MISSISSIPPI MEDICAID PROGRAM

REGULATORY REQUIREMENTS APPENDIX

DOWNSTREAM PROVIDER

THIS MISSISSIPPI MEDICAID PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between Ear Professionals International Corporation d/b/a EPIC Hearing Healthcare and d/b/a UnitedHealthcare Hearing ("Subcontractor") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care services that Provider provides directly to Covered Persons through Health Plan's (as defined herein) products or benefit plans including Mississippi Coordinated Access Network Program (the "MississippiCAN Program") as governed by the State's designated regulatory agencies. Provider has agreed to provide Covered Services to Covered Persons who receive their coverage pursuant to a contract between the State and Health Plan (the "State Contract" as defined herein). The State Contract and applicable State and federal law require that the provisions contained in this Appendix be part of the Agreement. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except with regard to benefit contracts outside the scope of this Appendix or unless otherwise required by law. In the event Subcontractor is required to amend or supplement this Appendix as required or requested by the State and requested by Health Plan, Provider agrees that Subcontractor shall be permitted to unilaterally initiate such additions, deletions or modifications. All provider agreements must be in writing and must include all specific activities and report responsibilities delegated to the Provider by Subcontractor.

SECTION 2
DEFINITIONS

Unless otherwise defined in this Appendix, all capitalized terms shall be as defined in the Agreement. For purposes of this Appendix, the following terms shall have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix or the Agreement is inconsistent with any definitions under the MississippiCAN Program, the definitions shall have the meaning set forth under the MississippiCAN Program.

2.1 Action: Health Plan's decision to deny or limit authorization or payment (in whole or in part) for health care services, including new authorizations and previously authorized services; the reduction, suspension, or termination of a previously authorized service; or Health Plan's failure to provide services in a timely manner; failure to resolve Complaints, Grievances, or Appeals within the specified time frames.

2.2 Appeal: A request for review by Health Plan of an Action related to a Covered Person or Provider. In the case of a Covered Person, an Action may include determinations on the health

care services a Covered Person believes he or she is entitled to receive, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the Covered Person). In the case of a Provider, the Action may include, but is not limited to, delay or non-payment for covered services.

2.3 Behavioral Health Services: Mental health and/or drug and alcohol abuse treatment services that are provided by the county intellectually delayed/developmentally delayed programs, the single county authority administrators, or other appropriately licensed health care practitioners.

2.4 CMS: Center for Medicare and Medicaid Services is an agency within the U.S. Department of Health & Human Services responsible for administration of several key federal health care programs.

2.5 Complaint: An expression of dissatisfaction received orally or in writing that is of a less serious or formal nature that is resolved within one (1) business day of receipt.

2.6 Covered Person: An individual who meets all of the eligibility requirements for Mississippi Medicaid and is currently enrolled with Health Plan for the provision of services under a MississippiCAN Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.7 Covered Services: Health care services or products for which a Covered Person is enrolled with Health Plan to receive coverage under the State Contract.

2.8 DOM: Division of Medicaid, Office of the Governor, State of Mississippi.

2.9 Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) Services: Defined by DOM to include:

a. Age appropriate, comprehensive health and development history that includes physician and mental health assessments along with counseling and anticipatory guidance and risk factor reduction interventions;
b. Calculation of Body Mass Index;
c. Growth measurements and head circumference;
d. Nutritional counseling;
e. Developmental surveillance and Developmental and autism Spectrum Disorders Screenings as appropriate;
f. Comprehensive unclothed exam;
g. Appropriate laboratory tests (including blood level assessment appropriate to age and risk);
h. Appropriate immunizations in accordance with Recommended Childhood and Adolescent Immunization Schedule adopted by DOM;
i. A vision assessment;
j. A hearing assessment;
k. A dental screening and/or referral to dental care;
l. Health education; and

m. Referrals for identified abnormalities.

2.10 Fraud and Abuse: Fraud is any type of intentional deception or misrepresentation made by an entity or person with the knowledge that the deception could result in some unauthorized benefit to the entity, him or herself, or some other person. The Fraud can be committed by many entities, including a vendor, a subcontractor, a provider, a State employee, or a Covered Person, among others. Abuse is any practice that is inconsistent with sound fiscal, business, or medical practices, and results in an unnecessary cost to the Medicaid program, a vendor, a subcontractor or Provider or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care.

2.11 Grievance: An expression of dissatisfaction about any matter or aspect of Health Plan or its operation, other than an Action as defined herein.

2.12 Health Plan: An appropriately licensed entity that has entered into a contract with Subcontractor, either directly or indirectly, under which Subcontractor provides certain administrative services for Health Plan pursuant to the State Contract. For purposes of this Appendix, Health Plan refers to UnitedHealthcare of Mississippi, Inc.

2.13 Marketing: The activities that promote visibility and awareness for the MississippiCAN Program and Health Plan's participation in the program. All activities are subject to prior review and approval by DOM.

2.14 Medical Record: A single complete record, which documents the entire treatment plan developed for, and medical services received by, the Covered Person including inpatient, outpatient, referral services and emergency medical services whether provided by contracted Providers or non-contracted providers.

2.15 Mississippi Coordinated Access Network (MississippiCAN) Program: Mississippi Medicaid's coordinated care program for select Medicaid Beneficiaries.

2.16 Primary Care Provider (PCP): Any physician or health care practitioner or group operating within the scope of his or her licensure who is responsible for supervising, prescribing and providing primary care and primary case management services in the MississippiCAN Program, whose practice is limited to the general practice of medicine or who is an Internist, Pediatrician, Obstetrician, Gynecologist, Family Practitioner, General Practitioner, Certified Nurse Practitioners whose specialty is pediatrics, adult, family, certified nurse midwife, obstetrics/gynecology, or a physician assistant.

2.17 Prior Authorization: A determination to approve a Provider's request, pursuant to services covered in the MississippiCAN Program, to provide a service or course of treatment of a specific duration and scope to a Member prior to the initiation or continuation of the service.

2.18 Provider: A hospital, ancillary provider, physician group, individual physician or other healthcare provider who has entered into an Agreement.

2.19 Provider Network: The Panel of health service Providers with which Subcontractor and/or Health Plan contracts for the provision of covered services to Covered Persons and Non-Contracted Providers administering services to Covered Persons.

2.20 State: The State of Mississippi or its designated regulatory agencies.

2.21 State Contract: Health Plan's contract with the State for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the MississippiCAN Program.

2.22 Third Party Resource: Any resource available to a Covered Person for the payment of medical expenses associated with the provision of covered services, other than those which are exempt under Title XIX of the Act, including but not limited to, insurers and workers' compensation plan.

SECTION 3
PROVIDER REQUIREMENTS

The MississippiCAN Program, through the State Contract and federal and State statutes and regulations, requires the Agreement to contain certain conditions that Health Plan, Subcontractor and Provider agree to undertake, which include the following:

3.1 Definitions Related to the Provision of Covered Services. Provider shall follow the applicable State Contract's requirements for the provision of Covered Services. Provider's decisions affecting the delivery of acute or chronic care services to Covered Persons shall be made on an individualized basis and in accordance with the following definitions:

(a) Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following: (1) 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; (2) serious impairment to body functions; or (3) serious dysfunction of any body organ or part.

(b) Emergency Services: Covered inpatient and outpatient services furnished by a provider who is qualified to furnish those health services and that are needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary Services: As set forth in the Social Security Act, Section 1905 (42 USC 1396d(a)), Medically Necessary Services are defined as services, supplies, or equipment provided by a licensed health care professional that are:

1. Appropriate and consistent with the diagnosis or treatment of the Covered Person's condition, illness, or injury;

2. In accordance with the standards of good medical practice consistent with the individual Covered Person's condition(s);

3. Not primarily for the personal comfort or convenience of the Member, family, or Provider;

4. The most appropriate services, supplies, equipment, or levels of care that can be safely and efficiently provided to the Covered Person;

5. Furnished in a setting appropriate to the Covered Person's medical need and condition and, when applied to the care of an inpatient, further mean that the Covered Person's medical symptoms or conditions require that the services cannot be safely provided to the Covered Person as an outpatient;

6. Not experimental or investigational or for research or education;

7. Provided by an appropriately licensed practitioner; and

8. Documented in the patient's record in a reasonable manner, including the relationship of the diagnosis to the service.

Medically Necessary Services may also be those services for children that are necessary to correct or ameliorate defects and physical and mental illnesses and conditions discovered during an interperiodic or periodic EPSDT screen, whether such services are covered or exceed the benefit limits in the Medicaid State Plan and Title 23 of Mississippi Administrative Code.

3.2 Provider Eligibility. Provider must be enrolled in the Mississippi Medicaid program and must use the same National Provider Identifier (NPI) number. Health Plan and Subcontractor will exclude from its network any provider who has been terminated or suspended from the Medicare or Medicaid program in any state.

3.3 Accessibility Standards. Provider shall provide for timely access for Covered Person appointments in accordance with the appointment availability requirements established under the State Contract, as further described in the applicable provider manual.

Type	Appointment Scheduling Time Frames
PCP (well care visit)	Not to exceed thirty (30) calendar days
PCP (routine sick visit)	Not to exceed seven (7) calendar days
PCP (urgent care visit)	Not to exceed twenty-four (24) hours
Specialists	Not to exceed forty-five (45) calendar days
Dental Providers (routine visits)	Not to exceed forty-five (45) calendar days
Dental Providers (urgent Care)	Not to exceed forty-eight (48) hours
Behavioral Health Providers (routine visit)	Not to exceed twenty-one (21) calendar days
Behavioral Health Providers (urgent visit)	Not to exceed twenty-four (24) hours

Behavioral Health Providers (post-discharge from an acute psychiatric hospital when the Contractor is aware of the Member's discharge)	Not to exceed seven (7) calendar days
Urgent Care Providers	Not to exceed twenty-four (24) hours
Emergency Providers	Immediately (twenty-four (24) hours a day, seven (7) days a week) and without Prior Authorization

3.4 Hours of Operation; Appointments. Provider shall offer hours of operation that are no less than the hours of operation offered to commercial beneficiaries or comparable to Medicaid fee-for-service if Provider serves only Medicaid beneficiaries.

3.5 Hold Harmless. Except for any applicable cost-sharing requirements under the State Contract, Provider shall look solely to Subcontractor and Health Plan for payment of Covered Services provided to Covered Persons pursuant to the Agreement and the State Contract and hold the State, DOM, the U.S. Department of Health and Human Services and Covered Persons harmless in the event that Subcontractor and/or Health Plan cannot or will not pay for such Covered Services. In accordance with 42 CFR 447.15, as may be amended from time to time, the Covered Person is not liable to Provider for any services for which Subcontractor and/or Health Plan is liable and as specified under the State's relevant health insurance or managed care statutes, rules or administrative agency guidance. Provider shall not require any copayment or cost sharing for Covered Services provided under the Agreement unless expressly permitted under the State Contract. Provider shall also be prohibited from charging Covered Persons for missed appointments if such practice is prohibited under the State Contract or applicable law. Neither the State, DOM nor Covered Persons shall be in any manner liable for the debts and obligations of Subcontractor and/or Health Plan and under no circumstances shall Subcontractor, Health Plan, or any providers used to deliver services covered under the terms of the State Contract, charge Covered Persons for Covered Services.

Covered Person may be responsible for non-covered item(s) and/or service(s), only if the Provider ensures that written documentation in compliance with the Advance Beneficiary Notification (ABN) is received from the Covered Person that an item(s) or service(s) rendered is a non-covered item and/or service(s) and that the Covered Person will be financially responsible for the item(s) and/or service(s). If Subcontractor and/or Health Plan determines a Covered Person was charged for Covered Services inappropriately, such payment may be recovered, as applicable.

This provision shall survive any termination of the Agreement, including breach of the Agreement due to insolvency.

3.6 Indemnification. To the extent applicable to Provider in performance of the Agreement, Provider shall indemnify, defend protect, save and hold DOM and its employees and Covered Persons harmless from and against all injuries, deaths, losses, damages, claims, suits, liabilities, judgments, costs and expenses, including, without limitation, court costs, investigative fees and expenses and attorney fees, to the extent proximately caused by any negligent act or other intentional misconduct or omission of Provider, its agents, officers, employees or contractors

arising from the Agreement. DOM may waive this requirement for public entities if Provider is a state agency or sub-unit as defined by the State or a public health entity with statutory immunity. This clause shall survive the termination of the Agreement for any reason, including breach due to insolvency.

3.7 Provider Selection. To the extent applicable to Provider in performance of the Agreement, Provider shall comply with 42 CFR 438.214, as may be amended from time to time, which includes, but is not limited to the selection and retention of providers, credentialing and recredentialing requirements and nondiscrimination. If Subcontractor and/or Health Plan delegates credentialing to Provider, Subcontractor and Health Plan will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with Health Plan's and the State Contract's credentialing requirements.

3.8 Restrictions on Referrals. Provider shall not make inappropriate referrals for designated health services to health care entities with which Provider or a member of Provider's family has a financial relationship, pursuant to federal anti-kickback and physician self-referral laws that prohibit such referrals.

3.9 Records Retention. As required under State or federal law or the State Contract, Provider shall maintain an adequate record keeping system for recording services, charges, dates and all other commonly accepted information elements sufficient to disclose the quality, quantity, appropriateness and timeliness of services rendered to Covered Persons. All financial records shall follow generally accepted accounting principles. Medical records and supporting management systems shall include all pertinent information related to the medical management of each Covered Person. Other records shall be maintained as necessary to clearly reflect all actions taken by Provider related to services provided under the State Contract. Such records shall be maintained for a period of not less than five (5) years from the close of the Agreement, or such other period as required by law. If records are under review or audit, they must be retained for a minimum of five (5) years following resolution of such action. Prior approval for the disposal of records must be requested and approved by Health Plan if the Agreement is continuous.

3.10 Records Access. Provider acknowledges and agrees that the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel shall have complete access to all records pertaining to services provided to Covered Persons. Provider shall provide immediate access to facilities, records and supportive materials pertinent to the State Contract for State or Federal fraud investigators. Copies of requested documents shall be provided to the State, DOM, the U.S. Department of Health and Human Services and other authorized federal and state personnel or their designees free of charge.

3.11 Government Audit; Investigations. Provider acknowledges and agrees that the State and the U.S. Department of Health and Human Services, the Centers for Medicare & Medicaid Services, the Office of Inspector General, the General Accounting Office, or any other auditing agency or their authorized representatives, with prior approval by DOM, shall, at all reasonable time, with or without notice, or their authorized representatives shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services provided under the

terms of the State Contract and any other applicable rules. There shall be no restrictions on the right of the State or federal government to conduct whatever inspections and audits are necessary to assure quality, appropriateness or timeliness of services provided pursuant to the State Contract and the reasonableness of their costs.

3.12 Privacy; HIPAA. Provider shall comply with all applicable privacy rule and security rule provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and associated implementing regulations, as may be amended from time to time, and shall safeguard information about Covered Persons in accordance with applicable federal and State privacy laws and rules including 42 CFR 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time. United agrees and shall require Provider to agree that confidential information, including but not limited to medical and other pertinent information relative to Covered Persons, shall not be disclosed to any person or organization for any purpose without the expressed, written authority of DOM or as otherwise required by law and that all such disclosures shall fully comply with HIPAA privacy and security standards.

3.13 Compliance with Law. Provider shall comply with all applicable federal and State laws and regulations, and all provisions of the State Contract, that pertain to a Covered Person's rights, including but not limited to the following to the extent applicable to Provider in performance of the Agreement:

(a) Title VI of the Civil Rights Act of 1964; Title XIX of the Social Security Act; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; The Genetic Information Non-Discrimination Act of 2008 (GINA); and the Americans with Disabilities Act, and their implementing regulations, as may be amended from time to time.

(b) 42 CFR 434 and 42 CFR 438.6, as may be amended from time to time.

(c) All relevant federal and State statutes, regulations and orders related to equal opportunity in employment, including but not limited to compliance with E.O. 11246, "Equal Employment Opportunity," as amended by E.O. 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and as supplemented by regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

(d) All federal and State professional and facility licensing and accreditation requirements/standards that apply to the services United and Provider perform pursuant to the Agreement, including but not limited to:

1. All applicable standards, orders or requirements issued under Section 306 of the Clean Air Act (42 USC 1857 (h)). Section 508 of the Clean Water Act (33 USC 1368), Executive Order 11738, and Environmental Protection Agency (EPA) regulations (40) CFR Part 15), which prohibit the use of facilities included on the EPA list of violating facilities. Any violations must be reported to DSHS, DHHS, and the EPA;

2. Any applicable mandatory standards and policies relating to energy efficiency that are contained in the State Energy Conservation Plan, including the Energy Policy & conservation Act (Pub. L. 94-165), and issued in compliance with the Federal Energy Policy & Conservation Act.

3. Those specified for laboratory services in the Clinical Laboratory Improvement Amendments (CLIA). All laboratory service sites must have a CLIA certificate of registration or waiver, and a CLIA identification number.

4. Section 1128B(d)(1) of the Balanced Budget Act of 1997; and,

5. Any other requirements associated with the receipt of federal funds.

3.14 Physician Incentive Plans. In the event Provider participates in a physician incentive plan ("PIP") under the Agreement, Provider agrees that such PIPs must comply with 42 CFR 417.479, 42 CFR 438.6(h), 42 CFR 422.208, and 42 CFR 422.210, as may be amended from time to time. Subcontractor, Health Plan nor Provider may make a specific payment directly or indirectly under a PIP to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an individual Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of services that meet the definition of Medical Necessity.

3.15 Lobbying. Provider agrees to comply with the following requirements related to lobbying:

(a) Prohibition on Use of Federal Funds for Lobbying: By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief, pursuant to 31 U.S.C. Section 1352 and 45 CFR Part 93, as may be amended from time to time, that no federally appropriated funds have been paid or will be paid to any person by or on Provider's behalf for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

(b) Disclosure Form to Report Lobbying: If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan, or cooperative agreement and the value of the Agreement exceeds $100,000,

Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.16 Excluded Individuals and Entities. Provider certifies that neither it nor any of its employees, principals, nor any providers, subcontractors or consultants or persons with an ownership or controlling interest in the Provider (an owner including the Provider himself or herself), or an agent or managing employee of the Provider, with whom Provider contracts and who are providing items or services that are significant and material to Provider's obligations under the Agreement is:

(a) excluded from participation in federal health care programs under either Section 1128 or section 1128A of the Social Security Act; or

(b) debarred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order no. 12549 or under guidelines implementing Executive Order No. 12549; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person.

Provider acknowledges and agrees that payment will not be made for any items or Covered Services provided by an excluded individual pursuant to 42 CFR 1001.1901(b) and is obligated to screen all employees, contractors, and subcontractors for exclusion as required under applicable State and Federal laws. Additionally, Provider acknowledges that pursuant to 42 CFR 1003.102(a)(2) civil monetary penalties may be imposed against Provider if he or she employs or enters into contracts with excluded individuals or entities to provide items or Covered Services to Covered Persons under this Agreement. Provider agrees not to employ or subcontract with individuals or entities whose owner, those with a controlling interest, or managing employees are on a State or Federal exclusion list to provide items or Covered Services under this Agreement. Provider shall immediately report to Subcontractor and/or Health Plan any exclusion information discovered. Provider can search the HHS-OIG website, at no cost, by the names of any individuals or entities. The database is called LEIE and can be accessed at http://www.oig.hhs.gov/fraud/exclusions.asp. The GSA EPLS/SAM database can be accessed at https://www.sam.gov. Applicable state exclusion databases can be accessed through the State's Medicaid website. Subcontractor and Health Plan will terminate the Agreement immediately and exclude from its network any provider who has been excluded from federal health care programs or terminated from the Medicare or the Medicaid program in any state. Subcontractor and Health Plan may also terminate the Agreement if Provider's owners, agents, or managing employees are found to be excluded on a State or Federal exclusion list.

3.17 Disclosure. Provider shall cooperate with Subcontractor and Health Plan in disclosing information DOM may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with 42 CFR Part 455 and shall provide information upon request. Provider shall submit information related to ownership and control of subcontractors or wholly owned suppliers within thirty-five (35) calendar days of a request for such information.

By executing this Agreement, Provider certifies that neither Provider nor any of its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in any State or federal health care program or from participating in transactions by any State or federal department or agency. Subcontractor and/or Health Plan will terminate the Agreement upon becoming aware or receiving notice from DOM, whichever is earlier, that Provider is or has been excluded from participation in any State or federal health care program or by any State or federal agency.

3.18 Cultural Competency. Provider shall participate in Subcontractor and Health Plan's and the State's efforts to promote the delivery of services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds and shall provide interpreter services in a Covered Person's primary language and for the hearing impaired for all appointments and emergency services. Provider shall provide information to Covered Persons regarding treatment options and alternatives, as well as information on complaints and appeals, in a manner appropriate to the Covered Person's condition and ability to understand.

3.19 Marketing. As required under State or federal law or the applicable State Contract, any marketing materials developed and distributed by Provider as related to the performance of the Agreement must be submitted to Health Plan for submission to DOM for prior approval.

3.20 Fraud, Waste and Abuse Prevention. Provider shall cooperate fully with Subcontractor and Health Plan's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, waste, and abuse in the administration and delivery of services under the State Contract and shall cooperate and assist DOM and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, waste, and abuse in state and/or federal health care programs.

In accordance with Health Plan's policies and the Deficit Reduction Act of 2005 (DRA), Provider shall have written policies for its employees, contractors or agents that: (a) provide detailed information about the federal False Claims Act (established under sections 3729 through 3733 of title 31, United States Code); (b) cite administrative remedies for false claims and statements (established under chapter 38 of title 31, United States Code) and whistleblower protections under federal and state laws; (c) reference state laws pertaining to civil or criminal penalties for false claims and statements; and (d) with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in federal health care programs (as defined in section 1128B(f)), include as part of such written policies, detailed provisions regarding Provider's policies and procedures for detecting and preventing fraud, waste, and abuse. Provider agrees to train its staff on the aforesaid policies and procedures.

3.21 Data; Reports. Provider shall cooperate with and release to Subcontractor and Health Plan any information necessary for Subcontractor and Health Plan to perform its obligations under the State Contract to the extent applicable to Provider in performance of the Agreement, including the timely submission of reports and information required by Subcontractor and Health Plan. Such reports shall include child health check-up reporting, if applicable, as well as

complete and accurate encounter data in accordance with the requirements of Subcontractor and Health Plan and the State.

3.22 Encounter Data. Provider agrees to cooperate with Subcontractor and Health Plan to comply with Subcontractor and Health Plan's obligation to prepare encounter data submissions, reports, and clinical information including, without limitation, child and adolescent health check-up reporting, EPSDT encounters, and cancer screening encounters, as applicable, and such other reporting regarding Covered Services as may be required under the State Contract.

3.23 Claims Information. Provider shall promptly submit to Subcontractor or Health Plan the information needed to make payment and shall identify third party liability coverage, including Medicare and other insurance, and if applicable seek such third party liability payment before submitting claims to Subcontractor or Health Plan. Provider understands and agrees that each claim Provider submits to Subcontractor constitutes a certification that the claim is true and accurate to the best of Provider's knowledge and belief and that the Covered Services are 1) Medically Necessary and 2) have been provided to the Covered Person prior to submitting the claim.

Effective July 1, 2014, Provider must submit claims within six (6) months from the date of service. Claims filed within the appropriate time frame but denied may be resubmitted to the Contractor within ninety (90) calendar days from the date of denial

3.24 Reserved.

3.25 Licensure. Provider represents that it is currently licensed and/or certified under applicable State and federal statutes and regulations and by the appropriate State licensing body or standard-setting agency, as applicable. Provider represents that it is in compliance with all applicable State and federal statutory and regulatory requirements of the Medicaid program and that it is eligible to participate in the Medicaid program. Provider represents that it does not have a Medicaid provider agreement with DOM that is terminated, suspended, denied, or not renewed as a result of any action of DOM, CMS, HHS, or the Medicaid Fraud Control Unit of the State's Attorney General. Provider shall maintain at all times throughout the term of the Agreement all necessary licenses, certifications, registrations and permits as are required to provide the health care services and/or other related activities delegated to Provider by United under the Agreement. If at any time during the term of the Agreement, Provider is not properly licensed as described in this Section, Provider shall discontinue providing services to Covered Persons.

3.26 Quality; Utilization Management. Pursuant to any applicable provider manuals and related protocols, or as elsewhere specified under the Agreement, Provider agrees to cooperate with Subcontractor and Health Plan's quality improvement and utilization review and management activities. This shall include, but not be limited to, participation in any internal and external quality assurance, utilization review, peer review, and grievance procedures established by Subcontractor and Health Plan or as required under the State Contract to ensure that Covered Persons have due process for their complaints, grievances, appeals, fair hearings or requests for external review of adverse decisions made by United or Provider. Provider shall adhere to the quality assurance and utilization review standards of the MississippiCAN Program and shall

monitor quality and initiate corrective action to improve quality consistent with the generally accepted level of care.

3.27 Non-Discrimination. Covered Persons must be provided Covered Services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual orientation, language, health status, disease or pre-existing condition (including genetic information), anticipated need for health care or physical or mental handicap, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

(a) Denying or not providing a Covered Person any Medicaid Covered Service. Health care and treatment necessary to preserve life must be provided to all Covered Persons who are not terminally ill or permanently unconscious, except where a competent Covered Person objects to such care on his/her own behalf.

(b) Subjecting a Covered Person to segregated, separate, or different treatment, including a different place or time from that provided to other Covered Persons or public or private patients, in any manner related to the receipt of any Medicaid Covered Service, except where Medically Necessary.

(c) The assignment of times or places for the provision of services on the basis of the race, color, creed, religion, age, sex, national origin, ancestry, marital status, sexual orientation, income status, program membership, language, health status, disease or pre-existing condition, anticipated need for health care or physical or mental disability of the Covered Persons to be served.

3.28 Advance Directives. Provider shall comply with the advance directives requirements set forth in the Uniform Health-Care Decisions Act, Section 41-41-215 of the Mississippi Code.

3.29 National Provider ID (NPI). Provider shall obtain a National Provider Identification Number (NPI) and when filing claims with United, the NPI used is the same NPI used when filing claims with DOM.

3.30 Termination. In the event of termination of the Agreement, Provider shall promptly supply to Subcontractor and Health Plan all information necessary for the reimbursement of any outstanding Medicaid claims.

3.31 Complaints; Grievances and Appeals. Information on how Provider or Provider's authorized representative can submit complaints and file grievances and appeals, and the resolution process, is contained in the applicable provider manual.

3.32 Health Care Acquired/Preventable Conditions. Provider agrees that no payment shall be made for the provision of medical assistance for health care acquired conditions and other provider preventable conditions as may be identified by the State. As a condition of payment, Provider shall identify and report to Subcontractor any provider preventable conditions in accordance with 42 CFR Part 438, including but not limited to 438.6(f)(2)(i).

3.33 Quality and Utilization Management Program. Provider shall cooperate with Subcontractor and Health Plan in meeting the Quality Management and Utilization Management Program standards outlined in the State Contract.

3.34 Referrals. Provider shall make referrals for social, vocational, education or human services when a need for such service is identified.

3.35 Insolvency. In the event Subcontractor and/or Health Plan becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State, DOM, or their officers, Agents, or employees, or the Covered Persons or their eligible dependents.

3.36 Third Party Resources. Provider will report all third party resources to Subcontractor and Health Plan identified through the provision of medical services.

3.37 Compliance with Mississippi Employment Protection Act (MEPA). Provider represents and warrants that it will ensure its compliance with the Mississippi Employment Protection Act, Section 71-11-1 et set of the Mississippi Code Annotated (Supp. 2008), and will register and participate in the status verification system for all newly hired employees. The term "employee" as used herein means any person that is hired to perform work within the State of Mississippi. As used herein, "status verification system" means the Illegal Immigration Reform and Immigration Responsibility Act of 1996 that is operated by the United States Department of Homeland Security, also known as the E-Verify Program, or any other successor electronic verification system replacing the E-Verify Program. Provider agrees to maintain records of such compliance and, upon request of the State and approval of the Social Security Administration or Department of Homeland Security, where required, to provide a copy of each such verification to the State. Provider further represents and warrants that any person assigned to perform services hereunder meets the employment eligibility requirements of all immigration laws of the State of Mississippi. Provider understands and agrees that any breach of these warranties may subject Provider to the following: (a) termination of this Agreement and ineligibility for any state or public contract in Mississippi for up to three (3) years, with notice of such cancellation/termination being made public, or (b) the loss of any license, permit, certification or other document granted to Provider by an agency, department or governmental entity for the right to do business in Mississippi for up to one (1) year, or (c) both.

3.38 Capitated Providers. If Provider is capitated and terminates its agreement with Subcontractor, for any reason, Provider will provide services to Covered Persons assigned to Provider up to the end of the month in which the effective date of termination falls.

3.39 Certification on Relationship to State, DOM and CMS. Provider certifies that no officer, director, employee, subcontractor or agent of Provider, or person with an ownership or control interest in Provider, is also employed by, or is a public official of, the State of Mississippi or any of its agencies, DOM or CMS.

3.40 Funding. Provider recognizes that the obligation of DOM to proceed under its Contract with CCO is conditioned upon the appropriation of funds by the Mississippi State Legislature and the

receipt of State and/or Federal funds. If the funds anticipated for the continuing fulfillment of the agreement are, at any time, not forthcoming or insufficient, either through the failure of the Federal government to provide or the State of Mississippi to appropriate funds, or the discontinuance, or material alteration of the program under which the funds were provided or if funds are not otherwise available to DOM, DOM has the right upon ten (10) working days written notice to CCO to terminate the Contract.

3.41 Gratuities. Provider represents that it has not violated, is not violating, and promises that it will not violate the prohibitions against gratuities set forth in Section 6-204 (Gratuities) of the Mississippi Personal Service Contract Procurement Regulations.

3.42 Assignment/Delegation. Provider shall not assign or delegate the Agreement without the express written consent of CCO or DOM. The transfer of five percent (5%) or more of the beneficial ownership in Provider at any time during the term of this Agreement shall be deemed an assignment under this Agreement.

3.43 Notice of Legal Action. Immediately upon obtaining knowledge or receiving notice of any legal action or notice listed below, Provider shall provide to CCO written notice of such legal action or notice and, upon request by CCO, a complete copy of all filings and other documents generated in connection with any such legal action:

(a) Any action, suit or counterclaim filed against Provider;

(b) Any regulatory action, or proposed action, respecting Provider's business or operations;

(c) Any notice received by Provider from the Department of Insurance or the State Health Officer;

(d) The filing of a petition in bankruptcy by or against Provider, or the insolvency of Provider;

(e) The conviction of any person who has an ownership or control interest in Provider, or who is an agent or managing employee of Provider, of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or Title XX of the Social Security Act; or

(f) A malpractice action against any Provider delivering service under an agreement.

3.44 Federal and State Funds Liability. Providers acknowledges and agrees that payments made to Provider for services provided under the Agreement are derived from federal and State funds and that any false claim or statement in documents or any concealment of material fact related to such services may be a cause for sanctions and prosecution under applicable federal and State laws. Provider shall be subject to all laws applicable to individuals and entities receiving State and federal funds and may be held civilly or criminally liable to both CCO and DOM in the event of nonperformance, misrepresentation, fraud, or abuse related to services provided

pursuant to the State Contract. Provider recognizes that payments made to the Provider are derived from federal and State funds, and are contingent upon and subject to availability and receipt of funds.

3.45 Insurance Requirements. As applicable, Provider shall secure and maintain during the term of the Agreement insurance appropriate to the services to be performed under the Agreement. Provider shall require that its providers secure and maintain during the term of the Agreement general liability insurance, professional liability insurance, and workers' compensation insurance for all employees connected with the provision of services under the Agreement. Such workers compensation insurance shall comply with Mississippi Workers' Compensation Laws. Such comprehensive general liability insurance and professional liability insurance shall provide coverage in an amount established by CCO pursuant to the Agreement or as required under the State Contract.

SECTION 4
ADDITIONAL PROVIDER REQUIREMENTS FOR SPECIFIC ACTIVITIES

4.1 Behavioral Health Providers. Behavioral health Providers shall ensure that all Covered Persons receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge from the inpatient psychiatric hospital if the Provider is aware of the Covered Person's inpatient hospitalization status. Behavioral health Providers will be provided daily reports identifying Covered Persons known to be admitted to an inpatient facility.

4.2 PCP Responsibilities. Providers acting as PCPs shall meet the following requirements:

(a) PCPs who serve Covered Persons under the age of twenty-one (21) are responsible for conducting all EPSDT screens for individuals on their Panel under the age of twenty-one (21). Should the PCP be unable to conduct the necessary EPSDT screens, the PCP is responsible for arranging to have the necessary EPSDT screens conducted by another network Provider and ensure that all relevant medical information, including the results of the EPSDT screens, are incorporated into the Covered Person's PCP Medical Record.

(b) PCPs who serve Members under the age of twenty-one (21) report encounter data associated with EPSDT screens, using a format approved by DOM, to the Contractor within ninety (90) calendar days from the date of service.

(c) PCPs are responsible for contacting new Members identified in the quarterly encounter lists sent by the Contractor that indicate who has not had an encounter during the first six (6) months of Enrollment. The PCP shall:

1. Contact Covered Persons identified in the quarterly Encounter lists as not complying with EPSDT periodicity and immunization schedules for children;

2. Identify to Subcontractor any such Covered Persons who have not come into compliance with the EPSDT periodicity and immunization schedules within one (1) month of such notification to the site by Subcontractor; and

3. Document the reasons for noncompliance, where possible, and to document its efforts to bring the Covered Person's care into compliance with the standards.

4.3 Specialists as PCPs. Covered Persons with disabling conditions, chronic illnesses, or child(ren) with special health care needs may request that their PCP be a specialist. The designation of a specialist as a PCP must be pursuant to a treatment plan approved by Subcontractor and Health Plan, in consultation with the PCP to which the Covered Person is currently assigned, the Covered Person and, as appropriate, the specialist.

The specialist as a PCP shall provide or arrange for all primary care, including routine preventive care, and to provide those specialty medical services consistent with the Covered Person's disabling condition, chronic illness, or special health care need in accordance with Subcontractor and Health Plan's standards and within the scope of the specialty training and clinical expertise.

The specialist as a PCP shall have admitting privileges at a hospital in Health Plan's network.

SECTION 5
HEALTH PLAN AND SUBCONTRACTOR REQUIREMENTS

5.1 Prompt Payment. Subcontractor or Health Plan shall pay Provider pursuant to the State Contract and applicable State and federal law and regulations, including but not limited to Mississippi Code Section 83-9-5, 42 CFR 447.46, 42 CFR 447.45(d)(2), 42 CFR 447.45(d)(3), 42 CFR 447.45(d)(5) and 42 CFR 447.45(d)(6), as applicable and as may be amended from time to time. If a third party liability exists, payment of claims shall be determined in accordance with federal and/or State third party liability law and the terms of the State Contract. Unless Subcontractor or Health Plan otherwise requests assistance from Provider, Subcontractor or Health Plan will be responsible for third party collections in accordance with the terms of the State Contract.

5.2 No Incentives to Limit Medically Necessary Services. Subcontractor and Health Plan shall not structure compensation provided to individuals or entities that conduct utilization management and concurrent review activities so as to provide incentives for the individual or entity to deny, limit, or discontinue Medically Necessary services to any Covered Person.

5.3 Provider Discrimination Prohibition. Subcontractor and Health Plan shall not discriminate with respect to participation, reimbursement, or indemnification of a provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. Subcontractor and Health Plan shall not discriminate against Provider for serving high-risk Covered Persons or if Provider specializes in conditions requiring costly treatments. This provision shall not be construed as prohibiting Subcontractor and/or Health Plan from limiting a provider's participation to the extent necessary to meet the needs of Covered Persons. This provision also is not intended and shall not interfere

with measures established by United that are designed to maintain quality of care practice standards and control costs.

5.4 Communications with Covered Persons. Covered Persons are entitled to the full range of their Providers' opinions and counsel about the availability of Medically Necessary Services under the provisions of the State Contract. Any contractual provisions, including gag clauses or rules, that restrict a Provider's ability to advise Covered Persons about Medically Necessary treatment options violate federal law and regulations.

Subcontractor and Health Plan shall not prohibit or otherwise restrict Provider, when acting within the lawful scope of practice, from advising or advocating on behalf of a Covered Person for the following:

(a) The Covered Person's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;

(b) Any information the Covered Person needs in order to decide among all relevant treatment options;

(c) The risks, benefits, and consequences of treatment or non-treatment;

(d) The Covered Person's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions; or

(e) Information regarding the nature of treatment options including those that may not reflect United's position or may not be covered by United.

Subcontractor and Health Plan also shall not prohibit a Provider from advocating on behalf of a Covered Person in any grievance system, utilization review process, or individual authorization process to obtain necessary health care services.

5.5 Termination, Revocation and Sanctions. In addition to its termination rights under the Agreement, Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement or impose other sanctions consistent with the State Contract if in Subcontractor and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate. Subcontractor and Health Plan shall also have the right to suspend, deny, refuse to renew or terminate Provider in accordance with the terms of the State Contract and applicable law and regulation. However, Subcontractor and Health Plan shall not exclude or terminate a Provider from participation in Subcontractor and/or Health Plan's Provider Network due to the fact that the Provider has a practice that includes a substantial number of patients with expensive medical conditions, and shall not terminate a Provider for filing a Complaint, Grievance, or Appeal on a Covered Person's behalf.

5.6 Rights of DOM. DOM shall have the right to invoke against Provider any remedy set forth in the State Contract, including the right to require the termination of the Agreement, for

each and every reason for which it may invoke such a remedy against CCO or require termination of the State Contract. Suspected Fraud and Abuse by Provider will be investigated by DOM.

SECTION 6
OTHER REQUIREMENTS

6.1 Compliance with State Contract. All tasks performed under the Agreement shall be performed in accordance with the requirements of the applicable State Contract, as set forth in this Appendix, applicable provider manuals, and protocols, policies and procedures that Subcontractor and/or Health Plan have provided or delivered to Provider. The applicable provisions of the State Contract are incorporated into the Agreement by reference. Nothing in the Agreement relieves Health Plan of its responsibility under the State Contract. If any provision of the Agreement is in conflict with provisions of the State Contract, the terms of the State Contract shall control and the terms of the Agreement in conflict with those of the State Contract will be considered waived.

6.2 Monitoring. Subcontractor and/or Health Plan shall perform ongoing monitoring (announced or unannounced) of services rendered by Provider under the Agreement and shall perform periodic formal reviews of Provider according to a schedule established by the State, consistent with industry standards or State managed care organization laws and regulations or requirements under the State Contract. As a result of such monitoring activities, Subcontractor and/or Health Plan shall identify to Provider any deficiencies or areas for improvement mandated under the State Contract and Provider and Subcontractor and/or Health Plan shall take appropriate corrective action. Provider shall comply with any corrective action plan initiated by Subcontractor and/or Health Plan and/or required by the MississippiCAN Program. In addition, Provider shall monitor and report the quality of services delivered under the Agreement and initiate a plan of correction where necessary to improve quality of care, in accordance with that level of care which is recognized as acceptable professional practice in the respective community in which Subcontractor, Health Plan and Provider practice and/or the performance standards established under the State Contract.

6.3 Enrollment. The parties acknowledge and agree that DOM is responsible for enrollment, reenrollment and disenrollment of Covered Persons.

6.4 No Exclusivity. Nothing in the Agreement or this Appendix shall be construed as prohibiting or penalizing Provider for contracting with a managed care organization other than Subcontractor and/or Health Plan or as prohibiting or penalizing Subcontractor and Health Plan for contracting with other providers. United may not require Providers who agree to participate in the MississippiCAN Program to contract with United's other lines of business.

6.5 Delegation. The parties agree that, prior to execution of the Agreement, Subcontractor and/or Health Plan evaluated Provider's ability to perform any duties delegated to Provider under the Agreement. Any delegated duties and reporting responsibilities shall be set forth in the Agreement or other written delegation agreement or addendum between the parties. Subcontractor and Health Plan shall have the right to revoke any functions or activities Subcontractor and/or Health Plan delegates to Provider under the Agreement if in Subcontractor

and/or Health Plan's reasonable judgment Provider's performance under the Agreement is inadequate.