MOLINA HEALTHCARE OF KENTUCKY, INC.
PROVIDER SERVICES AGREEMENT

SIGNATURE PAGE

In consideration of the promises and representations stated, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges and represents that he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement, and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Effective Date of Agreement ("Effective Date"): 1/1/2022

Provider Signature and Information:

Provider's Legal Name ("Provider") – Matching the applicable tax form (i.e. W-9, Line 1): University of Louisville Physicians, Inc	
Authorized Representative's Signature:	Authorized Representative's Name – Printed: Tom Miller
Authorized Representative's Title: CEO	Authorized Representative's Signature Date: 3/11/21
Telephone Number: 502-588-4210	Fax Number – Official Correspondence:
Mailing Address – Official Correspondence: UofL Health Attn: VP Managed Care 250 East Liberty St, Ste 504 Louisville, KY 40202	Payment Address – If different than Mailing Address: See roster
IRS 1099 Address – If different than Mailing Address: See W-9	Tax ID Number – As listed on corresponding tax form: 273645560
NPI – That corresponds to the above Tax ID Number: See Roster	Email Address – Official Correspondence: Paul.Nagy@uoflhealth.org

Health Plan Signature and Information:

Molina Healthcare of Kentucky, Inc., a Kentucky Corporation ("Health Plan")	
Authorized Representative's Signature:	Authorized Representative's Name – Printed: John C Wiley
Authorized Representative's Title: VP Network Strategy & Services	Authorized Representative's Countersignature Date: 3/16/2021
Mailing Address – Official Correspondence:	Email Address – Official Correspondence:

PROVIDER SERVICES AGREEMENT

Health Plan and Provider enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties".

RECITALS

A. WHEREAS, Health Plan is a corporation licensed and approved, or is seeking licensure and approval, by required agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services;

B. WHEREAS, Provider is approved to provide health care or related services and desires to provide services to eligible recipients; and

C. WHEREAS, the Parties intend by entering into this Agreement they will make health care or related services available to eligible recipients enrolled in various Products or who at a future date will be enrolled in Products covered under this Agreement.

NOW, THEREFORE, in consideration of the promises and representations stated, the Parties agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth below, unless Health Plan is required to follow a different definition pursuant to a Law or a Government Program Requirement.

a. **Advance Directive** means a Member's written instruction, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.

b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.

c. **Agreement** means this Provider Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.

d. **Centers for Medicare and Medicaid Services ("CMS")** means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medicaid Program, and the Health Insurance Marketplace.

e. **Claim** means a bill for Covered Services provided by Provider.

f. **Clean Claim** means a Claim for Covered Services submitted on an industry standard form, which has no defect, impropriety, lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely adjudication of the Claim.

g. **Covered Services** mean those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member's Product.

h. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.

i. **Date of Service** means the date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.

j. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, or MMP Products, below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

k. **Emergency Services** mean covered inpatient and outpatient services furnished by a provider who is qualified to furnish the services and the services are needed to evaluate or stabilize an emergency medical condition.

l. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.

m. **Government Contracts** mean those contracts between Health Plan and governmental agencies for the arrangement of health care and related services for Government Programs.

n. **Government Programs** mean various government sponsored health products in which Health Plan participates.

o. **Government Program Requirements** mean the requirements of governmental agencies for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contract.

p. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

q. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.

r. **Health Plan** means Molina Healthcare of Kentucky, Inc., a Kentucky Corporation.

s. **Law** means, without limitation, federal, state, commonwealth, tribal, or local statutes, codes, orders, ordinances, and regulations applicable to this Agreement.

t. **Medicaid** means the joint federal-state or federal-commonwealth program provided for under Title XIX of the Social Security Act, as amended.

u. **Medically Necessary or Medical Necessity** means health care services provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.

v. **Medicare Advantage ("MA")** means a program in which private health plans provide health care and related services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").

w. **Medicare-Medicaid Program ("MMP")** means a program in which private health plans provide health care and related services to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the State.

x. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.

y. **Molina Marketplace** means the Products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.

z. **Overpayment** means a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.

aa. **Participating Provider** means a healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan's designee.

bb. **Products** mean the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified on Attachment A, Products, and which will include any successors to such Products.

cc. **Provider** means the entity identified on the Signature Page of this Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an "Individual Provider".

dd. **Provider Manual** means Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.

ee. **Quality Improvement Program ("QI Program")** means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.

ff. **Responsible Entity** means an entity that is financially responsible for certain Covered Services and pays Claims that are part of its financial responsibility.

gg. **State Children's Health Insurance Program ("SCHIP" or "CHIP")** means the program established pursuant to Title XXI of the Social Security Act, as amended.

hh. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.

ii. **Utilization Review and Management Program ("UM Program")** means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provider Standards.**

a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider's business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, Laws, and Government Program Requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel, and administrative services will be at a level and quality necessary to perform Provider's duties under this Agreement and to comply with Laws and Government Program Requirements.

c. **Prior Authorization.** For a Covered Service that requires prior authorization, Provider will obtain prior authorization from Health Plan before providing such Covered Service. Provider will not have to obtain prior authorizations before providing Emergency Services.

d. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior authorization, Provider will make best effort to utilize Participating Providers to provide Covered Services. If a Participating Provider is not available, Provider will notify Health Plan so Health Plan can determine the appropriate provider to perform such services.

e. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will make best effort to follow Health Plan's Drug Formulary/Prescription Drug List, and prior authorization and prescription policies and to use a Participating Pharmacy. Provider acknowledges the authority of pharmacies to substitute generics or low cost alternative prescriptions for the prescribed medication.

f. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.

g. **Member Eligibility Verification.** Provider will verify eligibility of Members before providing services unless the situation involves the provision of Emergency Services.

h. **Availability of Services.** Provider will make necessary and appropriate arrangements to ensure availability of Covered Services twenty-four (24) hours a day, seven (7) days a week. Provider will meet applicable standards for timely access to care and service in accordance with Laws and Government Program Requirements.

i. **Admission Notifications.** Provider will immediately notify Health Plan of a Member hospital admission, including any inpatient admission, and when a Member is referred to the emergency department.

j. **Staffing Privileges for Providers.** Provider will have staff privileges with at least one (1) Health Plan contracted hospital as necessary to provide Covered Services. Provider will authorize each hospital to notify Health Plan if disciplinary or other action of any kind is initiated against Provider, which could result in the suspension, reduction, or modification of Provider's hospital privileges. If Provider does not have staff privileges with at least one (1) Health Plan contracted hospital, Provider must provide an acceptable arrangement to Health Plan that ensures Member continuity of care.

2.2 **Rights of Members.** Provider will observe, protect, and promote the rights of Members.

2.3 **Use of Name.** Provider will display Health Plan's promotional materials as practical and will cooperate in reasonable Health Plan marketing efforts that do not violate Laws or Government Program Requirements. Provider will not use Health Plan's name including, but not limited to, trademarks, service marks, or logos, in advertisements or promotional materials without the prior written consent of Health Plan. However, Provider may refer to Health Plan in Provider's listings of participating health plans. Additionally, Health Plan may use Provider's name and related information in: (i) publications to identify Provider as a Participating Provider; and (ii) as may be required to comply with the Laws and Government Program Requirements.

2.4 **Non-Discrimination.** Provider will not differentiate or discriminate against individuals based on their status as protected veterans or because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.5 **Recordkeeping.**

a. **Maintaining Member Record.** Provider will maintain a medical and billing record ("Record") for each Member to whom Provider provides health care services. The Member's Record will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Record for as long as required by Laws and Government Program Requirements. This section will survive any termination.

b. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or Record without obtaining appropriate authorization. This section does not affect or limit Provider's obligation to make available the Record, Encounter Data, and information concerning Member care to Health Plan, a governmental agency, or another provider of health care. This section will survive any termination.

c. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Health Plan's policies and procedures, Government Program Requirements, or third party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member. Provider is responsible for the fees associated with producing the first copy of the above items. Health Plan will otherwise reimburse Provider a copying fee of Ten Cents (.10¢) per page, not to exceed Ten Dollars ($10.00) per request or the amount permitted by Law, or Provider will allow the Health Plan electronic access to the necessary records. To be eligible for reimbursement under this section, Provider will deliver a written invoice to Health Plan within thirty (30) days of providing the requested records to Health Plan. Provider will further give direct access to the items as requested by Health Plan or as required by a governmental agency. Health Plan has the right to withhold compensation from Provider if Provider fails or refuses to give the items requested regarding a specific claim to Health Plan within thirty (30) days. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

d. **Member Access to Member Record.** Provider will give Members access to Members' Record and other applicable information, in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

2.6 **Program Participation.**

a. **Participation in Grievance Program.** Provider will participate in and comply with Health Plan's Grievance Program, and will cooperate with Health Plan in identifying, processing, and resolving Member grievances, complaints, or inquiries.

b. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan's QI Program, and will cooperate in conducting peer reviews and audits of care provided by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider will participate in and comply with Health Plan's credentialing and re-credentialing program established by Health Plan in accordance with Laws and Government Program Requirements. Provider must be credentialed by Health Plan or Health Plan's designee, and as provided in applicable Law and Government Program Requirements, before providing Covered Services and must remain credentialed throughout the term of the Agreement to continue to be eligible to provide Covered Services. Provider will promptly notify Health Plan in writing of any change in the information submitted or relied upon by Provider to achieve or maintain credentialed status.

e. **Health Education/Training.** Provider will participate in and comply with Health Plan's provider education and training efforts, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

f. **Provider Group.** If Provider is a group comprised of Individual Providers, Provider represents that it has the authority to bind its Individual Providers to this Agreement and agrees that each person or entity must be credentialed pursuant to the terms of this Agreement before providing Covered Services subject to applicable Laws and Government Program Requirements. Provider will further ensure that each Individual Provider complies with the applicable terms of this Agreement, which includes, but are not limited to, those terms requiring compliance with applicable Laws and Government Program Requirements.

2.7 **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement and may be unilaterally amended from time to time by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan's website. A physical copy of the Provider Manual is available upon request.

2.8 **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan's interactive web-portal, and a physical copy is available upon request. Supplemental Materials become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

2.9 **Health Plan's Electronic Processes and Initiatives.** Provider will make best effort to participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's interactive web-portal.

2.10 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete and accurate list of its business/practice/facility locations and, as applicable, a list of the Individual Providers that it uses to provide Covered Services every thirty (30) days, together with specific information required for administration. The information includes, but is not limited to, the information required by Health Plan to produce provider directories. If Provider does not deliver such information, Health Plan will use the last information received from Provider. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another manner or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.

2.11 **Standing.**

a. **Licensure.** Provider represents it has the appropriate licenses to provide Covered Services. This includes having and maintaining a current narcotics number issued by proper authorities when appropriate. Provider will deliver evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its licensure status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider represents to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants, members of its board of directors, officers, or contractors (collectively, "Personnel") have been excluded from participation in any Federal or state-funded health program (collectively "Federal Health Care Program"). Provider agrees complete all necessary processes to ensure its Personnel remain eligible to provide care to Federal Health Care Program Members at all times. Provider will notify Health Plan within 5 days if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and will require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this provision or any payments were made to Provider while under non-compliance with this provision, Health Plan may collect the amount: (i) by offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter and Provider agrees it will remit funds pursuant to the terms of the recoupment letter. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

c. **Legal Actions.** Provider will give prompt written notice to Health Plan of: (i) a legal claim asserted against it by a Member and of the judgment, settlement, or compromise of the claim; (ii) a criminal investigation or proceeding against Provider; (iii) a conviction for crimes involving moral turpitude or felonies; and (iv) a civil claim that may jeopardize Provider's financial soundness. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

d. **Liability Insurance.** Provider will maintain general and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and health care activities, and in compliance with Laws and Government Program Requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination of such insurance coverage. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

2.12 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan.

2.13 **Laws and Government Program Requirements.**

a. **Compliance with Laws and Government Program Requirements.** Provider will comply with Laws that are applicable to this Agreement. Provider acknowledges Health Plan entered into Government Contracts and Provider will comply with the applicable Government Program Requirements that must be satisfied under this Agreement. Upon written request, Health Plan will give Provider a redacted copy of applicable Government Contracts.

b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements related to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in investigations conducted by Health Plan or by a governmental agency. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.

2.14 **Transfer of Members.** Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of Health Plan.

2.15 **Members Condition Changes.** Upon becoming aware of a significant change in a Member's health or functional status, a Member is being abused or neglected, or a Member death, Provider will make best efforts to notify Health Plan's Member Services department as soon as possible, but not later than seven (7) days.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.2 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames governed by Laws and Government Program Requirements after receiving all necessary information from Provider.

3.3 **Medical Necessity Determination.** Health Plan's determination with regard to Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern, subject to applicable Law and Government Program Requirements. The primary concern with respect to Medical Necessity determinations is the interest of the Member.

3.4 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.

3.5 **Provider Services.** Health Plan will make available a provider services department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.

3.6 **Corrective Action.** Health Plan and governmental agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Provider's compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan. Provider is required to accept and implement such corrective action plan. In the case of such finding, Provider is not entitled to a corrective action plan prior to any immediate termination.

3.7 Reassignment of Members. Health Plan reserves the right to reassign, limit, or deny the assignment or selection of Members to Provider if Health Plan determines that Provider poses a threat to Members' health and safety or during a termination notice period. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When Health Plan reassigns Member, Provider will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

3.8 **Quality Bonus Payment Program.** Health Plan may offer Provider the opportunity to participate in Health Plan's Quality Bonus Payment Program ("QBPP"). If offered, the QBPP will promote quality of care. Payments under the QBPP are available to Provider based on qualifying criteria and events as described in the Provider Manual and related Supplemental Materials. QBPP payments are not guaranteed and are paid separately from and in addition to the compensation terms of this Agreement.

a. **Eligibility**. To be eligible for the QBPP, Provider must register with Health Plan's interactive web portal. Additionally, Provider must remain in full compliance with this Agreement, which includes, but is not limited, timely and accurate submission of Clean Claims and/or Encounter Data, and remittance of funds due to Health Plan under this Agreement. QBPP documentation submitted by Provider is subject to audit by Health Plan and the program is subject to Laws and Government Program Requirements.

b. **Terms and Conditions.** QBPP payments are subject to terms set forth in the program, which may be modified at any time by Health Plan without notice or amendment. Modifications may include, but are not limited to, exclusions or removal of measures from the program and changes to the calculation and payment methodologies. In the event of a conflict between the Agreement and QBPP, the QBPP will prevail.

ARTICLE FOUR - CLAIMS PAYMENT

4.1 **Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after ~~one~~ three hundred and sixty-five (365) days from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. When Health Plan is the secondary payer, Provider is not eligible for payment for Claims submitted after three hundred and sixty-five (365) days from the date the primary payer adjudicated the Claim, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.

4.2 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within thirty (30) days, unless otherwise required by Laws or Government Program Requirements. Provider agrees to accept such payments, applicable co-payments, co-insurances, deductibles, and coordination of benefits collections as payment in full for Covered Services. Provider's failure to comply with the terms of this Agreement may result in non-payment to Provider.

4.3 **Co-payments and Deductibles.** Provider is responsible for collection of co-payments, co-insurances, and deductibles, if any.

4.4 **Member Hold Harmless.** Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on Member's behalf, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.

4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another payer is primary payer. Provider will make reasonable inquiry of Members to learn if Member has health insurance or health benefits other than from Health Plan, or is entitled to payment by a third party under any other insurance or plan of any type. Provider will promptly notify Health Plan of said entitlement. In the event a coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers, and payers, not to exceed the amount specified in the Compensation Schedule of this Agreement.

4.6 **Offset.** In the event of an Overpayment, Health Plan will issue a recoupment letter to Provider and Provider has sixty (60) days to refund said amount to Health Plan. In the event Provider does not appeal such recoupment and does not refund the identified amount, Health Plan may collect the amount: (i) by offsetting from amounts due Provider. If required, the offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. This section will survive any termination.

4.7 **Claim Review.** Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal and state/commonwealth billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or that do not meet Medical Necessity criteria. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication, and clinical practices, federal and state/commonwealth guidelines, and Health Plan's policies and data to determine the appropriateness of the billing, coding, and payment. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

4.9 **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity (e.g. dental, vision, etc), Provider will look solely to the Responsible Entity for payment of such Covered Services. Pursuant to Health Plan's contract with Responsible Entity, Responsible Entity is to compensate Provider at the rate set forth in Provider's contract with Responsible Entity. If Responsible Entity and Provider do not have a contract or have not agreed to compensation terms, Provider will be reimbursed, as determined by Provider and Responsible Entity, at: (i) one hundred percent (100%) of the governing rates provided by Law specific to the Member's Product in place on the Date of Service; or (ii) at the rates set forth in this Agreement specific to the Member's Product in place on the Date of Service. Except as specifically stated in this section, Provider agrees that the compensation provisions of this Agreement will be binding upon Provider and that Provider will follow the hold harmless provisions of this Agreement.

4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

ARTICLE FIVE – TERM AND TERMINATION

5.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect until terminated by either Party in accordance with the provisions of this Agreement.

5.2 Termination without Cause. This Agreement, an individual Product, or an Individual Provider under this Agreement, may be terminated without cause at any time by either Party by giving at least ninety (90) days prior written notice to the other Party.

5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other Party. During this thirty (30) day period, the Parties agree to meet as reasonably necessary and to confer in an attempt to resolve the claimed breach. If the Party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the thirty (30) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.

5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:

a. Provider's license or any other approval needed to provide Covered Services is limited, suspended, or revoked or a disciplinary proceeding is commenced against Provider by a governmental or accrediting agency;

b. Either Party fails to maintain adequate levels of insurance;

c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including, but not limited to, having or maintaining credentialing status;

d. Either Party becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider or Health Plan is appointed by appropriate authority;

e. If Provider is capitated or participating in another risk-sharing compensation methodology and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility or equipment is insufficient to provide Covered Services;

g. Either Party is excluded from participation in state, commonwealth, or federal health care programs;

h. Provider is terminated as a provider by any state, commonwealth, or federal health care program;

i. Either Party engages in fraud or deception, or permits fraud or deception by another in connection with each Party's obligations under this Agreement;

j. Health Plan reasonably determines that Covered Services are not being properly provided, or arranged for by Provider, and such failure poses a threat to Members' health and safety;

k. Provider violates any Law;

l. Provider fails to satisfy the terms of a corrective action plan; or

m. Termination is required by a governmental agency.

5.5 **Notice to Members.** In the event of any termination, Health Plan will give reasonable advance notice to Members who are currently receiving care in accordance with Laws and Government Program Requirements.

5.6 **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

ARTICLE SIX – GENERAL PROVISIONS

6.1 **Indemnification.** Each Party will indemnify and hold harmless the other Party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying Party or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

6.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the Parties other than that of independent parties contracting with each other solely for the purpose of effectuating this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third party to enforce this Agreement.

6.3 **Governing Law.** The laws of the Commonwealth of Kentucky will govern this Agreement to the extent such laws are not deemed preempted by federal laws.

6.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.

6.5 **Severability.** If a term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.

6.8 **Amendments.**

a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider's consent. Such regulatory amendment will be binding upon Provider.

b. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider at the Correspondence Address noted in this Agreement. If Provider does not deliver a written disapproval to such amendment to the Health Plan Correspondence Address noted in this Agreement within the thirty (30) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the thirty (30) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.

6.9 **Delegation or Subcontract.** Upon the Effective Date, Provider will submit to Health Plan a list identifying each of Provider's Subcontractors and a description of the services the Subcontractor provides. Such arrangement with a Subcontractor will be in writing and will bind Subcontractor to the applicable terms of this Agreement. No such subcontracting will relieve Provider from any of its obligations or liabilities, and Provider will remain responsible for all obligations and liabilities of such Subcontractors.

6.10 **Assignment.** Neither Party may not assign or transfer, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of the other.

6.11 **Dispute Resolution.**

a. **Meet and Confer.** Any claim or controversy arising out of or in connection with this Agreement will first be resolved, to the extent possible, via "Meet and Confer". The Meet and Confer will begin when one Party delivers written notice to the other that it intends to arbitrate a dispute and the basis for its belief that it will prevail in arbitration. After providing notice of the intent to arbitrate, the Meet and Confer will be held as an informal face-to-face meeting held in good faith between appropriate representatives of the Parties and at least one (1) person authorized to settle outstanding claims and pending arbitration matters. The Parties will commence the face-to-face portion of the Meet and Confer within forty-five (45) days of receiving notice of an intent to arbitrate or service of an arbitration demand. Such face-to-face Meet and Confer discussion will occur at a time and location agreed to by the Parties (within the forty-five (45) days) and if both Parties agree that more face-to-face discussions would be beneficial, the Parties can agree to have more than one (1) in person settlement discussion or a combination of in person, phone meetings and exchange of correspondence.

b. **Binding Arbitration.** The Parties agree that any dispute not resolved via Meet and Confer will be settled in binding arbitration administered by Judicial Arbitration and Mediation Services ("JAMS"), or if mutually agreed upon, pursuant to another agreed upon Alternative Dispute Resolution ("ADR") provider in accordance with that ADR provider's Commercial Arbitration Rules, in Louisville, Kentucky. However, matters that primarily involve Provider's professional competence or conduct i.e., malpractice, professional negligence, or wrongful death will not be eligible for arbitration.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds one million dollars ($1,000,000.00) will be resolved by a panel of three (3) arbitrators. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator whose determination will be final and binding on the Parties. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds five hundred thousand dollars ($500,000.00), but less than one million dollars ($1,000,000.00), the claimant and respondent will each select a single arbitrator and the two (2) arbitrators selected by the claimant and respondent will select a single arbitrator who will be responsible for the arbitration proceedings ("Selected Arbitrator"). Each Party can strike no more than one (1) Selected Arbitrator. The Selected Arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) will be resolved by a single arbitrator. In the event a single arbitrator is used, the arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Civil discovery for use in such arbitration may be conducted in accordance with federal rules of civil procedure and federal evidence code, except where the Parties agree otherwise. The arbitrator selected will have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court in the same jurisdiction. The provisions of federal rules of civil procedure concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement. However, in any arbitration in which the total amount disputed by one Party is less than one million dollars ($1,000,000.00) the Parties agree that each Party will have the right to take no more than three (3) depositions of individuals or entities, excluding deposition of expert witnesses, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. The Parties agree that in any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) each Party will have the right to take no more than one (1) deposition of individuals or entities and one (1) expert witness, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. Regardless of the amount in dispute, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive or liquidated damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. The award may be reviewed, vacated, or modified pursuant to the Federal Arbitration Act ("FAA"), 9 USC sections 9-11. Grounds for vacating an award, include where the award was procured by corruption, fraud, or undue means, and where the arbitrators were guilty of misconduct, exceeded their powers, evident material miscalculation, evident material mistake, imperfect(ions) in (a) matter of form not affecting the merits, and where a decision is not grounded in applicable law. When a decision is not grounded in applicable law, any Party will have the right to appeal the decision in addition to those rights to vacate or appeal already existing pursuant to the FAA or applicable state or commonwealth arbitration laws. Any such appeal may be made to a court having jurisdiction over the Parties or the dispute. Notice of intent to Appeal based on failure to render a decision grounded in law must be given to the other Party within fifteen (15) days after the decision is communicated to the Parties; and the appeal must be formally initiated by filing in court within thirty (30) days after the decision is communicated to the Parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal, there is no right for any additional appeal in any other venue.

Each Party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration. The Parties agree that one or the other may request a court reporter transcribe the entire proceeding, in which case the Parties will split the cost of the court reporter, but each may elect to purchase or forego purchasing a transcript.

Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

6.12 **Notice.**

a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email.

b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the particular Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.

6.13 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

6.14 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

6.15 **Conflict with Health Plan Product.** Nothing in this Agreement modifies any benefits, terms, or conditions contained in the Member's Product. In the event of a conflict between this Agreement and any benefits, terms, or conditions of a Product, the benefits, terms, and conditions contained in the Member's Product will govern.

6.16 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any duty under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party if it is determined that such Party: (i) used the efforts a reasonable person would during a force majeure event to perform its duties under this Agreement; and (ii) the Party's inability to perform its duties during the force majeure event is not due to its failure to take measures to protect itself against the force majeure event.

6.17 **Confidentiality.** Any information disclosed by either Party in fulfillment of its duties under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, certification/credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.

6.18 **Adjustments.** If a governmental agency imposes a penalty, sanction, or other monetary adjustment or withhold due to Provider's non-compliance with this Agreement, Health Plan will be able to collect the amount imposed on or withheld from Health Plan. Health Plan may collect the amount: (i) by offsetting from amounts due to Provider; or (ii) Health Plan may issue a recoupment letter as described in this Agreement. If required, such offset or recoupment will be done in a manner that is compliant with Laws and Government Program Requirements. For occurrences that occurred during time the agreement was in force, this section will survive any termination.

6.19 **Expenses.** Unless otherwise specifically stated in the Agreement, all costs and expenses incurred in connection with this Agreement will be paid by the Party incurring the cost or expense.

ATTACHMENT A

Products

Provider's participation in the Medicaid Product listed below is contingent upon Health Plan executing a Government Contract with the appropriate governmental agency. Provider agrees to participate in the Medicaid Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement. For all other Products, Provider's participation in each Product listed below is contingent upon the Product being offered by the appropriate governmental agency and upon Health Plan executing a Government Contract with the appropriate governmental agency. Subject to applicable Laws and Government Program Requirements, Provider agrees to participate in each Product on the date it becomes operational for Health Plan under its Government Contract and Provider shall be bound to the terms of this Agreement.

1.1 **Health Insurance Marketplace** – including, but not limited to, Molina Marketplace.

ATTACHMENT B

Compensation Schedule

1.1 **Compensation for Health Insurance Marketplace.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Health Insurance Marketplace Product, that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to one-hundred thirty-six percent (136%) of the Medicare Fee-For-Service Program allowable payment rate, subject to any retrospective adjustments. The Medicare Fee-For-Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurances, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

In the event that there is no payment rate under the Medicare Fee-For-Service Program allowable payment rate, Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable amounts paid or to be paid by other liable third parties and the Member for cost sharing, including, but not limited to, co-payments, deductibles, or co-insurances, if any, the following amounts in effect for the Date of Service: (i) fifty percent (50%) of Provider's billed charges.

ATTACHMENT C

Commonwealth of Kentucky Required Provisions

Commonwealth Laws

This attachment sets forth applicable Commonwealth Laws or other provisions necessary to reflect compliance with Commonwealth Laws. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment does not apply to the Medicare Advantage Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

1.1 **Definitions**

a. **Clean Claim** means "a properly completed billing instrument, paper or Electronic, including the required Health Claim Attachments, submitted in the applicable forms. A clean claim from an institutional provider shall consist of: (i) the UB-92 data set or its successor submitted on the designated paper or Electronic format as adopted by the NUBC; (ii) entries stated as mandatory by the NUBC; and (iii) any state-designated data requirements determined and approved by the Kentucky State Uniform Billing Committee and included in the UB-92 billing manual effective at the time of service. A Clean Claim for dentists shall consist of the form and data set approved by the American Dental Association. A Clean Claim for pharmacists shall consist of a universal claim form and data set approved by the National Council on Prescription Drug Programs. A Clean Claim for all other providers shall consist of the HCFA 1500 data set or its successor submitted on the designated paper or Electronic format as adopted by the National Uniform Claims Committee.

b. **Electronic** or **Electronically** means electronic mail, computerized files, communications, or transmittals by way of technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

c. **Health Claim Attachments** means medical information from a covered person's medical record required by the insurer containing medical information relating to the diagnosis, the treatment, or services rendered to the covered person and as may be required pursuant to Kentucky Revised Statutes 304.17A-720.

1.2 **Hold Harmless and Continuity of Care.**

a. Provider may not, under any circumstance, including: (i) non-payment of moneys due to the Providers by Health Plan; (ii) insolvency of Health Plan; or (iii) breach of the Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against Member, dependent of Member, or any persons acting on their behalf, for services provided in accordance with the Agreement. This provision shall not prohibit collection of deductible amounts, copayment amounts, coinsurance amounts, and amounts for non-Covered Services.

b. If the Agreement is terminated for any reason, other than a quality of care issue or fraud, the Provider shall continue to provide Covered Services and Health Plan shall continue to reimburse Provider in accordance with the Agreement until Member or the dependent of the Member is discharged from an inpatient facility, or the active course of treatment is completed, whichever time is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy at the time the Agreement is terminated.

c. Sections 1.2 a. and b. will survive any termination of the Agreement.

1.3 **Payment or Fee Schedules.** Health Plan will, upon request of Provide, make available to Provider, when contracting or renewing an existing contract with Provider, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under the contract for the Provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of the amendment pursuant to KRS 304.17A-577.

1.4 **Subcontractor.** If Provider enters into any subcontract agreement with another provider to provide their licensed health care services to Members, dependent of the Member, where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all requirements of KRS 304.17A-527 and all such subcontract agreements shall be filed with the commissioner in accordance with this subsection.

1.5 **Material Change.**

a. For the purposes of this section, capitalized words or phrases will have the meaning set forth below.

i. **Material Change** means a change to a contract, the occurrence and timing of which is not otherwise clearly identified in the contract, that decreases the health care provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, and includes any changes to provider network requirements, or inclusion in any new or modified insurance products.

ii. **Real-Time Communication** means any mode of telecommunications in which all users can exchange information instantly or with negligible latency and includes the use of traditional telephone, mobile telephone, teleconferencing, and videoconferencing.

b. If Health Plan makes any Material Change to the Agreement, for any Products that are not preempted by federal Law, Health Plan shall provide Provider with at least ninety (90) days' notice of the Material Change. The notice of a Material Change required under this section shall: (i) provide the proposed effective date of the change; (ii) include a description of the Material Change; (iii) include a statement that the participating provider has the option to either accept or reject the proposed material change in accordance with this section; (iv) provide the name, business address, telephone number, and electronic mail address of a representative of the insurer to discuss the Material Change, if requested by the participating provider; (v) provide notice of the opportunity for a meeting using Real-Time Communication to discuss the proposed changes if requested by the participating provider (If requested by Provider, the opportunity to communicate to discuss the proposed changes may occur via electronic mail instead of Real-Time Communication); and (vi) provide notice that upon three (3) Material Changes in a twelve (12) month period, Provider may request a copy of the contract with Material Changes consolidated into it. Provision of the copy of the Agreement by the Health Plan shall be for informational purposes only and shall have no effect on the terms and conditions of the Agreement.

c. If a Material Change relates to Provider's inclusion in any new or modified insurance products, or proposes changes to the Provider's membership networks: (i) the Material Change shall only take effect upon the acceptance of the Provider, evidenced by a written signature; and (ii) the notice of the proposed Material Change shall be sent by certified mail, return receipt requested.

d. For any other Material Change not addressed in Sections 1.5 c:

i. (i) The Material Change shall take effect on the date provided in the notice unless Provider objects to the change in accordance with this paragraph; (ii). a participating provider who objects under this paragraph shall do so in writing and the written protest shall be delivered to Health Plan within thirty (30) days of the Provider's receipt of notice of the proposed Material Change; (iii) within thirty (30) days following Health Plan's receipt of the written objection, Health Plan and Provider shall confer in an effort to reach an agreement on the proposed change or any counterproposals offered by Provider; and (iv) if Health Plan and Provider fail to reach an agreement during the thirty (30) day negotiation period described in subparagraph "iii". of this paragraph, then thirty (30) days shall be allowed for the Parties to unwind their relationship, provide notice to patients and other affected parties, and terminate the Agreement pursuant to its original terms; and

ii. The notice of proposed Material Change shall be sent in an orange-colored envelope with the phrase "ATTENTION! CONTRACT AMENDMENT ENCLOSED!" in no less than fourteen (14) point boldface Times New Roman font printed on the front of the envelope. This color of envelope shall be used for the sole purpose of communicating proposed Material Changes and shall not be used for other types of communication from a Health Plan.

e. If Health Plan makes a change to this Agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, the insurer shall provide notice of the change to Provider at least fifteen (15) days prior to the change.

f. Any notice required to be mailed pursuant to this Section shall be sent to Provider's point of contact, as set forth in the Agreement. If no point of contact is set forth in the Agreement, Health Plan shall send the requisite notice to the Provider's place of business addressed to the Provider.

ATTACHMENT D

Molina Marketplace

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements or other provisions necessary to reflect compliance for the Molina Marketplace Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control for the Molina Marketplace Product. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Molina Marketplace Product.

1.1 **Definitions.** The following definitions apply only in this attachment:

a. **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("QHP") issuer to provide administrative services or health care services to qualified individuals and their dependents.

b. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

Consistent with the above definitions, Provider is a Delegated Entity and Health Plan is a QHP issuer.

1.2 **Timely Payment of Claims.** Health Plan will pay Provider for Clean Claims for Covered Services that are determined to be payable, in accordance with Section 4.2, Compensation.

1.3 **Delegated Entity and Downstream Entity Compliance.** To the extent that the activities and obligations applicable to Health Plan, as set forth in the standards enumerated at 45 CFR 156.340(a), are delegated to Provider, then Provider, as Delegated Entity, agrees to perform such activities and obligations in compliance with all applicable laws and regulations relating to such standards, and consistent with the requirements outlined in this attachment. Provider further agrees that it will require the same of any Downstream Entities. (45 CFR 156.340(b)(3)).

1.4 **Health Plan Accountability.** Notwithstanding any relationship Health Plan may have with Provider, as Delegated Entity, and any Downstream Entity, Health Plan maintains responsibility for its compliance, as well as the compliance of the Provider and any Downstream Entity, with all applicable standards enumerated at 45 CFR 156.340(a). (45 CFR 156.340(a)).

1.5 **Standards for Downstream and Delegated Entities.** The Agreement specifies the delegated activities and reporting responsibilities. (45 CFR 156.340(b)(1)).

1.6 **Right to Audit.** Provider, as Delegated Entity, and any Downstream Entity shall permit access to the Secretary of the United States Department of Health and Human Services ("HHS"), and the Office of the Inspector General, or their designees, to evaluate through audit, inspection, or other means, Provider's or Downstream Entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to Health Plan's obligations in accordance with the standards enumerated at 45 CFR 156.340(a), as applicable, until ten (10) years from the final date of the Agreement period. (45 CFR 156.340(b)(4)).

1.7 **Revocation of Delegated Activities.** In the event HHS or Health Plan determines, in its sole discretion, that Provider or any Downstream Entity, have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies, in lieu of revocation of the delegated activities or reporting responsibilities, if deemed appropriate by HHS or Health Plan, as applicable. (45 CFR 156.340(b)(2)).