PARTICIPATING PROVIDER AGREEMENT

THIS PARTICIPATING PROVIDER AGREEMENT ("**Agreement**") is made and entered into by and between WellCare of Nebraska, Inc. ("**Health Plan**") and Lancaster County of Nebraska d/b/a Mental Health Crisis Center ("**Contracted Provider**"). Health Plan and Contracted Provider are sometimes referred to together as the "**Parties**" and individually as a "**Party**".

WHEREAS, Health Plan issues (or is pursuing a license allowing it to issue) health benefit plans and seeks to include health care providers in one or more provider networks for such plans; and

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

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

NOW THEREFORE, the Parties agree as follows:

1. Construction.

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

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

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

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

2.2 "**Benefit Plan**" means a health benefit policy or other health benefit contract or coverage document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

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

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

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

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

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

2.8 "**Effective Date**" means the date this Agreement becomes effective as determined by Health Plan and set forth on the signature page of this Agreement. Federal law prohibits Health Plan from contracting with individuals or entities that are barred from participation in Federal Health Care Programs. Accordingly, the Effective Date is subject to Health Plan's completion of credentialing and determination that Contracted Provider meets the Credentialing Criteria.

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

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

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

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

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

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

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

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

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

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

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

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

2.20 "**Overpayment**" means the payments a Provider receives from Health Plan or its Affiliates to which the Provider is not entitled, including payments (a) for items and services that are not Covered Services, (b) paid in error, (c) resulting from enrollment errors, (d) resulting from claims payment errors, data entry errors or incorrectly submitted claims, or (e) for claims paid when Health Plan was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Health Plan makes to satisfy an obligation of a Provider, including refunds of improperly collected Member Expenses to a Member or reimbursement to subcontracted Providers.

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

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

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

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

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

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

2.27 "**Provider Manual**" means, collectively, Health Plan's provider manuals, quick reference guides, WellCare Companion Guide, and educational materials setting forth Health Plan's requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by Health Plan from time to time. The Provider Manual is available on Health Plan's website.

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

2.29 "**WellCare**" means WellCare Health Plans, Inc., an Affiliate of Health Plan.

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

3. Scope.

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

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

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

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

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

3.6 There shall be no joint liability among the Health Plan Affiliates with regard to each Health Plan's obligations under the Agreement. The parties further agree that only the legal entity issuing the applicable Benefit Plan shall incur any liability to Provider by virtue of the Agreement.

4. Provider Responsibilities.

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

4.2 Providers. Contracted Provider shall provide Health Plan with the information listed on the Attachment titled "Information for Providers" for itself and the Providers as of the Effective Date, in a form and format acceptable to Health Plan. Contracted Provider shall provide notice to Health Plan of any change in the information for itself and the Providers within 30 days of the change. When Contracted Provider terminates a Provider, other than for cause, Contracted Provider will give Health Plan at least 90 days prior written notice of the termination.

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

4.2.2 Subcontracted Providers. If Contracted Provider, such as an independent practice association, physician hospital organization or physician group, uses subcontracted Providers:

(a) Contracted Provider shall maintain and enforce written agreements with its subcontracted Providers that are consistent with and require adherence to this Agreement. Upon Health Plan's request, Contracted Provider shall provide Health Plan with copies of entire agreements between itself or other Providers and the subcontracted Providers. The compensation terms in such agreements may be redacted unless required by Governmental Authorities. In no event shall an agreement between or among Providers supersede this Agreement respecting matters covered by this Agreement. Notwithstanding anything to the contrary in any such agreement, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

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

would prohibit a subcontracted Provider from contracting directly with Health Plan pursuant to the Opt-In Agreement.

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

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

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

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

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

4.3.2 Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Health Plan provides member eligibility information through Health Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility no later than the next business day after the Member is stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Health Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Health Plan.

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

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

4.3.5 Non-Covered Services. Before a Provider provides items or services to a Member that are not Covered Services, Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider may contact Health Plan to determine if an item or service is a Covered Service.

4.3.6 Carve Out Agreements. While a Carve Out Agreement is in effect, Covered Services subject to the Carve Out Agreement shall be Non-Contracted Services and are not within the scope of this Agreement, except for (a) Emergency Services, or (b) Covered Services authorized by Health Plan in advance in accordance with the Provider Manual, in which cases the terms and conditions of this Agreement, including compensation, shall apply. Health Plan shall notify Contracted Provider of Carve Out Agreements through the Provider Manual or other notice. Upon expiration or termination of a Carve Out Agreement, Provider shall provide the Covered Services to Members that were subject to the Carve Out Agreement, subject to and in accordance with the terms of this Agreement, including compensation.

4.4 Claims and Encounter Data / EDI.

4.4.1 Clean Claims. Providers shall prepare and submit Clean Claims to Health Plan within 180 days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Health Plan may deny payment for any claims that fail to meet Health Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

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

4.4.3 NPI Numbers / Taxonomy Codes. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or encounter data submitted under this Agreement, and Health Plan may deny payment for Covered Services where a Provider fails to meet these requirements.

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

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

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

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

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

4.5 Member Protections.

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

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

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

4.5.4 Except where collection of Member Expenses is prohibited by Laws, Program Requirements, or this Agreement, a Provider shall (a) collect Member Expenses directly from the Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements regarding prohibited inducements to Federal Health Care Program beneficiaries.

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

4.6 Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Health Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Health Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of material revisions to the Provider Manual, Health Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 15 days after such posting or notice, or such other time period required for Health Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Health Plan's provider website, and check for revisions to the Provider Manual from time to time.

4.7 Quality Improvement. Providers shall comply with Health Plan's quality improvement programs, including those designed to improve quality measure outcomes in the then current Healthcare Effectiveness Data and Information Set (HEDIS) or other quality or outcome measures. Health Plan may audit Providers periodically and upon request Providers shall provide Records to Health Plan for HEDIS or other quality reasons and risk management purposes, including Records that will enable Health Plan to perform a thorough assessment of the overall care being provided to Members.

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

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

4.10 Compliance. In performing this Agreement, Providers shall comply with all Laws and Program Requirements. Providers shall (a) cooperate with Health Plan with respect to Health Plan's compliance with Laws and Program Requirements, including downstream requirements that are inherent to Health Plan's responsibilities under Laws or Program Requirements, and (b) not knowingly take any action contrary to Health Plan's obligations under Laws or Program Requirements.

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

4.10.2 Fraud, Waste and Abuse. Providers shall comply with Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False

Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

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

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

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

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

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

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

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

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

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

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

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

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

4.14 Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall notify Health Plan within five business days of Contracted Provider's knowledge, or when Contracted Provider should have known, of any event that could reasonably be expected to impair the ability of a Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of a Provider to be inaccurate, (b) a Provider fails to maintain insurance as required by this Agreement, (c) a Provider's license, certification or accreditation expires or is suspended, revoked, conditioned or otherwise restricted, (d) a Provider is excluded, suspended or debarred from, or sanctioned under a Federal Health Care Program, (e) a disciplinary action is initiated by a Governmental Authority against a Provider, (f) where applicable, a Provider's hospital privileges are

suspended, limited, revoked or terminated, (g) a Provider is under investigation for fraud or a felony, or (h) a Provider enters into a settlement related to any of the foregoing.

5. Health Plan Responsibilities.

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

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

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

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

5.5 Overpayments. Overpayment recovery shall be in accordance with Health Plan's Provider Manual and Providers shall refund Overpayments to Health Plan within 30 days (or such other timeframe as required by Laws or Program Requirements) of the Provider's receipt of notice from Health Plan of such Overpayments ("Notice Period") or Provider's knowledge of such Overpayment. This section regarding Overpayments shall survive expiration or termination of this Agreement. Health Plan shall not seek repayment of an Overpayment from a Provider beyond the time period set forth in Health Plan's Provider Manual, unless a longer time is required or permitted by Laws or Program Requirements. Notwithstanding anything to the contrary herein, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud.

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

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

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

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

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

6. Records, Access & Audits.

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

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

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

7. Term and Termination.

7.1 Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party

provides notice of nonrenewal to the other at least 90 days before the end of the then current (initial or renewal) term, unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

7.2 Termination.

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

7.2.2 Termination for Cause.

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

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

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

7.2.4 Transition of Care. To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and conditions of this Agreement shall apply to any such post expiration or termination activities, provided

that if a Provider is capitated, Health Plan shall pay the Provider for such Covered Services at 100 percent of Health Plan's then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

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

8. Dispute Resolution.

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

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

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

8.4 Mediation. Parties shall meet and confer in a timely manner and good faith in an attempt to resolve any and all disputes that arise under this Agreement. In the event that the Parties are unable to resolve a dispute as described above, either Party may give written notice to the other Party of its intention to mediate. In the mediation process, the Parties will try to resolve their differences voluntarily with the aid of an impartial mediator, who will attempt to facilitate negotiations. The mediator will be selected by agreement of the Parties. If the Parties cannot agree on a mediator, a mediator will be designated by the American Arbitration Association. Any mediator so designated must be acceptable to all Parties. The mediation will be conducted in Omaha, Nebraska, as specified by the mediator and agreed upon by the Parties. The Parties agree to discuss their differences in good faith and attempt, with the assistance of the mediator, to reach an amicable resolution of the dispute. The mediation will be treated as a settlement discussion and therefore will be confidential. The mediator may not testify for either Party in any later proceeding relating to the dispute. No recording or transcript shall be made of the

mediation proceedings. Each Party will bear its own costs and fees, including legal fees, in the mediation. The fees and expenses of the mediator shall be shared equally by the parties.

9. Miscellaneous.

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

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

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

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

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

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

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

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

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

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

9.11 Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

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

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

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

9.15 Health Plan Affiliates. If a Provider renders covered services to a member of a benefit plan issued or administered by a Health Plan Affiliate, the Health Plan Affiliate may pay for such covered services, and the Provider shall accept, the applicable out of network rates paid by the Health Plan Affiliate for the member's benefit plan. A list of Health Plan Affiliates is available in the Provider Manual or on Health Plan's provider website. There shall be no joint liability between or among Health Plan and its Affiliates.

9.16 Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes

(other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines, embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Health Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SIGNATURE PAGE

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

WellCare of Nebraska, Inc.	Lancaster County of Nebraska d/b/a Mental Health Crisis Center
By: _____	By: _____
Print Name: Lauralie Rubel	Print Name: _____
Title: State President	Title: _____
Date: _____	Date: _____
	Fed Tax ID: 476006482
Health Plan Notice Address:	Contracted Provider Notice Address:
10040 Regency Circle, Ste. 100	825 J St
Omaha, NE 68114	Lincoln, NE 68502
ATTN: State President	ATTN: _____
Fax: _____	Fax: _____
.	Revision # 12-11

FOR HEALTH PLAN USE ONLY

Effective Date: _____

(To be completed by Health Plan following approval of Contracted Provider as a Health Plan participating provider, which approval is subject to credentialing but not limited thereto. Any attempt by Contracted Provider to fill in an effective date shall have no force or effect.)

ATTACHMENT A
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES / INFORMATION

(See following attachments)

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(Ancillary/Medical Facility)

Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services that are ancillary or facility based health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

ATTACHMENT A-2
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
(PROFESSIONAL)

1. Additional Definitions.

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

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

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

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

   e. "**Primary Care Provider**" means a Physician, Nurse Practitioner, certified nurse midwife, physician assistant, or other duly licensed Provider who spends the majority of his/her clinical time providing Primary Care Services to patients, and may include a Provider in the practice of family medicine, general medicine, internal medicine or pediatrics, or obstetrics and gynecology.

   f. "**Primary Care Services**" means health care items or services available from Primary Care Provider within the scope of their medical or professional licenses or certifications, and shall include primary care items and services required by the Provider Manual or Program Requirements, which may include (i) assuring the timeliness of urgent, emergent, sick and preventive care to Members; (ii) conducting initial health assessments of new Members when such assessments are Covered Services under the applicable Benefit Plan; (iii) informing Members of specific health care needs that require follow up; (iv) instructing Members on measures they may take to promote their own health; (v) providing the coordination necessary for the referral of Members to specialists; or (vi) monitoring and follow-up of care provided by other providers for diagnosis and treatment.

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

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

2. Subject to and in accordance with the terms of this Agreement, applicable Laws, and Program Requirements, Contracted Provider shall provide or arrange for the provision of all Covered Services available from Providers that are within the scope of their medical or professional licenses or certifications.

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

4. If a Provider provides or arranges for the provision of Primary Care Services to Assigned Members:

a. The Provider shall have primary responsibility for arranging and coordinating the overall health care of Assigned Members, including (i) the provision of Primary Care Services from Primary Care Provider and appropriate referral to other Participating Providers, or if a Participating Provider is unavailable to any health care provider upon authorization of Health Plan, and (ii) managing and coordinating the performance of administrative functions relating to the delivery of Covered Services to Assigned Members.

b. The Provider shall ensure Primary Care Provider make all reasonable efforts to (i) establish satisfactory provider-patient relationships with their Assigned Members and (ii) instruct their Assigned Members on measures they may take to promote their own health.

5. If a Provider provides or arranges for the provision of Specialty Services, the Provider shall ensure that Specialty Provider (i) care for common medical conditions in their medical specialty, (ii) provide consultation summaries or appropriate periodic progress notes to the Member's Primary Care Provider on a timely basis, after a referral or routinely scheduled consultative visit, and (iii) notify the Member's Primary Care Provider when scheduling a hospital admission or other procedure requiring the Primary Care Provider's approval.

6. Except for Emergency Services, when a Member requires a hospital admission by a Primary Care Provider or other Provider that the Primary Care Provider has referred a Member to, the Primary Care Provider shall, or shall arrange for the other Provider to, secure authorization for such admission from Health Plan prior to the admission. Providers shall seek further authorization for any extension of the initial length of stay approved for the Member in accordance with the Provider Manual.

7. Subject to Laws and Program Requirements regarding provider to patient ratios, a Provider shall accept Members as patients as long as the Provider is accepting new patients. Contracted Provider shall give Health Plan 60 days' prior notice in advance of any circumstance where a Provider is not available to accept Members as patients.

ATTACHMENT A-3
INFORMATION FOR PROVIDERS

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

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
- For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person
- Ownership Disclosure Form, as required to comply with Laws, Program Requirements, and Government Contract

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

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

WHEREAS, Health Plan and Lancaster County of Nebraska d/b/a Mental Health Crisis Center ("**Contracted Provider**") are Parties to the Participating Provider Agreement (as now or hereafter amended, the "**PPA**"); and

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

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

1. Subcontractor has reviewed the PPA. The PPA is made a part of and incorporated into this Opt In Agreement. Capitalized terms not defined in this Opt In Agreement have the same definition as given in the PPA.

2. Subcontractor agrees to the terms and conditions of the PPA. Wherever in the PPA an action is required to be taken by Contracted Provider or a Provider, Subcontractor agrees to perform such action. Wherever in the PPA any representation or warranty is made by Contracted Provider or a Provider, Subcontractor agrees to comply with such representation or warranty.

3. Any obligation of Subcontractor in this Opt In Agreement or the PPA shall apply to Subcontractor's Providers to the same extent that it applies to Subcontractor. Subcontractor shall maintain and enforce internal policies and procedures or written agreements with its employed Providers that are consistent with and require adherence to the terms and conditions of this Opt In Agreement and the PPA. Subcontractor has the authority to bind its subcontracted Providers to this Opt In Agreement and PPA, and shall require the timely and faithful performance of this Opt In Agreement and the PPA by its subcontracted Providers.

4. Subcontractor hereby grants to Contracted Provider a power of attorney, coupled with an interest, to represent and bind Subcontractor in connection with all matters related to the PPA and this Opt In Agreement including granting any waivers of any of the terms of the PPA and this Opt In Agreement, and entering into any amendments or modifications of the PPA or this Opt In Agreement.

5. Subcontractor shall not assign any of its rights or delegate any of its duties or obligations under this Opt In Agreement or the PPA, in whole or in part, without the prior written consent of Health Plan.

6. If the PPA is terminated for any reason or Contracted Provider goes out of business, ceases operations or becomes insolvent, then Subcontractor: (a) for at least six months, shall continue to provide Covered Services to Members, subject to and in accordance with the terms and conditions of the PPA and this Opt In Agreement, (b) shall accept compensation from Health Plan for such Covered Services at the fee for service rates set forth in the PPA for the applicable Benefit Plans or, if the PPA does not include fee for service rates, at 100 percent of Health Plan's then current fee for service rates for the applicable Benefit Plans, and (c) after six months, may terminate its continuing participation under the PPA and this Opt-In Agreement upon 90 days prior notice to Health Plan.

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

8. This Opt In Agreement shall be governed by and construed and enforced in accordance with the laws of the State of Nebraska, except where Federal law applies, without regard to principles of conflict of laws.

9. Any dispute with respect to this Opt In Agreement or the PPA or Subcontractor's performance under this Opt In Agreement or PPA shall be subject to and resolved in accordance with the dispute resolution procedures in the PPA.

10. Subcontractor warrants and represents the Providers listed on the attached schedule are included in and subject to this Opt In Agreement and Subcontractor has the power and legal authority to, and has taken all necessary corporate or other action to, authorize the execution and delivery of this Opt In Agreement and the performance of its obligations hereunder and in accordance with the PPA.

The undersigned Subcontractor, with the intent to be legally bound, hereby agrees and accepts the terms of this Opt In Agreement by signing below.

Subcontractor:

Entity Name (if applicable):

_____

By: _____

Print Name: _____

Title: _____

Date: _____

TIN: _____

OPT IN AGREEMENT
SCHEDULE OF PROVIDERS

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

Name: Date:

ATTACHMENT B
PROGRAM ATTACHMENTS

(See following attachments)

ATTACHMENT B-1
NEBRASKA MEDICAID AND CHIP
PROGRAMS ATTACHMENT

1. Participation in Nebraska Contract. Subject to and in accordance with the terms of the Agreement, including this Attachment, Contracted Provider agrees to participate in Health Plan's provider networks and render Covered Services to Members pursuant to the Benefit Plan offered or administered by Health Plan for the Programs in accordance with the Nebraska Contract.

2. Compensation. Compensation for Covered Services provided to Members of Benefit Plans under the Nebraska Contract is set forth in Attachment C.

3. Additional Definitions. The following definitions shall be incorporated into the Agreement. Capitalized terms used and not otherwise defined in this Agreement shall have the meanings set forth in the Agreement or, if not defined in the Agreement, in the Nebraska Contract or under Nebraska law:

   a. "**Department**" means the Nebraska Department of Health and Human Services.

   b. "**Emergency Medical Condition**" means a medical condition manifesting itself by acute symptoms of sufficient severity (including, but not limited to severe pain) that a prudent layperson, who possesses an average knowledge of medicine and health, 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; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

   c. "**Emergency Services**" means covered inpatient and outpatient services that are as follows: (i) furnished by a provider that is qualified to furnish these services under Title 42 C.F.R.; or (ii) needed to evaluate or stabilize an Emergency Medical Condition.

   d. "**MLTC**" means the **M**edicaid and **L**ong-**T**erm **C**are division of the Department.

   e. "**Medicaid**" means Nebraska Medicaid Program.

   f. "**Medically Necessary**" or "**Medical Necessity**" means those Covered Services and supplies that are, under the terms and conditions of the Nebraska Contract, determined through Health Plan utilization management to be: (1) Necessary to meet the basic health needs of the Member; (2) Rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the covered service; (3) Consistent in type, frequency and duration of treatment with scientifically-based guidelines of national medical, research or health care coverage organizations or governmental agencies; (4) Consistent with the diagnosis of the condition; (5) Required for means other than the convenience of the Member, the Member's physician or other provider; and (6) No more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness and efficiency; (7) Of demonstrated value; and (8) No more intensive level of Covered Services than can be safely provided.

   g. "**Member**" means an individual enrolled in a Benefit Plan issued by Health Plan pursuant to the Nebraska Contract.

h. "**Nebraska Contract**" or "**NE Contract**" means the contract between the Department and Health Plan, and includes, without limitation, the collective documentation, exhibits, schedules, amendments, and addendums containing the terms, conditions and requirements to implement the Benefit Plan such as the General Terms, Special Terms (SOW) and Special Contract Attachments. The Nebraska Contract is a Government Contract as defined in the Agreement.

i. "**Nebraska Medicaid Program**" or "**NE Medicaid**" or "**Nebraska Medicaid**" means health care services to eligible elderly and disabled individuals and eligible low-income pregnant women, children and parents. NE Medicaid also includes the Children's Health Insurance Program and home and community-based services for individuals qualified for Medicaid waivers. NE Medicaid is administered by the MLTC.

j. "**Nebraska Medical Assistance Program**" means Nebraska Medicaid.

k. "**Patient-Centered Medical Home**" means a community-based primary care setting that provides and coordinates high quality, planned, family-centered, health promotion, acute illness care, and chronic condition management.

l. "**Post-Stabilization Care Services**" means, in accordance with 42 C.F.R. § 438.114(a), Covered Services, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain, improve or resolve the Member's stabilized condition.

m. "**State**" means the state of Nebraska or its designated regulatory agencies.

n. "**Subcontractor**" means any organization or person who provides a function or service for the Health Plan specifically related to securing or fulfilling the Health Plan's obligations under the terms of a contract. A subcontractor does not include a provider unless the provider is responsible for services other than those that could be covered by a provider agreement.

4. Cumulative Provisions. All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Program described in this Attachment. Any obligation of Contracted Provider in this Attachment shall apply to Providers. Contracted Provider agrees to include the terms and conditions contained herein in its contracts with Providers.

5. PCP Requirements. If Contracted Provider is a primary care provider, Contracted Provider shall comply with the requirements of 482 NAC 4-002.03.

6. Timely Access. Contracted Provider shall provide for timely access to Covered Services for Members appointments in accordance with access standards established within the Nebraska Contract. Health Plan shall take corrective action if Contracted Provider or Providers fail to comply with the timely access requirements in the Nebraska Contract.

7. Emergency Services. Providers shall not be required to seek prior authorization for Emergency Services before the Member has been stabilized. Once a Member who receives Emergency Services is stabilized, Health Plan shall reimburse Providers for Post Stabilization Care services provided to Members in accordance with 42 C.F.R. 438.114(e) and 42 C.F.R. 422.113(c)(2)(i), (ii), and (iii).

8. National Provider Identifier. Providers who are physicians shall have a national provider identifier (NPI). Providers shall supply Health Plan with their NPI number in order for it to be included on the provider file submitted to the State.

9. Drug Claims Processing. All prescribing Providers must have an individual NPI number. This must be the same NPI number(s) used for enrollment in the Nebraska Medicaid Program.

10. Cultural Competency. Providers are required to deliver services in a culturally competent manner to all Members, including those with limited English proficiency or diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 C.F.R. 438.206(c)(2).

11. Mainstreaming of Members. To ensure mainstreaming of Nebraska Medicaid members, the Provider must take affirmative action so that Members are provided Covered Services without regard to payer source, race, color, creed, gender, religion, age, national origin (to include those with limited English proficiency), ancestry, marital status, sexual-orientation, genetic information, or physical or mental illnesses. The Provider must take into account a Member's literacy and culture when addressing Members and their concerns, and must take reasonable steps to ensure subcontractors do the same. Examples of prohibited practices include, but are not limited to, the following, in accordance with 42 C.F.R. 438.6(f): (i) denying or not providing a Member any Covered Service or access to an available facility; (ii) providing to a Member any Medically Necessary Covered Service that is different, or is provided in a different manner or at a different time from than provided to other Members, other public or private patients or the public at large, except where Medically Necessary; (iii) subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service; or restricting a Member in any way in his/her enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service; and (iv) assigning times or places for the provision of Covered Services on the basis of the race, color, creed, religion, age, gender, national origin, ancestry, marital status, sexual orientation, income status, Medicaid membership, or physical or mental illnesses of the participants to be served. Should Health Plan identify any problems with a Provider involving discrimination, Health Plan shall promptly intervene and require a corrective action plan from the identified Provider. Failure to take prompt corrective measures shall subject the Provider to sanction or contract termination.

12. Wait Lists for Behavioral Health Services. In circumstances in which a Member requires residential behavioral health services and is placed on a waiting list, Contracted Provider shall offer interim services until residential services are available.

13. Deficit Reduction Act. In accordance with Section 6032 of the Deficit Reduction Act of 2005 ("DRA"), Contracted Provider shall, and shall require the other Providers to, comply with Health Plan's Fraud and Abuse Prevention Policy, as revised from time to time by Health Plan, and as otherwise may be required under the Nebraska Contract.

14. Compliance with Laws. Both Parties must comply with all applicable Laws including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding educational programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

15. Physician Incentive Plan Programs. The Parties shall comply with the requirements of the Physician Incentive Plan (PIP) regulations contained in 42 C.F.R. § 438.6(h), 42 C.F.R. §§ 422.208 and 422.210. No specific payment will be made directly or indirectly as an inducement to reduce or limit Medically Necessary services furnished to a Member. Contracted Provider shall provide any PIP information in an accurate and timely manner to Health Plan in the format requested by Health Plan.

As applicable, Contracted Provider agrees to incorporate the requirements of the PIP regulations and this provision into its agreements with any persons/entities for the provision of services under this Agreement.

16. Maintenance of Records. Contracted Provider shall maintain an adequate medical record system which includes a complete medical record for each Member in accordance with State laws and regulations. In addition, Contracted Provider will maintain a medical records system which maintains inactive medical records. Contracted Provider must document all medical services that the Member receives in accordance with all applicable laws and consistent with utilization control requirements in 42 C.F.R. § 456. Contracted Provider must maintain Members' medical records in a detailed and comprehensive manner that conforms to good professional medical practice, permits effective professional medical review and medical audit processes and facilitates an accurate system for follow-up treatment. Contracted Provider will maintain methods and procedures that guarantee each Member the right to request and receive a copy of his or her medical records. Medical records must be legible, signed, dated and maintained in accordance will all applicable Laws. The Provider must have online retrieval and access to documents and files for six (6) years in live systems and ten (10) years in archival systems, for audit and reporting purposes. The claims for services that have a once-in-a-life-time indicator (i.e., appendix removal, hysterectomy) must remain in the current/active claims history for claims editing and are not to be archived or purged. Online access to claims processing data must be possible by Medicaid ID number, provider ID number, and/or internal control number. The Provider must provide 48-hour turnaround or shorter for requests for access to information that is six (6) years old, and 72-hour turnaround or shorter for requests for access to information in machine readable form, that is between six (6) and ten (10) years old. If an audit or administrative, civil, or criminal investigation or prosecution is in progress; or audit findings or administrative, civil, or criminal investigations or prosecutions are unresolved; then, information must be kept in electronic form until all tasks or proceedings are completed. Historical encounter data submissions must be retained for a period of not less than six (6) years, following generally accepted retention guidelines.

17. Utilization/Encounter Data. If Contracted Provider received capitation payments under this Agreement, Contracted Provider shall submit encounter data within ninety (90) calendar days of the date of service. Submission of all utilization or encounter data must meet the same standards of completeness and accuracy, including pricing information, as required for proper adjudication of fee-for-service claims. Contracted Provider understands that such submissions shall meet these standards as a condition of receiving the capitation payment as Health Plan shall make every effort to enforce this provision to ensure the timely receipt of complete and accurate data.

18. Response to Record Requests. Contracted Provider shall furnish duly authorized and identified agents or representatives of the State and federal governments, including but not limited to, the MLTC, the Secretary of the Department of Health and Human Services, the DHHS Office of the Inspector General ("OIG"), or the Nebraska Medicaid Program Integrity Unit ("NMPI"), Medicaid Fraud and Patient Abuse Unit ("MFPAU") and Health Plan with such information as they may request regarding payments claimed for Medicaid services. The Contracted Provider must timely provide copies of the requested records within ten (10) business days to the agency, the agency's designee (including Health Plan) or MFPAU from the date of the request, unless the agency or MFPAU sets, at its sole discretion, a period greater than 10 days. If such original documentation is not made available as requested, Contracted Provider, must provide transportation, lodging and subsistence at no cost, for all State and/or Federal representatives to carry out their audit functions at the principal office of Contracted Provider (or Contracted Provider's other locations, as applicable). Additionally, Contracted Provider agrees to grant the MLTC, Department, DHHS, OIG, NMPI, MFPAU, other Governmental Authority, and Health Plan access during regular business hours to

examine health service and financial records related to a health service billed to the program. The MLTC will notify Health Plan no less than twenty-four (24) hours before obtaining access to a health service or financial record. All responses to requests for access to or copies of any records or data maintained by Contracted Provider or Providers shall be in the form and manner and by the due date requested by the requesting entity.

19. Confidentiality of Member Records. Contracted Provider must establish and implement procedures consistent with the confidentiality requirements in 45 C.F.R. Parts 160 and 164 for Member Records and any other health and enrollment information that identifies a Member, as well as any and all other applicable provisions of privacy law.

20. Business Transaction Disclosures. Contracted Provider shall provide full disclosure of significant business transactions as set forth in 42 C.F.R. § 455.105. Contracted Provider shall submit, within thirty (30) calendar days of a request made by MLTC, federal DHHS or Health Plan, full and complete information about: (i) the ownership of any subcontractor with whom the Contracted Provider has had business transactions totaling more than $25,000 during the twelve (12) month period ending on the date of the request; and (ii) any significant business transactions between the Contracted Provider and any wholly owned supplier, or between the Contracted Provider and any subcontractor, during the five (5) year period ending on the date of the request. In addition, Contracted Provider agrees to provide these disclosures to Health Plan at any time, upon Health Plan's request and within the time frame requested by Health Plan in order for Health Plan to meet its requirements under the Nebraska Contract.

21. Ownership Disclosures. Contracted Provider shall make full disclosure of ownership, management and control information for the Contracted Provider, any subcontracting entities or Providers as required by 42 C.F.R. §§ 455.100 through 455.106. This information shall be delivered to Health Plan upon execution of this Agreement, and to Health Plan or MLTC within thirty (30) calendar days after any change in ownership. In addition, Contracted Provider agrees to provide these disclosures to Health Plan at any time, upon Health Plan's request and within the time frame requested by Health Plan in order for Health Plan to meet its requirements under the Nebraska Contract.

22. No Balance Billing. Providers may not bill Members any amount greater than would be owed if Health Plan provided the services directly (i.e., no balance billing by Providers is permitted.

23. Continuation of Benefits for Dual Eligible Members. Continuation of benefits shall be in accordance with Nebraska laws and the Nebraska Contract. Upon the termination of the Agreement, except if the termination is for cause by Health Plan, Contracted Provider agrees to continue to provide care for non-pregnant Members who are undergoing a course of treatment for ninety (90) days, or if sooner, upon completion of the prescribed treatment plan. Contracted Provider agrees to continue to provide care to pregnant Members in their second or third trimester of pregnancy through postpartum care related to the child birth and delivery, which shall also include the post-partum visit.

24. Third-Party Liability for Dual Eligible Members. Additionally, Contracted Provider shall identify any third-party liability coverage, including Medicare and long-term care insurance, as applicable. Contracted Provider shall seek payments from any applicable third-party liability coverage prior to submitting claims to Health Plan.

25. Provider Preventable Conditions. No payment will be made for provider-preventable conditions, as identified by the Nebraska Contract or applicable federal or State law, as any may be amended. Contracted Provider agrees to comply with the reporting requirements of 42 C.F.R. § 447.26(d) as a condition of payment.

26. Coordination of Benefits. Contracted Provider must coordinate benefits in accordance with 42 C.F.R. 433.135, et seq., and 471 NAC 3-004 in order to avoid costs and recover payments from liable parties as appropriate. Contracted Provider must not pursue collection from the Member, but directly from the liable third party(ies), except as allowed in 468 NAC Chapter 4-002 and 471 NAC Chapter 3-004.

27. Claim Submission. Contracted Provider shall submit Clean Claims, which do not involve a third party payer, no more than six (6) months from the date of service to be considered timely (except as is provided for under 471 NAC 3-002.01A). Upon termination or expiration of the Agreement, Contracted Providers shall supply all information necessary for the reimbursement of any outstanding medical claims.

28. Nondiscrimination. Health Plan will not discriminate for the participation, reimbursement or indemnification of Providers acting within the scope their license solely on the basis of that license or certification and will not discriminate against Providers who serve high-risk populations or specialize in conditions that require costly treatment.

29. Timely Access. Contracted Provider must meet the Nebraska Contract timely access to care and services standards. Contracted Provider must meet the hours of operation and appointment time requirements set forth in the Nebraska Contract and Health Plan's Provider Manual. Contracted Provider agrees to maintain hours of operation for Members no less than hours of operation offered to commercial enrollees or comparable to other Medicaid fee-for-service enrollees. Contracted Provider shall be available to Members twenty-four (24) hours a day, seven (7) days a week as required by the Nebraska Contract and Contracted Provider acknowledges that Health Plan shall implement corrective actions for Providers identified through the audit as failing to meet this standard.

30. Newborn Enrollment Notification. If Contracted Provider is a hospital, Contracted Provider agrees to report births of Members to the Health Plan within 24 hours of the birth.

31. Provider-Patient Relationship. Subject to the limitations described in 42 C.F.R. 438.102(a)(2), Health Plan agrees that it will not prohibit or otherwise restrict Contracted Provider, when acting within the lawful scope of his/her/its practice, from advising or advocating on behalf of a Member, who is a patient of the Provider, regardless of whether benefits for such care or treatment are provided under the contract, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or non-treatment; or (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

32. Patient-Centered Medical Homes. Health Plan agrees to promote and facilitate the capacity of its Providers to provide patient-centered care by using systematic, patient-centered medical home management processes and health information technology to deliver improved quality of care, health outcomes, and patient compliance and satisfaction. Members must be cared for by a physician who leads a medical team that coordinates all aspects of the preventive, acute, and chronic needs of Members, using best available evidence and appropriate technology.

33. Inpatient Hospital Providers Utilization Management. If Contracted Provider is an inpatient hospital, Contracted Provider shall comply with Federal requirements regarding utilization management (UM) plans, UM committees, plans of care, and medical care evaluation studies, as described in 42 C.F.R. 44, 455 and 456.

34. Excluded Persons. Contracted Provider agrees that it will not execute any agreement with an individual or entity that has been excluded from participation in the Medicare, Medicaid, and/or CHIP Programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with a State's Medicaid program or the Medicare program. Contracted Provider agrees to disclose the identity of any person excluded or who may be excluded to Health Plan immediately upon Contracted Provider's knowledge. Contracted Provider shall disclose the identity of any person described in 42 C.F.R. § 1001.1001(a)(1). Health Plan must abide by any direction provided by the Department regarding whether or not to permit a Provider for participation in Health Plan's network. If any person who has ownership or control interest in Contracted Provider, or who is an agent or managing employee of Contracted Provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XXI Services program, or if the Department or Health Plan determines that Provider did not fully and accurately make any disclosure required pursuant to 42 C.F.R. § 1001.1001(a)(1), then Health Plan shall not permit the Provider into the provider network. Additionally, Contracted Provider shall not enter into any relationship with anyone or any entity debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from non-procurement activities under regulations issued under Executive Orders.

35. Laboratory Services. If Contracted Provider is a clinical laboratory, Contracted Provider shall provide to Health Plan, in accordance with the Clinical Laboratory Improvement Amendments (CLIA) and the requirements of 42 C.F.R. § 493, Subpart A, verification of CLIA licensure (including the CLIA identification number) or Certificate of Waiver during the Provider registration process. Failure to do so will result in either a termination of an active provider identification number or denial of initial registration. Pass-through billing or other activities conducted with the intent of avoiding these requirements is prohibited. Health Plan shall not reimburse Providers who do not comply with the above requirements.

36. Obligation to Suspend Payment to Providers. Health Plan, in compliance with 42 C.F.R. § 455.23 and the Nebraska Contract, shall suspend payments to a Provider when the Department notifies Health Plan that there is a credible allegation of fraud. Health Plan will comply with the applicable provisions of 42 C.F.R. § 455.23 and the Nebraska Contract when implementing this provision.

37. Enroll In State Medicaid Program. Contracted Provider shall enroll with the Department as an approved service provider. For specific requirements on provider enrollment, refer to the Department's website at: http://MLTC.ne.gov/medicaid/Pages/med_providerenrollment.aspx.

38. Credentialing. Contracted Provider and all Providers shall be credentialed by Health Plan in accordance with the Department's credentialing requirements. Additionally, as part of the credentialing process, Contracted Provider shall disclose, and shall require Providers to disclose, the following information in accordance with 42 C.F.R. § 455.104: (i) the name and address of each person with an ownership or controlling interest in the disclosing entity or in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more; (ii) whether any of the persons named is related to another as spouse, parent, child, or sibling; and (iii) the name of any other disclosing entity in which a person with an ownership or controlling interest in the disclosing entity also has an ownership or controlling interest. This requirement applies to the extent that the disclosing entity can obtain this information by requesting it in writing from the person. The disclosing entity must: (a) keep copies of all requests and responses, (b) make those requests and responses available to the Department upon request, and (c) advise the Department when there is no response to a request.

39. Required Disclosures of Nebraska Medicaid Fund Recipients. Contracted Provider shall comply with all Federal requirements (42 C.F.R. 455) about disclosure reporting. Contracted Provider shall submit

routine disclosures in accordance with timeframes specified in 42 C.F.R. 455(B), including at the time of initial contracting, contract renewal, within forty-five (45) calendar days of any change to the information on the disclosure form, a minimum of annually, and at any time on request.

40. Fraud, Waste, and Abuse. Contracted Provider shall take all the necessary actions to permit Health Plan to comply with the Fraud, Waste, and Abuse (FWA) and erroneous payments requirements included in the Nebraska Contract and State and Federal regulations. To the extent that Contracted Provider delegates oversight responsibilities to a third party, if allowed, Contracted Provider shall ensure that the third party complies with all provisions of this Agreement relating to FWA and erroneous payments. Additionally, Contracted Provider shall comply with regulations and any enforcement actions directly initiated by the Department under its regulations, including but not limited to, termination and restitution.

41. Certification Regarding Lobbying. Contracted Provider certifies that no federal appropriated funds have been paid or will be paid on behalf of the Contracted Provider or any subcontractor or Provider to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any federal agency, a Member of the Congress, an officer or employee of the Congress, or an employee of a Member of Congress in connection with the Nebraska Contract, grant loan, or cooperative agreement, Contracted Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Contracted Provider shall require that the language of this certification be included in contracts with Providers and subcontractors and ensure that all subrecipients shall certify and disclose accordingly.

42. Additional Requirements if Contracted Provider is a Subcontractor:

    a. Hold Harmless. The Contracted Provider agrees to defend, indemnify, hold, and save harmless the State of Nebraska and its employees, volunteers, agents, and its elected and appointed officials ("the indemnified parties") from and against any and all claims, liens, demands, damages, liability, actions, causes of action, losses, judgments, costs, and expenses of every nature, including investigation costs and expenses, settlement costs, and attorney fees and expenses ("the claims"), sustained or asserted against the State of Nebraska, arising out of, resulting from, or attributable to the willful misconduct, negligence, error, or omission of the Contracted Provider, its employees, subcontractors, consultants, representatives, and agents, except to the extent such Contracted Provider liability is attenuated by any action of the State of Nebraska which directly and proximately contributed to the claims.

    b. Maintenance of Records for Contracted Provider. Contracted Provider shall, at all times during the term of this contract and for a period of ten (10) years after the completion of this contract, maintain records, together with such supporting or underlying documents and materials. The Contracted Provider shall at any time requested by the State of Nebraska, whether during or after completion of this contract and at Contracted Provider's own expense make such records available for inspection and audit (including copies and extracts of records as required) by the State of Nebraska. Records shall include, but not be limited to, accounting records, written policies and procedures; all paid vouchers including those for out-of-pocket expenses; other reimbursement supported by invoices; ledgers; cancelled checks; deposit slips; bank statements;

journals; original estimates; estimating work sheets; contract amendments and change order files; back charge logs and supporting documentation; insurance documents; payroll documents; timesheets; memoranda; and correspondence. Records shall be made available to the State during normal business hours at the Contracted Provider's office or place of business. In the event that no such location is available, then the financial records, together with the supporting or underlying documents and records, shall be made available for audit at a time and location that is convenient for the State. Contracted Provider shall ensure the State of Nebraska has these rights with its assigns, successors, and subcontractors as it relates to fulfillment of the Contracted Provider's obligations to the State.

c. Marketing and Member Education Materials. Contracted Provider may not engage in any unfair, deceptive, or prohibited marketing or member education practices as specified in the Contract. Contracted Provider acknowledges and agrees that it must submit any marketing materials to Health Plan and written approval must be received from MLTC, prior to distribution of such marketing materials.

d. Staffing Requirements. Contracted Provider warrants and represents that all persons, including independent contractors and consultants assigned by it to perform services under the Agreement that relate to the NE Contract, shall be employees or formal agents of Contracted Provider and shall have the training, education, experience, and orientation necessary to perform services under the Agreement. The State of Nebraska reserves the right to require the Contracted Provider to reassign or remove from the project any employee.

ATTACHMENT C
COMPENSATION

(See following attachments)

ATTACHMENT C-1
NEBRASKA MEDICAID PROGRAM COMPENSATION
(Ancillary/Medical Facility)
(FEE FOR SERVICE)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Nebraska Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses, if any:

   100 percent of the applicable Nebraska Medicaid fee schedule published on the Department's website on the date the Covered Services are rendered, as adjusted in this Attachment.

3. Health Plan may adjust claim payments due to coordination of benefits or subrogation.

4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days or such other timeframe required by applicable Laws or Government Contract. The date of receipt is the date the Health Plan receives the Clean Claim as indicated by its data stamp on the claim. The date of payment is the date of the electronic funds transfer, check or other form of payment.

5. Health Plan follows the Department's guidelines regarding modifiers and only reimburses modifiers reimbursed by the Department.

6. As applicable to the Nebraska Contract, Health Plan may apply current Nebraska Medicaid Program payment rules, policies and guidelines related to Provider's claims.

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

8. Health Plan implements and prospectively applies the Department's changes to its Nebraska Medicaid fee schedules as of the later of (i) the effective date of the change, or (ii) 45 days from the date the Department publishes the change on its website. Health Plan will not retrospectively apply rate changes to claims that have already been paid.

9. Health Plan may update code numbers or delete retired codes, without notice to Contracted Provider or amendment to this Agreement, as such are revised or implemented by the Department from time to time. Where applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for items and services that are not included in the Department's payment system or fee schedule published on its website.

ATTACHMENT C-2
NEBRASKA MEDICAID PROGRAM COMPENSATION
(PROFESSIONAL)
(FEE FOR SERVICE)

1. The compensation rates set forth in this Attachment apply for Benefit Plans under Nebraska Contracts. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Compensation. Fee for service compensation for Covered Services provided to Members shall be the lesser of the Provider's usual and customary billed charges or the following, less Member Expenses, if any:

   a. Primary Care Services:

      100 percent of the Nebraska Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered, as adjusted in this Attachment.

   b. Specialty Services:

      100 percent of the Nebraska Medicaid physician fee schedule published on the Department's website on the date the Covered Services are rendered, as adjusted in this Attachment.

   c. Notwithstanding the foregoing, to the extent Health Plan is required by the Department to reimburse certain Covered Services rendered by eligible designated Providers at enhanced rates, Health Plan's reimbursement will be 100% of the applicable Department enhanced fee schedule.

3. Health Plan may adjust claim payments due to coordination of benefits or subrogation.

4. Health Plan shall process claims and pay or deny a Clean Claim within 30 days or such other timeframe required by applicable Laws or Government Contract. The date of receipt is the date the Health Plan receives the Clean Claim as indicated by its data stamp on the claim. The date of payment is the date of the electronic funds transfer, check or other form of payment.

5. Health Plan follows the Department's guidelines regarding modifiers and only reimburses modifiers reimbursed by the Department.

6. As applicable to the Nebraska Contract, Health Plan may apply current Nebraska Medicaid Program payment rules, policies and guidelines related to Provider's claims.

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

8. Health Plan implements and prospectively applies Department's changes to its Nebraska Medicaid fee schedules as of the later of (i) the effective date of the change, or (ii) 45 days from the date the Department publishes the change on its website. Health Plan will not retrospectively apply rate changes to claims that have already been paid.

9. Health Plan may update code numbers or delete retired codes, without notice to Contracted Provider or amendment to this Agreement, as such are revised or implemented by the Department from time to time. Where applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for items and services that are not included in the Department's payment system or fee schedule published on its website.