PARTICIPATING PROVIDER AGREEMENT

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

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

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

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

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

ARTICLE I - DEFINITIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE II – PRODUCTS AND SERVICES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ARTICLE III – CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

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

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

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

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

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

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

ARTICLE IV – RECORDS AND INSPECTIONS

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

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

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

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

ARTICLE V – INSURANCE AND INDEMNIFICATION

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

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

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

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

ARTICLE VI – DISPUTE RESOLUTION

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

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

ARTICLE VII – TERM AND TERMINATION

7.1. Term.

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

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

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

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

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

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

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

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

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

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

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

ARTICLE VIII - MISCELLANEOUS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

To Carolina Complete at:	To Provider at:
Attn: President	Attn: _____
Carolina Complete Health, Inc.	_____
3120 Highwoods Blvd., Suite 212	_____
Raleigh, NC 27604	_____, _____ _____
	_____

To CCHN at:

Attn:

Carolina Complete Health Network, Inc.

222 N. Person Street, Suite 010

Raleigh, NC 27601

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

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

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

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

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

* * * * *

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

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

CAROLINA COMPLETE:

Carolina Complete Health, Inc.

Authorized Signature:

Print Name: _____

Title: _____

Signature Date:

ECM #:

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

PROVIDER:

_____
(Legibly Print Name of Provider)

Authorized Signature:

Print Name:

Title:

Signature Date:

Tax Identification Number: _____

State Medicaid Number: _____

National Provider Identifier: _____

CCHN:

Carolina Complete Health Network, Inc.

Authorized Signature:

Print Name: _____

Title: _____

Signature Date:

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE A
CONTRACTED PROVIDER-SPECIFIC PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE B
PRODUCT PARTICIPATION

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

List of Product Attachments:

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

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE C
CONTRACTED PROVIDERS

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

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

PARTICIPATING PROVIDER AGREEMENT

SCHEDULE D
COMPANY AFFILIATES

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

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

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

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

Attachment A: Medicaid

MEDICAID PRODUCT ATTACHMENT

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

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

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

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

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

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

1.1 "***Amendment***" means any change to the terms of a contract, including terms incorporated by reference that modifies fee schedules. A change required by federal or state law, rule, regulation, administrative hearing, or court order is not an amendment.

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

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

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

1.5 "***Health Care Provider***" means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes of North Carolina or under the laws of another

state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes of North Carolina or is owned or operated by the State of North Carolina in which health care services are provided to patients.

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

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

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

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

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

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

2. Medicaid Product.

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

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

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

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

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

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

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

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

Attachment A: Medicaid

SCHEDULE A
GOVERNMENTAL PROGRAM REQUIREMENTS

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

1. Compliance.

1.1 Compliance with State and Federal Laws. Participating Provider understands and agrees that it, he or she is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to the Agreement and State Contract, and all persons or entities receiving state and federal funds. Participating Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the State Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law. *(Section VII, Section G(3)(a)).*

1.2 Department Authority Related to the Medicaid Program. Participating Provider agrees and understands that in the State of North Carolina, the Department of Health and Human Services ("***NC DHHS***") is the single state Medicaid agency designated under 42 C.F.R. § 431.10 to administer or supervise the administration of the state plan for medical assistance. The Division of Health Benefits is designated with administration, provision, and payment for medical assistance under the Federal Medicaid (Title XIX) and the State Children's Health Insurance (Title XXI) (CHIP) programs. The Division of Social Services (DSS) is designated with the administration and determination of eligibility for the two programs. *(Section VII, G(3)(e)).*

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

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

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

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

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

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

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

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

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

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

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

5. Non-Discrimination.

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

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

6. Term; Termination.

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

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

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

7. Covered Person Services.

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

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

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

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

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

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

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

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

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

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

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

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

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

8. Records.

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

8.2 Access to Provider Records.

(a) Participating Provider agrees to provide at no cost to the following entities or their designees with prompt, reasonable, and adequate access to Carolina Complete or Payor and the Agreement and any records, books, documents, and papers that relate to Carolina Complete or Payor and the Agreement and/or Participating Provider's performance of its responsibilities under this Agreement for purposes of examination, audit, investigation, contract administration, the making of copies, excerpts or transcripts, or any other purpose NC DHHS deems necessary for contract enforcement or to perform its regulatory functions: (i) the United States Department of Health and Human Services or its designee; (ii) the Comptroller General of the United States or its designee; (iii) NC DHHS, its Medicaid managed care program personnel, or its designee; (iv) the Office of Inspector General; (v) North Carolina Department of Justice Medicaid Investigations Division; (vi) any independent verification and validation contractor, audit firm, or quality assurance contractor acting on behalf of NC DHHS; (vii) the North Carolina Office of State Auditor, or its designee; (viii) a state or federal law enforcement agency; and (ix) any other state or federal entity identified by NC DHHS, or any other entity engaged by NC DHHS.

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

(c) Nothing in this section shall be construed to limit the ability of the federal government, the Centers for Medicare and Medicaid Services, the U.S. Department of Health and Human Services Office of Inspector

General, the U.S. Department of Justice, or any of the foregoing entities' contractors or agents, to enforce federal requirements for the submission of documentation in response to an audit or investigation. *(Section VII, G(3)(f))*.

9. Provider Ownership Disclosure. Participating Provider agrees to disclose the required information, at the time of application, and/or upon request, in accordance with 42 C.F.R.§ 455 Subpart B, related to ownership and control, business transactions, and criminal conviction for offenses against Medicare, Medicaid, CHIP and/or other federal health care programs. See 42 C.F.R. § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any federal health care programs. Participating Provider agrees to notify, in writing, Carolina Complete and the NC DHHS of any criminal conviction within twenty (20) days of the date of the conviction. *(Section VII, G(3)(g))*.

10. Provider Payment.

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

10.2 G.S. 58-3-225, Prompt Claim Payments under Health Benefit Plans. Unless otherwise provided by the NC DHHS's Advanced Medical Home Program Policy, Pregnancy Management Program Policy, Care Management for High-Risk Pregnancy Policy, or Care Management for At-Risk Children Policy, Participating Provider shall submit all claims to the Payor for processing and payments within one-hundred-eighty (180) calendar days from the date of covered service or discharge (whichever is later). However, Participating Provider's failure to submit a claim within this time will not invalidate or reduce any claim if it was not reasonably possible for Participating Provider to submit the claim within that time. In such case, the claim should be submitted as soon as reasonably possible, and in no event, later than one (1) year from the time submittal of the claim is otherwise required. *(Section VII, G(3)(h))*.

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

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

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

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

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

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

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

(c) If the requested additional information on a medical or pharmacy pended claim is not submitted within ninety (90) days of the notice requesting the required additional information, the Payor shall deny

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

(d) If the Payor fails to pay a Clean Claim in full pursuant to this provision, the Payor shall pay interest and penalty. Late Payments will bear interest at the annual rate of eighteen (18) percent beginning on the date following the day on which the claim should have been paid or was underpaid.

(e) Failure to pay a Clean Claim within thirty (30) days of receipt will result in the Payor paying Provider a penalty equal to one (1) percent of the total amount of the claim per day beginning on the date following the day on which the claim should have been paid or was underpaid.

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

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

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

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

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

14. Providers of Perinatal Care: To the extent that Participating Provider offers prenatal, perinatal, and postpartum services or is an obstetrician, Participating Provider shall comply with NC DHHS's Pregnancy Management Program. The Pregnancy Management Program is a set of mandatory standards and clinical initiatives aimed at improving the quality of pregnancy care, improving maternal and infant outcomes and reducing health care costs among participating providers. Participating Provider shall: (a) complete the standardized risk-screening tool at each initial visit; (b) allow Carolina Complete or Carolina Complete's designated vendor access to medical records for auditing purposes to measure performance on specific quality indicators; (c) commit to maintaining or lowering the rate of elective deliveries prior to thirty-nine (39) weeks gestation; (d) commit to decreasing the cesarean section rate among nulliparous women; (e) offer and provide 17 alpha-hydroxyprogesterone caproate (17p) for the prevention of preterm birth to women with a history of spontaneous preterm birth who are currently pregnant with a singleton gestation; (f) complete a high-risk screening on each pregnant Medicaid Managed Care Covered Person in the program and integrate the plan of care with local pregnancy care management; (g) decrease the primary cesarean delivery rate if the rate is over NC DHHS's designated cesarean rate (NC DHHS will set the rate annually at or below twenty percent (20%)); and (h) ensure comprehensive post-partum visits occur within fifty-six (56) days of delivery *(Section VII, G(1)(u)) and M(3))*.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Unless otherwise specified, any required element may be performed either by the Tier 3 AMH practice itself or by a clinically-integrated network ("CIN") with which the practice has a contractual agreement that contains equivalent contract requirements. The Carolina Complete shall maintain a contractual relationship with the AMH (not the CIN).

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

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

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

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

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

(e) The Tier 3 AMH practice must ensure that the whole care team understands the basis of the practice's risk scoring methodology (even if this involves only clinician judgment at the practice-level) and that the methodology is applied consistently.

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

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

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

(b) The Tier 3 AMH practice must perform a Comprehensive Assessment (as defined below) on each patient identified as a priority for care management to determine care needs. The Comprehensive Assessment can be performed as part of a clinician visit, or separately by a team led by a clinician with a minimum credential of RN or LCSW. The Comprehensive Assessment must include at a minimum:

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

(c) The Tier 3 AMH practice must have North Carolina licensed, trained staff organized at the practice level (or at the CIN level but assigned to specific practices) whose job responsibilities encompass care management and who work closely with clinicians in a team-based approach to care for high-need patients.

(d) For each high-need patient, the Tier 3 AMH practice must assign a care manager who is accountable for active, ongoing care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

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

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

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

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

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

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

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

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

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

(h) The Tier 3 AMH practice must track empaneled patients' utilization in other venues covering all or nearly all hospitals and related facilities in their catchment area, including local emergency departments (EDs) and hospitals, through active access to an admissions, discharge, and transfer (ADT) data feed that correctly identifies when empaneled patients are admitted, discharged, or transferred to/from an emergency department or hospital in real time or near real time.

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

i) Real time (minutes/hours) response to outreach from EDs relating to patient care or admission/discharge decisions, for example arranging rapid follow up after an ED visit to avoid an admission.
ii) Same-day or next-day outreach for designated high-risk subsets of the population to inform clinical care, such as beneficiaries with special health care needs admitted to the hospital;

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

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

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

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

(b) For each patient in transition identified as high risk for admission or other poor outcome with transitional care needs, the Tier 3 AMH practice must assign a care manager who is accountable for transitional care management that goes beyond office-based clinical diagnosis and treatment and who has the minimum credentials of RN or LCSW.

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

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

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

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

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

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

16.2 Care Management for High-Risk Pregnancy: Outreach. Participating Provider shall refer potentially Medicaid-eligible pregnant women for prenatal care and Medicaid eligibility determination, including promoting the use of presumptive eligibility determination and other strategies to facilitate early access to Medicaid coverage during pregnancy. Participating Provider shall contact patients identified as having a priority risk factor through claims data

(Emergency Department utilization, antepartum hospitalization, utilization of Labor & Delivery triage unit) for referral to prenatal care and to engage in care management.

16.3 Care Management for High-Risk Pregnancy: Population Identification and Engagement. Participating Provider shall review and enter all pregnancy risk screenings received from Pregnancy Management Program providers covered by the pregnancy care managers into the designated care management documentation system within five (5) calendar days of receipt of risk screening forms. Participating Provider shall utilize risk screening data, patient self-report information and provider referrals to develop strategies to meet the needs of those patients at highest risk for poor pregnancy outcome. Participating Provider shall accept pregnancy care management referrals from non-Pregnancy Management Program prenatal care providers, community referral sources (such as Department of Social Services or WIC programs), patient self-referral, and provide appropriate assessment and follow up to those patients based on the level of need. Participating Provider shall review available Carolina Complete data reports identifying additional pregnancy risk status data, including regular, routine use of the Obstetric Admission, Discharge and Transfer (OB ADT) report, to the extent the OB ADT report remains available to Participating Provider. Participating Provider shall collaborate with out-of-county Pregnancy Management Program providers and Care Management for High-Risk Pregnancy teams to facilitate cross-county partnerships to ensure coordination of care and appropriate care management assessment and services for all patients in the target population.

16.4 Care Management for High-Risk Pregnancy: Assessment and Risk Stratification. Participating Provider shall conduct a prompt, thorough assessment by review of claims history and medical record, patient interview, case review with prenatal care provider and other methods, on all patients with one or more priority risk factors on pregnancy risk screenings and all patients directly referred for care management for level of need for care management support. Participating Provider shall utilize assessment findings, including those conducted by Carolina Complete to determine level of need for care management support. Participating Provider shall document assessment findings in the care management documentation system. Participating Provider shall ensure that assessment documentation is current throughout the period of time the care manager is working with the patient and should be continually updated as new information is obtained. Participating Provider shall assign case status based on level of patient need.

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

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

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

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

16.8 Care Management for High-Risk Pregnancy: Training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend pregnancy care management training offered by Carolina Complete and/or NC DHHS, including webinars, new hire orientation or other programmatic training. Participating Provider shall ensure that pregnancy care managers and their supervisors attend continuing education sessions coordinated by Carolina Complete and/or NC DHHS. Participating Provider shall ensure that pregnancy care managers and their supervisors pursue ongoing continuing education opportunities to stay current in evidence-based care management of pregnancy and postpartum women at risk for poor birth outcomes. Participating Provider shall ensure that pregnancy care managers and their supervisors utilize Motivational Interviewing and Trauma Informed Care techniques on an ongoing basis.

16.9 Care Management for High-Risk Pregnancy: Staffing.

(a) Participating Provider shall employ care managers meeting pregnancy care management competencies defined as having at least one of the following qualifications: registered nurse; or social worker with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program. Care Managers for High- Risk Pregnancy hired prior to September 1, 2011 without a bachelor's or master's degree in social work may retain their existing position; however, this grandfathered status does not transfer to any other position. Participating Provider shall ensure that Community Health workers for Care Manager for High-Risk Pregnancy services work under the supervision and direction of a trained care manager. Participating Provider shall include both registered nurses and social workers in order to best meet the needs of the Target Population with medical and psychosocial risk factors on their team. If the Participating Provider only has a single Care Manager for High-Risk Pregnancy, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with a pregnant population at high risk for poor birth outcome. This skill mix should reflect the capacity to address the needs of patients with both medically and socially complex conditions. Participating Provider shall establish staffing arrangements to ensure continuous service delivery through appropriate management of staff vacancies and extended absences, including following Carolina Complete /NC DHHS guidance about communication with Carolina Complete about any vacancies or extended staff absences and adhering to guidance about contingency planning to prevent interruptions in service delivery. Vacancies lasting longer than sixty (60) days shall be subject to additional oversight by Carolina Complete.

(b) Participating Provider shall ensure that Pregnancy Care Managers must demonstrate: (i) a high level of professionalism and possess appropriate skills needed to work effectively with a pregnant population at high risk for poor birth outcomes; (ii) proficiency with the technologies required to perform care management functions; (iii) motivational interviewing skills and knowledge of adult teaching and learning principles; (iv) ability to effectively communicate with families and providers; and (v) critical thinking skills, clinical judgment and problem-solving abilities.

(c) Participating Provider shall provide qualified supervision and support for pregnancy care managers to ensure that all activities are designed to meet performance measures, with supervision to include: (i)

provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight; (iii) regular meetings with direct service care management staff; (iv) utilization of reports to actively assess individual care manager performance; and (v) compliance with all supervisory expectations delineated in the Care Management for High-Risk Pregnancy Program Manual.

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

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

17.2 Care Management for At-Risk Children: Outreach. Participating Provider shall educate patients, Advanced Medical Homes, other practices and community organizations about the benefits of the Care Management for At-Risk Children Program and target populations for referral; disseminate the Care Management for At-Risk Children Referral Form either electronically and/or in a paper version to potential referral sources. Participating Provider shall communicate regularly with the Advanced Medical Homes and other practice serving children, to ensure that children served by that medical home are appropriately identified for Care Management for At-Risk Children services. Participating Provider shall collaborate with out-of-county Advanced Medical Homes and other practices to facilitate cross-county partnerships to optimize care for patients who receive services from outside their resident county. Participating Provider shall identify or develop if necessary, a list of community resources available to meet the specific needs of the population. Participating Provider shall utilize the NC Resource Platform, when operational, and identify additional community resources and other supportive services once the platform has been fully certified by NC DHHS.

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

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

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

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

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

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

17.8 Care Management for At-Risk Children: Service Provision. Participating Provider shall document all care management activities in the care management documentation system in a timely manner. Participating Provider shall ensure that the services provided by Care Management for At-Risk Children meet a specific need of the family and work collaboratively with the family and other service providers to ensure the services are provided as a coordinated effort that does not duplicate services.

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

17.10 Care Management for At-Risk Children: Staffing.

(a) Participating Provider shall hire care managers meeting Care Management for At-Risk Children care coordination competencies and with at least one of the following qualifications: registered nurse; or social worker with a bachelor's degree in social work (BSW, BA in SW, or BS in SW) or master's degree in social work (MSW, MA in SW, or MS in SW) from a Council on Social Work Education accredited social work degree program. Non-degreed social workers cannot be the lead care manager providing Care Management for At-Risk Children even if they qualify as a Social Worker under the Office of State Personnel guidelines. Participating Provider shall engage care managers who operate with a high level of professionalism and possess an appropriate mix of skills needed to work effectively with high-risk children. This skill mix must reflect the capacity to address the needs of patients with both medically and socially complex conditions. Participating Provider shall ensure that the team of Care Management for At-Risk Children care managers shall include both registered nurses and social workers to best meet the needs of the target population with medical and psychosocial risk factors. If the Participating Provider has only has a single Care Management for At-Risk Children care manager, the Participating Provider shall ensure access to individual(s) to provide needed resources, consultation and guidance from the non-represented professional discipline. Participating Provider shall maintain services during the event of an extended vacancy. In the event of an extended vacancy, Participating Provider shall complete and submit the vacancy contingency plan that describes how an extended staffing vacancy will be covered and the plan for hiring if applicable. Participating

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

(b) Participating Provider shall ensure that Care Management for At-Risk Children Care Managers must demonstrate: (i) proficiency with the technologies required to perform care management functions – particularly as pertains to claims data review and care management documentation system; (ii) ability to effectively communicate with families and providers; (iii) critical thinking skills, clinical judgment and problem-solving abilities; and (iv) motivational interviewing skills, Trauma Informed Care, and knowledge of adult teaching and learning principles.

(c) Participating Provider shall provide qualified supervision and support for Care Management for At-Risk Children care managers to ensure that all activities are designed to meet performance measures, with supervision to include: (i) provision of program updates to care managers; (ii) daily availability for case consultation and caseload oversight; (iii) regular meetings with direct service care management staff; and (iv) utilization of monthly and on-demand reports to actively assess individual care manager performance.

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

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

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

18.3 N.C. Gen. Stat. § 58-50-275(a)-(b), Notice Contact. Provider and Carolina Complete have set forth in the Agreement a "notice contact" provision listing the name or title and address of the person to whom all correspondence, including proposed Amendments and other notices, pertaining to the contractual relationship between the Parties shall be sent. Notwithstanding anything in the Agreement to the contrary, means for sending all notices provided under the Agreement is one or more of the following, calculated as (i) five business days following the date the notice is placed, first-class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service, the date of delivery. Nothing in this section prohibits the use of an electronic medium for a communication other than an Amendment if agreed to by Carolina Complete and Provider (Section VII, G(1)(x)(iv)).

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

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

18.5 N.C. Gen. Stat. § 58-50-285 (a)-(b), Policies and Procedures. Carolina Complete or Payor shall provide a Health Care Provider with a copy of its policies and procedures prior to execution of a new or amended contract and annually to all Participating Providers. Such policies and procedures may be provided in hard copy, CD or other electronic format, and may also be provided by posting the policies and procedures on the Carolina Complete or Payor website. Such policies and procedures will not conflict with or override any term of a contract, including contract fee schedules. In the event of a conflict between a policy or procedure and the language in a contract, the contract language shall prevail. (Section VII, G(1)(x)(vi)).

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

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

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

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

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

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

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

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

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

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

(a) Hospital/Inpatient acute care and long-term acute care
(b) Nursing Facility
(c) Adult Care Home
(d) Inpatient behavioral health services
(e) Facility-based crisis services for children
(f) Facility-based crisis services for adults
(g) ADATC

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

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

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

29. Program Integrity. Participating Provider: (a) will have compliance plans that meet the requirements of 42 C.F.R. § 438.608 and policies and procedures that meet the requirements of the Deficit Reduction Act of 2005; (b) will have policies and procedures that recognize and accept Medicaid as "the payer of last resort"; and (c) is prohibited from billing Covered Persons for Covered Services any amount greater than would be owed if the Participating Provider provided the service directly as provided in 42 C.F.R. §§ 438.3(k) and 438.230(c)(1)-(2). *(Section V, D(2)(f); Section V, J(2)(b)(iii)(c)).*

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

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

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

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

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

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

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

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

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

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

(iv) "***Health Care Provider***" shall mean Provider if Provider is an individual who is licensed, certified, or otherwise authorized under Chapter 90 or Chapter 90B of the General Statutes or under the laws of another state to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program and a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

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

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

APPENDIX A TO SCHEDULE A GOVERNMENTAL PROGRAM REQUIREMENTS

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

Attachment A: Medicaid

MEDICAID MANAGED CARE ADDENDUM FOR INDIAN HEALTH CARE PROVIDERS

This MEDICAID MANAGED CARE ADDENDUM FOR INDIAN HEALTH CARE PROVIDERS (this "***Addendum***") is made and entered between Carolina Complete Health, Inc. ("Carolina Complete"), Carolina Complete Health Network, Inc. ("CCHN") and the undersigned provider ("***Provider***"), and attaches to that certain Medicaid Product Attachment ("***Product Attachment***") that is part of the Participating Provider Agreement entered into by Carolina Complete, CCHN and Provider, as the same may have been amended and supplemented from time to time (the "***Agreement***"). To the extent Provider is an Indian Health Care Provider (IHCP), Provider shall comply with the provisions of this Addendum. *(Section VII, H)*.

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

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

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

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

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

(ii) is an Eskimo or Aleut or other Alaska Native;

(iii) is considered by the Secretary of the Interior to be an Indian for any purpose; or

(iv) is determined to be an Indian under regulations issued by the Secretary.

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

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

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

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

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

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

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

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

3. Description of IHCP. The IHCP identified in Section 1 of this Addendum is (check the appropriate box):

/__/ IHS.

/__/ An Indian tribe that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/__/ A tribal organization that operates a health program under a contract or compact to carry out programs, services, functions, and activities (or portions thereof) of the IHS pursuant to the ISDEAA, 25 U.S.C. § 450 et seq.

/__/ A tribe or tribal organization that operates a health program with funding provided in whole or part pursuant to 25 U.S.C. § 47 (commonly known as the Buy Indian Act).

/__/ An urban Indian organization that operates a health program with funds in whole or part provided by IHS under a grant or contract awarded pursuant to Title V of the IHCIA.

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

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

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

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

7. Persons Eligible for Items and Services from IHCP. Nothing in this agreement shall be construed to in any way change, reduce, expand, or alter the eligibility requirements for services through the IHCP's programs, as

determined by federal law including the IHCIA, 25 U.S.C. § 1601, et seq. and/or 42 C.F.R. Part 136. No term or condition of the Managed Care Plan's network IHCP agreement or any addendum thereto shall be construed to require the IHCP to serve individuals who are ineligible for services from the IHCP. The Managed Care Plan acknowledges that pursuant to 45 C.F.R. § 80.3(d), an individual shall not be deemed subjected to discrimination by reason of his/her exclusion from benefits limited by federal law to individuals eligible for services from the IHCP. IHCP acknowledges that the nondiscrimination provisions of federal law may apply.

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

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

10. Insurance and Indemnification.

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

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

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

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

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

13. Governing Law. The Managed Care Plan's network IHCP agreement and all addenda thereto shall be governed and construed in accordance with federal law of the United States. In the event of a conflict between such agreement and all addenda thereto and federal law, federal law shall prevail. Nothing in the Managed Care Plan's network IHCP agreement or any addendum thereto shall subject an Indian tribe, tribal organization, or urban Indian organization to state law to any greater extent than state law is already applicable.

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

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

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

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

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

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

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

* * * * *

APPROVALS

For the Managed Care Plan: **Carolina Complete Health, Inc.**	**For the IHCP**:
By:	By:
Title:	Title:
Print Name:	Print Name:
Date:	Date:

For Carolina Complete Health Network, Inc.

By:

Title:

Printed Name:

Date:

(a) **The IHS as an IHCP**:

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

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

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

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

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

Attachment A: Medicaid

EXHIBIT 1
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES
PHYSICIANS AND PHYSICIAN EXTENDERS

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

The compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the rate floor as defined by the North Carolina Division of Health Benefits ("NCDHB") which is one hundred percent (100%) of the amount payable based on the Medicaid fee schedule for physicians and physician extenders set forth by NCDHB on the date of service (the "Rate Floor"); unless, the Allowable Charges is less than the Rate Floor in which case both Parties mutually agree as an alternative reimbursement arrangement that the Allowed Amount will be equal to the Allowable Charges. Payor agrees to reimburse Contracted Provider any additional payments such as medical home PMPM payments and pregnancy medical home incentive payments as directed by the North Carolina Division of Health Benefits or North Carolina Department of Health and Human Services as applicable.

Additional Provisions:

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

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

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Payment for Multiple Procedures. Where multiple outpatient surgical or scope procedures performed on a Covered Person during a single occasion of surgery, reimbursement will be as follows: i) the procedure for which the Allowed Amount under this Compensation Schedule is greatest will be reimbursed at one hundred percent (100%) of such Allowed Amount; ii) the procedures with second greatest Allowed Amounts under this Compensation Schedule will be reimbursed at twenty five percent (25%) of such Allowed Amounts; and iii) any additional procedures will not be eligible for reimbursement.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

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

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

Definitions:

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

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

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

Attachment A: Medicaid

EXHIBIT 2
COMPENSATION SCHEDULE
PROFESSIONAL SERVICES
SPECIALTY CARE PHYSICIANS AND SPECIALTY CARE PHYSICIAN EXTENDERS

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

The compensation for professional Covered Services rendered to a Covered Person shall be the "Allowed Amount." Except as otherwise provided in this Compensation Schedule, the Allowed Amount for professional Covered Services is the rate floor as defined by the North Carolina Division of Health Benefits ("NCDHB") which is one hundred percent (100%) of the amount payable based on the Medicaid fee schedule for specialty care physicians and specialty care physician extenders set forth by NCDHB on the date of service (the "Rate Floor"); unless, the Allowable Charges is less than the Rate Floor in which case both Parties mutually agree as an alternative reimbursement arrangement that the Allowed Amount will be equal to the Allowable Charges. Payor agrees to reimburse Contracted Provider any additional payments such as medical home PMPM payments and pregnancy medical home incentive payments as directed by the North Carolina Division of Health Benefits or North Carolina Department of Health and Human Services as applicable.

Additional Provisions:

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

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

3. Modifier. Unless specifically indicated otherwise, fee amounts listed in the fee schedule represent global fees and may be subject to reductions based on appropriate Modifier (for example, professional and technical modifiers). As used in the previous sentence, "global fees" refers to services billed without a Modifier, for which the fee amount includes both the professional component and the technical component. Any Cost-Sharing Amounts that the Covered Person is responsible to pay under the Coverage Agreement will be subtracted from the Allowed Amount in determining the amount to be paid.

4. Anesthesia Modifier Pricing Rules. The dollar amount that will be used in the calculation of time-based and non-time based anesthesia management fees in accordance with the anesthesia payment policy. Unless specifically stated otherwise, the anesthesia conversion factor indicated is fixed and will not change. The anesthesia conversion factor is based on an anesthesia time unit value of 15 minutes.

5. Payment for Multiple Procedures. Where multiple outpatient surgical or scope procedures performed on a Covered Person during a single occasion of surgery, reimbursement will be as follows: i) the procedure for which the Allowed Amount under this Compensation Schedule is greatest will be reimbursed at one hundred percent (100%) of such Allowed Amount; ii) the procedures with second greatest Allowed Amounts under this Compensation Schedule will be reimbursed at twenty five percent (25%) of such Allowed Amounts; and iii) any additional procedures will not be eligible for reimbursement.

6. Place of Service Pricing Rules. This fee schedule follows CMS guidelines for determining when services are priced at the facility or non-facility fee schedule (with the exception of services performed at Ambulatory Surgery Centers, POS 24, which will be priced at the facility fee schedule).

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

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

Definitions:

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

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

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