Adult Day Care Provider Participation Agreement

This Agreement is entered into by and between UnitedHealthcare of Florida, Inc. ("United") and **Brevard Alzheimer's Foundation, Inc. dba Joe's Club** ("Facility").

This Agreement is effective on the later of the following dates (the "Effective Date"):

i) 7-1, 2012 or
ii) the first day of the first calendar month that begins at least 30 days after the date when this Agreement has been executed by all parties.

Through contracts with physicians and other providers of health care services, United maintains one or more networks of providers that are available to Customers. Facility is a provider of health care services.

United wishes to arrange to make Facility's services available to Customers. Facility wishes to provide such services, under the terms and conditions set forth in this Agreement.

The parties therefore enter into this Agreement.

Article I.
Definitions

The following terms when used in this Agreement have the meanings set forth below:

1.1 "Benefit Plan" means a certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer.

1.2 "Covered Service" is a health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer.

1.3 "Customary Charge" is the fee for health care services charged by Facility that does not exceed the fee Facility would ordinarily charge another person regardless of whether the person is a Customer.

1.4 "Customer" is a person eligible and enrolled to receive coverage from a Payer for Covered Services.

1.5 "Payment Policies" are the guidelines adopted by United outside of this Agreement for calculating payment of claims to facilities (including claims of Facility under this Agreement). The Payment Policies may change from time to time as discussed in section 5.1 of this Agreement.

1.6 "Payer" is an entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan, and authorized by United to access Facility's services under this Agreement.

1.7 "Protocols" are the programs, protocols and administrative procedures adopted by United or a Payer to be followed by Facility in providing services and doing business with United and Payers under this Agreement. These Protocols may include, among other things, credentialing and recredentialing processes, utilization management and care management processes, quality improvement, peer review, Customer grievance, concurrent review, or other similar United or Payer programs. The Protocols may change from time to time as discussed in section 4.4 of this Agreement.

1.8 United's Affiliates" are those entities controlling, controlled by, or under common control with UnitedHealthcare of Florida, Inc.

Article II.
Representations and Warranties

2.1 Representations and Warranties of Facility. Facility, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

a) Facility is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

b) Facility has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by Facility have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by Facility and (assuming the due authorization, execution and delivery of this Agreement by United) constitutes a valid and binding obligation of Facility, enforceable against Facility in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

c) The execution, delivery and performance of this Agreement by Facility do not and will not violate or conflict with (i) the organizational documents of Facility, (ii) any material agreement or instrument to which Facility is a party or by which Facility or any material part of its property is bound, or (iii) applicable law.

d) Facility has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

e) Facility has been given an opportunity to review the Protocols and Payment Policies and acknowledges that it is bound by the Protocols and that claims under this Agreement will be paid in accordance with the Payment Policies.

f) Each submission of a claim by Facility pursuant to this Agreement shall be deemed to constitute the representation and warranty by it to United that (i) the representations and warranties of it set forth in this section 2.1 and elsewhere in this Agreement are true and correct as of the date the claim is submitted, (ii) it has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such claim, (iii) the charge amount set forth on the claim is the Customary Charge and (iv) the claim is a valid claim.

2.2 Representations and Warranties of United. United, by virtue of its execution and delivery of this Agreement, represents and warrants as follows:

a) United is a duly organized and validly existing legal entity in good standing under the laws of its jurisdiction of organization.

b) United has all requisite corporate power and authority to conduct its business as presently conducted, and to execute, deliver and perform its obligations under this Agreement. The execution, delivery and performance of this Agreement by United have been duly and validly authorized by all action necessary under its organizational documents and applicable corporate law. This Agreement has been duly and validly executed and delivered by United and (assuming the due authorization, execution and delivery of this Agreement by Facility) constitutes a valid and binding obligation of United, enforceable against United in accordance with its terms, except as such enforceability may be limited by the availability of equitable remedies or defenses and by applicable bankruptcy, insolvency, reorganization, moratorium or similar laws affecting the enforcement of creditors' rights generally.

c) The execution, delivery and performance of this Agreement by United do not and will not violate or conflict with (i) the organizational documents of United, (ii) any material agreement or instrument to which United is a party or by which United or any material part of its property is bound, or (iii) applicable law.

d) United has obtained and holds all registrations, permits, licenses, and other approvals and consents, and has made all filings, that it is required to obtain from or make with all governmental entities under applicable law in order to conduct its business as presently conducted and to enter into and perform its obligations under this Agreement.

Article III.
Applicability of this Agreement

3.1 Facility's Services. This Agreement applies to Facility's service locations set forth in Appendix 1. In the event Facility begins providing services at other locations (either by operating such locations itself, or by acquiring, merging or affiliating with an existing provider that was not already under contract with United or one of United's Affiliates to participate in a network of health care providers), such additional locations will become subject to this Agreement only upon the written agreement of the parties.

In the event Facility acquires or is acquired by, merges with, or otherwise becomes affiliated with another provider of health care services that is already under contract with United or one of United's Affiliates to participate in a network of health care providers, this Agreement and the other agreement will each remain in effect and will continue to apply as they did prior to the acquisition, merger or affiliation, unless otherwise agreed to in writing by all parties to such agreements.

Facility may transfer all or some of its assets to another entity, with the result that all or some of the Covered Services subject to this Agreement will be rendered by the other entity rather than by Facility, but only if Facility requests that United approve the assignment of this Agreement as it relates to those Covered Services and only if the other entity agrees to assume this Agreement. This paragraph does not limit United's right under Section 9.4 of this Agreement to elect whether to approve the assignment of this Agreement.

3.2 Payers and Benefit Plan types. United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types described in Appendix 2. Appendix 2 may be modified by United upon 30 days written or electronic notice.

3.3 Services not covered under a Benefit Plan. This Agreement does not apply to services not covered under the applicable Benefit Plan. Facility may seek and collect payment from a Customer for such services, provided that the Facility first obtains the Customer's written consent.

This section does not authorize Facility to bill or collect from Customers for Covered Services for which claims are denied or otherwise not paid. That issue is addressed in sections 6.5 and 6.8 of this Agreement.

3.4 Patients who are not Customers. This Agreement does not apply to services rendered to patients who are not Customers at the time the services were rendered. Section 6.6 of this Agreement addresses circumstances in which claims for services rendered to such persons are inadvertently paid.

3.5 Health Care. Facility acknowledges that this Agreement and Customer Benefit Plans do not dictate the health care provided by Facility, or govern Facility's determination of what care to provide its patients, even if those patients are Customers. The decision regarding what care is to be provided remains with Facility and with Customers and their physicians, and not with United or any Payer.

3.6 Communication with Customers. Nothing in this Agreement is intended to limit Facility's right or ability to communicate fully with a Customer and the Customer's physician regarding the Customer's health condition and treatment options. Facility is free to discuss all treatment options without regard to whether or not a given option is a Covered Service. Facility is free to discuss with a Customer any financial incentives Facility may have under this Agreement, including describing at a general level the payment methodologies contained in this Agreement.

Article IV.
Duties of Facility

4.1 Provide Covered Services. Facility will provide Covered Services to Customers. Facility must be in compliance with section 2.1(d) of this Agreement and credentialed by United or its delegate prior to furnishing any Covered Services to Customers under this Agreement.

4.2 Nondiscrimination. Facility will not discriminate against any patient, with regard to quality of service or accessibility of services, on the basis that the patient is a Customer.

4.3 Accessibility. Facility will be open 24 hours a day, seven days a week.

4.4 Cooperation with Protocols. Facility will cooperate with and be bound by United's and Payers' Protocols, including but not limited to the following:

Facility will provide notification for certain Covered Services, accept and return telephone calls from United staff, and respond to United requests for clinical information, as required by United or Payer as described in the Protocols.

The Protocols will be made available to Facility online or upon request. Some or all Protocols also may be disseminated in the form of an administrative manual or guide or in other communications.

United may change the Protocols from time to time. United will use reasonable commercial efforts to inform Facility at least 30 days in advance of any material changes to the Protocols. United may implement changes in the Protocols without Facility's consent if such change is applicable to all or substantially all of the facilities in United's network located in the same state as Facility. Otherwise, changes to the Protocols proposed by United to be applicable to Facility are subject to the terms of section 9.2 of this Agreement applicable to amendments.

4.5 Employees and subcontractors. Facility will assure that its employees, affiliates and any individuals or entities subcontracted by Facility to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit Facility's obligations and accountability under this Agreement with regard to such services. Facility affiliates are those entities that control, are controlled by or are under common control with Facility.

4.6 Licensure. Facility will maintain, without material restriction, such licensure, registration, permits and/or accreditation as are necessary to enable Facility to lawfully perform this Agreement.

4.7 Liability Insurance. Facility shall procure and maintain liability insurance. Except to the extent coverage is a state mandated placement, Facility's coverage must be placed with responsible, financially sound insurance carriers authorized or approved to write coverage in the state in which the Covered Services are provided. Facility's liability insurance shall be, at a minimum, of the types and in the amounts set forth below. Facility's medical malpractice insurance shall be either occurrence or claims made with an extended period reporting option. Prior to the Effective Date of this Agreement and within 10 days of each policy renewal thereafter, Facility shall submit to United in writing evidence of insurance coverage.

TYPE OF INSURANCE	MINIMUM LIMITS
Medical malpractice and/or professional liability insurance	Two Hundred and Fifty Thousand Dollars ($250,000.00) per occurrence and aggregate
Commercial general and/or umbrella liability insurance	Two Hundred and Fifty Thousand Dollars ($250,000.00) per occurrence and aggregate

In lieu of purchasing the insurance coverage required in this section, Facility may, with the prior written approval of United, self-insure its medical malpractice and/or professional liability, as well as its commercial general liability. Facility shall maintain a separate reserve for its self-insurance. Prior to the Effective Date, Facility shall provide a statement, verified by an independent auditor or actuary, that its reserve funding levels and process of funding appears adequate to meet the requirements of this section and fairly represents the financial condition of the fund. Facility will provide a similar statement during the term of this Agreement upon United's request, which will be made no more frequently than annually. Facility will assure that its self-insurance fund will comply with applicable laws and regulations.

4.8 Notice. Facility will give notice to United within 10 days after any event that causes Facility to be out of compliance with section 4.6 or 4.7 of this Agreement, or of any change in Facility's name, ownership, control, or Taxpayer Identification Number. In addition, Facility will give written notice to United 45 days prior to the effective date of changes in existing remit address(es) and other demographic information. This section does not apply to changes of ownership or control that result in Facility being owned or controlled by an entity with which it was already affiliated prior to the change.

4.9 Customer consent to release of medical record information. Facility will obtain any Customer consent required in order to authorize Facility to provide access to requested information or records as contemplated in section 4.10 of this Agreement, including copies of the Facility's medical records relating to the care provided to Customer.

4.10 Maintenance of and Access to Records. Facility will maintain adequate medical, financial and administrative records related to Covered Services rendered by Facility under this Agreement, including claims records, for at least 6 years following the end of the calendar year during which the Covered Services are provided, unless a longer retention period is required by applicable law.

Facility will provide access to these records as follows:

i) to United or its designees, in connection with United's utilization management/ Care Coordination℠, quality assurance and improvement and for claims payment and other administrative obligations, including reviewing Facility's compliance with the terms and provisions of this Agreement and appropriate billing practice. Facility will provide access during ordinary business hours within fourteen days after a request is made, except in cases of a United audit involving a fraud investigation or the health and safety of a Customer (in which case, access shall be given within 48 hours after the request) or of an expedited Customer appeal or grievance (in which case, access will be given so as to enable United to reasonably meet the timelines for determining the appeal or grievance); and

ii) to agencies of the government, in accordance with applicable law, to the extent such access is necessary to comply with regulatory requirements applicable to Facility, United, or Payers.

Facility will cooperate with United on a timely basis in connection with any such audit including, among other things, in the scheduling of and participation in an audit exit interview within 30 days of United's request.

If such information and records are requested by United, Facility shall provide copies of such records free of charge.

4.11 Access to Data. Facility will provide to United any aggregate data relating to quality of care rendered by Facility to Customers that Facility provides to other third parties, such as other insurers, government agencies, and accrediting bodies.

4.12 Compliance with law. Facility will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information.

4.13 Electronic connectivity. When made available by United, Facility will do business with United electronically. Facility will use www.unitedhealthcareonline.com to check eligibility status, claims status, and submit requests for claims adjustment for products supported by

UnitedHealthcare Online® or other online resources as supported for additional products. Facility agrees to use www.unitedhealthcareonline.com for additional functionalities (for instance, notification of admission) after United informs Facility that such functionalities have become available for the applicable Customer.

Article V.
Duties of United and Payers

5.1 Payment of Claims. As described in further detail in Article VI of this Agreement, Payers will pay Facility for rendering Covered Services to Customers. United will make its Payment Policies available to Facility online or upon request. United may change its Payment Policies from time to time.

5.2 Liability Insurance. United will procure and maintain professional and general liability insurance and other insurance, as United reasonably determines may be necessary, to protect United and United's employees against claims, liabilities, damages or judgments that arise out of services provided by United or United's employees under this Agreement.

5.3 Licensure. United will maintain, without material restriction, such licensure, registration, and permits as are necessary to enable United to lawfully perform this Agreement.

5.4 Notice. United will give written notice to Facility within 10 days after any event that causes United to be out of compliance with section 5.2 or 5.3 of this Agreement, or of any change in United's name, ownership, control, or Taxpayer Identification Number. This section does not apply to changes of ownership or control that result in United being owned or controlled by an entity with which it was already affiliated prior to the change.

5.5 Compliance with law United will comply with applicable regulatory requirements, including but not limited to those relating to confidentiality of Customer medical information and those relating to prompt payment of claims, to the extent those requirements are applicable.

5.6 Electronic connectivity United will do business with Facility electronically by providing eligibility status, claims status, and accepting requests for claim adjustments, for those products supported by www.unitedhealthcareonline.com. United will communicate enhancements in www.unitedhealthcareonline.com functionality as they become available, as described in Section 4.13, and will make information available as to which products are supported by www.unitedhealthcareonline.com.

5.7 Employees and subcontractors. United will assure that its employees, affiliates and any individuals or entities subcontracted by United to render services in connection with this Agreement adhere to the requirements of this Agreement. The use of employees, affiliates or subcontractors to render services in connection with this Agreement will not limit United's obligations and accountability under this Agreement with regard to such services.

Article VI.
Submission, Processing, and Payment of Claims

6.1 Form and content of claims. Facility must submit claims for Covered Services in a manner and format prescribed by United, as further described in the Protocols. Unless otherwise directed by United, Facility shall submit claims using current UB04, CMS1500 or successor forms for paper claims and HIPAA standard professional or institutional claim formats for

electronic claims, as applicable, with applicable coding including, but not limited to, ICD-9-CM, CPT, Revenue and HCPCS coding.

6.2 Electronic filing of claims. Within six months after the Effective Date of this Agreement, Facility will use electronic submission for all of its claims under this Agreement that United is able to accept electronically.

6.3 Time to file claims. All information necessary to process a claim must be received by United no more than 90 days from the date of discharge or 90 days from the date all outpatient Covered Services are rendered. In the event United requests additional information in order to process the claim, Facility will provide such additional information within 90 days of United's request. If Payer is not the primary payer, and Facility is pursuing payment from the primary payer, the 90 day filing limit will begin on the date Facility receives the claim response from the primary payer.

6.4 Payment of claims. Payer will pay claims for Covered Services as further described in the applicable Payment Appendix to this Agreement and in accordance with Payment Policies.

Claims for Covered Services subject to coordination of benefits will be paid in accordance with the Customer's Benefit Plan and applicable state and federal law.

The obligation for payment under this Agreement is solely that of Payer, and not that of United unless United is the Payer.

6.5 Denial of Claims for Not Following Protocols or Not Filing Timely. Payment may be denied in whole or in part if Facility does not comply with a Protocol or does not file a timely claim under section 6.3 of this Agreement.

In the event that payment of a claim is denied for lack of notification or for untimely filing, the denial will be reversed if Facility appeals within 12 months after the date of denial and can show all of the following:

- i) that, at the time the Protocols required notification or at the time the claim was due, Facility did not know and was unable to reasonably determine that the patient was a Customer,
- ii) that Facility took reasonable steps to learn that the patient was a Customer, and
- iii) that Facility promptly provided notification, or filed the claim, after learning that the patient was a Customer.

6.6 Retroactive correction of information regarding whether patient is a Customer. Prior to rendering services, Facility shall ask the patient to present his or her Customer identification card. In addition, Facility may contact United to obtain the most current information on the patient as a Customer.

However, Facility acknowledges that such information provided by United is subject to change retroactively, under the following circumstances, (1) if United has not yet received information that an individual is no longer a Customer; (2) if the individual's Benefit Plan is terminated retroactively for any reason including, but not limited to, non-payment of premium; (3) as a result of the Customer's final decision regarding continuation of coverage pursuant to state and federal laws; or (4) if eligibility information United receives is later proven to be false.

If Facility provides health care services to an individual, and it is determined that the individual was not a Customer at the time the health care services were provided, those services shall not be eligible for payment under this Agreement and any claims payments made with regard to such services may be recovered as overpayments under the process described in section 6.10 of this Agreement. Facility may then directly bill the individual, or other responsible party, for such services.

6.7 Payment under this Agreement is payment in full. Payment as provided under section 6.4, together with any co-payment, deductible or coinsurance for which the Customer is responsible under the Benefit Plan, is payment in full for a Covered Service. Facility will not seek to recover, and will not accept, any payment from Customer, United, Payer or anyone acting in their behalf, in excess of payment in full as provided in this section 6.7, regardless of whether such amount is less tha Facility's billed charge or Customary Charge.

6.8 Customer "Hold Harmless." Facility will not bill or collect payment from the Customer, or seek to impose a lien, for the difference between the amount paid under this Agreement and Facility's billed charge or Customary Charge, or for any amounts denied or not paid under this Agreement due to:

- i) Facility's failure to comply with the Protocols,
- ii) Facility's failure to file a timely claim,
- iii) Payer's Payment Policies,
- iv) inaccurate or incorrect claim processing,
- v) insolvency or other failure by Payer to maintain its obligation to fund claims payments, if Payer is United, or is an entity required by applicable law to assure that its Customers not be billed in such circumstances.

This obligation to refrain from billing Customers applies even in those cases in which Facility believes that United or Payer has made an incorrect determination. In such cases, Facility may pursue remedies under this Agreement against United or Payer, as applicable, but must still hold the Customer harmless.

In the event of a default by a Payer other than those Payers covered by subsection v) of this Section 6.8, Facility may seek payment directly from the Payer or from Customers covered by that Payer. However, Facility may do so only if it first inquires in writing to United as to whether the Payer has defaulted and, in the event that United confirms that Payer has defaulted (which confirmation will not be unreasonably withheld), Facility then gives United 15 days prior written notice of Facility's intent to seek payment from Payer or Customers. For purposes of this paragraph, a default is a systematic failure by a Payer to fund claims payments related to Customers covered through that Payer; a default does not occur in the case of a dispute as to whether certain claims should be paid or the amounts that should be paid for certain claims.

This section 6.8 and section 6.7 will survive the termination of this Agreement, with regard to Covered Services rendered prior to when the termination takes effect.

6.9 Consequences for failure to adhere to Customer protection requirements. If Facility collects payment from, brings a collection action against, or asserts a lien against a Customer for Covered Services rendered (other than for the applicable co-payment, deductible or coinsurance), contrary to section 6.7 or 6.8 of this Agreement, Facility shall be in breach of this Agreement. This section 6.9 will apply regardless of whether Customer or anyone purporting to act on

Customer's behalf has executed a waiver or other document of any kind purporting to allow Facility to collect such payment from Customer.

In the event of such a breach, Payer may deduct, from any amounts otherwise due Facility, the amount wrongfully collected from Customers, and may also deduct an amount equal to any costs or expenses incurred by the Customer, United or Payer in defending the Customer from such action and otherwise enforcing sections 6.7 through 6.9 of this Agreement. Any amounts deducted by Payer in accordance with this provision shall be used to reimburse the Customer and to satisfy any costs incurred. The remedy contained in this paragraph does not preclude United from invoking any other remedy for breach that may be available under this Agreement.

6.10 Correction of overpayments or underpayments of claims. In the event that either Party believes that a claim has not been paid correctly, or that funds were paid beyond or outside of what is provided for under this Agreement, either party may seek correction of the payment, except that Facility may not seek correction of a payment more than 12 months after it was made.

Facility will repay overpayments within 30 days of notice of the overpayment. Facility will promptly report any credit balance that it maintains with regard to any claim overpayment under this Agreement, and will return such overpayment to United within 30 days after posting it as a credit balance.

Facility agrees that recovery of overpayments may be accomplished by offsets against future payments.

Article VII.
Dispute Resolution

The parties will work together in good faith to resolve any and all disputes between them (hereinafter referred to as "Disputes") including but not limited to all questions of arbitrability, the existence, validity, scope or termination of the Agreement or any term thereof.

If the parties are unable to resolve any such Dispute within 60 days following the date one party sent written notice of the Dispute to the other party, and if either party wishes to pursue the Dispute, it shall thereafter be submitted to binding arbitration before a panel of three arbitrators in accordance with the Commercial Dispute Procedures of the American Arbitration Association, as they may be amended from time to time (see http://www.adr.org). Unless otherwise agreed to in writing by the parties, the party wishing to pursue the Dispute must initiate the arbitration within one year after the date on which notice of the Dispute was given or shall be deemed to have waived its right to pursue the dispute in any forum.

Any arbitration proceeding under this Agreement shall be conducted in **Brevard**, Florida. The arbitrator(s) may construe or interpret but shall not vary or ignore the terms of this Agreement and shall be bound by controlling law. The arbitrator(s) shall have no authority to award punitive, exemplary, indirect or special damages, except in connection with a statutory claim that explicitly provides for such relief.

The parties expressly intend that any dispute relating to the business relationship between them be resolved on an individual basis so that no other dispute with any third party(ies) may be consolidated or joined with the dispute. The parties agree that any arbitration ruling by an arbitrator allowing class action arbitration or requiring consolidated arbitration involving any

third party(ies) would be contrary to their intent and would require immediate judicial review of such ruling.

If the Dispute pertains to a matter which is generally administered by certain United procedures, such as a credentialing or quality improvement plan, the policies and procedures set forth in that plan must be fully exhausted by Facility before Facility may invoke any right to arbitration under this Article VII.

The decision of the arbitrator(s) on the points in dispute will be binding, and judgment on the award may be entered in any court having jurisdiction thereof. The parties acknowledge that because this Agreement affects interstate commerce the Federal Arbitration Act applies.

In the event that any portion of this Article or any part of this Agreement is deemed to be unlawful, invalid or unenforceable, such unlawfulness, invalidity or unenforceability shall not serve to invalidate any other part of this Article or Agreement. In the event any court determines that this arbitration procedure is not binding or otherwise allows litigation involving a Dispute to proceed, the parties hereby waive any and all right to trial by jury in, or with respect to, such litigation. Such litigation would instead proceed with the judge as the finder of fact.

In the event a party wishes to terminate this Agreement based on an assertion of uncured material breach, and the other party disputes whether grounds for such a termination exist, the matter will be resolved through arbitration under this Article VII. While such arbitration remains pending, the termination for breach will not take effect.

This Article VII governs any dispute between the parties arising before or after execution of this Agreement, and shall survive any termination of this Agreement.

Article VIII.
Term and Termination

8.1 Term. This Agreement shall take effect on the Effective Date. This Agreement shall have an initial term of one year and renew automatically for renewal terms of one year, unless terminated pursuant to section 8.2.

8.2 Termination. This Agreement may be terminated under any of the following circumstances:

i) by mutual written agreement of the parties;
ii) by either party, upon at least 180 days prior written notice, effective at the end of the initial term or effective at the end of any renewal term;
iii) by either party upon 60 days written notice in the event of a material breach of this Agreement by the other party, except that such a termination will not take effect if the breach is cured within 60 days after notice of the termination; moreover, such termination may be deferred as further described in Article VII of this Agreement;
iv) by either party upon 10 days written notice in the event the other party loses licensure or other governmental authorization necessary to perform this Agreement, or fails to have insurance as required under section 4.7 or section 5.2 of this Agreement; or
v) by United upon 10 days written notice in the event Facility loses accreditation.
vi) By United, upon 90 days notice, in the event:
    a) Facility loses approval for participation under United's credentialing plan, or
    b) Facility does not successfully complete the United's re-credentialing process as required by the credentialing plan.

8.3 Ongoing Services to Certain Customers After Termination Takes Effect. In the event Payer is required by applicable law to provide transition coverage of Covered Services rendered by Facility after Facility leaves the network accessed by Payer, Facility shall continue to provide such Covered Services, and this Agreement will continue to apply to those Covered Services, in accordance with applicable law.

Article IX.
Miscellaneous Provisions

9.1 Entire Agreement. This Agreement is the entire agreement between the parties with regard to the subject matter herein, and supersedes any prior written or unwritten agreements between the parties or their affiliates with regard to the same subject matter.

9.2 Amendment. This Agreement may only be amended in a writing signed by both parties, except that this Agreement may be unilaterally amended by United upon written notice to Facility in order to comply with applicable regulatory requirements. United will provide at least 30 days notice of any such regulatory amendment, unless a shorter notice is necessary in order to accomplish regulatory compliance.

9.3 Nonwaiver. The waiver by either party of any breach of any provision of this Agreement shall not operate as a waiver of any subsequent breach of the same or any other provision.

9.4 Assignment. This Agreement may not be assigned by either party without the written consent of the other party, except that this Agreement may be assigned by United to any of United's Affiliates.

9.5 Relationship of the Parties. The sole relationship between the parties to this Agreement is that of independent contractors. This Agreement does not create a joint venture, partnership, agency, employment or other relationship between the parties.

9.6 No Third-Party Beneficiaries. United and Facility are the only entities with rights and remedies under the Agreement.

9.7 Delegation. United may delegate (but not assign) certain of its administrative duties under this Agreement to one or more other entities. No such delegation will relieve United of its obligations under this Agreement.

9.8 Notice. Any notice required to be given under this Agreement shall be in writing, except in cases in which this Agreement specifically permits electronic notice, or as otherwise permitted or required in the Protocols. All written or electronic notices shall be deemed to have been given when delivered in person, by electronic communication, by facsimile or, if delivered by first-class United States mail, on the date mailed, proper postage prepaid and properly addressed to the appropriate party at the address set forth on the signature portion of this Agreement or to another more recent address of which the sending party has received written notice. Notwithstanding the previous sentence, all notices of termination of this Agreement by either party must be sent by certified mail, return receipt requested. Each party shall provide the other with proper addresses, facsimile numbers and electronic mail addresses of all designees that should receive certain notices or communication instead of that party.

9.9 Confidentiality. Neither party will disclose to a Customer, other health care providers, or other third parties any of the following information (except as required by an agency of the government):

a) any proprietary business information, not available to the general public, obtained by the party from the other party;
b) the specific reimbursement amounts provided for under this Agreement, except for purposes of administration of benefits.

At least 48 hours before either party issues a press release, advertisement, or other media statement about the business relationship between the parties, that party will give the other party a copy of the material the party intends to issue.

Except as otherwise required by applicable law or stock exchange rule, Facility will not, and will not permit any of its representative affiliates, representatives or advisors to, issue or cause the publication of any press release or make any other public announcement, including, without limitation, any "tombstone" or other advertisements, with respect to this Agreement without the consent of United.

9.10 Governing Law. This Agreement will be governed by and construed in accordance with the laws of the state in which Facility renders Covered Services, and any other applicable law.

9.11 Regulatory Appendices. One or more regulatory appendix may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy regulatory requirements under applicable law. These regulatory appendices, and any attachments to them, are expressly incorporated into this Agreement and are binding on the parties to this Agreement. In the event of any inconsistent or contrary language between a regulatory appendix and any other part of this Agreement, including but not limited to appendices, amendments and exhibits, the regulatory appendix will control, to the extent it is applicable.

9.12 Severability. Any provision of this Agreement that is unlawful, invalid or unenforceable in any situation in any jurisdiction shall not affect the validity or enforceability of the remaining provisions of this Agreement or the lawfulness, validity or enforceability of the offending provision in any other situation or jurisdiction.

9.13 Survival. Sections 4.10, 6.7, 6.8, Article VII and sections 8.3 and 9.9 (except for the last paragraph) of this Agreement will survive the termination of this Agreement.

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

Brevard Alzheimer's Foundation, Inc. dba Joe's Club [Facility]

Address to be used for giving notice to Facility under the Agreement:

Signature ____________

Print Name Chris Stagman

Title Executive Director

Date 1/19/12

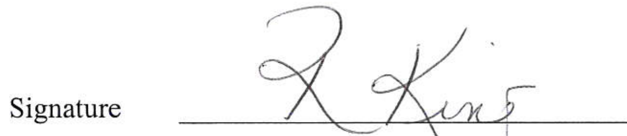
Street 4676 North Wickham Road

City Mebourne

State FL Zip Code 32935

E-mail CStagman@brevardalz.org

United Healthcare of Florida, Inc., as signed by its authorized representative:



Signature ____________

Print Name **Robyn A King**
Vice President
Complex Care Provider Networks

Title ____________

Date 5.26.12

[Address to be used for giving notice to United under the Agreement]
UnitedHealthcare of Florida, Inc.
Attn: Medicaid Contract Installation Specialist
Mail Route: FL080-1000
601 Brooker Creek Blvd
Oldsmar, FL 34677

Attachments

__X__ Appendix 1: Facility Location and Service Listings
__X__ Appendix 2: Benefit Plan Descriptions
__X__ Appendix 3: Protocols
__X__ Payment Appendix
____ Florida Long Term Care Product (formally known as Evercare At Home)
_X_ Florida Long Term Care Product (formally known as Evercare Health and Home Connection)
__X__ Florida Medicaid Regulatory Requirements Appendix
__X__ Florida Long-Term Care Community Diversion Program Regulatory Requirements Appendix
__X__ Florida Regulatory Requirements Appendix
_ ___ Other

IMPORTANT NOTE: Facility acknowledges its obligation under Section 4.8 to promptly report any change in Facility's name or Taxpayer Identification Number. Failure to do so may result in denial of claims or incorrect payment.

Appendix 1
Facility Location and Service Listings

Brevard Alzheimer's Foundation, Inc. dba Joe's Club Facility System Name

BILLING ADDRESS

Facility Name: Brevard Alzheimer's Foundation, Inc. dba Joe's Club
Street Address: 4676 North Wickham Road
City, State Zip: Melbourne, FL 32935
Tax ID Number [TIN]: 59-3369526

FACILITY LOCATIONS

Location #1		**Location #2**	
Name	Joe's Club	Name	Joe's Club
Address	4676 North Wickham Road	Address	7951 Ron Beatty Blvd.
City, State Zip	Melbourne, FL 32935	City, State Zip	Micco, FL 32976
Phone #	321-253-4430	Phone #	321-253-4430
TIN	59-3369526	TIN	59-3369526
Location #3		**Location #4**	
Name	Joe's Club	Name	
Address	830 Park Avenue	Address	
City, State Zip	Tistuville, FL 32780	City, State Zip	
Phone #	321-268-9144	Phone #	
TIN	59-3369526	TIN	

OTHER SERVICE LOCATIONS

Name		Name	
Address		Address	
City, State Zip		City, State Zip	
Phone #		Phone #	
TIN		TIN	
Name		Name	
Address		Address	
City, State Zip		City, State Zip	
Phone #		Phone #	
TIN		TIN	

Appendix 2
Benefit Plan Descriptions

United may allow Payers to access Facility's services under this Agreement for the Benefit Plan types listed below.

- Medicaid Benefit Plans sponsored or issued by United for its Florida Long Term Care Product (formally known as Evercare Health and Home Connection) program.
- Medicaid Benefit Plans sponsored or issued by United for its Florida Long Term Care Product (formally known as Evercare At Home) program

This Agreement does not apply to any other Benefit Plans

This Agreement does not supersede existing agreements between the parties or their affiliates under which Facility participates in a network for other Benefit Plans, or preclude the parties or their affiliates from entering into such agreements in the future.

Appendix 3
Protocols

Protocol for Evercare Medicaid Customers

For Evercare Medicaid Customers enrolled in Medicaid Benefit Plans administered by United's business unit Evercare, as indicated by a reference to Evercare on the face of the valid identification card of any Customer eligible for and enrolled in such Benefit Plan, Facility will be subject to requirements described in or made available to Facility through the Evercare Medicaid manual (the "Evercare Medicaid Manual"), which can be viewed and downloaded at www.evercarehealthplans.com. When this Agreement refers to the Administrative Guide, it is also referring to this other manual. In the event of any conflict between this Agreement or the "UnitedHealthcare Physician, Health Care Professional, Facility and Facility Administrative Guide" or other UnitedHealthcare administrative protocols, and the Evercare Medicaid Manual, in connection with any matter pertaining to an Evercare Medicaid Customer, the Evercare Medicaid Manual will govern, unless applicable statutes and regulations dictate otherwise. United may make changes to the Administrative Guide, Evercare Medicaid Manual or other administrative protocols upon 30 days' electronic or written notice to Facility unless applicable state statutes or regulations require otherwise.

FLORIDA MEDICAID LONG TERM CARE PRODUCTS
(formally known as EVERCARE HEALTH AND HOME CONNECTION)
PAYMENT APPENDIX
ADULT DAY CARE SERVICES

APPLICABILITY

The provisions in this Appendix apply to Covered Services rendered by Facility to Customers covered by Benefit Plans sponsored or issued by United for its Heath and Home Connection Program. Such customers and the counties served are defined in United's contract with the Department of Elder Affairs ("DOEA").

SECTION 1
Additional Definitions

Adult Day Care Services: Services provided pursuant to Florida Stat. Ch. 400, Part V. Typically, these are services furnished in an outpatient setting, encompassing both the health and social services needed to ensure optimal functioning of a Customer, including social services to help with personal and family problems, and planned group therapeutic activities. Adult Day Care Services include nutritional meals when the Customer is at the center during meal times; medical screening which emphasizes prevention and continuity of care (i.e., routine blood pressure checks and diabetic maintenance checks); physical, occupational and speech therapies if included in the Customer's plan of care; and nursing services which include periodic evaluation, medical supervision and supervision of self-care services directed toward activities of daily living and personal hygiene. **Maximum allowed Adult Day Care Services per day is 9 hours or 36 units.**

Care Manager: Serves as the primary contact between the Customer and United (when applicable). Authorizes, arranges for and coordinates all of the long term care health care services, establishes a plan of care and provides communication to the Customer, family and physician.

Non-Emergency Transportation: If applicable, the arrangement and provision of an appropriate mode of transportation for Customers who do not require life sustaining support during the travel. Examples of this transportation include transport to physician appointments, adult day care, grocery shopping, etc. Customers are able to communicate direction and information to the transporter.

Per Day: The payment made to Facility for each day of services.

Per Unit: The payment for services associated with the care rendered by Facility to a Customer on a unit basis.

Respite Care Services: Services provided to Customers unable to care for themselves furnished on a short-term basis due to the absence or need for relief of persons normally providing the care. Respite Care Services do not substitute for the care usually provided by a registered nurse, a licensed practical nurse or a therapist. Respite Care Services are provided in the Customer's home/place of residence, a Medicaid licensed hospital, a nursing facility, or an assisted living facility.

SECTION 2
Payment for Services

2.1 Payment for Services. Facility shall be reimbursed only for those services where a rate is listed in Table 1 below. Payer shall pay Facility for Covered Services rendered to a Customer the lesser of: 1) Facility's Customary Charge, less any applicable co-payment, coinsurance or deductibles; or 2) the rates set forth in Table 1 below, less any applicable co-payment, coinsurance or deductibles. The payment set forth in Table 1 includes any costs associated with providing Adult Day Care Services to a Customer. In addition, unless specifically indicated otherwise, amounts listed in Table 1 represent global fees and may be subject to reductions based on appropriate modifiers. Any co-payment, coinsurance or deductibles that Customer is responsible to pay under Customer's Benefit Plan will be subtracted from the listed amount in determining the amount to be paid by Payer. The actual payment amount also is subject to the terms of the Agreement, such as the applicable Payment Policies. This information is subject to the confidentiality provisions of the Agreement.

Table 1. Rates

Service	Code	Modifier	Rate	Units
Adult Day Care	S5100	U2	$1.88	Per Unit/15 Minutes
Non-emergency Transportation	T2002	None	$7.52	Per Day

2.3 Coding Updates. United will routinely update Table 1 in response to published coding changes, such as additions, deletions and changes to HCPCS Codes by the Centers for Medicare & Medicaid Services and to CPT Codes by the American Medical Association. Such changes will be incorporated automatically within ninety (90) days from the date of final publication of the change. United generally will not notify Facility of these routine coding updates.

2.3 Rate Adjustments. United reserves the right to adjust the rates set forth in this Section 2 in the event DOEA makes adjustments to the rates paid to United under United's contract with DOEA for the provision of Covered Services to Customers enrolled in the Florida Long-Term Care Community Diversion program. Such rate adjustments will become effective upon ninety (90) days prior written notice to Facility by United.

SECTION 3
Additional Protocols

In addition to the Protocols described in the Agreement, Facility shall:

1. Cooperate with the goal of an integrated and coordinated service delivery system for the Customer.
2. Maintain confidentiality of Customers' medical and treatment planning information.
3. Work with the Care Manager to coordinate services, address the comprehensive needs of the Customer, and provide continuity of care.
4. Work with the Care Manager to understand the Customer's plan of care for services, any short-term and long-term treatment goals, and their role in the provision of objective, specific treatment strategies.
5. Communicate to the Care Manager the Customer's response to the individualized Customer plan of care.
6. Provide services in the authorized service area, regardless of the level of functioning, cultural heritage, or degree of illness of the Customer.

7. Provide communication regarding services in a language spoken by the Customer whenever possible, using staff fluent in a language representative of 5% of the membership, the AT&T Language line and in-person interpreters may be made available.
8. Make services available in accordance with the Customer's plan of care.
9. If applicable, provide services under the direction of a physician.
10. If applicable, be certified by Medicare and Medicaid in the State of Florida.
11. If applicable, be accredited by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") or show evidence that it is seeking such accreditation on a timely basis.
12. If applicable, have available upon request by United, JCAHO accreditation results, Customer satisfaction surveys, Medicare/Medicaid surveys and any other documents referenced in this Agreement, subject to rules and regulations governing confidentiality.
13. Have nurses and/or therapists submit regular reports on a Customer's progress to the Customer's prescribing physician at no extra charge to Customer or United.

SECTION 4
Additional Requirements

4.1 Lobbying. Facility agrees to comply with the provisions of Florida Stat. § 216.347, which prohibits the expenditure of contract funds for the purpose of lobbying the Legislature or a state agency.

SECTION 5
Additional Claims Protocols

In addition to the Protocols and Payment Policies described in the Agreement, Facility shall comply with the following:

1. Submit claims on a monthly basis.
2. Submit the Explanation of Benefits from Medicare on all claims with dual payment.
3. Submit a separate HCFA 1500 for each service code authorized.
4. Type or print when completing the HCFA 1500 form.
5. Submit all claims to the address listed on the back of the Customer's ID card.

SECTION 6
Payer Provider Identification Number

United shall issue to Facility a specific provider identification number. Facility must submit all claims for Covered Services under this Agreement using the appropriate Payer provider identification number for the type of provider rendering the Covered Services. Failure to comply with this requirement may result in denial or inaccuracy of payment to Facility.

FLORIDA LONG-TERM CARE COMMUNITY DIVERSION PROGRAM
REGULATORY REQUIREMENTS APPENDIX
PROVIDER VERSION

THIS FLORIDA LONG-TERM CARE COMMUNITY DIVERSION PROGRAM REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the provider agreement (the "Agreement") between UnitedHealthcare of Florida, Inc., ("United") and the provider named in the Agreement ("Provider").

SECTION 1
APPLICABILITY

This Appendix applies with respect to the provision of health care or health care-related services that Provider provides directly to Covered Persons under the State of Florida Long-Term Care Community Diversion Program (the "LTCCD Program"), as governed by the State's designated regulatory agencies and pursuant to United's contract with DOEA. 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 plans outside the scope of this Appendix or unless otherwise required by law. In the event United is required to amend or supplement this Appendix as required or requested by the State, Provider agrees that United shall be permitted to unilaterally initiate such additions, deletions or modifications.

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 LTCCD Program, the definitions shall have the meaning set forth under the LTCCD Program.

2.1 **AHCA:** The Florida Agency for Health Care Administration.

2.2 **Covered Person:** An individual who is currently enrolled with United for the provision of services under the LTCCD Program. A Covered Person may also be referred to as an Enrollee, Member or Customer under the Agreement.

2.3 **Covered Services:** A health care service or product for which a Covered Person is enrolled to receive coverage under the LTCCD Contract.

2.4 **Direct Service Provider:** Pursuant to 430.0402, F.S., a "Direct Service Provider" is a person eighteen (18) years of age or older who, pursuant to a program to provide services to the elderly, has direct, face-to-face contact with a client while providing services to the client or has access to the client's living areas or to the client's funds or personal property. The term includes coordinators, managers, and supervisors of residential facilities and volunteers.

2.5 **DOEA or Department:** The Florida Department of Elder Affairs.

2.6 **LTCCD Contract:** United's contract with DOEA for the purpose of providing and paying for Covered Services to Covered Persons enrolled in the LTCCD Program.

2.7 **LTCCD Program:** The Florida Long-Term Care Community Diversion Program administered by DOEA in consultation with AHCA, which is designed to provide an alternative to nursing home care for frail elders age sixty-five (65) and older who would otherwise qualify for Medicaid nursing home placement. The LTCCD Program offers integrated acute and long-term care services to dually eligible Medicare and Medicaid recipients by contracting with managed care organizations and other qualified providers.

2.8 **Service Area:** The designated geographical area within which United is authorized by the LTCCD Contract to provide Covered Services to Covered Persons and within which the Covered Persons reside, as set forth in the LTCCD Contract.

2.9 **State:** The State of Florida or its designated regulatory agencies.

SECTION 3
PROVIDER REQUIREMENTS

The LTCCD Program, through contractual requirements and federal and State statutes and regulations, requires the Agreement to contain certain conditions that United and Provider agree to undertake, which include the following:

3.1 **QI, UM, Peer Review & Grievance Procedures.** Provider shall cooperate and participate in any internal or external quality improvement, utilization review, peer review, and grievance procedures established by United.

3.2 **Appointment Availability; Hours of Operation.** Provider shall provide for timely access to appointments and services in accordance with the requirements of the LTCCD Contract and shall offer hours of operation that are no less than the hours of operation offered to commercial health plan members or comparable to Medicaid fee-for-service recipients if Provider serves only Medicaid recipients.

3.3 **Records.** Provider shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered under the Agreement. Provider shall maintain all client records, financial records, supporting documents, statistical records, and any other documents (including electronic storage media) pertinent to the LTCCD Contract for a period not less then six (6) years from the close of the Agreement or such other period as required by law. In addition, if the records are under review or audit related to the LTCCD Contract, they shall be maintained for a minimum of six (6) years after the audit report is issued or until resolution of any audit findings or litigation based on the LTCCD Contract, or such longer period as required by law. Prior approval for the disposition of records must be requested and approved by United if the Agreement is continuous.

3.4 **Government Access to Records.** Provider acknowledges and agrees that the United States Department of Health and Human Services (DHHS), AHCA, including the Medicaid Program Integrity (MPI) unit and the Medicaid Fraud Control Unit (MFCU), DOEA, or their designees, and persons duly authorized by DOEA and federal auditors, shall have the right to inspect, evaluate, audit and copy any records pertinent to the LTCCD Contract, regardless of the form in which the records are kept, including:

(a) Pertinent books,
(b) Financial records,

(c) Medical records, and
(d) Documents, papers, and records of Provider involving transactions, financial or otherwise, related to the LTCCD Contract.

Upon request of AHCA or DOEA, at no additional cost to either, Provider shall facilitate the duplication and transfer of any records or documents during the required retention period set forth in Section 3.3.

3.5 **Government Audit, Inspection, Investigation.** Provider agrees that AHCA, DOEA and DHHS, or their designees, may evaluate through inspection or other means the quality, appropriateness and timeliness of services performed under the LTCCD Contract. Provider shall fully cooperate in any investigation by DOEA or any other State or federal entity and in any subsequent legal action that may result from such an investigation. This shall include but not be limited to complying and cooperating immediately with any inspections, reviews, investigations, or audits deemed necessary by the office of the Inspector General pursuant to Section 20.055, F.S.

3.6 **Termination by Provider.** Provider shall comply with applicable law and the LTCCD Contract's requirements for notice of termination of the Agreement. Provider shall provide United and DOEA with at least sixty (60) days advance written notice, or such longer period as required under the Agreement, before terminating the Agreement for any reason. Nonpayment for goods or services rendered by Provider to United is not a valid reason for avoiding the sixty (60) day advance notice of termination requirement set forth herein.

3.7 **Definitions Related to the Provision of Covered Services.** Provider shall follow the LTCCD Program's guidelines for the coverage of Covered Services. Determinations regarding the provision of Covered 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: (i) placing the health of the individual in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

(b) Emergency Services: Covered inpatient and outpatient services that are: (i) furnished by a provider qualified to furnish such services under the Medicaid and LTCCD Programs; and (ii) needed to evaluate or stabilize an Emergency Medical Condition.

(c) Medically Necessary or Medical Necessity: Services provided in accordance with 42 CFR 438.210(a)(4) and as defined in Section 59G-1.010(166), F.A.C., to include that medical or allied care, goods, or services furnished or ordered must:

(i) Meet the following conditions:
(1) Be necessary to protect life, prevent significant illness or significant disability, or to alleviate severe pain;

(2) Be individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

(3) Be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

(4) Be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

(5) Be furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

(ii) For those services furnished in a hospital on an inpatient basis, Medically Necessary or Medical Necessity means that appropriate medical care could not be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

The fact that a provider has prescribed, recommended or approved medical or allied care, goods or services does not, in itself, make such care, goods or services Medically Necessary or a Medical Necessity or a Covered Service.

3.8 **Information for Payment.** Provider shall promptly submit to United all information necessary for United to make payment to Provider, as further specified in the Agreement.

3.9 **Reports.** Provider shall provide for timely and complete submission of all reports and clinical information required by United.

3.10 **Privacy.** 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 42 CFR, Part 438.224 and 42 CFR Part 431, Subpart F, as may be amended from time to time.

3.11 **Hold Harmless.** In accordance with 42 CFR 447.15, Provider shall not hold Covered Persons, AHCA, DOEA or DHHS liable for any debts of Provider or United. Provider also shall not seek payment from or hold Covered Persons liable for any Covered Services provided pursuant to the Agreement or for any services for which United is liable, as specified in Section 641.3154, F.S. This clause shall survive termination of the Agreement for any reason, including beach due to insolvency.

3.12 **Indemnification.** Provider shall indemnify, defend and hold AHCA, DOEA, DHHS and Covered Persons harmless from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees, to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This clause shall survive termination of the Agreement for any reason, including breach due to insolvency. DOEA may waive this requirement for itself, but not for Covered Persons, for damages in excess of the statutory cap on damages for public entities if Provider is a state agency or sub-unit as defined by

Section 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by DOEA.

3.13 **Workers' Compensation Insurance.** Provider shall secure and maintain during the life of the Agreement workers' compensation insurance for all of its employees connected with the services provided under the LTCCD Contract unless such employees are covered by the protection afforded by United. Such insurance shall comply with Florida's workers' compensation law set forth at Chapter 440, F.S.

3.14 **Subcontracts.** If Provider enters into any contracts, agreements, or subcontracts for the delivery of Covered Services to Covered Persons or the performance of any other activities delegated to Provider by United under the LTCCD Contract, such arrangements must be in writing and must contain assurances that the individual(s) signing the contract are authorized to do so. Such contracts, agreements or subcontracts shall include all the requirements of this Appendix and all applicable requirements of the LTCCD Contract.

3.15 **Fraud & Abuse; Deficit Reduction Act**. Provider shall cooperate and comply fully with United's policies and procedures designed to protect program integrity and prevent and detect potential or suspected fraud, abuse and waste in the administration and delivery of services under the LTCCD Contract. United is responsible for reporting suspected fraud and abuse by participating and non-participating providers, as well as Covered Persons, when detected. Provider also shall cooperate and assist DOEA, AHCA and any other State or federal agency charged with the duty of preventing, identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste in state and federal health care programs.

In accordance with Section 6032 of the federal Deficit Reduction Act of 2005 (codified at 42 U.S.C. §1396a(a)(68)), United's policies and procedures with which Provider must comply will include information about the federal False Claims Act; penalties for submitting false claims and statements; applicable whistleblower protections; the law's role in preventing and detecting fraud, waste, and abuse; and each person's responsibility relating to detection and prevention.

3.16 **Eligibility for Medicaid Program.** Provider must be eligible for participation in the Medicaid program. If Provider was involuntarily terminated from the Florida Medicaid program other than for purposes of inactivity, Provider is not considered an eligible Medicaid provider.

3.17 **Compensation.** Provider agrees that prior to execution of the Agreement, United made full disclosure of the method and amount of compensation or other consideration to be received from United for the provision of Covered Services to Covered Persons, which shall be as set forth in the Agreement. In addition to the Covered Person hold harmless requirements set forth in this Appendix, Provider shall not charge for any service provided to Covered Persons at a rate in excess of the rates established under the Agreement and Provider may not bill a Covered Person any amount greater than would be owed if United provided the services directly.

3.18 **Services.** Provider shall provide Covered Services to Covered Persons in the amount, duration and scope as set forth in the Agreement. Provider shall continue to provide services through the term of the capitation period for which AHCA has paid United.

3.19 **Licensure.** Provider shall be currently licensed and/or certified under applicable State and federal statutes and regulations and credentialed in accordance with United's and the LTCCD Contract's credentialing requirements if credentialing of Provider is required by United, the LTCCD Contract and/or applicable law. Provider shall maintain throughout the term of the

Agreement all necessary licenses, certifications, registrations, permits and insurance as required to provide the services and any delegated activities under the Agreement. Provider shall notify United in the event of a lapse in general liability or medical malpractice insurance (if applicable), or if Provider's assets fall below the amount necessary for licensure under Florida Statutes.

3.20 **Mandatory Reporting.** Provider shall comply with State law regarding mandatory reporting of abuse, neglect, or exploitation of a child, aged person, or disabled adult, as set forth in Chapters 39 and 415, F.S. This shall include immediately reporting knowledge or reasonable suspicion of abuse, neglect or exploitation of a child, aged person or disabled adult to the Florida Abuse Hotline on the statewide toll-free telephone number (1-800-96ABUSE). Provider shall verify to United that all staff mandated to report abuse, neglect and exploitation have received appropriate training in reporting abuse, neglect and exploitation.

3.21 **Non-discrimination.** Provider shall comply with all applicable State and federal statutes related to non-discrimination and shall not discriminate against any person in the provision of services under the Agreement or through employment practices based on age, race, religion, color, disability, national origin, marital status, or sex.

3.22 **Lobbying.** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that no federally appropriated funds have been paid or will be paid to any person by or on behalf of Provider for the purpose of influencing or attempting to influence an officer or employee of any state or federal agency, a member of congress, an officer or employee of congress, an employee of a member of congress, or an officer or employee of the state legislature in connection with the awarding of any federal grant or contract, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence any of the above persons or entities in connection with the Agreement or LTCCD Contract, Provider shall complete and submit Standard Form-LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions.

3.23 **Notice of Covered Person Death or Change of Residence.** Facility and home health Providers shall provide notice to United within twenty-four (24) hours when a Covered Person dies, leaves the facility or moves to a new residence.

3.24 **Assisted Living Facility Records.** Providers that are assisted living facilities shall maintain a Covered Person's current care plan in the Covered Person's record, which shall be subject to inspection by authorized State and federal agencies.

3.25 **Compliance with State and Federal Law.** Provider shall comply with all applicable State and federal laws, rules and regulations applicable to the provision of services under the LTCCD Program.

3.26 **Level 2 Background Screening.** If Provider is a Direct Service Provider, Provider shall pass a Level 2 criminal history background screening in accordance with s. 430.0402, F.S. and chapter 435, F.S., as amended, prior to delivering services under the Agreement. Provider shall ensure that all employees, contractors and volunteers of Provider who meet the definition of Direct Service Provider under s. 430.0402, F.S. shall also pass a Level 2 criminal history background as a condition of employment, volunteerism or contracting and prior to delivering any services to Covered Persons. Provider shall submit to United a signed affidavit attesting to

Provider's compliance with this section or with the requirements of Provider's licensing agency if the licensing agency requires Level 2 background screening of Direct Service Providers.

3.27 **Incident Reporting.** Provider shall notify United immediately upon the occurrence of an incident that may jeopardize the health, safety and welfare of a Covered Person or impair continued service delivery so that United may notify DOEA of such incident within forty-eight hours of its occurrence, as required under the LTCCD Contract. Provider shall maintain an incident log in a format required by United that shall be available for inspection by United and DOEA. Provider shall submit to United an incident log for every individual Covered Person for whom an incident has occurred. Reportable conditions include but are not limited to:

(a) If Provider is a facility, license violations that result in closure of the facility;
(b) Financial concerns/difficulties of Provider;
(c) Loss or destruction of Covered Person records;
(d) Compromise of data integrity;
(e) Fire or natural disasters; and
(f) Critical issues or adverse incidents that effect the health, safety, and welfare of Covered Persons.

The incident log Provider submits to United shall contain a brief summary of the problem(s). United will work with Provider to develop a proposed corrective action plan(s) and timeframes for implementation of such plan(s) within a reasonable time after the incident is reported by Provider. Upon report of an incident by Provider, United will submit an incident log to the Department within thirty (30) days of the occurrence date in accordance with the requirements of the LTCCD Contract.

3.28 **Reporting of Bankruptcy Filing.** If Provider files a claim for bankruptcy, Provider shall immediately report such to United, including: (a) the date of filing of the bankruptcy petition; (b) the case number; (c) the court name and division in which the petition was filed; and (d) the name, address and telephone number of the bankruptcy attorney.

3.29 **Continuity of Care upon Termination.** Provider shall cooperate with United in providing a Covered Person with continuity of treatment in the event the Agreement terminates during the course of a Covered Person's treatment by Provider.

3.30 **Cultural Competency.** Provider shall comply with United's cultural competency plan and shall participate in United's and DOEA'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. Provider shall provide information to Covered Persons regarding treatment options and alternatives in a manner appropriate to the Covered Person's condition and ability to understand.

3.31 **Marketing.** Provider is prohibited from participating in cold-call or other unsolicited marketing. Any marketing materials related to the LTCCD Contract that are distributed or displayed by Provider must be submitted to United to submit to DOEA for written approval prior to use.

3.32 **Transitioning Covered Persons.** In providing services to transitioning Covered Persons, Provider shall cooperate in all respects with providers of other DOEA contracted health plans or managed care entities to assure maximum health outcomes for such Covered Persons.

3.33 **Coordination and Continuity of Care.** Provider shall cooperate with the goal of an integrated and coordinated service delivery system for Covered Persons and shall comply with United's policies, procedures and protocols regarding coordination and continuity of care, in accordance with the LTCCD Contract.

3.34 **NPI.** If Provider is required to have an NPI, Provider shall submit Provider's NPI, as well as NPI(s) for its physicians and other health care providers required to have an NPI, to United within fifteen (15) business days of receipt.

3.35 **Excluded Individuals.** By signing the Agreement, Provider certifies to the best of Provider's knowledge and belief that neither it nor any of its principals, nor any providers, subcontractors or consultants with whom Provider contracts for 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 § 1128 or § 1128A of the Social Security Act;

(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.

3.36 **Disclosure.** Provider shall cooperate with United in disclosing information DOEA and/or United may require related to ownership and control, significant business transactions, and persons convicted of crimes in accordance with State and federal law, including but not limited to 42 C.F.R. §§ 455.104, 455.105, and 455.106.

3.37 **Utilization Management Activities.** If Provider is performing any utilization management activities on behalf of United, as described in the Agreement or a delegation addendum between the parties, Provider shall:

(a) have in place and follow written policies and procedures for processing requests for initial and continuing authorization of services;
(b) have in place mechanisms to ensure consistent application of review criteria for authorization decisions; and
(c) consult with the requesting provider when appropriate.

SECTION 4
UNITED REQUIREMENTS

4.1 **Covered Person Communication.** United will not prohibit Provider, when acting within the scope of Provider's license or certification under applicable State law, from:

(a) discussing medical care, treatment or non-treatment options with Covered Persons, including those that may not reflect United's position or may not be covered by United, when Provider deems knowledge of such information to be in the best interest of the health of the Covered Person; or

(b) advocating on behalf of a Covered Person in any grievance system, utilization management process, or individual authorization process to obtain necessary services.

4.2 **Provider Non-discrimination.** United shall not discriminate with respect to participation, reimbursement, or indemnification of a provider acting within the scope of such provider's license or certification under applicable state law, solely on the basis of such license or certification. This provision shall not be construed as prohibiting United from limiting provider participation to the extent necessary to meet the needs of Covered Persons and shall not interfere with measures established by United that are designed to maintain quality and control costs.

4.3 **Non-discrimination for High Risk Populations**. United shall not discriminate against Provider for serving high-risk populations or for specializing in conditions requiring costly treatments.

4.4 **Non-Exclusivity.** Pursuant to Section 641.315(6), F.S., United shall not, in any way, prohibit or restrict Provider from entering into a commercial contract with any other health plan or managed care entity.

4.5 **Contracting for United Long-Term Care Products.** Pursuant to Section 641.315(10), F.S., United shall not require Provider to contract for more than one United long-term care product or otherwise be excluded from participating in the United network.

4.6 **Inpatient Services by Physicians.** Pursuant to Section 641.315(9), F. S., United shall not prohibit a physician from providing inpatient services in a contracted hospital to a Covered Person if such services are determined to be Medically Necessary and Covered Services under the LTCCD Contract.

4.7 **Payment.** United shall pay Provider pursuant to all applicable State and federal laws, rules and regulations, as may be amended from time to time, including but not limited to: Section 641.3155, F.S.; 42 CFR 447.46; and 42 CFR 447.45(d)(2), (d)(3), (d)(5) and (d)(6).

4.8 **Third Party Liability.** United shall assume full responsibility for third party collections and shall be responsible for making every reasonable effort to determine the legal liability of third parties to pay for Covered Services rendered to Covered Persons under the Agreement. United shall do so in a manner consistent with and in compliance with United's contractual obligations under the LTCCD Contract.

4.9 **Approval of Subcontracts.** United shall comply with all DOEA procedures for the review, approval and submission of provider agreements. All model agreements and amendments shall be submitted by United to DOEA for approval and United shall receive the required approval prior to use.

4.10 **Exclusion.** United shall not employ or contract with individuals on the State or federal exclusions list and shall terminate the Agreement immediately in the event Provider becomes an excluded provider. United shall use the List of Excluded Individuals and Entities (LEIE), or its equivalent, to identify excluded parties during the process of engaging the services of new providers to ensure they are not in a nonpayment status or sanctioned from participation in federal health care programs. United shall not engage the services of a provider if that provider is in nonpayment status or excluded from participation in federal health care programs under sections 1128 and/or 1128A of the Social Security Act.

4.11 **United Accountability.** Neither the Agreement nor this Appendix in any way relieves United of any responsibility for the provision of services or duties under the LTCCD Contract. United shall assure that all services and tasks related to the Agreement are performed in accordance with the terms of the LTCCD Contract.

4.12 **Termination by United or DOEA.** United shall comply with all State and federal laws and LTCCD Contract requirements regarding provider termination, including the following:

(a) Pursuant to Section 641.315(2)(b), F.S., United shall provide at least sixty (60) days advance written notice to Provider and DOEA before canceling the Agreement without cause. However, if a Covered Person's health is subject to imminent danger or a physician's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency, notice shall be provided to DOEA immediately.

(b) If Provider is an assisted living facility or nursing facility in which Covered Persons reside, United shall give ten (10) days prior written notice to DOEA before notifying Provider of United's intent to terminate the Agreement; provided, however, that this requirement is waived if Provider is not licensed or if DOEA waives the notice period.

(c) In addition to any other right to terminate the Agreement, and notwithstanding any other provision of the Agreement, this Appendix, or the LTCCD Contract, United or DOEA may request immediate termination of the Agreement if, as determined by DOEA, Provider fails to abide by the terms and conditions of the Agreement and this Appendix, or in the sole discretion of DOEA, Provider fails to come into compliance with the Agreement and this Appendix within fifteen (15) calendar days after receipt of notice from United specifying such failure and requesting that Provider abide by the terms and conditions thereof.

4.13 **Revocation of Delegated Functions.** In addition to its termination rights under the Agreement, United shall have the right to revoke any functions or activities United delegates to Provider under the Agreement or impose other sanctions consistent with the LTCCD Contract if in United's reasonable judgment Provider's performance under the Agreement is inadequate.

4.14 **Physician Incentive Plans.** United acknowledges and agrees that all physician incentive plans ("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. United may not 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 a Covered Person. PIPs must not contain provisions that provide incentives, monetary or otherwise, for the withholding of Medically Necessary care. If any other type of withhold arrangement currently exists with Provider, it must be omitted from the Agreement.

SECTION 5
OTHER REQUIREMENTS

5.1 **Monitoring.** United shall perform ongoing monitoring of services rendered by Provider to Covered Persons and shall perform periodic formal reviews of Provider consistent with the requirements of the LTCCD Contract and State and federal law and regulations. Such monitoring shall include, but not be limited to, verification of compliance with Level 2 background

screenings for all Direct Service Providers. In the event United identifies deficiencies or areas for improvement, United and Provider shall take corrective action to address such deficiencies or areas for improvement.

5.2 **Compliance with the LTCCD Contract.** Provider agrees that all services performed under the Agreement shall comply with the provisions of the LTCCD Contract. Any provisions of the Agreement or this Appendix which, as they pertain to Medicaid recipients, are in conflict with the specifications of the LTCCD Contract shall be considered waived.

5.3 **Delegated Credentialing.** If United has delegated credentialing to Provider under the Agreement, United will provide monitoring and oversight and Provider shall ensure that all licensed medical professionals are credentialed in accordance with DOEA's credentialing requirements as set forth in the LTCCD Contract. Monitoring by United shall include, but not be limited to, at least annual reviews of Provider to ensure compliance with the LTCCD Contract's credentialing requirements and review, pre-approval and periodic audits of Provider's credentialing process.

5.4 **Termination Appeals.** In the event of termination of the Agreement for any reason, Provider shall utilize the applicable appeals procedures outlined in the Agreement and/or United's administrative guide or other applicable protocols, policies and procedures. No additional or separate right of appeal to DOEA or United is created as a result of United's act of terminating, or decision to terminate, Provider with respect to the provision of services to Covered Persons under the LTCCD Contract. Notwithstanding termination of the Agreement, the LTCCD Contract shall remain in full force and effect with respect to all other applicable providers in United's network.

5.5 **Extension; Termination; Renegotiation.** Except as otherwise provided in this Appendix, the Agreement may be extended, terminated, or renegotiated as set forth in the Agreement.

CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION

PROVIDER

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, signed February 18, 1986. The guidelines were published in the May 29, 1987, Federal Register (52 Fed. Reg., pages 20360 – 20369).

INSTRUCTIONS

A. Each entity whose contract/subcontract equals or exceeds twenty-five thousand dollars ($25,000.00) in federal monies must sign this certification prior to execution of each contract/subcontract. Additionally, entities who audit federal programs must also sign, regardless of the contract amount. United cannot contract with these types of entities if they are debarred or suspended by the Federal Government.

B. This certification is a material representation of fact upon which reliance is placed when this contract/subcontract is entered into. If it is later determined that the signer knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Department may pursue available remedies, including suspension and/or debarment.

C. Provider shall provide immediate written notice to United at any time Provider learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

D. The terms "debarred," "suspended," "ineligible," "person," "principal," and "voluntarily excluded," as used in this certification, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. Provider may contact United for assistance in obtaining a copy of those regulations.

E. Provider agrees by submitting this certification that it shall not knowingly enter into any subcontract with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in the contract between Provider and United unless authorized by the Federal Government.

F. Provider further agrees by submitting this certification that it will require each subcontractor of the agreement between Provider and United whose payment will equal or exceed twenty-five thousand dollars ($25,000.00) in federal monies to submit a signed copy of this certification.

G. United may rely upon a certification of Provider that it is not debarred, suspended, ineligible, or voluntarily excluded from contracting\subcontracting unless it knows that the certification is erroneous.

H. This signed certification must be kept in United's business location.

CERTIFICATION

Provider certifies, by signing this certification, that neither Provider nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in the agreement between Provider and United by any federal agency.

Where Provider is unable to certify to any of the statements in this certification, Provider shall attach an explanation to this certification.

Signature

Chris Stagman

Printed Name of Authorized Signer

1/19/12

Date Signed

Executive Director

Title

Florida Regulatory Requirements Appendix

This Florida Regulatory Requirements Appendix (the "Appendix") is made part of the Agreement entered into between **United HealthCare Insurance Company,** contracting on behalf of itself, **United HealthCare of Florida, Inc.,** and the other entities that are United's Affiliates (collectively referred to as "United") and the health care professional or entity named in the Agreement ("Provider").

This Appendix applies to products or benefit plans sponsored, issued or administered by or accessed through United to the extent such products are regulated under Florida laws applicable to HMOs, managed care, insurance and/or preferred provider organizations; provided, however, that the requirements in this Appendix will not apply to the extent they are preempted by the Medicare Modernization Act or other applicable law.

United and Provider each agree to be bound by the terms and conditions contained in this Appendix. In the event of a conflict or inconsistency between this Appendix and any term or condition contained in the Agreement, this Appendix shall control, except with regard to Benefit Plans outside the scope of this Appendix.

This Appendix will be deemed to be updated to incorporate any changes to the laws and regulations referenced herein, including any changes to definitions referenced herein, effective as of the date of such changes.

Unless otherwise defined in this Appendix, all capitalized terms contained in the Appendix shall be defined as set forth in the Agreement.

Provisions applicable to Benefit Plans regulated under Florida HMO laws:

1. Hold Harmless. Provider agrees that Customers shall not be liable to Provider for any sums owed by United or Payer in the event that United or Payer fails to pay for Covered Services as set forth in that Customer's Benefit Plan. Provider further agrees that neither Provider, its agent, trustee, nor assignee, may bill or maintain any action at law against a Customer to collect sums owed by United or Payer.

Neither Provider nor any representative of Provider shall collect or attempt to collect money from, maintain any action at law against or report to a credit agency a Customer for payment of Covered Services for which United or Payer is liable, if Provider in good faith knows or should know that United or Payer is liable. This prohibition applies during the pendency of any claim for payment made by Provider to United or Payer for payment of Covered Services and any legal proceedings or dispute resolution process to determine whether United or Payer is liable for Covered Services if Provider is informed that such proceedings are taking place. It is presumed that Provider does not know and should not know that United or Payer is liable unless: (a) Provider is informed by United or Payer that it accepts liability; (b) a court of competent jurisdiction determines that United or Payer is liable; or (c) the Office of Insurance Regulation of the Florida Department of Financial Services, or Florida Agency for Health Care Administration makes a final determination that United or Payer is required to pay for such services subsequent to a recommendation made by the Florida Subscriber Assistance Panel.

2. Communication. Provider and United agree that nothing in this Agreement shall be construed to restrict Provider's ability to communicate information to Customers regarding medical care or treatment options when Provider deems knowledge of such information by Customer to be in the best interest of that Customer's health.

3. Termination Provisions.

(a) Notice. Provider agrees that it shall give advance written notice as provided in the Agreement, but in no case less than sixty (60) days, to United and the Office of Insurance Regulation of the Florida Department of Financial Services before canceling this Agreement for any reason. Upon receipt of such a cancellation notice, United may, if requested by Provider, terminate this Agreement in less than sixty (60) days if United is not financially impaired or insolvent. Provider further agrees that nonpayment by United for goods or services rendered by Provider is not a valid reason for avoiding this notice requirement.

United agrees that it shall provide advance written notice as provided in the Agreement, but in no case less than sixty (60) days, to Provider and the Office of Insurance Regulation of the Florida Department of Financial Services before canceling, without cause, this Agreement, except in a case where a Customer's health is subject to imminent danger or Provider's ability to practice medicine is effectively impaired by an action by the Florida Board of Medicine or other governmental agency.

Notwithstanding the provisions of this Section, this Agreement shall be canceled upon issuance of an order by the Office of Insurance Regulation of the Florida Department of Financial Services, as provided by Florida law.

(b) Reason for Termination. The party terminating this Agreement shall provide the terminated party with a written reason for termination, which may include business reasons of the terminating party. The reason provided in the notice required in this Section or any other information relating to the reason for termination does not create any new administrative or civil action and may not be used as substantive evidence in any such action, but may be used for impeachment purposes. This sub-paragraph (b) applies only to physicians licensed under chapter 458, chapter 459, chapter 460, or chapter 461 of the Florida statutes.

(c) Continuity of Care. If this Agreement is terminated for any reason other than for cause, Provider and United shall allow Customers for whom treatment was active to continue coverage and care, through completion of treatment of a condition for which the Customer was receiving care at the time of the termination, until the Customer selects another treating provider, or during the next open enrollment period offered by United, whichever is longer, but not longer than six (6) months after termination of this Agreement. Each party shall allow a Customer who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent Provider from refusing to continue to provide care to a Customer who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this subsection, United and Provider shall continue to be bound by the terms of this Agreement. Changes made within thirty (30) days before termination of this Agreement are effective only if agreed to by the parties.

4. Claims Communication. Provider acknowledges that it has received the mailing address or electronic address where claims should be sent for processing, the telephone number regarding claim questions or concerns, and the address of any separate claims-processing centers for specific types of services, if applicable.

5. Claims Payment. United or Payer, as applicable, shall comply with the provisions of Florida Statutes, Section 641.3155. Further, Provider shall exhaust all internal dispute resolution procedures pursuant to the Agreement as a prerequisite to the submission of a claim by Provider or United to the

resolution organization established by the Florida Agency for Health Care Administration, pursuant to Florida Statutes, Section 408.7057.

6. **Records Retention.** Provider shall maintain complete records relating to this Agreement and United's Customers for at least three (3) years, or such longer time as may be required by the Florida Agency for Health Care Administration, the Office of Insurance Regulation of the Florida Department of Financial Services, the Internal Revenue Service, the Centers for Medicare and Medicaid Services and/or any other applicable governmental agency or accrediting organization.

7. **Medical Records.** Provider shall maintain a medical records system that is consistent with professional standards and Florida Statutes and Regulations. Provider shall also give United's risk manager unencumbered access to all Customer medical records. In order to investigate any quality of care issue, the Florida Agency for Health Care Administration shall have access to Customer medical records, with the consent of the Customer or by court order. Finally, with regard to Customer's medical records, if Provider is a licensed facility, Provider shall comply with Florida Statutes, Section 395.3025, otherwise, Provider shall comply with Florida Statutes, Section 456.057.

8. **No Restrictions on Other Contracts.** Nothing in this Agreement shall be construed to prohibit or restrict Provider from entering into a commercial contract with any other health maintenance organization; or United from entering into a commercial contract with any other health care provider.

9. **Inpatient Services.** Nothing in this Agreement shall be construed to prohibit Provider, if Provider is a primary care or admitting physician, from providing inpatient services in a contracted hospital to a Customer if such services are determined by United to be medically necessary and covered services under the Customer's Benefit Plan.

10. **Accreditation and External Quality Assurance Assessment.** United has an ongoing internal quality assurance program for Covered Services in compliance with Florida Statutes, Section 641.51. Provider shall cooperate with United and comply with such quality assurance activities as directed by United.

11. **Consumer Assistance Notice.** In accordance with Section 641.511, Florida Statutes, you must post a consumer assistance notice prominently displayed in your reception area, clearly noticeable by all patients. The consumer assistance notice must state the addresses and toll-free telephone numbers of the Agency for Health Care Administration, the Subscriber Assistance Program, and the Department of Financial Services. The consumer assistance notice must also clearly state that the address and toll-free telephone numbers of our grievance department and any participating entities' grievance department shall be provided upon request.

12. **Provider Financial Information.** If Provider has assumed, through capitation or other means, more than ten percent (10%) of the health care risks of United, Provider shall provide to United and United shall file, upon the request of the Office of Insurance Regulation of the Florida Department of Financial Services, financial statements for Provider. However, this Section shall not apply if Provider is an individual physician.

Provisions applicable to Benefit Plans regulated by the State of Florida but not subject to Florida HMO laws:

1. **Medical Records.** Provider shall maintain a medical records system that is consistent with professional standards and Florida Statutes and Regulations. Provider shall also give United risk manager free access to all Customer medical records. In order to investigate any quality of care issue, the Florida

Agency for Health Care Administration shall have access to Customer medical records, with the consent of the Customer or by court order. Finally, Provider shall comply with Florida Statutes, Section 456.057 with regard to Customers' medical records.

2. **Claims Payment.** United or Payer, as applicable, shall comply with the provisions of Florida Statutes, Section 627.613. Further, Provider shall exhaust all internal dispute resolution procedures pursuant to the Agreement as a prerequisite to the submission of a claim by Provider or United to the resolution organization established by the Florida Agency for Health Care Administration, pursuant to Florida Statutes, Section 408.7057.