HEALTH CARE SERVICES AGREEMENT

THIS HEALTH CARE SERVICES AGREEMENT ("Agreement") is entered into and effective the 1st____ day of August, 20 12 ("Effective Date") by and between Coventry Health and Life Insurance Company ("MCO"), a managed care organization that maintains a valid certificate of authority from the Kentucky Commissioner of Insurance to operate an insurance company under the laws of the Commonwealth of Kentucky, and Cincinnati Children's Hospital Medical Center, on behalf of itself and its subsidiaries, and its employed physicians ("Hospital").

WHEREAS, MCO has as its primary objective the delivery or arrangement for delivery of health care services to Members that are persons who are eligible for health care services by virtue of enrollment in MCO and the Commonwealth of Kentucky Medicaid programs; and

WHEREAS, MCO desires to contract with Hospital to provide certain healthcare services to its Members enrolled in a Medicaid product called CoventryCares of Kentucky as part of MCO's contract with the Cabinet for Health and Family Services, Department for Medicaid Services (the "Agency"); and

WHEREAS, Hospital provides certain services for the pediatric community, including without limitation, inpatient and outpatient hospital services, behavioral health services, professional services, primary care services, specialty care services, dental services, and ancillary services including, but not limited to, home health, home infusion therapy, durable medical equipment, hospice, ground and air ambulance, and reference laboratory and desires to provide certain of these health care services to Members under the terms and conditions set forth in this Agreement;

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree as follows:

I. DEFINITIONS

Defined terms are set forth herein. The following terms shall have the meanings set forth below.

Benefit Plan means the program that specifies services to be provided to or for the benefit of, or arranged for or reimbursed to or for the benefit of Members, the terms and conditions under which those services are to be provided or reimbursed, and is consistent with requirements as indicated in this Agreement and as required by the Agency.

Clean Claim means the standard billing forms required by the Kentucky Department of Insurance pursuant to KRS § 304.17A-700(3) (or any amended or successor statute); subject, however, upon their effective date, to the federal administrative regulations that prescribe standardized national requirements for transactions and data elements in accordance with the Federal Health Insurance Portability and Accountability Act of 1996, 42 USC Chapter 6A, Subchapter XXV, sec. 300gg *et seq* and shall include all information required to be submitted. Further, in accordance with federal Medicaid regulations, a Clean Claim is one that can be processed without obtaining additional information from the Hospital or a third party; provided, however, that it does not include a claim from Hospital that is under investigation for fraud or abuse, or under review for Medical Necessity.

Clinically Appropriate shall mean appropriate pursuant to the nationally recognized clinical criteria known as Interqual and developed by McKesson Health Solutions.

Code means the nationally recognized coding structures, descriptive terms and identifying codes as described by Uniform Billing Code, the current American Medical Association (AMA) Physicians' Current Procedural Terminology (CPT4), Centers for Medicare and Medicaid Services' (CMS) Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRGs) (version as defined by DMS), ICD-9 Diagnosis and Procedure codes, National Drug Codes (NDC), and the American Society of Anesthesiologists (ASA) relative values. As changes are made to nationally recognized Codes, MCO will make best efforts to update internal systems to accommodate new codes in a timely fashion.

Covered Services means those medical services provided to a Member in accordance with the applicable Benefit Plan and (a) that are Medically Necessary; (b) that are generally available at Hospital; and (c) Hospital is licensed to provide to Members. For Medicaid Members, Hospital must provide at a minimum all Medicaid-covered medical services within the practice scope of Hospital.

DMS means the Department for Medicaid Services. This is a department within the KCHFS that administers the Medicaid program in Kentucky.

Emergency or Emergency Services means a medical condition, or services performed in Hospital's emergency room department to treat and/or stabilize such condition, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

HIPAA Privacy Regulations means the federal regulations issued by the Centers for Medicare and Medicaid Services pursuant to the Health Insurance Portability and Accountability Act of 1996.

KAR means Kentucky Administrative Regulations.

KCHFS means the Kentucky Cabinet for Health and Family Services. This is the agency in Kentucky responsible for administering Kentucky's social service programs, including the Medicaid program through the Department for Medicaid Services hereinafter referred to as Kentucky Department of Insurance.

KRS means Kentucky Revised Statutes. **Medically Necessary** shall mean those services that are:

i. reasonable and required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or other medical condition, including pregnancy;

ii. appropriate in terms of the service, amount, scope, and duration based on generally-accepted standards of good medical practice;

iii. provided for medical reasons rather than primarily for the convenience of the individual, the individual's caregiver, or the health care provider, or for cosmetic reasons;

iv. provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided;

v. needed, if used in reference to an emergency medical services, to exist using the prudent layperson standard;

vi. provided in accordance with EPSDT requirements established in 42 U.S.C. 1396(r) and 42 CFR 441, Subpart B for individuals under age 21; and

vii. provided in accordance with 42 CFR 440.230.

Medicaid means medical assistance provided under a state plan approved under Title XIX of the Social Security Act. In Kentucky, the Medicaid program is administered by the Kentucky Cabinet for Health and Family Services (KCHFS) through Department for Medicaid Services (DMS).

Member means a person enrolled in MCO who is eligible to receive Covered Services pursuant to a Benefit Plan. For the purposes of this Agreement, Members shall be limited to those individuals enrolled in MCO by virtue of MCO's contract with the Agency.

Participating Facility means a hospital that has a direct or indirect contractual agreement with MCO and to which a Participating Facility may admit a Member for care and treatment.

Participating Provider means a hospital, a physician or any other health care practitioner or entity that has a direct or indirect contractual arrangement with MCO to provide Covered Services to Members.

Primary Care Provider or PCP means a licensed physician (M.D. or D.O.) who has contracted with MCO to provide primary care/case manager services to Members that have chosen or has been assigned, as appropriate, the physician as their primary care physician.

Quality Assurance Program means the processes established and operated by MCO or its designee relating to the quality of Covered Services.

Represented Physician and Provider means a physician or any other health care practitioner who: (a) is employed by Hospital; (b) is authorized to provide services pursuant to this Agreement, and (c) has agreed to be subject to the requirements of this Agreement to the extent applicable.

Provider Manual. shall mean the policies and procedures of MCO applicable to Participating Hospitals and Physicians.

Utilization Review is a process to monitor whether certain health care services provided or to be provided to Members are in accordance with this Agreement.

II. PARTIES' OBLIGATIONS

A. Services

1. Hospital and MCO shall act in accordance with the terms of this Agreement and will be governed by and operate in accordance with all applicable federal and state laws, regulations and contractual obligations. Hospital shall accept the rates set forth in this Agreement as payment in full for all services provided to Members pursuant to this Agreement. Hospital agrees to not charge Members or DMS co-payments for Covered Services unless approved by DMS or otherwise permitted by state or federal law.

2. Hospital shall provide Covered Services with the same standard of care, skill and diligence customarily used by similar providers in the community in which such services are rendered, and with the same availability, as offered to other patients. Hospital shall not differentiate or discriminate in the treatment of any Member because of race, color, national origin, ancestry, religion, gender, marital status, sexual orientation, age, health status, use of Covered Services, income level or on the basis that Member is enrolled in a managed care organization or is a Medicaid beneficiary and in accordance with a children's hospital scope of care, health status or presence of handicap, source of payment or need for health services.

3. Hospital shall be a Participating Facility and provide to each Member those Covered Services which Hospital is qualified by law to provide and customarily provides and in conformity with generally accepted pediatric medical and surgical practices in effect at the time of service. Hospital shall provide Covered Services to Member through the last day the Agreement is in effect. The Hospital shall provide Covered Services through professional personnel and physical facilities according to generally accepted medical standards of medical practice and hospital management. Represented Physicians and Providers shall designate one or more Participating Facilities where Represented Physicians and Providers will admit Members under their care unless otherwise approved by MCO or its designee. Represented Physicians and Providers shall admit Members only to Participating Facilities except in the case of an Emergency or as otherwise required by law. Hospital also agrees to implement credentialing of physicians, nurse practitioners, physician assistants and other ancillary personnel who provide health care to Members on behalf of Hospital.

4. Hospital shall not subcontract any services required to be provided under the Agreement or any portion of the Agreement without prior written consent of MCO if the subcontract requires a Member to occupy an inpatient bed or receive hospital services at locations other than Hospital locations. In the event that a subcontract is approved, the other hospital/facility shall be held to the requirements set forth herein and all requirements of Commonwealth law applicable hereto.

5. For referrals for specialty care, Represented Physicians and Providers shall refer Members to Participating Providers except in the case of an Emergency or as otherwise required by law.

6. Hospital shall use good faith effort to comply with the reasonable requirements of and shall participate in MCO's Quality Assurance Program. Hospital agrees to comply with all MCO policies and procedures. Hospital agrees to use commercially reasonably best efforts to comply with MCO's Provider Manual, quality improvement, utilization review, peer review, grievance and appeal procedures, credentialing and recredentialing procedures, adverse event monitoring policy, and any other policies that MCO

or Payor may implement, including amendments made to the above mentioned policies, procedures and programs from time to time. MCO shall notify Hospital of any material modifications to such policies, or to edit programs or a specific edit, thirty (30) days in advance of their applicability. Hospital further agrees to provide MCO access to any and all billing records, including medical records as it relates to member.

7. Hospital agrees to provide healthcare services to Members on a twenty four (24) hour per day, seven (7) day per week basis. Hospital shall provide healthcare services in accordance with this Agreement, and the bylaws, rules, regulations, policies and procedures of Hospital and its medical staff. Hospital shall not discriminate against a Coventry enrollee on the basis of race, color, creed, religion, gender, sexual preference, national origin, health status, use of Covered Services, income level, or on the basis that an enrollee is enrolled in a managed care organization or is a Medicaid beneficiary. Except in the case of provision of Emergency Services and pursuant to Coventry's prior authorization list, Hospital shall, prior to rendering Covered Services: (a) contact Coventry or its designee directly and obtain an authorization number during normal business hours, authorizing the performance of Covered Services and confirming the Member's eligibility to receive Covered Services and any limitations or conditions on such Covered Services; and (b) verify the identity of the Member by: (i) requiring the Member to produce his/her Identification Card and whenever possible another form of photo identification.. If Member is a minor, parent's identification will be acceptable if Member's eligibility is verified with Coventry as set forth in this section. In the event of Emergency admissions, Hospital shall use commercially reasonable best efforts to notify Coventry of the admission within one working day when ID Card is made available to Hospital upon admission or as soon as possible.

8. MCO will maintain an electronic eligibility verification procedure and/or some other reasonable means of verification procedure such as a telephonic Member verification system available to Hospital 7 days/week, 24 hours/day, 365 days/year for Hospital to verify coverage of Member under the applicable Benefit Plan. MCO shall provide Members a means of identification identifying MCO eligibility. Sample identification cards shall be provided to Hospital upon request. MCO shall provide Primary Care Providers a monthly roster of their assigned Members.. In addition, the identification card will also identify the Member's benefit plan and the telephone number that Hospital may call to confirm Member's benefit plan, including any limitations or conditions on Covered Services. At such time as MCO receives an inquiry from Hospital regarding a Member's benefit plan or Covered Services, MCO shall use information given by Hospital to make preliminary benefit decisions. MCO shall retain the right and sole responsibility to determine whether a service is a Covered Service. Except in the case of provision of Emergency Services, prior to: (i) admitting Members as inpatients; (ii) performing outpatient services that are included as Covered Services for Members; and (iii) performing any non-Emergency Service, Hospital shall: (a) contact Coventry or its designee directly, by phone, and obtain an authorization number during normal business hours, authorizing the performance of Covered Services and confirming the Member's eligibility to receive Covered Services and any limitations or conditions on such Covered Services; and (b) verify the identity of the Member by: (i) requiring the Member to produce his/her Identification Card and another form of identification with a photo whenever possible; or (ii) if no membership card has yet been issued, two forms of identification, at least one of which shall be a photo identification whenever possible. If Member is a minor, parent's identification will be acceptable if Member's eligibility is verified with Coventry as set forth in this section.

9. MCO acknowledges that Hospital shall be considered a Participating Facility and its Represented Physicians and Providers shall be considered Participating Providers for all inpatient and outpatient services that he/she/it provides, including but not limited to, reference laboratory, radiology, mental health, urgent care, ambulance, home infusion, home health, hospice, and durable medical equipment. MCO understand that the rates set forth in Exhibit A are contingent on all Hospital services being available to Members. Hospital understands that if during the term of this Agreement, MCO deems it necessary to carve-out any additional services provided by Hospital, Hospital will be notified of MCO's subcontractor relationship and Hospital's written consent shall not be required.

10. MCO may contract directly with a third party administrator (TPA) who agrees to pay claims on behalf of MCO in accordance with this Agreement for Covered Services rendered by Hospital. MCO shall provide Hospital, in Exhibit D, attached hereto and incorporated herein: (a) the mailing or electronic address where claims should be sent for processing; (b) the MCO phone number for questions and/or concerns regarding claims; (c) the TPA, if any, to which MCO has delegated claims payment functions; (d) the address of any separate claim processing center for specific types of services (e.g. transplant or mental health services); and (e) any claim attachments that are routinely required prior to payment of claims. MCO shall provide thirty (30) days prior written notice to Hospital of any changes to Exhibit D including those that materially change the type or content of the claim attachments or other documents to be submitted in accordance with this Agreement.

11. Hospital will provide Covered Services to each Member in such a manner as to (1) deliver health care in a reasonably cost-effective manner; (2) safeguard the confidentiality of medical records in accordance with all federal and state laws including but not limited to the HIPAA Privacy Regulations; and (3) provide Covered Services in accordance with generally accepted community standards, surgical and scientific practices and standards at the time such Covered Services are provided.

12. Hospital shall, on the date of this Agreement and throughout the term of this Agreement, complete the necessary hospital registration requirements mandated by the Commonwealth of Kentucky, and remain accredited by the Joint Commission on Accreditation of Healthcare Organizations.

13. MCO shall, on the date of this Agreement and throughout the term of this Agreement, maintain all licenses, certificates, and permits that are necessary to operate as a health maintenance organization in Kentucky or that are required by KCHFS or DMS, the Kentucky Department of Insurance and any other state or federal regulatory agency.

14. Hospital, including Represented Physicians and Providers, shall, on the date of this Agreement and throughout the term of this Agreement, maintain and warrant that it is an acute care hospital licensed by the appropriate regulatory body in the State in which Hospital is located and certified as a provider in good standing under Titles XVIII and Title XIX (Medicaid) of the Social Security Act. Hospital agrees to maintain, and require its employed providers and hospital based providers to maintain, in good standing all licenses required by law and certification under Titles XVIII and XIX of the Social Security Act.

15. During the term of this Agreement, representatives of Hospital and MCO will meet monthly, or less frequently if mutually agreed upon, to review the payment status of

claims sent to MCO, to address any issues Hospital and/or MCO may be having with the claims processing or utilization management, and the status of appeals filed by Hospital for claims denied by MCO.

B. Utilization Management

1. MCO's Utilization Review Committee shall conduct prospective, concurrent and retrospective reviews of inpatient care in conformity with applicable Commonwealth and Federal laws, regulations and reporting requirements. Hospital agrees to cooperate with, participate in and abide by decisions of MCO Utilization Review Committees. In illustration, and not limitation, of the foregoing, Hospital agrees that it shall use its best efforts to cooperate with MCO employees conducting concurrent utilization review. If there is a conflict between Hospital's utilization review standards and MCO's utilization review standards, for purposes of the Agreement, the decision of MCO's Medical Director, or Medical Director's designee, shall control.

2. In addition, Hospital agrees to secure prior authorization for certain services and in accordance with policies and procedures as contained in the Provider Manual attached as Exhibit B. Such services shall be limited to those services that MCO requires prior authorization including, but not limited to elective inpatient admissions, certain outpatient surgeries, and certain dental services. MCO shall maintain an telephonic or for securing such prior authorizations with access available to Hospital 7 days/week, 24 hours/day, 365 days/year. MCO shall respond to routine prior authorization requests for inpatient services within one business day and outpatient services within two business days.

3. MCO agrees to conduct its utilization management programs and make its utilization management decisions in a fair and consistent manner. Notwithstanding anything in this Agreement to the contrary, where MCO, or its designated representative, has authorized a proposed admission, treatment, or health care service to be provided by Hospital based upon the Hospital's complete and accurate submission of all necessary information relative to a Member, MCO may retroactively deny if the services are later determined to be non-Covered Services or the patient is not an eligible Member. Furthermore, in the event Hospital fails to seek authorization for services before they are rendered and such services required prior authorization, MCO shall review Hospital's claim to determine whether the services in question were (a) Covered Services, and (b) Medically Necessary. If it is determined that the claim meets this criteria, MCO shall pay the claim in its entirety

4. A Primary Care Provider shall use best efforts to refer or admit Members only to Participating Providers for Covered Services, and shall furnish such Participating Providers with complete information on treatment procedures and diagnostic tests performed prior to such referral or admission.

5. MCO agrees that it shall comply with applicable federal regulations regarding the coverage of Emergency Services and post-stabilization services.

6. MCO shall conduct quality improvement audits and evaluations on a periodic basis, in accordance with the requirements of applicable Commonwealth and Federal laws, regulations and reporting requirements. Hospital agrees to cooperate with MCO in the conduct of such reviews and to provide MCO with access to the records and other information

needed by MCO to complete such audits and evaluations. Hospital agrees to be bound by the policies adopted by and the decisions of MCO's Quality Improvement Committees.

C. Compensation and Billing

1. Hospital shall receive payments from MCO, or TPA, for Covered Services at rates set forth in Exhibit A. Hospital shall look solely to MCO for compensation for Covered Services and shall not seek payment from the Members in the event that MCO is insolvent or cannot or will not pay for Covered Services performed by the Hospital pursuant to this Agreement. For purposes of this section, services rendered under the Agreement include those health care services delivered to Members by any and all health care professionals employed by or independently contracted with the Hospital.

2. In no event will the Commonwealth, the Agency, or any Member be liable for the payment of any debt or fulfillment of any obligation of Hospital, MCO, or any subcontractor to any subcontractor, supplier, out-of-network provider or any other party, for any reason whatsoever, including the insolvency of Hospital, MCO or any subcontractor. Hospital agrees that any subcontractor contract will contain a hold harmless provision.

3. Hospital, subcontractors, and referral providers are prohibited from directly receiving payment or any type of compensation from Members for providing Covered Services, except for Member co-pays, co-insurance or deductibles from Members for providing Covered Services specifically authorized by the Agency in writing. Member co-pay, co-insurance or deductible amounts cannot exceed amounts specified in 907 KAR 1:604.

4. Hospital shall not bill a Member for Medically Necessary Covered Services, with the exception of applicable co-pays or other cost sharing requirements. If Hospital knowingly and willfully bills a Member for a Medicaid Covered Service, Hospital shall be guilty of a felony and upon conviction shall be fined as defined in Section 1128B(d)(1), 42 U.S.C. 1320a-7b of the Social Security Act. This provision shall remain in effect even if MCO becomes insolvent.

5. If Hospital is involved in coordination of benefits collections, Hospital shall report coordination of benefits information to MCO. Hospital shall not pursue collection from the Member, but directly from the third party payer or the provider. Access to Covered Services shall not be restricted due to coordination of benefits collection. The Agency has the right to review all billing histories and other data related to collection of benefits activities for Members.

6. Hospital shall not bill a Member for performance of non-Covered Services, unless the Member agrees in advance in writing to pay for the non-Covered Service. The standard release form signed by the Member at the time of services does not relieve the Hospital from the prohibition against billing a Medicaid Member in the absence of a knowing assumption of liability for a Non-Covered Service. The form or other type of acknowledgement relevant to the Medicaid Member liability shall specifically state the services or procedures that are not covered by Medicaid.

7. Hospital agrees that in no event, including, but not limited to, nonpayment by Coventry or a Payor, Coventry or a Payor insolvency or breach of the Agreement shall Physician bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons other than Coventry

or a Payor acting on their behalf, for Covered Services rendered under the Agreement. For purposes of this section, services rendered under the Agreement include those health care services delivered to Members by any and all health care professionals employed by or independently contracted with the Physician. This section shall not prohibit collection of copayments, coinsurance, or deductibles in accordance with the Member's Member Contract.

8. Hospital further agrees that: (i) this provision shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member; and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Physician and a Member or a person acting on Member's behalf.

9. Hospital shall bill for Covered Services in accordance with the following:

a. Hospital agrees to submit its claims for reimbursement and encounter forms, as required by MCO on a UB04 Form or Centers for Medicare and Medicaid Services ("CMS") 1500 forms, or their successor forms, with current CMS coding, current International Classification of Diseases, Ninth Revision ("ICD9") and Current Procedural Terminology Fourth Edition ("CPT4") coding in accordance with the then current Medicare guidelines, whichever MCO prefers. Hospital shall submit bills within three hundred and sixty-five (365) days of the date of service or as set forth in applicable law, whichever is less, of the date of discharge unless coordination of benefit issues exist. Hospital may not bill MCO for inpatient Covered Services prior to the date of discharge and shall not separate bills for Covered Services for purposes of additional payments under the Agreement, except when hospitalizations of Member are greater than or equal to thirty (30) days, in which case interim billing may be allowed. Hospital understands and agrees that failure to submit claims in accordance with the requirements of this section may result in the denial of such claims. Hospital understands and agrees that all payment corrections shall be submitted within twenty-four (24) months in accordance with KRS 304.17A-708. For appeals that are not related to requests for payment corrections, Hospital has one (1) year from the date that service was rendered to appeal payment by MCO.

b. In accordance with the law in the Commonwealth of Kentucky, with the exception of claims for organ transplants, which shall be paid within sixty (60) days from the date of receipt, payments to Hospital shall be made within thirty (30) days of receipt of a Clean Claim. MCO payments shall be accompanied by an explanation of payment. The explanation of payment shall be inclusive of: (a) Member receiving the Covered Services and their identification number; (b) billed charge amount, Member responsibility, if any, contractual adjustment amount, and date(s) of service; (c) the applicable tax identification number; and (d) MCO name.

c. For the purposes of this Agreement, if a dispute exists between Hospital and MCO as to the day a claim form was received by MCO, both of the following apply: (1) If the Hospital submits a claim directly to MCO by mail and retains a record of the day the claim was mailed, there exists a rebuttable presumption that the claim was received by MCO on the fifth business day after the day the claim was mailed, unless it can be proven otherwise; and (2) If the

Hospital submits a claim directly to MCO electronically, there exists a rebuttable presumption that the claim was received by MCO 24 hours after the day the claim was submitted, unless such claim was reported to Hospital as rejected by the claims clearinghouse.

d. If after receiving a claim from Hospital, MCO determines it needs an attachment or additional information in accordance with Exhibit D to process the claim, MCO shall: 1) notify the Hospital, in writing or electronically within the claims payment time frame established above of the service that will be reviewed and the specific information needed from Hospital regarding MCO's review of a claim; and 2) upon receipt of the specific information requested, MCO shall complete the review within the time permitted by Kentucky law. Any claim denied under this paragraph may be resubmitted by the Hospital, and any resubmitted claim shall not be denied on the basis of timeliness if the resubmitted claim is made within the timeframe for submitting claims established in this Agreement.

10. MCO shall not be liable to make any payments for Covered Services for which Hospital fails to follow the preadmission authorization and eligibility verification (for inpatient or outpatient services) procedures set forth in the Agreement and under the Medicaid Program. Further, all or a portion of payment due to the Hospital may be denied by MCO if such payment is specifically attributable to Hospital's rendering or ordering: (i) services that are not Medically Necessary, (ii) elective hospitalization not authorized by MCO, (iii) services provided other than at an authorized level of care, (iv) services that are not Covered Services. In the event Hospital does not agree with a denial of payment determination made, an appeal may be filed in accordance with the appeal procedures set forth in the Provider Manual.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Hospital appeals within three hundred and sixty five (365) days after the date of service and can show all of the following: (a) that at the time the protocols required authorization/notification or at the time the claim was due, Hospital did not know and was unable to reasonably determine that the patient was a Member; (b) that Hospital took reasonable and timely steps to learn that the patient was a Member and as demonstrated in screen shots from Hospital's patient account management system to be provided with any appeal request; and (c) that the Hospital promptly provided notification, or filed the claim, after learning that the patient was a Member; and (d) that Covered Services are Medically Necessary.

11 MCO and Hospital agree to abide by MCO's policy on "Hospital-Acquired Conditions" and "Wrong Site/Person/Procedure" (the " HAC-WSPP Policy"), or such similar policy. The HAC-WSPP Policy shall be provided to Hospital upon request and may be updated from time to time by MCO. Reimbursement for care associated with Hospital-Acquired Conditions and Wrong Site/Person/Procedure shall be determined solely in accordance with MCO's HAC-WSPP Policy.

12. MCO shall assume responsibility for cost-avoidance measures for third party collections in accordance with the Agency Contract. Hospital agrees that Medicaid payment is secondary to other sources of payment for Covered Services, and is the payer of last resort. Coventry is required to pursue assignment and subrogation, and Hospital shall cooperate with Coventry in such efforts.

13. Payment Error Disputes. As used in this Agreement, a "payment error" occurs when a claim has been paid, but has not been paid according to the contracted rate. Each party will respond to the other party within thirty (30) calendar days of receiving documentation verifying the error from the party claiming incorrect payment. In the event of such a dispute, the parties agree to work toward a mutually agreeable resolution of such dispute using process set forth in this Agreement. Hospital shall have no more than twenty-four (24) months from the date that the Hospital received payment for the claim from MCO to request MCO process the claim correctly or re-submit the claim properly to MCO in accordance with KRS 304.17a-708.

a. Failure to make a timely submission of a claim shall not be considered a payment error for purposes of this paragraph.

b. If a claim was not paid according to the contracted rate in this Agreement, Hospital shall submit written documentation to that effect to MCO and MCO shall not require Hospital to appeal payment error. Written documentation will include: (i) patient name; (ii) date of service; (iii) CPT Code or DRG billed; (iv) billed charge; (v) expected payment (MCO fee schedule); (vi) MCO actual payment; (vii)allowed amount; (viii) alleged underpayment; and (ix) provider name.

c. Hospital may choose either to correct payment errors by either refunding any overpayment. If Hospital fails to refund, then MCO may deduct such monies from any outstanding monies that MCO may owe to Hospital.

d. Neither MCO nor Hospital shall be required to correct payment errors if the request, accompanied by documentation verifying the payment error, is first received by the other party more than twenty four (24) months after the date that the Hospital received payment for the claim from MCO.

14. Hospital Dispute of Claim Denial. Any other appeals raised by Hospital that (a) are not being brought on behalf of a Member or (b) that do not fall within the scope of Section 13 immediately above, must be filed with MCO within one year of the date of service or incident giving rise to the appeal (whichever is longer). As applicable, Hospital shall provide at a minimum the following information: Member name and identification number, date of service, claim number, name of the provider of services, and a brief explanation of the basis for the dispute. MCO will review such dispute(s) and respond to Hospital within thirty (30) days of the date of receipt by MCO of such dispute.

15. Overpayments. MCO reserves the right to recover over-paid claims from Hospital up to 24 months after the date the claim was paid, except in cases of fraud or misrepresentation, in which case MCO shall not be time-limited. In the event MCO determines that Hospital was overpaid, and such overpayment was not due to an error in the payment rate or method, MCO shall provide written or electronic notice to Hospital of the amount of the overpayment, the Member's name, ID number, date(s) of service to which the overpayment applies, MCO's' reference number for the claim, and the basis for determining that an overpayment exists. MCO will either request a refund from Hospital or indicate on its notice that, within 60 days of the postmark date/electronic delivery date of the notice, if Hospital has not disputed the overpayment recovery request, and has not provided the refund, then the amount of the overpayment will be recouped from future payments through offset. Hospital can send a notice of disagreement with the overpayment recovery request within 60 days from the

postmark date/electronic delivery date, and submit additional relevant information to MCO. In such instance, MCO shall not proceed with the recoupment until the dispute is resolved. Disputes shall be resolved within 30 days of receipt through MCO's provider appeals process, outlined in this Agreement and MCO's Provider Manual. In the event MCO determines that Hospital was overpaid, and such overpayment was due to an error in the payment rate or method, MCO may request a refund. Alternatively, MCO can immediately recoup the overpayment, and at the actual time of the recoupment, give Hospital the written or electronic documentation that specifies the amount of the recoupment, the Member's name and ID number, and the date of service. Hospital may dispute such recoupment. Hospital shall notify MCO if Hospital identifies an overpayment by contacting Customer Services and requesting that an adjustment be made to remove the money from future claim payments or by sending a check in the amount of the overpayment with a copy of the remittance advice identifying the claim that was overpaid.

16. Notwithstanding any other provision in this Agreement, should MCO, or designated representative, request access to Hospital medical and financial records directly related to this Agreement for the purposes of auditing previously paid claims by MCO, such audits shall be completed in accordance with Exhibit C, attached hereto and incorporated herein.

17. MCO may reduce or deny payment for services which are not submitted for payment in accordance with the provisions of Section C. or which are not billed or coded in accordance with MCO's criteria and standards as applicable for billing and coding practices, which includes the use of software to edit claims to ensure appropriate billing and coding practices. MCO may require appropriate documentation and coding to support payment for Covered Services. Hospital shall have the opportunity to correct any billing or coding error within twenty four (24) months of denial related to any such claim submission. Pursuant to applicable Kentucky law, MCO may recover payment or retain portions of future payments in the event that MCO determines that an individual was not an eligible Member at the time of services, or in the event of duplicate payment, overpayment, payment for non-covered services or fraud.

18. The following provisions apply regarding coordination of benefits:

a. Certain claims for services rendered to Members are claims for which another payor may be primarily responsible under coordination of benefit rules. Hospital shall bill such claims to the primary payor when information regarding such primary payor is available, or upon MCO's request.

b. When MCO is primary under applicable coordination of benefits rules, MCO shall pay benefits as set forth in this Agreement without regard to the obligations of any secondary payor.

c. When MCO is determined to be secondary to any other payor, including without limitation Medicare, MCO will pay no greater amount than the difference between the amount payable to Hospital by the primary payor and the amount for Covered Services owing under this Agreement. MCO shall not be liable for any amount unless MCO has received Hospital's claim for such secondary payment within ninety (90) days of the date upon receipt of the explanation of benefits.

19. Hospital and MCO agree to use best effort to utilize all electronic connectivity resources including, but not limited to, Member eligibility verification, claims status queries, billing, remittance, and payment.

D. Records

1. MCO and Hospital agree that clinical records of Members and other "Protected Health Information" or PHI as such term is defined by the HIPAA Privacy Regulations shall be regarded as confidential and both shall comply with all applicable federal and state laws and regulations regarding such records including but not limited to the HIPAA Privacy Regulations.

2. Hospital understands and agrees that neither MCO nor Members shall be required to reimburse Hospital for expenses related to providing copies of patient records or documents to any local, Commonwealth or Federal agency or MCO: (i) pursuant to a request from any local, Commonwealth or Federal agency (including, without limitation, the Centers for Medicare and Medicaid "**CMS**") or such agencies' subcontractors; (ii) pursuant to administration of MCO's Quality Improvement, Utilization Review, and Risk Management Programs; or (iii) in order to assist MCO in making a determination regarding whether a service is a Covered Service for which payment is due hereunder.

3. All records, books, and papers of Hospital pertaining to Members, including without limitation, records, books and papers relating to professional and ancillary care provided to Members and financial, accounting and administrative records, books and papers, shall be open for inspection and copying by MCO, its designee and/or authorized Commonwealth or Federal authorities during Hospital's normal business hours. Hospital further agrees that it shall release a Member's medical records to MCO upon Hospital's receipt of a Member consent form or as otherwise required by law.

4. In addition to the requirements set forth in the Agreement, Hospital shall maintain Member medical records on paper or in an electronic format. Hospital shall maintain Member medical records timely, legible, current, detailed and organized to permit effective and confidential patient care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals' findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Agency Contract. Medical records shall be signed by the Hospital.

5. Although the medical records are the property of the provider who generates the record, each Member or the Member's representative is entitled to one (1) free copy of his/her medical record. Additional copies shall be made available at cost. Hospital shall preserve and maintain Member medical records for no less than seven (7) years unless federal requirements mandate a longer retention period (i.e. immunization and tuberculosis records shall be maintained for a Member's lifetime).

6. Hospital's medical records shall meet MCO's medical record documentation standards. Medical records will reflect all aspects of patient care, including ancillary services. The documentation standards shall be established by the Agency. Hospital shall provide access to the medical records of Members to MCO, the Agency, the Office of the Inspector General and other authorized Commonwealth and federal agents thereof, for purposes of auditing.

7. If any Covered Service provided by Hospital requires completion of a specific form (e.g., hospice, sterilization, hysterectomy, or abortion), the form shall be properly completed according to the appropriate Kentucky Administrative Regulation (KAR). Hospital shall retain the form in the event of an audit and a copy shall be submitted to the Agency upon request.

8. Access to Records. Hospital shall make all of its books, documents, papers, provider records, medical records, data, surveys and computer databases (collectively "Records") available for examination and audit by the Agency, the Attorney General of the Commonwealth of Kentucky, the Kentucky Department of Insurance, the U.S. Department of Health and Human Services, CMS, Office of Inspector General Comptroller, authorized federal or Commonwealth personnel, and the authorized representatives of the governments of the United States and the Commonwealth of Kentucky including, without limitation, any employee, agent, or subcontractor of the Agency, CMS, or the Agency's fiscal agent. Access shall be at the discretion of the requesting authority and shall be either through on site review of records or by submission of records to the office of the requesting authority. Any records requested shall be produced immediately for on-site reviews or sent to the requesting authority by mail within thirty (30) days following a request. All records shall be provided at the sole cost and expense of Hospital including, without limitation, any costs associated with making excerpts or transcripts, copying, reproducing, shipping and/or mailing of records. The Agency shall have unlimited rights to use, disclose, and duplicate, for any purpose whatsoever, all information and data developed, derived, documented, or furnished by Hospital. The terms and conditions of this paragraph shall survive the termination of the Agreement.

9. Subject to compliance with all applicable state and federal patient privacy laws, including but not limited to the HIPAA Privacy Regulations, during regular business hours and upon reasonable notice, Hospital shall give MCO or its designee access to Members' medical records for a period of not less than six (6) years from the last date of service. MCO's access shall be limited to the amount of access necessary for Hospital and MCO to conduct necessary Quality Assurance Program activities, Utilization Management, peer review, to facilitate the transfer of copies of records to new providers, for treatment or billing purposes, or to conduct other health care operations or activities as required by DMS or any other applicable state or federal agency. Hospital shall provide records or copies of records requested by MCO within a reasonable period from the date such request is made.

10. If a federal or state patient privacy law requires Member consent or authorization before medical records or other PHI may be accessed or disclosed, MCO shall be responsible for obtaining Members consent before releasing medical record information by Hospital. Additionally, MCO shall indemnify and hold harmless Hospital for any claim by a Member for breach of confidentiality resulting from Hospital compliance with this section. Hospital acknowledges that the only medical records release which MCO will possess with respect to Members shall be MCO's enrollment form and Hospital agrees to accept such release for all purposes contemplated under this Agreement for the period of time until all billing issues are resolved.

E. Member Grievance

1. MCO will provide Hospital with the following written information regarding MCO's grievance, appeal and state fair hearing procedures:

a. The Member's right to file grievances and appeals and the requirements and timeframes for filing;

b. MCO's toll-free telephone number to file oral grievances and appeals;

c. The Member's right to a state fair hearing, the requirements and timeframes for requesting a hearing, and representation rules at a hearing;

d. The availability of assistance from the MCO in filing any grievance action; and

e. Hospital's rights to participate in these processes on behalf of patients and to challenge the failure of MCO to cover a service.

2. Hospital shall reasonably cooperate with MCO in the implementation of its Member grievance procedure and shall assist MCO in taking appropriate corrective action. Hospital shall comply with all final determinations made by MCO pursuant to such grievance procedure.

F. Insurance and Liability

1. Hospital shall, on the date of this Agreement and throughout the term of this Agreement, maintain a policy or policies of general liability and professional liability insurance adequate in its judgment to protect it and its employees and or agents against any claim or claims for damages arising out of the performance of any Covered Services provided hereunder or the use of any property or facility provided by the Hospital pursuant to this Agreement; provided, however, Hospital may, in lieu of such policy or policies, maintain such protection, in whole or in part, through a duly adopted plan of self-insurance. Hospital shall furnish MCO with certificates of such coverage upon MCO's request.

2. MCO shall, on the date of this Agreement and throughout the term of this Agreement, maintain a policy or policies of general liability and insurance as required by KCHFS. MCO shall furnish Hospital with a certificate of coverage upon request.

3. Neither party hereto shall be liable for defending or for the expense of defending the other party, its agent, or employees, against any claim, legal action, dispute resolution or administrative or regulatory proceeding arising out of or related to such other party's actions or omissions under this Agreement. Neither party hereto shall be liable for any liability of the other party, its agents, or employees, whether resulting from judgment, settlement, award, fine, or otherwise, which arises out of such other party's actions or omissions under this Agreement.

G. Inspections

1. Upon reasonable notice and at reasonable hours, and subject to compliance with applicable state and federal patient privacy laws including, but not limited to the HIPAA Privacy Regulations, MCO or its agents may inspect Hospital premises and operations to ensure that they are adequate to meet Member's needs and applicable Quality Assurance guidelines.

2. The terms and conditions of this G shall survive termination of the Agreement.

H. Other Obligations

1. Duty To Notify MCO. Hospital agrees to notify MCO, in writing, of (i) any change in its business address or ownership or management structure; (ii) change in its licensure or accreditation status action against any of its licenses, accreditation by JCAHO, or certifications including, but not limited to, those under Titles XVIII or XIX of the Social Security Act; (iii) loss or substantial decrease in the limits or change of its medical malpractice policy; (iv) any judgments or settlements decreed or entered into on behalf of Hospital specific to Members; and, (v) any other situation that may materially interfere with Hospital's duties and obligations under the Agreement including, but not limited to such things as: reduction in number of Hospital beds or Hospital services, reductions in numbers of health care providers employed or privileged at the Hospital. Hospital also shall use commercially reasonable best efforts to notify MCO of any complaints it receives from Members regarding Hospital, MCO or Participating Providers. MCO shall notify Hospital of any complaints it receives from Members regarding Hospital. Hospital and MCO agree to cooperate fully in the investigation and resolution of any such Member complaint.

2 **Any Willing Providers**. MCO shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan, and is willing to meet the terms and conditions for participation established by MCO.

3 **Anti-Gag Clauses**. MCO shall not limit Hospital's disclosure to Members, or to medical condition or treatment options. Hospital shall not be penalized, and this Agreement shall not be terminated, because Hospital discusses Medically Necessary or Clinically Appropriate care with a Member or another person on the Member's behalf. MCO shall not prohibit Hospital from discussing all treatment options with the Member. Other information determined by Hospital to be in the Member's best interest may be disclosed by Hospital to Member or to another person on Member's behalf. Hospital shall not be penalized for discussing financial incentives and arrangements between the Hospital and MCO with the Member.

4 **Information Upon Contracting and Renewal.** Upon request, MCO shall provide or make available to Hospital the payment or fee schedule or other information sufficient to enable Hospital to determine the manner and amount of payments under the Agreement for Hospital services prior to the final execution or renewal of the Agreement, and shall provide any change in such schedules at least ninety (90) days prior to the effective date of any such amendment.

5. **Drug Formulary/Generic Substitutions.** Represented Physician shall use the drug formulary designated by MCO ("Drug Formulary") when prescribing medications for Members, a copy of which has been provided to Hospital. Hospital understands and agrees that the Drug Formulary may be modified from time to time by MCO.

6. Practice of Medicine. Hospital and Represented Physician acknowledges that MCO does not practice medicine or exercise control over the methods or professional judgments by which Represented Physician renders medical services to Members. Represented Physician shall be responsible for clinical decisions regarding admission, discharge or other medical treatment of Members regardless of receipt by Physician of any recommendations, authorizations or denials of payment for treatment provided to Members from MCO, its agent or any other person or entity performing quality improvement or utilization management. MCO encourages Hospital and Represented Physician to communicate with patients regarding the treatment options available to them, including alternative medications, regardless of benefit coverage limitations.

7. Marketing Activities. Hospital shall comply with all allowable and unallowable marketing activities and practices.

8. Prohibited Payments. MCO is prohibited by applicable federal law from making payments to (a) Hospitals for the provision of medical assistance for health care-acquired conditions and other provider-preventable conditions as may be identified by the Agency; and (b) financial institutions and entities located outside of the United States for items or services provided under a Medicaid state plan or waiver (e.g., payments to providers who outsource readings of imaging services to entities located outside of the United States).

9. Compliance with Technology Standards. Hospital agrees to adhere to and sign all applicable Commonwealth policies and standards related to technology use and security.

10. Stop-Loss Coverage. If Hospital assumes substantial financial risk for services not provided by Hospital, Hospital shall maintain adequate stop-loss protection, sufficient proof of which, including the amount and type of stop-loss coverage maintained, shall be provided to MCO by Hospital upon request.

11. Quality Assessment/Performance Improvement Program. Hospital shall use commercially reasonable best efforts to participate in MCO's Quality Assessment/Performance Improvement program activities, including, but not limited to, submission of complete encounter records of Hospital employees and contractors, and shall cooperate with MCO's Quality Improvement Committee.

12. Orientation and Training. Hospital shall use commercially reasonable best efforts to have appropriate Hospital staff to attend initial orientation conducted by MCO within thirty (30) days after Hospital is placed on active status, and shall require same to attend any ongoing orientation and education required by MCO as necessary to ensure full compliance with the Agency Contract and all applicable Federal and Commonwealth requirements.

III. MISCELLANEOUS OBLIGATIONS

A. Independent Contractor Relationship

This Agreement is not intended to create nor shall be construed to create any relationship between MCO and Hospital other than that of independent entities contracting for the purpose of effecting provisions of this Agreement. Neither party nor any of their representatives shall be construed to be the agent, employer, employee or representative of the other. Nothing in this Agreement, including Hospital and its Represented Physicians and Providers participating in the Quality Assurance and Utilization Management process, shall be construed to interfere with or in any way affect Represented Physicians' and Providers' obligation to exercise independent medical judgment in rendering health care services to Members.

B. Term of Agreement

The initial term of this Agreement shall begin on the Effective Date and shall be for one (1) year ("Initial Term"). The Agreement will be automatically renewed from year to year on the anniversary date of the Effective Date thereafter, unless terminated as set forth below.

C. Termination

1. For Cause. Either party may terminate this Agreement at any time for cause. Any for cause termination that involves quality of care concerns or adverse findings by a regulatory agency can occur immediately. Termination for any reason other than quality of care concerns or adverse findings by a regulatory agency shall be effective at least sixty (60) days following a party's receipt of notice. Cause for termination includes, but is not limited to, the following:

a. Material failure of MCO, or TPA, when paying claims on behalf of MCO, to make required compensation payments to Hospital.

b. Failure of MCO to maintain licenses or certifications required to operate in conformity with this Agreement.

c. Any material change or alteration by MCO of plan requirements if such action is unacceptable to Hospital, and the parties cannot agree on a compromise.

d. Habitual neglect or continued failure by either party to perform its duties under this Agreement.

e. Initiation of bankruptcy proceedings by or against either party.

f. Material breach of this Agreement by either party.

g. Failure by Hospital to maintain licenses required to perform Hospital's duties under this Agreement, or to comply with applicable laws, regulations or plan requirements.

h. Any material misrepresentation or falsification of any information submitted by Hospital to MCO or by MCO to Hospital.

i. Commission or omission of any act or any conduct or allegation of conduct for which Hospital's license or certification may be subject to revocation or suspension, whether or not actually revoked or suspended, or if Hospital is otherwise disciplined by any licensing, regulatory, professional entity or any professional organization with jurisdiction over Hospital.

j. Failure of Hospital or MCO to maintain required liability coverage protection.

k. Failure of Hospital to maintain good standing status with the KCHFS.

l. Commission or omission of any act or conduct by Hospital which is detrimental to Members' health or safety, or in the event MCO believes, in good faith, that Hospital's continued participation in MCO's network may harm Members.

2. Without Cause. This Agreement may be terminated after the initial term without cause or prejudice upon one hundred twenty (120) days prior notice..

3. Member Notice. At least thirty (30) days prior to the effective date of termination of this Agreement, MCO will notify all Members in writing. Hospital and MCO shall cooperate on the form and content of the notice to Members.

D. Rights and Obligations Upon Termination

1. Upon termination of this Agreement for any reason, the rights of each party hereunder shall terminate, except as provided in any Exhibit to this Agreement. Any such termination, however, shall not release Hospital or MCO from obligations under this Agreement prior to the effective date of termination.

2. Continuation of Care. In accordance with KRS § 304.17A-527(1)(b), Hospital shall provide for the following continuation of care in the event that this Agreement is terminated, so long as the termination is not due to a quality of care issue or fraud:

a. Hospital shall continue to provide services in accordance with this Agreement until the Member is discharged from an inpatient facilities, or the active course of treatment is completed, which ever time is greater.

b. In the case of a pregnant woman, Hospital shall continue to provide services through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy.

During the continuation period described in this section, Hospital shall continue accepting the contract terms and conditions, together with applicable deductibles and co-payments, as payment in full. Hospital is prohibited by Kentucky law from billing the Member for any amount in excess of the Member's applicable deductible or co-payment. The provisions of this section shall survive the termination of this Agreement.

3. Transfer of Records. As permitted by applicable law, Hospital agrees to make available for transfer copies of the Members medical records.

4. Insolvency of MCO. In the event that MCO should become insolvent, Hospital agrees to provide Covered Services to each Member of the insolvent entity until the sooner of: (i) the expiration of the period for which a Member's premiums have been paid to MCO and, in the case of a Member confined as an inpatient in Hospital's facility at the time of such expiration, until the time of discharge from the facility; or (ii) until the Member becomes covered under another health insurance plan with similar benefits.

E. **No Solicitation of Members.** So long as the Agreement is in effect, and for a period of one (1) year from the date of termination, Hospital agrees that Hospital will not, within the service area of MCO solicit, advise or counsel any employer, Payor, or Member to disenroll from MCO or otherwise interfere with MCO's relationship with Members or any of the foregoing entities. MCO shall be responsible for notifying Members that Hospital is no longer a Participating Hospital. Nothing in the Agreement shall be construed to prohibit Hospital or hospital employees from freely communicating with patients regarding: (i) medically necessary and appropriate care with or on behalf of an Member, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests, regardless of benefit coverage limitations; (ii) the process that MCO or any entity contracting with MCO uses or proposes to use to deny payment for a health care service; or (iii) the decision of MCO to deny payment for a health care service. In the event that either party violates its duties under this provision, the other party may seek injunctive relief. This Section shall survive the termination of the Agreement.

F. **No Third Party Beneficiaries.** Other than as expressly set forth in the Agreement, no third persons or entities are intended to be or are third party beneficiaries of or under the Agreement, including, without limitation, Members. Nothing in the Agreement shall be construed to create any liability on the part of MCO, Payors, Hospital or their respective directors, officers, shareholders, employees or agents, as the case may be, to any such third parties for any act or failure to act of any Party hereto.

G. **Assignment and Delegation of Duties.** The Agreement, being intended to secure the services of and be personal to each Party, shall not be assigned or transferred by either Party without the prior written consent of the other Party. MCO may assign this Product without the consent of Hospital to any other Coventry Company upon thirty (30) days prior written notice. The assignment of this Product to any other Coventry Company will have no effect on any other Product in which Hospital participates.

H. **Use of Name.** Hospital agrees that Hospitals' names, telephone numbers, addresses, and affiliations may be included in literature distributed to existing or potential Members, Participating Facilities, Participating Providers, and/or TPA. Hospital's use of MCO's name shall be upon prior written approval by MCO or as the parties may agree. Any use of Hospital's name other than listed shall be upon prior written approval by Hospital or as the parties may agree. MCO agrees to allow Hospital to use MCO name as a contracting plan. Except as noted herein this paragraph, MCO and Hospital each reserve the right to and control of the use of their name, symbols, trademarks, and service marks presently existing or later established. In addition, except as noted in this paragraph, neither MCO nor Hospital shall use the other Party's name, symbols, trademarks, or service marks in advertising or promotional

materials or otherwise, without the prior written consent of that Party and shall cease any such usage immediately upon written notice of the Party or on termination of the Agreement, whichever is sooner.

I. **Interpretation.** The validity, enforceability and interpretation of this Agreement shall be governed by any applicable federal law and by the applicable laws of the Commonwealth of Kentucky.

J. **Compliance with Law.** Hospital shall recognize and abide by all Commonwealth and federal laws, regulations and guidelines applicable to the provision of services under the KY Medicaid Program. Hospital agrees to adhere to the mandates dictated by Titles VI and VII of the Civil Rights Act of 1964, as amended; the Vietnam Era Veterans' Readjustment Assistance Act of 1974; Americans with Disabilities Act of 1990 as amended; the Rehabilitation Act of 1973 as amended; Sec. 202 of Executive Order 11246 as amended, and all requirements imposed by or pursuant to the regulations of the U. S. Department of Health and Human Services. Hospital agrees not to discriminate in the rendering of services to and/or employment of individuals because of race, gender, color, religion, sex, age, national origin, handicap, political beliefs, disabled veteran, veteran status, sexual orientation, or any other non-merit factor. In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et. seq.) (2001, as amended) and its implementing regulation at 45 C.F.R. Part 80 (2001, as amended), Hospital must take adequate steps to ensure that persons with limited English skills receive free of charge the language assistance necessary to afford them meaningful and equal access to the benefits and services provided under this agreement. Hospital's service locations shall meet all requirements of the Americans with Disabilities Act and all Commonwealth and local requirements pertaining to adequate space, supplies, sanitation, and fire and safety procedures which are applicable to health care facilities. Hospital understands and agrees that this Agreement incorporates by reference all applicable federal and Commonwealth laws or regulations, and revisions of such laws or regulations shall automatically be incorporated into this Attachment as they become effective. In the event that changes in the Agreement as a result of revisions and applicable federal or Commonwealth law materially affect the position of either party, MCO and Hospital agree to negotiate such further amendments as may be necessary to correct any inequities.

K. **Federal Prohibitions.** Consistent with Federal disclosure requirements described in 42 C.F.R. § 455.100 through 42 C.F.R. § 455.106 and 42 C.F.R. § 438.610, and to ensure that MCO does not make a payment to an individual or entity who has been criminally convicted of a felony, is debarred, suspended, or otherwise excluded from participating in Federal health care programs, or excluded from participating in procurement activities under the Federal Acquisition Regulation, or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, Hospital shall disclose to Payor the required ownership and control, relationship, financial interest information; any changes to ownership and control, relationship, and financial interest, and information on criminal conviction regarding Hospital and any owner(s) and managing employee(s) at the time this Agreement is executed and annually thereafter, and any time there are changes to such information.

L. **Amendment.** This Agreement, including Exhibits, may only be amended by mutual agreement in writing by both parties unless otherwise specifically noted herein. In the event there is change in state or federal law or regulation, such that the provision of any services or the payment of any compensation pursuant to this Agreement would violate

applicable law, regulations, governmental policy, or impose unreasonable burdens on either party not existing on the Effective Date of this Agreement, MCO and Hospital agree to negotiate in good faith to amend the Agreement to comply with such change. If an amendment is not feasible by the date in which the law requires the parties to have fully implemented the change, either party may terminate the Agreement upon written notice to the other party.

M. Exhibits. The Exhibits attached hereto are a part of this Agreement. In the event of conflict between the Exhibits and the Agreement, the terms of the Agreement shall control.

N. Entire Contract. This Agreement, together with all Exhibits, represents the entire Agreement and contains all the terms and conditions agreed upon by the parties and supersedes all other agreements, express or implied, regarding the subject matter.

O. Notice

Any notice required hereunder shall be in writing and shall be sent by certified mail, postage prepaid, return receipt requested, to MCO and Hospital at the addresses set forth below.

If to Hospital:

Michael Fisher	and	Michael L. Taylor
President and CEO		Vice President, Revenue Cycle
CHMC		CHMC
3333 Burnet Avenue		3333 Burnet Avenue, ML 9011
Cincinnati, OH 45229-3039		Cincinnati, OH 45229-3039

If to MCO:

Michael Murphy	and	Michael Montgomery
CEO		Vice President, Network Dev.
Coventry Cares of Kentucky		Coventry Cares of Kentucky
Louisville, KY 40223		Louisville, KY 40223

P. Enforceability and Waiver. The invalidity and non-enforceability of any term or provision of this Agreement shall in no way affect the validity or enforceability of any other term or provision. The waiver by either party of a breach of any provision of this Agreement shall not operate as or be construed as a waiver of any subsequent breach thereof.

Q. Representation by Counsel. Each Party acknowledges that it has had the opportunity to be represented by counsel of such Party's choice with respect to the Agreement. In view of the foregoing and notwithstanding any otherwise applicable principles of construction or interpretation, the Agreement shall be deemed to have been drafted jointly by the Parties and in the event of any ambiguity, shall not be construed or interpreted against the drafting Party.

R. Confidentiality

1. All Memoranda, notes, records, lists or other documents made available by one party to another party during the term of this Agreement concerning Members or anything covered under this Agreement are and shall at all times remain the property of the party providing it and the same shall be returned to the party providing it upon such party's request. Neither party shall use for its own benefit or for the benefit of others,

any proprietary information, knowledge or data acquired from the other party during the term of this Agreement.

2. MCO and Hospital will have access to and become familiar with each other's various confidential and proprietary information. This confidential and proprietary information includes information relating to rates of reimbursement, terms of reimbursement, reimbursement methodologies, or any information which by the nature of the circumstances surrounding disclosure, should in good faith be treated as proprietary or confidential ("Confidential Information"). All Confidential Information disclosed by any party to the Agreement shall remain confidential and shall not be used or disclosed to any third party except as required or permitted to carry out obligations under this Agreement, or as required by applicable law. Further, each party shall take steps to protect the confidentiality of the other party's Confidential Information.

3. Each party expressly agrees that the other party shall, in addition to any other rights and remedy that may be available, be entitled to injunctive and other equitable relief to prevent a breach of the provisions of this Section III.M.

S. Business Associates

Hospital and MCO acknowledge that other organizations or individuals may perform or assist in the performance of a covered function or activity involving the use or disclosure of Protected Health Information ("PHI") on their behalf ("Business Associates"). In accordance with the HIPAA Privacy Regulations, each party shall enter into Business Associate Agreements with all Business Associates acting on its behalf in accordance with the requirements of 45 C.F.R. § 164.532. Hospital and MCO shall verify the identity of their Business Associates when such Business Associates require access to or disclosure of PHI under control of the other party. In no event shall either party release PHI to a Business Associate of the other party without proper verification of the identity of the Business Associate and the existence of a compliant Business Associate Agreement.

T. Force Majeure

Neither party shall be deemed to be in violation of this Agreement if such party is prevented from performing any of its obligations hereunder for any reason beyond its reasonable control, including without limitation, acts of God, acts of any public enemy, floods, statutory or other laws, regulations, rules, or orders of the federal, state, or local government or any agency thereof.

U. Headings

Any section or paragraph title or caption contained in this Agreement or any attached Exhibits or Attachments is for convenience only, and in no way defines, limits or describes the scope or intent of this Agreement or any of its provisions.

V. Counterparts

This Agreement and any amendments may be executed in any number of counterparts, each of which shall be treated as an original, but all of which, collectively, shall constitute a single instrument.

IN WITNESS WHEREOF, the parties hereto have executed and delivered this Agreement as of the EFFECTIVE DATE.

Coventry Health and Life Insurace Company

By: _____
Printed Name: Michael Murphy
Title: CEO
Date: 1-14-13

Cincinnati Children's Hospital Medical Center
on behalf of itself and its subsidiaries and affiliates

By: _____
Printed Name: Michael L. Taylor
Title: Vice President, Revenue Cycle Mgt
Date: 9/25/2012

Federal Tax Identification Numbers
31-0833936 – Children's Hospital Medical Center
31-0833936 – Children's Employed

Kentucky Medicaid Provider Numbers
01540871 – CHMC inpatient and outpatient hospital services,
34000323 – CHMC home health agency
54021670 – CHMC pharmacy
0307822 – Represented Physicians and Providers
55000152 - Emergency Transport
5614228 – Non-emergency Transport
9027228700 – CHMC DME
31000425 – Primary Care Center
65901886 – CHMC Physicians

Exhibits:
Exhibit A (1,2,3) - Reimbursement and Compensation
Exhibit B – Provider Manual
Exhibit C – Third Party Payor Audit Policy
Exhibit D – MCO Billing Information