicating their presence within the Pregnancy Management Program. Participating Provider shall establish a cooperative working relationship and mutually-agreeable methods of patient-specific and other ongoing communication with the Pregnancy Management Program providers. Participating Provider 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. Participating Provider shall assure the assigned care manager participates in relevant Pregnancy Management Program meetings addressing care of patients in the target population. Participating Provider shall ensure awareness of Carolina Complete Covered Persons' "in network" status with providers when organizing

referrals. Participating Provider shall ensure understanding of Carolina Complete's prior authorization processes relevant to referrals.

16.7 Care Management for High-Risk Pregnancy: Collaboration with Carolina Complete. Participating Provider shall work with Carolina Complete to ensure program goals are met. Participating Provider shall review and monitor Carolina Complete reports created for the Pregnancy Management Program and Care Management for High Risk Pregnancy services to identify individuals at greatest risk. Participating Provider shall communicate with Carolina Complete regarding challenges with cooperation and collaboration with Pregnancy Management Program and non-Pregnancy Management Program prenatal care providers. Participating Provider shall participate in pregnancy care management and other relevant meetings hosted by Carolina Complete.

16.8 Care Management for High-Risk Pregnancy: Training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by Carolina Complete and/or NC DHHS, including webinars, new hire orientation or other programmatic training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by Carolina Complete and/or NC DHHS. Participating Provider 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. Participating Provider shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

16.9 Care Management for High-Risk Pregnancy: Staffing.

(a) Participating Provider shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications: registered nurse; or social worker 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. Participating Provider 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. Participating Provider 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. If the Participating Provider only has a single Care Manager for High-Risk Pregnancy, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider 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 patients with both medically and socially complex conditions. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Carolina Complete /NC DHHS guidance about communication with Carolina Complete about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by Carolina Complete.

(b) Participating Provider 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.

(c) Participating Provider 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.

17. Care Management for At-Risk Children. To the extent Participating Provider is a LHD offering care management for at-risk children, this Section applies. Care Management for At-Risk Children is care management services provided by to a subset of the Medicaid population ages 0-5 identified as being "high-risk" *(Section VII, M(5))*.

17.1 Care Management for At-Risk Children: General Requirements. Participating Provider shall accept referrals from Carolina Complete for children identified as requiring Care Management for At-Risk Children. Participating Providers shall comply with the requirements of NC DHHS' Care Management for At-Risk Children Policy.

17.2 Care Management for At-Risk Children: Outreach. Participating Provider 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. Participating Provider 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. Participating Provider shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county. Participating Provider shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population. Participating Provider 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 NC DHHS.

17.3 Care Management for At-Risk Children: Population Identification. Participating Provider shall use any claims-based reports and other information provided by Carolina Complete, as well as Care Management for At-Risk Children Referral Forms received to identify priority populations. Participating Provider shall establish and maintain contact with referral sources to assist in methods of identification and referral for the target population. Participating Provider 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.

17.4 Care Management for At-Risk Children: Family Engagement. Participating Provider shall involve families (or legal guardian when appropriate) in the decision-making process through a patient-centered, collaborative partnership approach to assist with improved self-care. Participating Provider shall foster self-management skill building when working with families of children. Participating Provider shall prioritize face-to-face family interactions (home visit, PCP office visit, hospital visit, community visit, etc.) over telephone interactions for children in active case status, when possible.

17.5 Care Management for At-Risk Children: Assessment and Stratification of Care Management Service Level. Participating Provider shall use the information gathered during the assessment process to determine whether the child meets the Care Management for At-Risk Children target population description. Participating Provider shall review and monitor Carolina Complete reports created for Care Management for At-Risk Children, along with the information obtained from the family, to assure the child is appropriately linked to preventive and primary care services and to identify individuals at risk. Participating Provider shall use the information gained from the assessment to determine the need for and the level of service to be provided.

17.6 Care Management for At-Risk Children: Plan of Care. Participating Provider shall provide information and/or education to meet families' needs and encourage self-management using materials that meet

literacy standards. Participating Provider shall ensure children/families are well-linked to the child's Advanced Medical Home or other practice; provide education about the importance of the medical home. Participating Provider shall provide care management services in accordance with program guidelines, including condition-specific pathways, utilizing those interventions that are most effective in engaging patients, meeting their needs and achieving care plan goals. Participating Provider shall identify and coordinate care with community agencies/resources to meet the specific needs of the child; use any locally-developed resource list (including NC Resource Platform) to ensure families are well linked to resources to meet the identified need. Participating Provider shall provide care management services based upon the patient's level of need as determined through ongoing assessment.

17.7 Care Management for At-Risk Children: Integration with Carolina Complete and Providers. Participating Provider shall collaborate with Advanced Medical Home/PCP/care team to facilitate implementation of patient-centered plans and goals targeted to meet individual child's needs. Participating Provider shall ensure that changes in the care management level of care, need for patient 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. Where care management is being provided by Carolina Complete and/or Advanced Medical Home practice in addition to the Care Management for At-Risk program, the Carolina Complete/AMH practice must explicitly agree on the delineation of responsibility and document that agreement in the child's Plan of Care to avoid duplication of services Participating Provider shall ensure that changes in the care management level of care, need for patient 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 Carolina Complete. Participating Provider shall ensure awareness of Carolina Complete Covered Person's "in network" status with providers when organizing referrals. Participating Provider shall ensure understanding of Carolina Complete's prior authorization processes relevant to referrals.

17.8 Care Management for At-Risk Children: Service Provision. Participating Provider shall document all care management activities in the care management documentation system in a timely manner. Participating Provider 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.

17.9 Care Management for At-Risk Children: Training. Participating Provider shall participate in NC DHHS/ Carolina Complete-sponsored webinars, trainings and continuing education opportunities as provided. Participating Provider shall pursue ongoing continuing education opportunities to stay current in evidence-based care management of high risk children.

17.10 Care Management for At-Risk Children: Staffing.

(a) Participating Provider shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications: registered nurse; or social worker 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. Participating Provider 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 patients with both medically and socially complex conditions. Participating Provider 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. If the Participating Provider has only has a single Care Management for At-Risk Children care manager, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall maintain services during the event of an extended vacancy. In the event of an extended vacancy, Participating Provider 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. Participating

Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following NC DHHS guidance regarding vacancies or extended staff absences and adhering to NC DHHS guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days will be subject to additional oversight. Participating Provider shall ensure that supervisors who carry a caseload must also meet the Care Management for At-Risk Children care management competencies and staffing qualifications. Participating Provider 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.

(b) Participating Provider 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.

(c) Participating Provider 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.

18. N.C. Gen. Stat. Ch. 58 Requirements.

18.1 N.C. Gen. Stat. § 58-3-200(c), Coverage Determinations. If Carolina Complete or Payor determines that services, supplies or other items are Covered Services, Carolina Complete or Payor shall not subsequently retract its determination after such services have been provided, or reduce payments for such services furnished in reliance on such a determination, unless the determination was based on a material misrepresentation about the Covered Person's health condition that was knowingly made by the Covered Person or the provider of the service, supply or other item. *(Section VII, G (1)(x)(i))*.

18.2 N.C. Gen. Stat. § 58-3-227(h), Contract Negotiations. When offering a contract to a Health Care Provider, Carolina Complete or Payor shall make available to Health Care Provider its schedule of fees associated with the top 30 services or procedures most commonly billed by the class of Provider. Upon the request of the Health Care Provider, Carolina Complete or Payor shall also make available the full schedule of fees for services or procedures billed by that class of provider(s). If Health Care Provider requests fees for more than 30 services and procedures, Carolina Complete or Payor may require the Health Care Provider to specify the additional requested services and procedures and may limit the Health Care 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 such Health Care Provider. *(Section VII, G(1)(x)(ii))*.

18.3 N.C. Gen. Stat. § 58-50-275(a)-(b), Notice Contact. Provider and Carolina Complete have set forth in the Agreement a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed Amendments and other notices, pertaining to the contractual relationship between the Parties shall be sent. Notwithstanding anything in the Agreement to the contrary, means for sending all notices provided under the Agreement is one or more of the following, calculated as (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 section prohibits the use of an electronic medium for a communication other than an Amendment if agreed to by Carolina Complete and Provider (Section VII, G(1)(x)(iv)).

18.4 N.C. Gen. Stat. § 58-50-280(a)-(d), Proposed Amendment. Carolina Complete shall date, label "Amendment," sign, include an effective date, and send any proposed Amendment to this Agreement or this

Attachment to the notice contact of Provider. Provider will have sixty (60) days from the date of receipt to object to the proposed Amendment in writing. If Provider fails to object in writing within such sixty (60) days, the Amendment will be effective. If Provider timely objects to a proposed Amendment in writing, then Carolina may terminate the Agreement or this Attachment upon sixty (60) days' written notice to Provider. *(Section VII, G(1)(x)(v)).*

18.5 N.C. Gen. Stat. § 58-50-285 (a)-(b), Policies and Procedures. Carolina Complete or Payor shall provide a Health Care Provider with a copy of its policies and procedures prior to execution of a new or amended contract and annually to all Participating Providers. Such policies and procedures may be provided in hard copy, CD or other electronic format, and may also be provided by posting the policies and procedures on the Carolina Complete or Payor website. Such policies and procedures will 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. (Section VII, G(1)(x)(vi)).

18.6 N.C. Gen. Stat. § 58-51-37(d)-(e), Pharmacy Participation. To the extent Participating Provider is a pharmacy or pharmacist, this Section applies. Participating Provider shall not waive, discount, rebate, or distort a copayment or a Covered Person's portion of a prescription drug coverage or reimbursement. If Participating Provider provides a pharmacy service to a Covered Person that meets the terms and requirements of the Coverage Agreement, Participating Provider shall provide its pharmacy services to all Covered Persons covered by that Coverage Agreement on the same terms and requirements. A violation of the foregoing is a violation of the Pharmacy Practice Act subjecting the pharmacist to disciplinary authority of the North Carolina Board of Pharmacy. At least sixty (60) days before the effective date of a Payor providing reimbursement to North Carolina residents for prescription drugs, which restricts pharmacy participation, Carolina Complete or Payor shall notify, in writing, all pharmacies within the geographical coverage area of the Coverage Agreement and offer to the pharmacies the opportunity to participate under identical reimbursement terms for providing pharmacy services, including prescription drugs. Carolina Complete shall, through reasonable means, on a timely basis, and on regular intervals in order to effectuate the purposes of this section, inform the Covered Persons of the Coverage Agreement 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 their customers through a means acceptable to the pharmacy and Carolina Complete. The pharmacy notification provisions of this section do not apply when an individual or group is enrolled, but when Carolina Complete enters a particular county of the State. *(Section VII, G(1)(x)(vii)).*

19. Indian Health Care Providers. To the extent Participating Provider is an Indian Health Care Provider, Participating Provider shall execute and comply with the Medicaid Managed Care Addendum for Indian Health Care Providers. *(Section VII, H).*

20. Conflict of Interest. Participating Provider will comply with all applicable federal and state conflict of interest laws, including Section 1902(a)(4)(C) of the Social Security Act, 42 C.F.R. § 438.58, and N.C. Gen. Stat. §§ 108A-65 and 143B-139.6C. Participating Provider agrees that financial considerations will not influence decisions to provide medically appropriate care. Participating Provider shall abide by his or her professional obligations to patients and Covered Persons and will not take any actions that conflict with such obligations. *(Section V, A.9.i)*

21. Vaccines for Children Program. If Participating Provider is a Primary Care Provider who services Covered Persons under age 19, Participating Provider is encouraged to participate in the Vaccines for Children Program. If Participating Provider is a Primary Care Provider, Participating Proivder will administer vaccines consistent with the AAP/Bright Future periodicity schedule. *(Section V, C(1)(c)(ix)* and *Section V, C(2)(v)(vii)).*

22. PCPs. If Participating Provider is a Primary Care Provider, Participating Provider will: (a) perform, during preventive service visits, and as necessary at any visit, oral health assessments, evaluations, prophylaxis and oral hygiene counseling for children under twenty-one (21) years of age in accordance with the NC DHHS's Oral Health Periodicity Schedule; (b) refer infant Medicaid Covered Persons to a dentist or a dental professional working under the supervision of a dentist at age one (1), per the requirements of the NC DHHS's Oral Health Periodicity Schedule; and (c) include all of the following components in each medical screening: (i) routine physical examinations as

recommended and updated by the American Academy of Pediatrics (AAP) "Guidelines for Health Supervision III" and described in "Bright Futures: Guidelines for Health Supervision of Infants, Children and Adolescents", screening for developmental delay at each visit through the 5th year and screening for Autistic Spectrum Disorders per AAP guidelines, (ii) comprehensive, unclothed physical examination, (iii) all appropriate immunizations, in accordance with the schedule for pediatric vaccines established by the Advisory Committee on Immunization Practices, (iv) laboratory testing (including blood lead screening appropriate for age and risk factors); and (e) health education and anticipatory guidance for both the child and caregiver. *(Section V, C.2.i)*.

23. Behavioral Health Providers. If Participating Provider is a behavioral health provider, Participating Provider will coordinate with Primary Care Providers and specialists conducting EPSDT screenings. *(Section V, C.2.j)*.

24. 340B Covered Entities. If Participating Provider is a 340B covered entity, the Participating Provider will: (a) submit National Council for Prescription Drug Programs (NCPDP) code "08" in Basis of Cost Determination field 423-DN or in Compound Ingredient Basis of Cost Determination field 490-UE at the point of sale to identify claims submitted for drugs purchased through the 340B program; (b) identify outpatient hospital and physician-administered drug claims submitted for drugs purchased through the 340B program using a UD modifier or other claim modifiers defined by the NC DHHS (42 C.F.R. § 438.3(s)(3)); (c) comply with the point of sale identification of drugs purchased through the 340B program (42 C.F.R. § 438.3(s)(3)); and (d) resubmit the claims with the appropriate NCPDP 340B claims identification codes when 340B claims are retroactively identified (42 C.F.R. § 438.3(s)(3)). *(Section V, C(3)(i)(v))*.

25. Exclusion. Participating Provider represents and warrants that he, she or it is not excluded from participation in federal health care programs under either section 1128 or 1128A of the Social Security Act. 42 C.F.R. § 438.610(b). Participating Provider will immediately notify Carolina Complete in writing upon any change regarding foregoing. *(Section V, D(2)(c)(iv))*.

26. High Level Clinical Setting Discharge. Participating Provider will notify Carolina Complete when a Covered Person in a high level clinical setting is being discharged. For the purpose of this section, a High Level Clinical Setting includes but is not limited to:

(a) Hospital/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
(g) ADATC

(Section V, D(2)(c)(xiv)).

27. Claim Submission. Participating Provider will not submit claim or encounter data for services covered by Medicaid managed care and Carolina Complete directly to the NC DHHS. *(Section V, D(2)(c)(xviii))*.

28. Provider Preventable Conditions. Participating Provider will comply with 42 C.F.R. § 438.3(g), which, at a minimun, means non-payment of provider-preventable conditions as well as appropriate reporting, as required by Carolina Complete. *(Section V, D(2)(d)(ii))*.

29. Program Integrity. Participating Provider: (a) will 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; (b) will have policies and procedures that recognize and accept Medicaid as "the payer of last resort"; and (c) is prohibited from billing Covered Persons for Covered Services any amount greater than would be owed if the Participating Provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2). *(Section V, D(2)(f); Section V, J(2)(b)(iii)(c))*.

30. No Auto-Enrollment in Other Products. Carolina Complete will not require individual practitioners, as a condition of contracting with it, to agree to participate or accept other products offered by the Carolina Complete nor will Carolina Complete automatically enroll the provider in any other product offered by it. This requirement does not apply to facility providers. *(Section V, D(2)(c) (viii))*

31. Grievance and Appeals. Carolina Complete shall handle appeals and grievances raised by Provider in connection with the Medicaid Product promptly, consistently, fairly, and in compliance with state and federal law and Department requirements, through an appeals and grievance system that is distinct from that offered to Covered Persons. Such appeals and grievance system, additional information about which is set forth in the Provider Manual, shall meet the requirements set forth below:

(a) Grievances. Carolina Complete will have a process in place to receive and resolve complaints or disputes with Provider, in a timely manner, where remedial action is not requested. Carolina Complete will accept and resolve Provider's grievances regarding Carolina Complete that are referred from the Department. Carolina Complete will make available to Provider a method for submitting grievances through Carolina Complete's provider portal.

(b) Appeals. Carolina Complete will offer Provider appeal rights as described in the State Contract and Provider Manual. Carolina Complete will provide written notice of Provider's right to appeal along with any notice of a decision giving rise to Provider's right to appeal. Carolina Complete will make available to Provider a method for submitting appeals through Carolina Complete's provider portal. Carolina Complete will accept a written request for an appeal from Provider within thirty (30) calendar days of the date on which (i) Provider received written notice from Carolina Complete of the decision giving rise to the right to appeal; or (ii) Carolina Complete should have taken a required action and failed to take such actions. Carolina Complete will acknowledge receipt of each appeal request within five (5) calendar days of receipt of the request, and will extend such timeframe by thirty (30) calendar days if Provider's request is for an appeal for good cause shown, as determined by Carolina Complete. Carolina Complete will consider the voluminous nature of required evidence/supporting documentation, and the appeal of an adverse quality decision, as good cause reasons to extend such timeframe. Provider shall exhaust Carolina Complete's internal appeals process before seeking recourse under any other process permitted by contract or law.

(c) Resolution of Appeal. Carolina Complete will establish a committee to review and make decisions on Provider's appeals, which committee will consist of at least three (3) qualified individuals who were not involved in the original decision, action, or inaction giving rise to the right to appeal, as well as an external peer reviewer when the issue on appeal involves whether the provider met the Objective Quality Standards. Carolina Complete will provide written notice of decision of the appeal (which notice shall include information regarding further appeal rights) within thirty (30) calendar days of receiving a complete appeal request, or if an extension is granted to the provider to submit additional evidence, the date on which all evidence is submitted to Carolina Complete. Provider may be represented by an attorney during the appeals process.

(d) Appeals of Suspension or Withhold of Provider Payment. In cases of the suspension or withholding of Provider payments, Carolina Complete will limit the issue on appeal to whether Carolina Complete had good cause to commence the withholding or suspension of payments to Provider; Carolina Complete will not address whether Provider has or has not committed fraud or abuse. Carolina Complete will offer Provider an in-person or telephone hearing when Provider is appealing whether Carolina Complete has good cause to withhold or suspend payments to Provider. Carolina Complete will schedule such hearing and issue a written decision regarding whether Carolina Complete had good cause to suspend or withhold payments within fifteen (15) business days of receiving Provider's appeal. Upon a finding that Carolina Complete did not have good cause to suspend or withhold payments, Carolina Complete will reinstate any payments that were withheld or suspended within five (5) business days. Carolina Complete will pay interest and penalties for overturned denials, underpayments, or findings that it did not have good cause to suspend or withhold payment from the original Date of Payment, suspension, withhold or denial. *(Attachment G-1.q)*

32. Contract Amendments with Individual Providers. For the purposes of this Section 32 only, the following terms shall have the following definitions:

(i) "***Amendment***" shall mean any change to the terms of this Medicaid Product Attachment, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an Amendment.

(ii) "***Contract***" shall mean this Agreement, which is an agreement between Carolina Complete and Provider for the provision of health care services by the provider on a preferred or in-network basis.

(iii) "***Health Benefit Plan***" shall mean a policy, certificate, contract, or plan as defined in N.C. Gen. Stat. §58-3-167.

(iv) "***Health Care Provider***" shall mean Provider if Provider is 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.

(v) "***Insurer***" shall mean Carolina Complete (as otherwise defined herein), which is an entity as defined in N.C. Gen. Stat. §58-3-227(a)(4).

Insurer shall send any proposed Contract Amendment to the notice contact of Health Care Provider pursuant to N.C. Gen. Stat. §58-50-275. The proposed Amendment shall be dated, labeled "Amendment," signed by the Insurer, and include an effective date for the proposed Amendment. Health Care Provider receiving a proposed Amendment shall be given at least sixty (60) days from the date of receipt to object to the proposed Amendment. The proposed Amendment shall be effective upon Health Care Provider failing to object in writing within sixty (60) days. If Health Care Provider objects to a proposed Amendment, then the proposed Amendment is not effective and the initiating Insurer shall be entitled to terminate the Contract upon sixty (60) days written notice to Health Care Provider. Nothing in this Part prohibits Health Care Provider and Insurer from negotiating Contract terms that provide for mutual consent to an Amendment, a process for reaching mutual consent, or alternative notice contacts. *(Attachment G-1.x.iii)*

APPENDIX A TO
SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

Section VII Attachment M.2. Table 1: Required Preventive Services													
		Required for providers who serve the following age ranges (The age ranges are not displayed to the provider on this screen. The age ranges will be used in PEGA workflow for approval and verification purposes.)											
Reference Number	**AMH Preventative Health Requirements**	**0 to 3**	**0 to 6**	**0 to 11**	**0 to 18**	**0 to 21**	**0 to 121**	**3 to 17**	**7 to 120**	**11 to 18**	**11 to 121**	**18 to 121**	**21 to 121**
1	Adult Preventative and Ancillary Health Assessment						Y		Y		Y	Y	Y
2	Blood Lead Level Screening	Y	Y	Y	Y	Y	Y						
3	Cervical Cancer Screening (applicable to Females only)						Y		Y		Y	Y	Y
4	Diphtheria, Tetanus Pertussis Vaccine (DTaP)	Y	Y	Y	Y	Y	Y	Y					
5	Haemophilus Influenzae Type B Caccine Hib	Y	Y	Y	Y	Y	Y	Y					
6	Health Check Screening Assessment	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
7	Hearing		Y	Y	Y	Y	Y	Y	Y	Y	Y		
8&9	Hemoglobin or Hematocrit	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
10	Hepatitis B Vaccine	Y	Y	Y	Y	Y	Y	Y					
11	Inactivated Polio Vaccine (IPV)	Y	Y	Y	Y	Y	Y	Y					
12	Influenza Vaccine	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
13	Measles, Mumps, Rubella Vaccine (MMR)	Y	Y	Y	Y	Y	Y	Y					
14	Pneumococcal Vaccine	Y	Y	Y	Y	Y	Y	Y	Y		Y	Y	Y
15	Standardized Written Developmental	Y	Y	Y	Y	Y	Y	Y					
16	Tetanus			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
17	Tuberculin Testing (PPD Intradermal Injection/Mantoux Method)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
18	Urinalysis								Y		Y	Y	Y
19	Varicella Vaccine	Y	Y	Y	Y	Y	Y	Y					
20	Vision Assessment		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	

Attachment A: Medicaid

MEDICAID MANAGED CARE ADDENDUM FOR INDIAN HEALTH CARE PROVIDERS

This MEDICAID MANAGED CARE ADDENDUM FOR INDIAN HEALTH CARE PROVIDERS (this "***Addendum***") is made and entered between Carolina Complete Health, Inc. ("Carolina Complete"), Carolina Complete Health Network, Inc. ("CCHN") and the undersigned provider ("***Provider***"), and attaches to that certain Medicaid Product Attachment ("***Product Attachment***") that is part of the Participating Provider Agreement entered into by Carolina Complete, CCHN and Provider, as the same may have been amended and supplemented from time to time (the "***Agreement***"). To the extent Provider is an Indian Health Care Provider (IHCP), Provider shall comply with the provisions of this Addendum. *(Section VII, H)*.

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

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; or

(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. 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. 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 Addendum.

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:
Carolina Complete Health, Inc.

By: _____

Title: _____

Print Name: _____

Date: _____

For the IHCP:

By: _____

Title: _____

Print Name: _____

Date: _____

For Carolina Complete Health Network, Inc.

By: _____

Title: _____

Printed Name: _____

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

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES
PHYSICIANS AND PHYSICIAN EXTENDERS

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the rate floor as defined by the North Carolina Division of Health Benefits ("NCDHB") which is one hundred percent (100%) of the amount payable based on the Medicaid fee schedule for physicians and physician extenders set forth by NCDHB on the date of service (the "Rate Floor"); unless, the Allowable Charges is less than the Rate Floor in which case both Parties mutually agree as an alternative reimbursement arrangement that the Allowed Amount will be equal to the Allowable Charges. Payor agrees to reimburse Contracted Provider any additional payments such as medical home PMPM payments and pregnancy medical home incentive payments as directed by the North Carolina Division of Health Benefits or North Carolina Department of Health and Human Services as applicable.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

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

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Payment for Multiple Procedures. Where multiple outpatient surgical or scope procedures performed on a Covered Person during a single occasion of surgery, reimbursement will be as follows: i) the procedure for which the Allowed Amount under this Compensation Schedule is greatest will be reimbursed at one hundred percent (100%) of such Allowed Amount; ii) the procedures with second greatest Allowed Amounts under this Compensation Schedule will be reimbursed at twenty five percent (25%) of such Allowed Amounts; and iii) any additional procedures will not be eligible for reimbursement.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

8. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claim processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

EXHIBIT 2
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES
SPECIALTY CARE PHYSICIANS AND SPECIALTY CARE PHYSICIAN EXTENDERS

This compensation schedule ("Compensation Schedule") sets forth the maximum reimbursement amounts for Covered Services provided by Contracted Providers to Covered Persons enrolled in a Medicaid Product. Where the Contracted Provider's tax identification number ("TIN") has been designated by the Payor as subject to this Compensation Schedule, Payor shall pay or arrange for payment of a Clean Claim for Covered Services rendered by the Contracted Provider according to the terms of, and subject to the requirements set forth in, the Agreement and this Compensation Schedule. Payment under this Compensation Schedule shall consist of the Allowed Amount as set forth herein less all applicable Cost-Sharing Amounts. All capitalized terms used in this Compensation Schedule shall have the meanings set forth in the Agreement, the applicable Product Attachment, or the Definitions section set forth at the end of this Compensation Schedule.

The compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the rate floor as defined by the North Carolina Division of Health Benefits ("NCDHB") which is one hundred percent (100%) of the amount payable based on the Medicaid fee schedule for specialty care physicians and specialty care physician extenders set forth by NCDHB on the date of service (the "Rate Floor"); unless, the Allowable Charges is less than the Rate Floor in which case both Parties mutually agree as an alternative reimbursement arrangement that the Allowed Amount will be equal to the Allowable Charges. Payor agrees to reimburse Contracted Provider any additional payments such as medical home PMPM payments and pregnancy medical home incentive payments as directed by the North Carolina Division of Health Benefits or North Carolina Department of Health and Human Services as applicable.

Additional Provisions:

1. Code Change Updates. Payor utilizes nationally recognized coding structures (including, without limitation, revenue codes, CPT codes, HCPCS codes, ICD codes, national drug codes, ASA relative values, etc., or their successors) for basic coding and descriptions of the services rendered. Updates to billing-related codes shall become effective on the date ("Code Change Effective Date") that is the later of: (i) the first day of the month following sixty (60) days after publication by the governmental agency having authority over the applicable Product of such governmental agency's acceptance of such code updates, (ii) the effective date of such code updates as determined by such governmental agency or (iii) if a date is not established by such governmental agency or the applicable Product is not regulated by such governmental agency, the date that changes are made to nationally recognized codes. Such updates may include changes to service groupings. Claims processed prior to the Code Change Effective Date shall not be reprocessed to reflect any such code updates.

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

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Payment for Multiple Procedures. Where multiple outpatient surgical or scope procedures performed on a Covered Person during a single occasion of surgery, reimbursement will be as follows: i) the procedure for which the Allowed Amount under this Compensation Schedule is greatest will be reimbursed at one hundred percent (100%) of such Allowed Amount; ii) the procedures with second greatest Allowed Amounts under this Compensation Schedule will be reimbursed at twenty five percent (25%) of such Allowed Amounts; and iii) any additional procedures will not be eligible for reimbursement.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

7. Carve-Out Services. With respect to any "Carve-Out" Covered Services as contemplated in this Agreement, any payment arrangement entered into between Provider and a third party vendor of such services shall supersede compensation hereunder.

8. Payment under this Compensation Schedule. All payments under this Compensation Schedule are subject to the terms and conditions set forth in the Agreement, the Provider Manual and any applicable billing manual and claim processing policies.

Definitions:

1. **Allowed Amount** means the amount designated in this Compensation Schedule as the maximum amount payable to a Contracted Provider for any particular Covered Service provided to any particular Covered Person, pursuant to this Agreement or its Attachments.

2. **Allowable Charges** means a Contracted Provider's billed charges for services that qualify as Covered Services.

3. **Cost-Sharing Amounts** means any amounts payable by a Covered Person, such as copayments, cost-sharing, coinsurance, deductibles or other amounts that are the Covered Person's financial responsibility under the applicable Coverage Agreement, if applicable.

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.

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.

9.2 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).

AmeriHealth Caritas
North Carolina

AmeriHealth Caritas North Carolina
Ancillary Data Intake Form

Section 1 Instructions: Please complete all fields below for the provider

Entity Name (as written on W9):			
IPA name (if applicable):	Billing Type: ☐ UB-04/Institutional ☐ CMS-1500/Professional		
Name Doing Business As (if applicable):	W-9 TIN/EIN (nine characters):	NCTracks Provider ID:	
Primary Contact Name:	Primary Contact Email:	Primary Contact Phone:	

	Address Line 1	Address Line 2	City	State	ZIP + 4 Digits	Telephone *(with Area Code)*
Pay to Address						
Recoveries Address ☐ *Same as Pay To Address*						
Organization Website:						

Section 2 Instructions: Please complete each section below for all locations including applicable NPI or Atypical ID information. **(Make additional copies if needed.)**

Practice Location #	Group/Facility Name *(as appearing in provider directory)*	Address Line 1	Address Line 2	City	State	ZIP + 4 Digits	County	Fax *(with Area Code)*	Telephone *(with Area Code)*
1 *Main Location*									

Group NPI/Atypical ID:

Taxonomy Code:

CLIA ID:

Languages Spoken:

☐ Arabic ☐ ASL ☐ Chinese
☐ French ☐ Hmong ☐ Korean
☐ Russian ☐ Spanish ☐ Vietnamese
Other (please list):

Practice Location 1 — Office Hours					
Day	**No Set Hours**	**Start**	**AM/PM**	**End**	**AM/PM**
Monday	☐ Closed ☐ Open 24 Hours				
Tuesday	☐ Closed ☐ Open 24 Hours				
Wednesday	☐ Closed ☐ Open 24 Hours				
Thursday	☐ Closed ☐ Open 24 Hours				
Friday	☐ Closed ☐ Open 24 Hours				
Saturday	☐ Closed ☐ Open 24 Hours				
Sunday	☐ Closed ☐ Open 24 Hours				

Practice Location #	Group/Facility Name *As it will appear in provider directory*	Address Line 1	Address Line 1	City	State	ZIP + 4 Digits	County	Fax *(with Area Code)*	Telephone *(with Area Code)*
2									

Group NPI/Atypical ID:

Taxonomy Code:

CLIA ID:

Languages Spoken:

☐ Arabic ☐ ASL ☐ Chinese
☐ French ☐ Hmong ☐ Korean
☐ Russian ☐ Spanish ☐ Vietnamese
Other (please list):

Practice Location 2 — Office Hours					
Day	No Set Hours	Start	AM/PM	End	AM/PM
Monday	☐ Closed ☐ Open 24 Hours				
Tuesday	☐ Closed ☐ Open 24 Hours				
Wednesday	☐ Closed ☐ Open 24 Hours				
Thursday	☐ Closed ☐ Open 24 Hours				
Friday	☐ Closed ☐ Open 24 Hours				
Saturday	☐ Closed ☐ Open 24 Hours				
Sunday	☐ Closed ☐ Open 24 Hours				

Practice Location #	Group/Facility Name *(as appearing in provider directory)*	Address Line 1	Address Line 2	City	State	ZIP + 4 Digits	County	Fax *(with Area Code)*	Telephone *(with Area Code)*
3									

Group NPI/Atypical ID:

Taxonomy Code:

CLIA ID:

Languages Spoken:

☐ Arabic ☐ ASL ☐ Chinese
☐ French ☐ Hmong ☐ Korean
☐ Russian ☐ Spanish ☐ Vietnamese
Other (please list):

Practice Location 3 — Office Hours					
Day	No Set Hours	Start	AM/PM	End	AM/PM
Monday	☐ Closed ☐ Open 24 Hours				
Tuesday	☐ Closed ☐ Open 24 Hours				
Wednesday	☐ Closed ☐ Open 24 Hours				
Thursday	☐ Closed ☐ Open 24 Hours				
Friday	☐ Closed ☐ Open 24 Hours				
Saturday	☐ Closed ☐ Open 24 Hours				
Sunday	☐ Closed ☐ Open 24 Hours				

Practice Location #	Group/Facility Name *(as appearing in provider directory)*	Address Line 1	Address Line 2	City	State	ZIP + 4 Digits	County	Fax *(with Area Code)*	Telephone *(with Area Code)*
4									

Group NPI/Atypical ID:

Taxonomy Code:

CLIA ID:

Languages Spoken:

☐ Arabic ☐ ASL ☐ Chinese
☐ French ☐ Hmong ☐ Korean
☐ Russian ☐ Spanish ☐ Vietnamese
Other (please list):

Practice Location 4 — Office Hours					
Day	No Set Hours	Start	AM/PM	End	AM/PM
Monday	☐ Closed ☐ Open 24 Hours				
Tuesday	☐ Closed ☐ Open 24 Hours				
Wednesday	☐ Closed ☐ Open 24 Hours				
Thursday	☐ Closed ☐ Open 24 Hours				
Friday	☐ Closed ☐ Open 24 Hours				
Saturday	☐ Closed ☐ Open 24 Hours				
Sunday	☐ Closed ☐ Open 24 Hours				

Practice Location #	Group/Facility Name *(as appearing in provider directory)*	Address Line 1	Address Line 2	City	State	ZIP + 4 Digits	County	Fax *(with Area Code)*	Telephone *(with Area Code)*
5									

Group NPI/Atypical ID:

Taxonomy Code:

CLIA ID:

Languages Spoken:

☐ Arabic ☐ ASL ☐ Chinese
☐ French ☐ Hmong ☐ Korean
☐ Russian ☐ Spanish ☐ Vietnamese
Other (please list):

Practice Location 5 — Office Hours					
Day	No Set Hours	Start	AM/PM	End	AM/PM
Monday	☐ Closed ☐ Open 24 Hours				
Tuesday	☐ Closed ☐ Open 24 Hours				
Wednesda	☐ Closed ☐ Open 24 Hours				
Thursday	☐ Closed ☐ Open 24 Hours				
Friday	☐ Closed ☐ Open 24 Hours				
Saturday	☐ Closed ☐ Open 24 Hours				
Sunday	☐ Closed ☐ Open 24 Hours				

Section 3 Instructions: Please indicate ADA compliance for each location, as appropriate.

ADA Compliance	Group Locations
Blind/ Visually Impaired (ADA5)	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Cognitively Disabled (ADA6)	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Deaf or Hard of Hearing (ADA7)	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Examination Rooms - Compliant Access (ADA3)	☐All ☐1 ☐2 ☐3 ☐4 ☐5

ADA Compliance	Group Locations
Handicap Accessible Medical Equipment (ADA4)	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Rest Rooms - Compliant Access (ADA2)	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Service Location - Compliant Access (ADA1)	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Section 4 instructions: Please complete all fields below by selecting which service(s) are provided at each location and ages served.

Habilitative and Rehabilitative Services

Cardiac Rehabilitation	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Physical Therapy	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Imaging

Imaging Center	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Mammography	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Radiology Service Available	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Ultrasound	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Home Health Services (Clinical)

Home Health Care - Adult	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Home Health Care - Pediatric	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Home Infusion Services - Adult	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Home Infusion Services - Pediatric	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Home Care Services (Non-Clinical)

Home And Vehicle Modifications	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Home Delivered Meals	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Home Modification	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Personal Care Services - Non-Skilled	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Personal Care Services - Skilled	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Personal Emergency Response System (PERS)	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Respite Care – In Home	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Respite Care - Institutional	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Medical Therapies

Chemotherapy	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Hemodialysis	☐All ☐1 ☐2 ☐3 ☐4 ☐5
IV Outpatient Services	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Peritoneal Dialysis	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Transplants

Transplant - Heart	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Transplant - Intestinal	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Transplant - Kidney	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Transplant - Liver	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Transplant - Lung	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Transplant - Pancreas	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Transportation

Services	Locations
Ambulance Services	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Non-Emergency Medical Transportation	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Sleep Testing

In Center Sleep Testing	☐All ☐1 ☐2 ☐3 ☐4 ☐5
In Home Sleep Testing	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Telemedicine

Telepsychiatry	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Miscellaneous Services

Durable Medical Equipment	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Family Planning Services	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Laboratory Services Available	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Nutritional Counseling	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Orthotics and Prosthetics	☐All ☐1 ☐2 ☐3 ☐4 ☐5
School Based Clinic	☐All ☐1 ☐2 ☐3 ☐4 ☐5
Care Management Services	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Please add any unlisted services below and indicate age range and location.

Unlisted Services	Locations
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Unlisted Services	Locations
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5
	☐All ☐1 ☐2 ☐3 ☐4 ☐5

Section 5 Instructions: Please complete all fields below, including practice location number(s) for each practitioner. *See Section 2 for corresponding location number.* If you have more than 6 practitioners, please attach a roster with the same fields listed in this section.

Category	First Name	Last Name	MI	Degree/Title *(e.g, MD, ARNP, MSW, etc.)*	Gender	Specialty / Taxonomy Code	Accepting New Patients? / Age Range	Practitioner NPI/Atypical ID / Affiliated Hospital with Admitting Privileges	Practice Location Number for Practitioner
☐Specialist ☐Hospital Based					☐M ☐F	Specialty: Taxonomy:	Accepting New Patients? ☐Yes ☐No From Age ___ to ___ ☐All Ages	NPI/Atypical ID Affiliated Hospital with Admit Privilege	☐All ☐3 ☐1 ☐4 ☐2 ☐5

Cultural Competency Training Completed? ☐Yes ☐No ☐Exclude from Directory

Languages Spoken: ☐Arabic ☐ASL ☐Chinese ☐French ☐Hmong ☐Korean ☐Russian ☐Spanish ☐Vietnamese Other (please list):

Provider Training/Experience: Blindness or Visual Impairment ☐Child Welfare ☐Chronic Illness ☐Cognitively Disabled ☐Co-occurring Disorders ☐Deafness or Hard of Hearing ☐HIV/AIDS ☐Homelessness ☐Physical Disability ☐Serious Mental Illness ☐Substance Abuse ☐Trauma

☐Specialist ☐Hospital Based					☐M ☐F	Specialty: Taxonomy:	Accepting New Patients? ☐Yes ☐No From Age ___ to ___ ☐All Ages	NPI/Atypical ID Affiliated Hospital with Admit Privilege	☐All ☐3 ☐1 ☐4 ☐2 ☐5

Cultural Competency Training Completed? ☐Yes ☐No ☐Exclude from Directory

Languages Spoken: ☐Arabic ☐ASL ☐Chinese ☐French ☐Hmong ☐Korean ☐Russian ☐Spanish ☐Vietnamese Other (please list):

Provider Training/Experience: ☐Blindness or Visual Impairment ☐Child Welfare ☐Chronic Illness ☐Cognitively Disabled ☐Co-occurring Disorders ☐Deafness or Hard of Hearing ☐HIV/AIDS ☐Homelessness ☐Physical Disability ☐Serious Mental Illness ☐Substance Abuse ☐Trauma

☐Specialist ☐Hospital Based					☐M ☐F	Specialty: Taxonomy:	Accepting New Patients? ☐Yes ☐No From Age ___ to ___ ☐All Ages	NPI/Atypical ID Affiliated Hospital with Admit Privilege	☐All ☐3 ☐1 ☐4 ☐2 ☐5

Cultural Competency Training Completed? ☐Yes ☐No ☐Exclude from Directory

Languages Spoken: ☐Arabic ☐ASL ☐Chinese ☐French ☐Hmong ☐Korean ☐Russian ☐Spanish ☐Vietnamese Other (please list):

Provider Training/Experience: ☐Blindness or Visual Impairment ☐Child Welfare ☐Chronic Illness ☐Cognitively Disabled ☐Co-occurring Disorders ☐Deafness or Hard of Hearing ☐HIV/AIDS ☐Homelessness ☐Physical Disability ☐Serious Mental Illness ☐Substance Abuse ☐Trauma

Category	First Name	Last Name	MI	Degree/Title *(e.g, MD, ARNP, MSW, etc.)*	Gender	Specialty / Taxonomy Code	Accepting New Patients? / Age Range	Practitioner NPI/Atypical ID / Affiliated Hospital with Admitting Privileges	Practice Location Number for Practitioner
☐ Specialist ☐ Hospital Based					☐ M ☐ F	Specialty: Taxonomy:	Accepting New Patients? ☐ Yes ☐ No From Age ___ to ___ ☐ All Ages	NPI/Atypical ID Affiliated Hospital with Admit Privilege	☐ All ☐ 3 ☐ 1 ☐ 4 ☐ 2 ☐ 5

Cultural Competency Training Completed? ☐ Yes ☐ No ☐ Exclude from Directory

Languages Spoken: ☐ Arabic ☐ ASL ☐ Chinese ☐ French ☐ Hmong ☐ Korean ☐ Russian ☐ Spanish ☐ Vietnamese Other (please list):

Provider Training/Experience: ☐ Blindness or Visual Impairment ☐ Child Welfare ☐ Chronic Illness ☐ Cognitively Disabled ☐ Co-occurring Disorders ☐ Deafness or Hard of Hearing ☐ HIV/AIDS ☐ Homelessness ☐ Physical Disability ☐ Serious Mental Illness ☐ Substance Abuse ☐ Trauma

☐ Specialist ☐ Hospital Based					☐ M ☐ F	Specialty: Taxonomy:	Accepting New Patients? ☐ Yes ☐ No From Age ___ to ___ ☐ All Ages	NPI/Atypical ID Affiliated Hospital with Admit Privilege	☐ All ☐ 3 ☐ 1 ☐ 4 ☐ 2 ☐ 5

Cultural Competency Training Completed? ☐ Yes ☐ No ☐ Exclude from Directory

Languages Spoken: ☐ Arabic ☐ ASL ☐ Chinese ☐ French ☐ Hmong ☐ Korean ☐ Russian ☐ Spanish ☐ Vietnamese Other (please list):

Provider Training/Experience: ☐ Blindness or Visual Impairment ☐ Child Welfare ☐ Chronic Illness ☐ Cognitively Disabled ☐ Co-occurring Disorders ☐ Deafness or Hard of Hearing ☐ HIV/AIDS ☐ Homelessness ☐ Physical Disability ☐ Serious Mental Illness ☐ Substance Abuse ☐ Trauma

☐ Specialist ☐ Hospital Based					☐ M ☐ F	Specialty: Taxonomy:	Accepting New Patients? ☐ Yes ☐ No From Age ___ to ___ ☐ All Ages	NPI/Atypical ID Affiliated Hospital with Admit Privilege	☐ All ☐ 3 ☐ 1 ☐ 4 ☐ 2 ☐ 5

Cultural Competency Training Completed? ☐ Yes ☐ No ☐ Exclude from Directory

Languages Spoken: ☐ Arabic ☐ ASL ☐ Chinese ☐ French ☐ Hmong ☐ Korean ☐ Russian ☐ Spanish ☐ Vietnamese Other (please list):

Provider Training/Experience: ☐ Blindness or Visual Impairment ☐ Child Welfare ☐ Chronic Illness ☐ Cognitively Disabled ☐ Co-occurring Disorders ☐ Deafness or Hard of Hearing ☐ HIV/AIDS ☐ Homelessness ☐ Physical Disability ☐ Serious Mental Illness ☐ Substance Abuse ☐ Trauma

ACNC Use Only

ACNC Ancillary Release 1.01

SF #

Please email to ProviderEnrollment_NC@amerihealthcaritas.com

Service Questionnaire

Please complete the following questionnaire so we may respond to your contracting request. When you have completed, please email, along with attachments to: rebeca_oliva@uhc.com

Provider Name_____

DBA, if applicable_____

Tax ID(s)_____

NPI#_____

Medicaid #_____

Medicare #_____

Billing Address_____

_____

Phone Number_____

Fax #_____ Email Address_____

Place of Service Address_____

_____

Phone number_____

Fax #_____

Name of Contact_____

Phone number_____ Email address_____

Directions: Please answer the following questions:

1. Are your currently contracted with United Healthcare? Y____ N___
2. If yes, do you have a copy of your United contract? Y____ N___
3. Do you bill on a 1500 or UB claim form?_____
4. Are you owned by a Hospital or Health System? Y____ N___
   If yes, provide the Hospital/Health System Name_____
5. Please provide the names of the Skilled Nursing Facilities you service:

   _____

6. What counties do you service? _____

Attachments: Please send with questionnaire

- W-9
- Sample claims form
- Copy of Liability Insurance and Business License

Commissioners
Bennie Heath - Chairman
James T. Shackleford-Vice Chair
Jerry Jones
Susan Blizzard
Derek Burress

GREENE COUNTY
A Place To Grow. The Way To Live.

County Manager
Kyle J. DeHaven

Finance Officer
Beverly T. Stroud

County Attorney
Gay Stanley

From: Kyle J. DeHaven, County Manager

Re: FY 2020/21 End of Year Budget Amendment

Date: June 28, 2021

An End of Year Budget Amendment has been prepared to bring the County back in line with state statutes. The County has forecasted spending with some room for deviation from norms to maintain compliance with General Statutes. The Manager will be available to go through this BA in as much or little detail as desired.

Action Recommended:

Motion to approve the BA as presented

Board Action is Needed

"Greene County is an equal opportunity provider, employer and lender."
To file a complaint of discrimination write USDA, Director, Office of Civil Rights, 1400 Independence Ave., SW, Washington, DC 20250-9410 or call (800) 795-3272 or (202) 720-6382 (TDD)