CONTRACT FOR DENTAL SERVICES AND COVERAGE BETWEEN FLORIDA HEALTHY KIDS CORPORATION AND MANAGED CARE OF NORTH AMERICA, INC.

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Contract to Provide Dental Services and Coverage

This Contract is entered into between the Florida Healthy Kids Corporation ("FHKC"), a Florida not-for-profit corporation established pursuant to Chapter 617 and Section 624.61, Florida Statutes, and with offices at 1203 Governors Square Boulevard, Suite 400, Tallahassee, Florida 32301, and Managed Care of North America, Inc. d/b/a MCNA ("Insurer") 200 West Cypress Creek Road, Suite 500, Fort Lauderdale, FL 33309 (each a "Party" and collectively, the "Parties") to provide dental services and coverage, and supersedes all prior contracts, negotiations, representations or agreements either written or oral between the Parties relating to this Contract. The below recitals are hereby incorporated into the Contract by reference.

Recitals

WHEREAS, FHKC requires services to provide dental services and coverage to enrollees; and

WHEREAS, Insurer agrees to provide dental services and coverage to Enrollees in accordance with and pursuant to the terms of this Contract.

NOW THEREFORE, in consideration of the premises and mutual covenants set forth herein, the Parties agree as follows:

Section 1: Contract, Contract Interpretation Instructions, and Definitions

1.1 Entire Agreement

This Contract contains all terms and conditions agreed upon by the Parties relating to the subject matter of this Contract and supersedes all other agreements, negotiations, understanding, or representations, verbal or written, between the Parties relative to the subject matter hereof. Each Party acknowledges that it is entering into the Contract solely on the basis of the representations contained herein, and for its own purposes and not for the benefit of any third party. This Contract will not apply to any events or transactions occurring prior to the Effective Date of Services.

1.2 Hierarchy of Documents

In the event of conflict among the Contract documents, the order of precedence is as follows:

a. Attachment B: Business Associate Agreement
b. This contract document;
c. The attachments to this contract document, which are incorporated by reference;
d. ITN 2021-300-01 including all addenda, in reverse order of posting by date on the Florida Healthy Kids website, which are incorporated by reference;

e. Insurer's best and final offer to ITN 2021-300-01, which is incorporated by reference; and
f. Insurer's response to ITN 2021-300-01, which is incorporated by reference.

In the event the terms of this Contract conflict with federal or state laws or regulations, the federal or state laws or regulations prevail.

1.3 Rules of Interpretation

This Contract is and shall be deemed jointly drafted and written by all Parties to it and shall not be construed or interpreted against the Party originating or preparing it.

Unless otherwise indicated or required by context, the following rules of interpretation apply:

a. All references to an attachment are to an attachment of this Contract;
b. The term "section" refers to sections, subsections, sub-subsections, etc. of this Contract, as indicated by the text;
c. The table of contents and section headings are for reference purposes only and do not limit or affect the meaning or interpretation of the text;
d. All singular terms include the plural and all plural terms include the singular;
e. Masculine, feminine, and neutral gender terms include all genders;
f. The word "include" and its derivatives are deemed to be followed by the phrase "but not limited to";
g. Reference to a governmental entity or person includes the authorized successors and assigns of the governmental entity or person;
h. Reference to a federal or state law or regulation includes the federal or state law or regulation as amended or replaced; and
i. References to "medical" or "health" includes dental.

1.4 Attachments

The following attachments are hereby incorporated into the Contract by reference:

Attachment A: Benefit Schedule

Attachment B: Business Associate Agreement

Attachment C: Performance Guarantees

Attachment D: Reports and Deliverables

1.5 Modification of Terms

This Contract may be modified upon a written amendment signed by the authorized representatives of both Parties.

The terms of this Contract shall be automatically modified without written agreement to the extent necessary to comply with federal or State laws or regulations.

Upon FHKC's Notice to Insurer, the terms of this Contract shall be automatically modified without a written agreement to the extent necessary to comply with the requirements of FHKC's contract with AHCA.

1.6 Definitions

Capitalized terms used in this Contract without definition shall have the meanings ascribed below:

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care, or Enrollee practices that result in unnecessary cost to the Program.

Access: to review, inspect, approach, instruct, communicate with, store data in, retrieve data from, or otherwise make use of any data, regardless of type, form, or nature of storage. Access to a computer system or network includes local and remote access.

Act: The Social Security Act.

Adverse Benefit Determination: the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure of Insurer to provide services in a timely manner, as defined by FHKC; the failure of Insurer to act within the timeframes required by law for standard resolution of Grievances and Appeals; and the denial of an Enrollee's request to dispute a financial liability, including cost sharing, premiums, and other Enrollee financial liabilities.

After-hours Services: outpatient Covered Services that are not Emergency Services and are provided at a time other than Monday through Friday, 8:00 a.m. to 5:00 p.m.

Agency for Health Care Administration: the lead agency for Title XXI of the Act for purposes of receipt of federal funds, reporting, and for ensuring compliance with federal and State regulations and rules.

Appeal: a review by Insurer of an Adverse Benefit Determination.

Applicant: a parent or guardian of a child or a child whose disability of nonage has been removed under Chapter 743, Florida Statutes, who applies for determination of eligibility for health benefits coverage under Sections 409.810-820, Florida Statutes.

Business Day: means any day of the week excluding weekends and holidays approved by FHKC.

Calendar Day: means any day in a month, including weekends and holidays.

Centers for Medicare and Medicaid Services: the federal agency responsible for administering the Children's Health Insurance Program.

Children's Health Insurance Program (CHIP): health benefits offered pursuant to Title XXI of the Social Security Act.

Confidential Information: business information that is confidential, proprietary, trade secret, exempt, or otherwise not subject to disclosure pursuant to Chapter 119, Florida Statutes, the Florida Constitution, or other authority.

Contract: this dental services and coverage agreement between FHKC and Insurer resulting from ITN 2021-300-01.

Contract Term: the period(s) of time in which this Contract is effective, including the initial term, any Renewal period(s), and extensions.

Contract Year: July 1st through June 30th.

Corrective Action Plan: a step-by-step plan of action, including the estimated dates of completion, that is developed and implemented to appropriately address errors or deficiencies in Insurer's policies, processes, or other work under this Contract.

Coverage Month: the calendar month in which benefits and services may be provided to Enrollees.

Covered Services: benefits and services covered under this Program applicable to this Contract as described in Attachment A.

Data: any representation of information, knowledge, facts, concepts, computer software, computer programs, or instructions related to or arising from this Contract. Data may be in any form, including storage media, computer memory, in transit, presented on a display device, or in physical media such as paper, film, microfilm, or microfiche. Data includes the original form of the Data and all metadata associated with the Data.

Effective Date of Services: the date on which Insurer is required to commence the provision of Covered Services to Enrollees (anticipated July 1, 2022).

Emergency Medical Condition: a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a. Placing the health of the individual (or, for a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

b. Serious impairment to bodily functions; or
c. Serious dysfunction of any bodily organ or part.

Emergency Services: covered inpatient and outpatient services that are as follows:

a. Furnished by a Provider that is qualified to furnish these services under Title 42 of the United States Code.
b. Needed to evaluate or stabilize an Emergency Medical Condition.

Enrollee: an individual enrolled in Insurer's Florida Healthy Kids plan.

Event of Default: an action or failure that renders the Contract terminable as set forth in section 44.10.

Execution Date: the date on which the last Party to this Contract signed.

Florida Healthy Kids or "Program": the benefits program established by Sections 624.91 and 409.813, Florida Statutes, administered by FHKC, and offered to children age five (5) through the end of age eighteen (18).

Florida KidCare: the benefits programs established by Section 409.813, Florida Statutes.

Fraud: an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Financial Consequences: the amount Insurer shall be assessed for failure to perform as specified in this Contract. Financial Consequences are not liquidated damages.

Full-pay Plan: the non-Title XXI Florida Healthy Kids insurance coverage available to children ages five (5) through the end of age eighteen (18) who are ineligible for subsidized Florida Healthy Kids coverage but who are otherwise eligible for health benefits established by FHKC.

Grievance: an expression of dissatisfaction about any matter other than an Adverse Benefits Determination. Grievances include the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider or employee, failure to respect the Enrollee's rights regardless of whether remedial action is requested, and an Enrollee's right to dispute an extension of time proposed by Insurer to make an authorized decision.

HIPAA: As may from time-to-time may be amended, the (i) Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, including its Omnibus Rule; (ii) applicable provisions of the Health Information Technology for Economic and Clinical Health Act as incorporated in the American Recovery and Reinvestment Act of 2009; and (iii) their accompanying regulations, including the Privacy Rule (as defined herein) and the Security Rule (as defined herein). "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 CFR, part 160 and part 164, subparts A and E, providing for federal

privacy protections for an individual's protected health information held by entities subject to HIPAA requirements and describing patient rights with respect to their PHI. "Security Rule" means the HIPAA Security Standards at 5 CFR Parts 160 and 164, Subparts A and C, providing for federal security protections for individuals' electronic personal health information.

Intellectual Property Rights: worldwide common law and statutory rights associated with:

a. Patents and patent applications of any kind;
b. Copyrights, copyright registrations, and copyright applications, "moral", "economic" rights, and mask work rights;
c. The protection of trade and industrial secrets and similar Confidential Information
d. Logos, trademarks, trade names, and service marks;
e. Domain names and web addresses; and
f. Any other proprietary rights relating to technology, including any analogous rights to those set forth above.

Marketing: communication from Insurer or Insurer's employees, network Providers, agents, or Subcontractors that can reasonably be interpreted as intended to influence an individual who is not enrolled with Insurer to enroll with Insurer's particular Florida Healthy Kids product or to enroll in or disenroll from another insurer's Florida Healthy Kids product.

Medically Necessary or **Medical Necessity:** the use of any medical treatment, service, equipment, or supply necessary to palliate the effects of a terminal condition or to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a condition that threatens life, causes pain or suffering, or results in illness or infirmity and which is:

a. Consistent with the symptom(s), diagnosis, and treatment of an Enrollee's condition;
b. Provided in accordance with generally accepted standards of medical practice;
c. Not primarily intended for the convenience of the Enrollee, the Enrollee's family, or the Provider;
d. The most appropriate level of supply or service for the diagnosis and treatment of the Enrollee's condition; and
e. Approved by the appropriate medical body or health care specialty involved as effective, appropriate, and essential for the care and treatment of the Enrollee's condition.

The fact that a Provider has prescribed, recommended, or approved a medical treatment, service, equipment, or supply does not in itself make such medical treatment, service, equipment, or supply Medically Necessary.

Notice: formal written notification in accordance with section 38 from one Party to the other Party under this Contract.

Ownership Interest: the possession of equity in the capital, the stock, or the profits of a disclosing entity, as defined in 42 CFR 455.101.

Ownership or Control Interest: a person (individual or corporation) that:

a. Has Ownership Interest totaling five percent (5%) or more in a disclosing entity;
b. Has an indirect Ownership Interest equal to five percent (5%) or more in a disclosing entity;
c. Has a combination of direct Ownership Interest and indirect Ownership Interest equal to five percent (5%) or more in a disclosing entity;
d. Owns an interest of five percent (5%) or more in any mortgage, deed of trust, note, or other obligation secured by the disclosing entity if that interest equals at least five percent (5%) of the value of the property or assets of the disclosing entity;
e. Is an officer or director of a disclosing entity that is organized as a corporation; or
f. Is a partner in a disclosing entity that is organized as a partnership.

Personally Identifiable Information: information that can be used to distinguish or trace an individual's identity, either alone or when combined with other personal or identifying information that is linked or linkable to a specific individual.

Primary Dental Provider: A general dentist or pediatric dentist responsible for the diagnosis, treatment, and coordination of services related to an Enrollee's oral health needs; equivalent to a primary care provider.

Post-stabilization Care Services: Covered Services related to an Emergency Medical Condition that are provided after an Enrollee is stabilized to maintain the stabilized condition, or, under the circumstances described in 42 CFR 438.114(e) to improve or resolve the Enrollee's condition pursuant to 42 CFR 422.113.

Protected Health Information: individually identifiable health information received or created by Insurer pursuant to performance under this Contract that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium, except for individually identifiable health information:

a. In education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g;
b. In records described at 20 U.S.C. 1232g(a)(4)(B)(iv);
c. In employment records held by a covered entity (under HIPAA) in its role as employer; and
d. Regarding a person who has been deceased for more than fifty (50) years.

Provider: an appropriately licensed individual or entity that provides dental care services to an Enrollee.

Renewal: extending the initial Contract Term pursuant to section 2.2.

Region: any of the eleven (11) geographical areas designated by FHKC and encompassing specified Florida counties pursuant to Section 409.966, Florida Statutes.

Service Area: the designated Region(s) for which Insurer is authorized by the Contract to provide Covered Services to those Enrollees whose home address is located in such Region(s).

Subcontractor: any individual or entity, including an independent contractor, that has an agreement with Insurer to perform or fulfill any of the obligations of Insurer under this Contract. The term "Subcontractor" includes Insurer's subsidiaries and affiliates. A network Provider is not a Subcontractor by virtue of the network Provider agreement with Insurer.

Subcontract: a contract or other agreement between Insurer and a Subcontractor or proposed Subcontractor.

Waste: overuse of services or other practices that, directly or indirectly, result in unnecessary costs to the Program, generally caused by the misuse of resources rather than criminally negligent actions.

1.7 Acronyms

Acronyms commonly used in this Contract shall have the meanings ascribed in this section unless otherwise expressly stated.

AHCA: Agency for Health Care Administration

BAA: Business Associate Agreement

CAHPS®: Consumer Assessment of Healthcare Providers and Systems

CAP: Corrective Action Plan

CMS: Centers for Medicare and Medicaid Services

CHIP: Children's Health Insurance Program

CHIPRA: Children's Health Insurance Program Re-Authorization Act of 2009

COOP: Continuity of Operations Plan

EQR: External Quality Review

EQRO: External Quality Review Organization

HHS: U.S. Department of Health and Human Services

IRO: Independent Review Organization

ITN: Invitation to Negotiate

MLR: Medical Loss Ratio

PDP: Primary Dental Provider

PHI: Protected Health Information

PII: Personally Identifying Information

PMPM: Per member (i.e., Enrollee) per month

Title XXI: Children's Health Insurance Program

Section 2: Contract Term; Service Area; Compensation

2.1 Initial Term

The initial term of this Contract is three (3) years beginning on July 1, 2022 and expiring on June 30, 2025 unless extended, terminated, or renewed.

2.2 Renewal Term

FHKC may elect to renew this Contract beyond the initial term for up to two (2), one- (1) year Renewal terms. FHKC may exercise the Renewal options of this Contract either in whole or in part.

The Parties acknowledge the Renewal is contingent upon satisfactory performance, as determined solely by FHKC, and subject to the availability of funds. Insurer may not charge costs associated with the Renewal of the Contract.

2.3 Service Area and Premiums

Effective July 1, 2022, Insurer shall provide Covered Services in the Regions and at the per member (Enrollee) per Month (PMPM) premium rates specified as follows:

Region	PMPM Premium Rate
1	$14.49
2	$12.79
3	$10.43
4	$12.99
5	$13.06
6	$14.44
7	$12.19
8	$16.29
9	$12.40
10	$15.53
11	$16.11

2.4 Compensation and Payment to Insurer

Insurer agrees to perform all obligations under this Contract for the compensation and financial arrangements set forth in this Contract.

FHKC shall compensate Insurer on a monthly basis an amount equal to the PMPM premium rate for each Region specified in section 2.3, multiplied by the monthly enrollment of such Region. FHKC shall determine monthly enrollment in each Region by the Enrollee's Region of residency, as documented in FHKC's system of record maintained by FHKC's third-party administrator.

Insurer shall only retain payments for Enrollees for the applicable Coverage Month. FHKC will compensate Insurer no later than the twentieth (20^{th}) day of each enrollment month. Insurer shall not invoice or bill FHKC. Retroactive disenrollments will be netted out from the active and retroactive enrollments. Payments made for individuals determined to be ineligible for coverage or who are otherwise disenrolled from Insurer's plan for the Coverage Month shall be returned to FHKC.

FHKC reserves the right to delay payment without change in enrollment or any of Insurer's obligations under this Contract when such payment delay is the result of any act described in section 13 Force Majeure, changes to Florida's CHIP State Plan, or other temporary shortfalls resulting from an emergency or urgent situation. In the event of such delay, FHKC shall act in good faith in resolving and making the delayed premium payments to Insurer.

No additional compensation shall be allowed under this Contract unless specifically agreed upon in writing by the authorized representative of each Party.

2.5 Advanced Funds

Insurer agrees to use advanced funds only for the purposes identified under this Contract, if any.

2.6 Overpayments to Insurer

Insurer shall return any overpayments due to unearned or disallowed funds that were paid under this Contract to FHKC within forty-five (45) Calendar Days of identification by either Party.

2.7 Appropriations

FHKC's ability and obligation to make payment for services performed under this Contract is contingent upon annual funding from the Florida Legislature and the federal government. FHKC will diligently seek appropriation from AHCA and/or the Florida Legislature to fund the Contract.

The foregoing does not in any way limit, abrogate, or otherwise modify Insurer's rights or remedies under applicable law, including Insurer's rights to seek a legislative claims bill.

2.8 Premium Rate Modifications

2.8.1 Annual Premium Rate Adjustment Requests

Insurer shall provide an annual premium rate adjustment request for the upcoming Contract Year to FHKC by December 1 of each year unless there are no additional Renewal years available under the Contract or this provision is otherwise waived by FHKC. In the annual premium rate adjustment request, Insurer may request to reduce premium rates, make no change to premium rates, increase premium rates, or any combination thereof for the Regions in Insurer's Service Area.

Failure to comply with the requirements of section 2.8 may result in the denial of a premium rate adjustment request without recourse at FHKC's sole discretion.

A. Service Area

The premium rate adjustment request shall be inclusive of Insurer's Service Area. Insurer shall provide a premium rate adjustment for each Region in Insurer's Service Area in the premium rate adjustment request.

B. Timeframe

The premium rate adjustment request applies to an entire Contract Year and to all of Insurer's Enrollees in a Region. Premium rates shall not:

a. Include planned mid-plan year premium rate changes;
b. Require different premium rates based on when an Enrollee enrolls with Insurer;
c. Require different premium rates based on an Enrollee's age;
d. Require different premium rates based on an Enrollee's sex; or
e. Be discriminatory in any way.

C. Offshoring

Insurer shall not consider any claims paid to a network Provider, out-of-network Provider, Subcontractor, or financial institution located outside the United States in the development of actuarially sound rates.

D. Actuarial Soundness

Insurer shall provide an actuarial memorandum supporting the premium rate adjustment request. The actuarial memorandum shall include the information and level of detail required by FHKC.

The proposed premium rates shall:

a. Be consistent with actuarially sound principles as required by 42 CFR 457.1203;
b. Not be excessive nor inadequate in accordance with the applicable requirements of Chapter 409, Florida Statutes; and
c. Be designed to reasonably achieve a medical loss ratio (MLR) standard for the Contract year that is at least equal to the greater of eighty-five percent (85%) or as presented in response to the ITN and provide for reasonable administrative costs in accordance with 42 CFR 457.1203 and section 9.5 of this Contract.

E. Rights and Responsibilities

FHKC may choose to provide Insurer with available trend information that FHKC may utilize when reviewing the premium rate adjustment request.

FHKC may initiate and enter into premium rate adjustment negotiations following Insurer's rate adjustment request submission. FHKC maintains the right to deny a rate adjustment request, require Insurer decrease rates, or require Insurer hold rates flat based on the data provided by Insurer, FHKC's analysis, and other relevant factors as determined by FHKC.

Insurer shall respond to FHKC's requests for additional or clarifying information during the premium rate adjustment review process.

F. Premium Rate Adjustment Approval

Any changes to the premium rates must be approved by FHKC's Board of Directors. Premium rate adjustments are also subject to the maximum average rate adjustment recommended by the Social Services Estimating Conference and approval by the Florida Legislature and Governor.

2.8.2 Benefit Schedule Change Premium Rate Adjustments

Changes in federal and state law may require changes to the benefit schedule during the Contract term.

FHKC shall notify Insurer of the required change in writing. Insurer may submit a premium rate adjustment request to accommodate the change within thirty (30) Calendar Days of receipt of notice. The premium rate adjustment request must comply with section 2.8.1 (A)-(F).

If the benefit schedule change results in a reduction in coverage or increases Enrollee cost sharing, FHKC may require that Insurer reduce its premium rate by an amount actuarially equivalent to the benefit reduction.

2.8.3 Other Premium Rate Adjustment Requests

Changes in federal law, state law, FHKC policy, or to this Contract may have a substantial cost impact during the Contract Year. FHKC shall notify Insurer of the required change in writing. Insurer may submit a premium rate adjustment request to accommodate the change within

thirty (30) Calendar Days of receipt of notice. The premium rate adjustment request must comply with section 2.8.1 (A)-(F).

2.8.4 Changes in Law

Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), Insurer must do no work on that part after the effective date of the loss of program authority. FHKC must adjust premium rates to remove costs that are specific to any program or activity that is no longer authorized by law. If Insurer works on a program or activity no longer authorized by law after the date the legal authority for the work ends, Insurer will not be paid for that work. If FHKC paid Insurer in advance to work on a no-longer-authorized program or activity and under the terms of this Contract the work was to be performed after the date the legal authority ended, Insurer shall return the payment for such work to FHKC. However, if Insurer worked on a program or activity prior to the date legal authority ended for that program or activity, and FHKC included the cost of performing that work in its payments to Insurer, Insurer may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

2.9 Payment Upon Expiration or Termination

Upon expiration or termination of this Contract, FHKC agrees to pay Insurer the amounts due and owing to Insurer for services rendered pursuant to this Contract. Within sixty (60) Calendar Days prior to expiration or termination, Insurer must submit to FHKC a request for payment of such amounts; however, FHKC shall also pay any amounts previously invoiced and not paid, as well as amounts due and owing pursuant to section 45 of this Contract. Requests submitted later than sixty (60) Calendar Days prior to expiration or termination shall not be honored and will be returned unpaid. Payment for services requested and provided after termination or expiration shall be paid in the same manner as set forth in this section.

Section 3: Insurer Organization Administration

3.1 Independent Contractor

Insurer performs work under this Contract as an independent contractor and not as an agent, representative, or employee of FHKC. Neither Party has the authority to make any representation, warranty, or binding commitment on behalf of the other Party, except as expressly provided in this Contract or as otherwise agreed to in writing by the Parties.

In connection with this Contract, each Party is considered an independent entity and as such shall not have any authority to bind or commit the other. Nothing herein shall be deemed or construed to create a joint venture, partnership, or agency relationship between the Parties for

any purpose. Under no circumstance shall one Party's employees be construed to be employees of the other Party, nor shall one Party's employees be entitled to participate in the profit sharing, pension, or other plans established for the benefit of the other Party's employees. Neither Party shall be deemed a joint employer of the other's employees; each Party being responsible for any and all claims by its employees. Neither Party's employees shall be deemed "leased" employees of the other Party for any purpose. The agreements of the Parties set forth in this Contract are not intended for, nor shall they be for the benefit of or be enforceable by, any person not a Party.

3.2 Assignment

Insurer shall not assign this Contract or any of Insurer's obligations under the Contract without prior written consent of FHKC. Any purported assignment without consent is void. Approval of such assignment by FHKC shall not be deemed to provide for the incurrence of any obligation of FHKC in addition to the amount agreed upon in this Contract.

In the event of an assignment, Insurer shall comply with all transition provisions set forth in section 45.

At least one hundred twenty (120) Calendar Days prior to the earlier of (i) the anticipated effective date of an assignment or (ii) the anticipated effective date of a merger or acquisition for which assignment of this Contract is required in section 3.8, Insurer shall provide FHKC with the transition plan required in section 45.

Failure to comply with this section renders this Contract subject to termination under section 44. The resulting damages of any such failure will not be readily ascertainable, entitling FHKC to liquidated damages in an amount of two hundred fifty thousand dollars ($250,000). These liquidated damages are intended only to cover FHKC's internal staffing and administrative costs as well as the diminished value of services provided under the Contract and will not preclude FHKC from recovering out-of-pocket damages it may suffer as a result of such violation.

3.3 Warranty of Security; No Offshoring

Insurer shall be located and conduct all obligations under this Contract within the United States. Additionally, Insurer shall not send, store, or allow Access to PII or PHI Data outside the United States. The Parties agree that a violation of this provision will:

a. Result in immediate and irreparable harm to FHKC, entitling FHKC to immediate injunctive relief provided; however, this shall not constitute an admission by Insurer to any liability for damages under subsection c below or any claims, liability, or damages to a third-party, and is without prejudice to Insurer in defending such claims;
b. Entitle FHKC to a credit of twenty-five thousand dollars ($25,000) per violation. This credit is intended to cover FHKC's internal staffing and administrative costs of

investigations and audits regarding the sending, transmitting, or Accessing of PII or PHI Data outside the continental United States;

c. Entitle FHKC to recover damages, if any, arising from a breach of this section and beyond those covered under subsection b; and
d. Constitute an Event of Default not subject to cure in section 44.10 or the dispute resolution provisions in section 40.

The credit in subsection b are in the nature of liquidated damages and not intended to be a penalty. Insurer acknowledges and agrees the costs intended to be covered by subsection b are not readily ascertainable. Insurer agrees that it will not argue, and is estopped from arguing, that such costs are a penalty or otherwise unenforceable. For purposes of determining the amount of credits due hereunder, a group of violations relating to a common set of operative facts (e.g., same location, same time period, same off-shore entity) shall be treated as a single violation.

Insurer shall provide an annual certification attesting compliance with the warranty of security.

3.4 Prohibited Affiliations

Insurer may not have a relationship with the following:

a. An individual who is 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.
b. An individual who is an affiliate, as defined in the Federal Acquisition Regulation at 48 CFR 2.101, of a person described above.

For this section, the term “relationship” is defined as any of the following:

a. A director, officer, or partner of Insurer;
b. A person with beneficial ownership of five percent (5%) or more of Insurer’s equity;
c. A network Provider or person with an employment, consulting, or other arrangement with Insurer for the provision of items and services that are significant and material to Insurer’s obligations under its Contract with FHKC; or
d. A Subcontractor.

Insurer understands that failure to comply with this provision is subject to 42 CFR 438.610(d), which is incorporated by 42 CFR 457.1285.

Insurer shall submit an annual disclosure of any prohibited affiliations to FHKC.

For any of Insurer’s employees, agents, and Subcontractor’s employees providing health care, administrative, or management services under this Contract, Insurer shall be responsible for conducting screen for debarment, ineligibility, or exclusion from participation under Medicare,

Medicaid, CHIP, and any other government health care program. At the time of execution of this Contract, Insurer shall submit to FHKC an FHKC-approved certification regarding debarment, suspension, ineligibility, and exclusion, as provided by FHKC. Such certification must, at a minimum, attest that neither Insurer nor any of its owners, directors, officers, employees, Subcontractors, or Providers is presently debarred, suspended, proposed for debarment, declared ineligible, or excluded from participation in the Contract by any federal agency. Insurer shall also require each of its Subcontractors and agents to sign a copy of the certification.

3.5 Scrutinized Company List

In executing this Contract, Insurer certifies that it is not listed on either the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List, created pursuant to section 215.473, Florida Statutes. Insurer agrees FHKC may immediately terminate this Contract for cause if Insurer is found to have submitted a false certification or if Insurer is placed on the Scrutinized Companies with Activities in Sudan List or the Scrutinized Companies with Activities in the Iran Petroleum Energy Sector List during the Contract Term.

3.6 Public Entity Crimes

Insurer certifies that during the Contract Term that neither Insurer, nor any of its Subcontractors, are listed on any convicted vendor list maintained by the State of Florida or the federal government. Insurer agrees that it may not be awarded or perform work as an insurer, supplier, Subcontractor, or consultant for the State of Florida for a period of thirty-six (36) months from the date of being placed on the convicted vendor list. The Parties agree that failure to comply with this section is an Event of Default and shall be grounds for FHKC to terminate this Contract in accordance with section 44.10.

3.7 Ownership or Control Interest Disclosures

Insurer shall provide written disclosures of the following Ownership or Control Interest information to FHKC upon Contract execution, upon any Renewal or extension of the Contract, and within thirty-five (35) Calendar Days of any change in ownership of Insurer.

Insurer shall submit the following information for any person (individual or corporation) with an Ownership or Control Interest in Insurer:

a. Name;
b. Address;
    a. For corporations with an Ownership or Control Interest, this includes the primary business address, every business location address, and all P.O. box addresses.
c. Date of birth and Social Security Number (in the case of an individual);

d. Tax identification number, for corporations with an Ownership or Control Interest in Insurer or in any Subcontractor in which Insurer has a five percent (5%) or more interest;
e. Whether the person with Ownership or Control Interest in Insurer is related to (as a spouse, parent, child or sibling) another person with Ownership or Control Interest in Insurer;
f. Whether the person with Ownership or Control Interest in any Subcontractor in which Insurer has a five percent (5%) or more interest is related to (as a spouse, parent, child or sibling) another person with Ownership or Control Interest in Insurer;
g. The name of any other disclosing entity, as defined in 42 CFR 455.101, in which an owner of Insurer has Ownership or Control Interest; and
h. The following information for Insurer's managing employees, as defined in 42 CFR 455.101:
    a. Name;
    b. Address;
    c. Date of birth; and
    d. Social Security Number.

Failure to adhere to this requirement may result in Insurer's ineligibility for federal financial participation in payments made to Insurer and may result in termination of this Contract or other consequences in accordance with the Contract and 42 CFR 457.1285, which incorporates 42 CFR 438.610.

3.7.1 Determination of Ownership or Control Interest Percentages

Direct Ownership or Control Interest is determined by multiplying the percentage of interest that a person (individual or corporation) owns by the percentage of Insurer's assets used to secure the obligation. By way of example, if a person owns ten percent (10%) of a note secured by sixty percent (60%) of Insurer's assets, the person's direct interest in Insurer is six percent (6%) and must be reported.

Indirect Ownership or Control Interest is determined by multiplying the percentage of ownership in each entity. By way of example, if a person owns ten percent (10%) of the stock in a corporation which owns eighty percent (80%) of Insurer's stock, the person's indirect interest in Insurer is eight percent (8%) and must be reported.

3.8 Change of Ownership Structure or Controlling Interest

No change in Insurer's ownership structure or controlling interest releases Insurer from its obligations under this Contract. For purposes of this section, a change in ownership structure or controlling interest results when a person or entity acquires control, due to an ownership interest, over any aspect of Insurer's business operations, including through an asset or stock purchase.

Insurer shall give FHKC at least one hundred eighty (180) Calendar Days' Notice prior to the effective date of any change in ownership structure or controlling interest. Insurer shall provide FHKC with Notice of regulatory agency approval, if applicable, prior to any change in ownership structure or controlling interest.

FHKC has the right to elect to continue or terminate this Contract, at its sole discretion, in the event of a change in Insurer's ownership structure or controlling interest. In such event, FHKC shall provide at least thirty (30) Calendar Days' Notice to Insurer of the decision to terminate the Contract.

FHKC intends to provide Enrollees with a choice of at least two (2) managed care entities in each area of the state. In the event of a proposed merger or acquisition between Insurer and another managed care entity that would result in the common ownership of all FHKC-contracted managed care entities in an area of the State of Florida, Insurer or the other FHKC-contracted managed care entity(ies) may be required, at FHKC's sole discretion, to assign one of the FHKC contracts in accordance with section 3.2. In such case, the entities will have the option to determine which entity shall assign its contract, subject to approval by FHKC. If applicable, Insurer must comply with section 628.4615, Florida Statutes, and receive OIR approval before a merger or acquisition can occur. Failure to comply with this paragraph renders this Contract subject to termination under section 44. The resulting damages of any such failure will not be readily ascertainable, entitling FHKC to liquidated damages in an amount of two hundred fifty thousand dollars ($250,000). These liquidated damages are intended only to cover FHKC's internal staffing and administrative costs as well as the diminished value of services provided under the Contract and will not preclude FHKC from recovering out-of-pocket damages it may suffer as a result of such violation.

3.9 Conflicts of Interest

Insurer agrees that its obligations under this Contract are not in conflict with any other interest to which Insurer is obligated or from which Insurer benefits. Insurer affirms that it meets or exceeds the federal safeguards of 41 U.S.C. 423.

Insurer must disclose:

1. The name of any of its officers, directors, or employees who is also an FHKC employee, Board member, ad hoc Board member, or committee member;
2. The name of any FHKC employee, Board member, or committee member who owns an interest of five percent (5%) or more in Insurer; and
3. The name of any FHKC employee, Board member, ad hoc Board member, committee member, or agent; any member of his or her immediate family; his or her partner; or an organization which employs or is about to employ any such individual, has a financial or other interest in, or a tangible personal benefit from, Insurer.

Insurer shall submit the conflict of interest disclosure form provided by FHKC identifying any potential conflicts of interest:

a. Within five (5) Business Days after Insurer's receipt of the executed Contract;
b. Annually by July 15th; and
c. Within ten (10) Business Days after becoming aware of any potential conflicts of interest.

FHKC shall be the sole determiner of whether a conflict of interest exists and the action needed to resolve the conflict.

3.10 Lobbying Disclosure

Insurer shall disclose information regarding the lobbying activities of Insurer, its Subcontractors, or its authorized agents in compliance with applicable state and federal requirements. Insurer shall certify that no State of Florida or federal funds have been or will be used in lobbying activities. Insurer shall provide the lobbying certification at Contract execution and annually by July 15th.

3.11 Gift Prohibitions

Insurer shall not offer any gifts, including any meal, service or item of value, even if such value is *de minimis*, to FHKC Board members, ad hoc Board members, employees, committee members, or agents.

3.12 Non-Solicitation

Insurer acknowledges that FHKC recruits and trains personnel to perform work directly and indirectly related to this Contract and that this is a costly and time-consuming effort. Insurer agrees that during the Contract Term and the twelve (12) months following the termination or expiration of this Contract, Insurer shall not recruit or directly or indirectly employ any individual who is employed by FHKC during the Contract Term. Further, for a period of two (2) years after Contract execution, Insurer shall not employ or contract with any individual who participated personally and substantially through development, decision, approval, disapproval, recommendation, rendering of advice, investigation, or administration of the Contract; however, an employment or contractual relationship is allowable with a division or affiliate of Insurer if the division or affiliate does not produce the same or similar products or services as Insurer. FHKC may waive any of these provisions in writing.

3.13 Insurance

During the term of this Contract and entirely at Insurer's expense, Insurer shall continuously maintain insurance coverage that may be reasonably associated with the Contract. Failure to comply with these requirements shall constitute an Event of Default. Insurer shall not perform

any work in connection with this Contract until such insurance has been secured by Insurer and approved by FHKC. Such coverage must include the following:

a. Commercial general liability insurance. Insurer must continuously maintain commercial general liability insurance (inclusive of any amounts provided by an umbrella or excess policy) with limits of liability necessary to provide reasonable financial protections to Insurer and FHKC under the Contract for the life of the Contract. Such insurance shall include a hold harmless agreement in favor of FHKC and must include FHKC as an additional insured for the entire length of the Contract.
b. Professional liability/errors and omissions insurance. Insurer must continuously maintain professional liability or errors and omissions insurance with limits of liability necessary to provide reasonable financial protections to Insurer and FHKC under the Contract for the life of the Contract. Such insurance shall include an agreement that Insurer shall provide thirty (30) Calendar Days' prior Notice of any cancellation of coverage to FHKC.
c. Cyber liability insurance. Insurer must continuously maintain cyber liability insurance with limits of liability necessary to provide reasonable financial protections to Insurer and FHKC under the Contract for the life of the Contract. If Insurer self-insures for cyber liability insurance, Insurer shall provide FHKC with the total amount self-insured and the total amount of any excess coverage in place. If Insurer's self-insured amount is lower than the minimum required aggregate, Insurer must provide proof of insurance coverage for an amount that at least meets the minimum required amount in combination with the self-insurance.
d. Worker's compensation insurance. Insurer shall comply with all worker's compensation laws and regulations. Insurer may be self-insured to the extent permitted by law and such self-insurance shall comply with the Florida Worker's Compensation law. In the event hazardous work is being performed by Insurer's employees under this Contract and any class of employees performing the hazardous work is not protected under worker's compensation statutes, Insurer shall provide adequate insurance satisfactory to FHKC for the protection of its employees not otherwise covered. Insurer may use a self-insurance program approved by the Florida Department of Financial Services, Division of Worker's Compensation, or if a force majeure condition causes Services to be provided by Insurer's employees located outside of the State of Florida, Insurer may use a self-insurance worker's compensation program approved by the state in which the Services are performed and Insurer's employees are located. Insurer shall ensure all Subcontractors comply with this provision.

Insurer shall provide a certificate of insurance as proof of coverage for each type of insurance required within ten (10) Business Days after Contract execution. Insurer shall provide proof of continuing coverage to FHKC by December 31st each year or by the date of expiration of the certificate of insurance, whichever is earlier.

3.14 Fidelity Bond

Insurer shall maintain a blanket fidelity bond on all personnel in its employment during the life of the Contract. The bond shall be issued in the amount of at least one hundred fifty thousand dollars ($150,000) per occurrence for the life of the Contract. The surety company issuing the bond must comply with the provisions of Chapter 624, Florida Statutes. The bond shall protect FHKC from any losses sustained through any fraudulent or dishonest act or acts committed by any employees of Insurer and Subcontractors. Proof of coverage shall be submitted to FHKC within ten (10) Business Days after Contract execution. Insurer shall provide proof of continuing coverage to FHKC by June 30th each year or by the date of expiration of the certificate of insurance, whichever is earlier.

3.15 Performance and Payment Bonds

Within ten (10) Calendar Days after execution of this Contract by both Parties, Insurer shall provide a surety commitment letter to provide the performance and payment bonds required by this section.

No later than thirty (30) Calendar Days before the Effective Date of Services, Insurer shall furnish a performance bond in an amount of three hundred thousand dollars ($300,000) for the life of the Contract. The performance bond shall be issued by a surety authorized to do business in the State of Florida and approved in writing by FHKC, and such bond shall be payable to, in favor of, and for the protection of FHKC. The bond shall be conditioned for the prompt and faithful performance of this Contract. Insurer shall maintain the performance bond throughout the Contract Term.

No later than thirty (30) Calendar Days before the Effective Date of Services, Insurer shall furnish a payment bond in an amount of five hundred thousand dollars ($500,000) for the life of the Contract. The payment bond shall be issued by a surety authorized to do business in the State of Florida and approved in writing by FHKC, payable to, in favor of, and for the protection of FHKC. The bond shall be conditioned for the prompt payment of all persons furnishing labor, materials, equipment, supplies, services, and licenses to or for Insurer in its performance of this Contract. Insurer shall maintain the payment bond throughout the Contract Term.

Insurer shall provide proof of its performance and payment bonds annually by June 30th and upon the request of FHKC.

3.16 Employment; E-Verify

Insurer shall comply with section 274A(e) of the Immigration and Naturalization Act (“INA”). The employment of unauthorized aliens by Insurer, Insurer’s agent, or Subcontractor is a violation of the INA. If Insurer knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of this Contract. Insurer shall include this provision in all Subcontracts.

Insurer shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility System to verify the employment status of all new employees employed by Insurer during the term of this Contract.

Insurer shall require all Subcontractors to utilize the E-Verify system to verify the employment status of all new employees contracted by the Subcontractor during the term of the Contract and include such requirement in all Subcontracts.

Compliance with this section is a condition of funds provided through this Contract.

3.17 Background Screenings

3.17.1 Background Screening Requirement

All Insurer employees, Subcontractors, and agents performing work under the Contract must comply with all security and administrative requirements of FHKC.

Insurer will conduct a criminal background screening of, or ensure that such a screening is conducted for, each employee, Subcontractor personnel, independent contractor, leased employee, volunteer, licensee, or any other person (hereinafter referred to as "Person" or "Persons") who has Access to the PHI, PII, or financial information of an Enrollee or Applicant.

Insurer shall perform, or ensure performance of, a criminal background screening comparable to a level 2 background screening as described in section 435.04, Florida Statutes, for all Persons, regardless of whether a background screening is required by law; however, for non-emergency transportation provider drivers, Insurer shall perform, or ensure performance of, a criminal background screening comparable to a level 1 background screening, as approved by AHCA for Florida Medicaid non-emergency transportation providers.

The minimum background screening process shall include a check of the following databases through a law enforcement agency or a professional background screener accredited by the National Association of Professional Background Screeners or a comparable standard: (a) Social Security Number Trace; and (b) Criminal Records (federal, state, and county criminal felony and misdemeanor, national criminal database for all states which make such data available).

Unless an exemption is granted by FHKC in writing, Insurer shall not allow any Person to have Access to such PHI, PII, or financial information if the Person's background screening reveals any of the following:

a. Any offense described in section 435.04(2) and (3), Florida Statutes;

b. Any offense relating to the criminal use of PII as described in chapter 817, Florida Statutes;

c. Any offense described in sections 812.0195, 815.04, or 815.08, Florida Statutes; or

d. Any offense that was subject to criminal penalties for the misuse of PHI under 42 U.S.C. § 1320d-5.

The look-back period for such background screenings shall be for a minimum of ten (10) years where ten (10) years of historical information is available.

Insurer warrants that all Persons will have passed the background screening described herein before they have Access to PHI, PII, or financial information, and all Persons will undergo a background screening every five (5) years thereafter. Insurer shall maintain documentation of all background screening records pursuant to section 10 Record Retention.

Insurer shall develop policies and procedures related to the background screening requirement, including a procedure to grant an exemption from disqualification for disqualifying offenses revealed by background screening, as described in section 435.07, Florida Statutes. Insurer must submit such policies and procedures to FHKC for approval by the date required in the approved implementation plan.

Insurer is responsible for all costs and expenses in obtaining and maintaining the criminal background screening information for each Person described above. Insurer shall maintain documentation of the background screening, and FHKC may review any Person's background screening file upon request. Insurer shall abide by all applicable laws, rules, and regulations including the Fair Credit Reporting Act and equal opportunity laws, rules, regulations, or ordinances.

Insurer shall be liable for Financial Consequences in the amount of one thousand dollars ($1,000) per Person per month for each month in which Insurer failed to timely complete the background screening for such Person(s). Financial Consequences also apply to Subcontractors in the same manner.

Insurer shall provide an annual attestation of compliance with this section.

3.17.2 Alternative background screening for Subcontractors

FHKC may waive level 2 background screening requirements set forth in section 3.17.1 for a Subcontractor if the Subcontractor meets one of the following two circumstances:

1. Subcontractor, at no fault of its own, is unable to comply; OR

2. Subcontractor refuses to agree to the background screening requirements and:

- Insurer has made significant good-faith efforts to obtain the Subcontractor's agreement; AND

- Subcontractor provides goods or services that are reasonably expected to cause undesirable disruption for Enrollees should Subcontractor cease/delay provision of such goods or services, such as benefit or claims administration/processing (including Medical Necessity reviews and similar review activities) and Provider network processing (including credentialing/recredentialing activities and similar contracting activities); OR

- Subcontractor is the only vendor that can reasonably provide the goods or services.

If FHKC agrees with Insurer's request to waive the level 2 background screening requirements, Subcontractor must meet the following requirements:

1. Subcontractor must conduct each of the following record checks for all employees:

    - Civil lawsuits, federal, and county level
    - Criminal case searches:
        - County level, all 50 states
        - State level, all 50 states
        - Federal level
        - Department of Justice
        - Global
    - Other searches:
        - Office of Foreign Assets Control (international economic and trade sanctions)
        - Fraud Abuse Control Information System (FACIS) (sanctions from federal administrative agencies, e.g., OIG, DEA, FDA).
        - Consent Based Social Security Number Verification (CBSV)
        - Social Security Number trace
        - Global sanctions (international sanctioning bodies, etc.)
        - Licensure verification (professional license and any administrative action)
        - Credit report
        - Driver license records
        - Education verification
        - Employment verification

2. Insurer and/or Subcontractor shall not allow any employee to perform work under the Subcontract if the background screening determines:

- The employee would be precluded from any type of employment under Section 435.04(2)-(4), Florida Statutes;

- The employee has violated sections 812.0195, 815.04, 815.06, or 817.568, Florida Statutes; or

- The employee has violated 42 U.S.C. 1320d-5.

3. Subcontractor shall maintain a blanket fidelity bond on all personnel in its employment during the life of the Subcontract. The bond shall be issued in the amount of at least $500,000 per occurrence. The surety company issuing the bond must comply with the provisions of Chapter 624, Florida Statutes. The bond shall protect FHKC and Insurer from any losses sustained through any fraudulent or dishonest act or acts committed by any of Subcontractor's employees. Proof of coverage shall be submitted to and approved by FHKC prior to Subcontractor performing any services or deliverables under the Subcontract.

4. Subcontractors that refused to agree to the background screening requirements set forth in section 3.17.1 must provide a performance bond in the amount of $100,000 with both Insurer and FHKC as beneficiaries.

5. Insurer must increase the frequency with which it reviews and audits the Subcontractor. The frequency of reviews and audits will vary depending on the circumstances, including goods or services provided by the Subcontractor and other factors. FHKC and Insurer will determine review and audit requirements on a case-by-case basis.

In its sole discretion, FHKC may require any additional requirements that the Subcontractor, Insurer, and/or employees must meet.

FHKC will review all requests to waive the background screening requirements on a case-by-case basis. In its sole discretion, FHKC may approve, reject, modify, or limit any request to waive the level 2 background screening requirement.

3.18 Drug Free Workplace Program

Insurer agrees to implement a drug free workplace program as defined in section 287.087, Florida Statutes, throughout the Contract Term. The Parties agree that failure to comply with this section shall constitute an Event of Default and shall be grounds for termination of this Contract in accordance with section 44.

3.19 Insurer's Property

Insurer, at no cost to FHKC, shall furnish, install, operate, and maintain all property required to perform Insurer's obligations under this Contract. FHKC and its authorized agent, provided such agent is not a competitor of Insurer, reserve the right to inspect the area in Insurer's facilities where services are performed at any time.

3.20 Liquidated Damages for Late Notice Under Business Associate Agreement

If Insurer fails to provide timely notice to individuals as provided in Sections 4.5 and 4.6 of the Business Associate Agreement, then FHKC shall be entitled to liquidated damages equal to one thousand dollars ($1,000) per day for the first thirty (30) Calendar Days; thereafter, liquidated damages will equal one thousand dollars ($1,000) per day plus fifty thousand dollars ($50,000) for each thirty (30) Calendar Day period (prorated if less than thirty (30) Calendar Days) from the date Insurer was required to provide notice to individuals. These liquidated damages shall cover FHKC's internal staffing and administrative costs as well as the diminished value of services provided under this Contract. Such costs and damages are not readily ascertainable. These liquidated damages and corresponding invoice credits shall not exceed five hundred thousand dollars ($500,000) per event. FHKC may choose to offset these liquidated damages owed by Insurer from any payments owed to Insurer or may choose to require Insurer pay the liquidated damages by electronic fund transfer or check.

Section 4: Subcontractors

Insurer may delegate performance of work required under this Contract to Subcontractors with prior written approval from FHKC; however, Insurer maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Contract. Insurer is responsible to FHKC for all acts or omissions of Subcontractors that Insurer utilizes during the Contract Term to the same extent that Insurer would be responsible to FHKC if Insurer had performed such service. FHKC has no liability of any kind for any Subcontractor demands, losses, damage, negligence or direct or indirect expenses. If Insurer lets any Subcontract, Insurer must, when applicable, take affirmative steps to assure that small and minority businesses, women's business enterprises, and labor surplus area firms are used when possible and in accordance with 45 CFR 75.330(b)(1)-(5).

In the event FHKC determines a Subcontract is not in compliance with the requirements of this Contract, Insurer must correct the deficiency to receive FHKC approval. FHKC has the right to withhold approval of any Subcontracts or amendments to approved Subcontractor contracts.

Insurer shall submit any proposed new or amended Subcontracts to FHKC for review at least ninety (90) Calendar Days before the proposed effective date of the delegation or amendment.

FHKC may, at its sole discretion, waive the submission timeframe upon Insurer request and evidence of good cause.

All requests for Subcontractor approval shall include a copy of the Subcontract. If a request solely involves an amendment, Insurer may submit the proposed amendment without a copy of the approved Subcontract in effect with prior approval from FHKC.

Insurer shall provide Subcontractor disclosures pursuant to 42 CFR 457.1285, which incorporates 42 CFR 438.608(c).

Insurer shall provide the following information about Insurer's Grievance and Appeal process to applicable Subcontractors upon entrance into the Subcontract in accordance with 42 CFR 457.1260, which incorporates 42 CFR 438.414:

a. The right to file Grievances and Appeals;

b. The requirements and timeframes for filing a Grievance or Appeal;

c. The availability of assistance in the filing process; and

d. The right to request an independent review after Insurer has made an adverse Appeal determination.

Insurer shall ensure that its Subcontractors are required to submit necessary data to Insurer within a timeframe that allows Insurer to comply with the requirements of 42 CFR 457.730.

Insurer's failure to comply with the provisions of this section shall constitute an Event of Default.

4.1 Subcontracts

Insurer must enter into a written Subcontract with all Subcontractors. All Subcontracts must be executed by both Insurer and the Subcontractor before the Subcontractor begins work directly or indirectly related to this Contract. Insurer shall provide any executed Subcontract to FHKC within seven (7) Business Days after request of such documents.

The Subcontract shall:

a. Specify the delegated activities or obligations, including related reporting responsibilities;
b. Require performance of the delegated activities and reporting responsibilities specified in compliance with Insurer's obligations under this Contract, including section 3.3;
c. Provide for the revocation of the delegation of activities or obligations or specify other remedies in instances where either Party determine that the Subcontractor has not performed in accordance with the requirements of the Subcontract or this Contract;

d. Subcontractor shall not contract with an entity to perform services without prior written approval by FHKC;
e. Require compliance with all applicable laws, regulations and subregulatory guidance and contract provisions, including audit and record retention requirements; and
f. Require Subcontractor to maintain complete and accurate records.

If the Subcontractor delegation involves coverage of services and claims payment, the Subcontract shall require the Subcontractor to implement and maintain arrangements or procedures designed to detect and prevent Fraud, Waste, and Abuse.

If the Subcontractor delegation is for management of Covered Services, the Subcontract shall also include the following in the Subcontractor approval request:

a. Documentation supporting network adequacy and capacity to serve, as applicable for the specific delegations;
b. Copy of applicable licensure, as appropriate;
c. Specification of the Regions covered by the Subcontractor;
d. Description of Insurer's plan to monitor compliance; and
e. Confirmation of the Subcontractor's ability to accurately process and pass claims and encounter data to Insurer in a manner that can be stored and utilized by Insurer, including seamless passthrough to FHKC, AHCA, and their designees. The confirmation shall include a summary description of Insurer's testing activities with the proposed Subcontractor.

4.2 Subcontractor Monitoring

Insurer shall conduct routine monitoring of all Subcontractors. Insurer shall also conduct risk assessments of all Subcontractors and their delegated activities related to this Contract. The outcome of the risk assessment shall directly inform Insurer's Subcontractor monitoring plan. Insurer shall conduct non-routine monitoring, as needed. Insurer shall provide a Subcontractor monitoring schedule for all Subcontractors by the date established in the approved implementation plan and then annually by June 1st.

Insurer shall provide a quarterly summary of Subcontractor monitoring, including any findings and corrective action taken during the quarter. FHKC, at FHKC's sole discretion, may require more frequent reporting based on Insurer's performance, the Subcontractor's performance, other risk, or the perceived value of increased reporting frequency.

Insurer shall have a contingency plan for each Subcontractor to safeguard performance of the delegated obligations should the Subcontractor cease to perform or inadequately perform its obligations under the Subcontract.

In the event FHKC determines a Subcontractor is not in compliance with the requirements of this Contract, Insurer shall promptly correct the Subcontractor's non-compliance. Insurer shall

inform FHKC of any Subcontractor termination, in whole or in part, within the following timeframes:

a. For Subcontractors delegated management of a Covered Benefit: ninety (90) Calendar Days prior to termination or expiration of the Subcontract;
b. For Subcontractors terminated for cause: three (3) Business Days of the earlier of the date Insurer notifies Subcontractor of intention to terminate the Subcontract or the date of termination; and
c. For all others: thirty (30) Calendar Days prior to termination the Subcontract. In the event the termination is unforeseeable, Insurer shall notify FHKC within seven (7) Calendar Days of the termination.

4.3 Subcontractor Solvency

In the event Insurer learns that a Subcontractor has become insolvent or is at unacceptable risk for insolvency, Insurer shall promptly cease delegation of any obligations directly or indirectly related to this Contract to Subcontractor.

Insurer shall notify FHKC within one (1) Business Day of the insolvency or the filing of a petition for bankruptcy by or against a Subcontractor.

FHKC, at its sole discretion, may choose to continue or terminate this Contract in the event any of Insurer's Subcontractors file a petition for bankruptcy or for approval of a plan of reorganization or arrangement under the Bankruptcy Act.

4.4 Failure to Perform

Each time Insurer fails to obtain the necessary Subcontractor approvals or otherwise fails to perform a material obligation under section 4, the resulting damages to FHKC will not be readily ascertainable; therefore, FHKC shall be entitled to credit the monthly invoice for liquidated damages equal to 10 thousand dollars ($10,000) per occurrence. This invoice credit shall cover FHKC's internal staffing and administrative costs as well as the diminished value of services provided under the Contract. Insurer's failure to perform these obligations shall also be an Event of Default, subject to cure upon Notice from FHKC as provided in section 44.10 and will entitle FHKC to recover any other damages it incurs (including any actual out-of-pocket expenses incurred by FHKC to investigate and remediate the violation) and to pursue injunctive relief.

Section 5: Systems; Security

Insurer shall maintain policies, procedures, and practices related to system security and integrity that are in line with national industry standards and best practices. At least annually, Insurer shall review and update its policies, procedures, and practices for the following areas:

a. Access Control;
b. Incident Response;
c. Data Loss Prevention;
d. Disaster Recovery;
e. Telework and remote access; and
f. Information and Data security.

Insurer shall provide ninety (90) Calendar Days' prior notice of any planned, significant system changes, including changes or upgrades to claims processing, customer service, enrollment, or operating systems or any other systems that may materially impact services provided under this Contract.

Insurer shall notify FHKC within three (3) Business Days of identification of any issues impacting Insurer's claims processing related to this Contract.

Insurer's mail gateways shall be capable of sending and receiving encrypted emails for all services related to this Contract. Insurer's use of an email gateway using a Transport Layer Security 1.2 connection satisfies this requirement. Insurer shall send only encrypted emails when such email contains PHI or PII.

Insurer shall obtain a National Institute of Standards and Technology (NIST) compliant information security risk assessment conducted by an independent third party at least every three (3) years or be HITRUST certified. Insurer must obtain the first assessment within the first Contract Year unless Insurer completed such an assessment within two (2) years prior to the Contract Effective Date. An independent assessment following the NIST SP 800-30 guidance, or its successor, satisfies this requirement.

5.1 Loss of Data

In the event of loss of any Data where such loss is not due to FHKC's action, Insurer shall provide Notice within 24 hours of such loss and be responsible for recreating such lost Data in the manner it existed or in a comparable manner reasonably acceptable to FHKC and on a reasonable schedule set by FHKC.

5.2 Security Officers

Each Party will provide an employee to serve as a security officer. Each Party's security officer will work with the other Party's security officer with respect to security matters and related issues concerning the Contract. This does not preclude either security officer from working on other matters unrelated to the Contract. Insurer's security officer shall oversee security issues at Insurer facilities where services are provided.

5.3 Security Incidents

In accordance with Attachment B, Business Associate Agreement, Insurer shall report all security incidents (as defined in Attachment B) to FHKC. Insurer shall be liable for Financial Consequences in the amount of five hundred dollars ($500) per Calendar Day for failure to provide all necessary information to FHKC in the format and timeframe required. Financial Consequences apply to each Calendar Day beyond the due date until provided to FHKC in the required format, inclusive of the day provided to FHKC.

5.4 Health Information System

Insurer shall maintain a health information system that collects, analyzes, integrates and reports data, including utilization, claims, and Grievances and Appeals.

Insurer shall implement and maintain health information systems as required by 42 CFR 438.242(a), (b)(1) through (4), (c), (d), and (e), including:

a. Complying with Section 6504(a) of the Affordable Care Act;

b. Collecting Data on Enrollee and Provider characteristics;

c. Collecting Data on all services provided to Enrollees through an encounter Data system, including Data sufficient to identify the Provider who delivers any item or service to Enrollees;

d. Ensuring that Data received from Providers is accurate and complete by:

    i. Verifying the accuracy and timeliness of reported Data, including Data reported by Providers with a capitated payment arrangement;

    ii. Screening the Data for completeness, logic and consistency; and

    iii. Collecting Data from Providers in standardized formats to the extent feasible and appropriate.

e. Making all collected Data available to FHKC, AHCA, and CMS, upon request.

Insurer shall also implement and maintain a publicly accessible standards-based Application Programming Interface (API), as required by 42 CFR 457.760 and 457.1233(d).

5.5 Continuity of Operations Plan

Insurer shall have a continuity of operations plan (COOP) or disaster recovery and business continuation plan, along with corresponding policies and procedures, that:

a. Include alternate locations for the provision of key services to Enrollees and Providers such as:

i. Member Services
ii. Claims processing
iii. Appeals and Grievances

b. Maintains information systems backups in a manner that mitigates disruption of service (including system Access) and ensures against loss of Data and Data integrity due to hardware or software failures, operational errors, destruction (physical and otherwise), and malicious attacks, including:

   i. Alternate locations for Data storage or other means of off-site Data backup;

   ii. Safeguards and regular testing against malicious external activities; and

   iii. Appropriate partitioning and system monitoring to mitigate the risk of malicious and inadvertent harmful actions by internal parties.

c. Include regular, periodic testing of such plans, policies, and procedures, including identification and timely correction of any failures, errors, or opportunities for improvement. At a minimum, Insurer shall conduct at least one (1) mock-disaster exercise per Contract Year.

d. Appropriately consider Access and use of PHI and PII.

e. Is reviewed and updated by Insurer on a regular basis, and no less than annually.

Insurer shall cooperate with FHKC's COOP, including providing a designated emergency contact to provide and receive status updates.

5.6 Telework and Telecommuting

Insurer shall maintain policies and procedures for telework (i.e., user Access from a facility where Data does not reside) and telecommuting (i.e., user Access from home or travel (e.g., hotel) environment). For purposes of this section, "telework" includes "telecommuting". Telework policies, procedures, and other related documents shall meet the standards required for compliance with all laws and regulations, including HIPAA and the Gramm-Leach-Bliley Act.

In addition, Insurer's telework policies and procedures shall at least meet the minimum recommendations and best practices identified in the National Institute of Standards and Technology (NIST) Special Publication 800-53 Rev 4, AC-17, Baseline Allocation Moderate, and NIST, U.S. Department of Commerce Special Publication 800-46, Revision 2 or its replacement, including the minimum recommendations and best practices contained in relevant cross-referenced NIST publications. Insurer shall conduct and consider risk assessments when developing, implementing, or changing its telework security policy, particularly for those aspects of the telework security policy for which various approaches may provide acceptable safeguards or for which unauthorized Access to PHI or PII is likely to occur without appropriate safeguards.

Insurer shall require multifactor authentication or more stringent practices for any level of remote Access.

Upon request, Insurer shall provide FHKC with enough information to assure FHKC that appropriate policies, procedures, and practices are in place. Such release of information is not required to be at the level of detail that may present a notable security risk.

5.7 Single Sign-On

Insurer shall implement single sign-on between FHKC's Enrollee portal and Insurer's Enrollee portal at the direction of FHKC, subject to the Parties' abilities to satisfy the security requirements of the other Party. Insurer shall cooperate with FHKC during all stages of implementing single sign-on, including any exploratory or information gathering stages. FHKC shall determine any project timeframes, including the final effective date; however, Insurer shall assist FHKC in determining reasonable timeframes by providing any information requested by FHKC.

Section 6: Confidentiality and Public Records

6.1 Confidentiality

Insurer shall treat all information obtained through its performance under this Contract as confidential to the extent such information is protected under Florida and federal law. Insurer shall not use any information except as necessary for the proper discharge of its obligations under this Contract.

Insurer shall not use or disclose any PHI, PII or other identified information obtained through its performance under this Contract, except as allowed under this Contract and Florida and federal laws, including HIPAA and Sections 624.91 and 409.821, Florida Statutes, and Chapter 119, Florida Statutes. Such information shall not be disclosed without the written consent of FHKC, the Applicant, or the Enrollee, except as otherwise required under Florida or federal law.

This provision does not prohibit the disclosure of information in summary, statistical or other de-identified forms.

The Parties agree to maintain the integrity of the other Party's confidential, trade secret or proprietary information to the extent provided under the law and this Contract. Neither Party will disclose or allow others to disclose the other Party's confidential, trade secret or proprietary information except as provided by law or this Contract.

6.2 Marked and Redacted Copies of Confidential Information

Records produced or used in relation to the performance of this Contract may be subject to chapter 119, Florida Statutes. If Insurer considers any portion of any documents, Data, or

records submitted to FHKC to be Confidential Information, Insurer must (i) clearly mark "CONFIDENTIAL INFORMATION" on every page that contains Confidential Information and (ii) simultaneously provide FHKC with a separate, redacted copy of the information it claims as exempt and briefly describe in writing the grounds for claiming exemption from the public records law, including the specific statutory citation for such exemption. This redacted copy shall contain the Contract name and number and shall be clearly titled "Redacted Copy." The redacted copy should only redact those portions of material that Insurer claims are confidential, proprietary, trade secret, or otherwise not subject to disclosure. The following methods of redacting are not sufficient for designating information as confidential, proprietary, trade secret, or otherwise not subject to disclosure:

a. Statements to the effect that the record "may" contain confidential, trade secret, proprietary, or exempt information;

b. Designations outside the body of the record such as in an electronic document title or in the body of an email providing the record; or

c. Placement or formatting that interferes with FHKC's ability to access the information such as using an opaque watermark.

Insurer is solely responsible for ensuring the adequacy and completeness of any redactions.

If Insurer fails to submit a redacted copy of information it claims is confidential, proprietary, trade secret, or otherwise not subject to disclosure, FHKC is authorized to produce the entire documents, Data, or records in response to a public records request or other lawful request for those records.

Records in which the sole Confidential Information is PHI or PII are excluded from this redaction requirement.

6.3 Request for Confidential Information

In the event of a public records or other disclosure request pursuant to Chapter 119, Florida Statutes, the Florida Constitution or other authority, to which redacted documents are responsive, FHKC will provide Insurer-redacted copies to the requestor. If a requestor asserts a right to the Confidential Information, FHKC will notify Insurer such an assertion has been made. It is Insurer's responsibility to assert that the Confidential Information is not subject to disclosure under Chapter 119, Florida Statutes, or other applicable law. If FHKC becomes subject to a demand for discovery or disclosure under legal process regarding the Confidential Information, FHKC shall give Insurer prompt Notice of the demand prior to releasing the information (unless otherwise prohibited by applicable law). Insurer shall be responsible for defending its determination that the redacted portions of its records are confidential, proprietary, trade secret, or otherwise not subject to disclosure.

6.4 Public Records Indemnification

Insurer shall protect, defend, and indemnify FHKC for any third-party claims, suits, proceedings of any kind, demands, losses, damages, costs, or expenses (including attorneys' fees, outside counsel attorneys' fees, and court costs) arising from or relating to Insurer's determination that any portion of any document, Data, or record submitted by Insurer to FHKC is confidential, proprietary, trade secret, or otherwise not subject to disclosure.

6.5 Insurer as Agent

Insurer agrees to advise FHKC prior to the release of any information in response to a request for public records and, upon FHKC's request, provide FHKC with a copy of the requested records at no cost. All records stored electronically must be provided to FHKC in a format that is compatible with the FHKC's information technology systems.

Section 409.821, Florida Statutes, provides certain public records exemptions to Florida KidCare documents. If, under this Contract, Insurer is providing services and is acting on behalf of a public agency, as provided by Section 119.0701, Florida Statutes, Insurer shall:

a. Keep and maintain public records required by the public agency to perform the service.

b. Upon request from the public agency's custodian of public records, provide the public agency with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in this chapter or as otherwise provided by law.

c. Ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of the Contract term and following completion of the Contract if Insurer does not transfer the records to the public agency.

d. Upon completion of the Contract, transfer, at no cost, to the public agency all public records in possession of the Insurer or keep and maintain public records required by the public agency to perform the service. If Insurer transfers all public records to the public agency upon completion of the Contract, the Insurer shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If Insurer keeps and maintains public records upon completion of the Contract, Insurer shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the public agency, upon request from the public agency's custodian of public records, in a format that is compatible with the information technology systems of the public agency.

e. **IF INSURER HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO INSURER'S DUTY TO PROVIDE PUBLIC**

RECORDS RELATING TO THIS CONTRACT, CONTACT THE EMAIL ADDRESS AND MAILING ADDRESS PROVIDED FOR THE CONTRACT MANAGER.

6.6 Access to records

Insurer recognizes and acknowledges the requirements of chapter 119, Florida Statutes, and Article I, Section 24 of the Florida Constitution. Upon reasonable notice, Insurer shall provide FHKC with reasonable access to inspect and copy all public records and information, including physical and electronic records and information, related to or created as a result of this Contract. Except as expressly provided herein, under no circumstances whatsoever shall Insurer refuse to provide, delay, or prohibit FHKC's access to public records in the possession of Insurer or its Subcontractors.

6.7 Insurer's Failure to Comply

Insurer must allow public access to all documents, papers, letters, or other material made or received by Insurer in conjunction with the Contract, unless the records are exempt from Article I §24(a) of the Florida Constitution and chapter 119.07, Florida Statutes. FHKC may unilaterally terminate this Contract for Insurer's failure to comply with this section.

Section 7: Intellectual Property

Intellectual Property Rights existing prior to the execution of this Contract will remain with the respective Party. In the event of a dispute, Insurer is responsible for producing evidence substantiating prior ownership of the intellectual property. Intellectual property developed by Insurer specifically for FHKC under this Contract shall be the property of FHKC.

FHKC shall have unlimited rights to use, disclose, and duplicate all information and Data developed, derived, or provided by Insurer under this Contract regardless of whether such information and Data is copyrightable, patentable, or trademarkable.

Insurer's use of intellectual property in connection with this Contract that results in any royalties or costs are understood to be included in Insurer's compensation under this Contract and shall not be charged to FHKC.

Insurer shall indemnify and hold FHKC harmless from any third-party claim or action and any loss, liability, damage, or expense (including attorneys' fees, outside counsel attorneys' fees, and court costs) resulting from any intellectual property provided by Insurer to the extent such claim, action, loss, liability, damage, or expense results from or is based on a claim or allegation that the Intellectual Property infringes a U.S. patent, copyright, or a trade secret of a third party. Insurer shall not be held liable when such a claim results solely from FHKC's alteration of the intellectual property or solely from the combination, operation, or use of the intellectual property with material that was not provided by Insurer or a Subcontractor.

If any services are, or in Insurer's opinion likely to be, held to be infringing, Insurer shall at its expense and option either: (i) procure the right for FHKC to continue using it, (ii) replace it, as approved by FHKC, with a non-infringing product or service equivalent in function and capabilities, or (iii) modify it, as approved by FHKC, to make it non-infringing but equivalent in function and capabilities. This section shall survive termination and expiration of the Contract.

Section 8: Documents and Data

In the course of Insurer's performance of this Contract, Insurer agrees that Data and FHKC-generated data is and shall remain the sole and exclusive property of FHKC, free and clear of any and all claims of Insurer.

All Data and FHKC-generated data shall be immediately delivered to FHKC in the format to be mutually agreed upon by the Parties as requested or upon commencement of transition as set forth in section 45.

Section 9: Financial Requirements

9.1 General Financial Requirements

At a minimum, Insurer shall meet the solvency requirements necessary to maintain a certificate of authority in the State of Florida, as determined by the applicable laws and regulations and the Office of Insurance Regulation.

In no event shall FHKC or Enrollees be held liable for Insurer's debt. Insurer shall make sufficient provision against the risk of insolvency to ensure Enrollees will not be liable for Insurer's debt in the event Insurer becomes insolvent.

Insurer shall provide Insurer's audited financial statements to FHKC for Insurer's preceding fiscal year by July 1st each year.

Failure to comply with the solvency requirements of this provision constitutes an Event of Default and renders the Contract subject to unilateral cancellation by FHKC, at FHKC's sole discretion.

9.2 Bankruptcy

Insurer shall provide FHKC Notice of intent to petition for bankruptcy or reorganization or arrangement at the time of the filing and immediately provide a copy of such filing to FHKC. In the event FHKC chooses to terminate the Contract in accordance with section 44.5 Termination for Insolvency or Bankruptcy, FHKC shall provide Insurer thirty (30) Calendar Days' Notice.

9.3 Enrollee Protections from Collection

Neither Insurer nor any representative of Insurer shall collect or attempt to collect from an Enrollee any money for services covered by the Program or any monies owed to Insurer by FHKC.

In no event shall an Enrollee be held liable for monies Insurer owes to a Provider for Covered Services. If a Provider is paid less than billed charges, neither the Provider nor Insurer may hold the Enrollee liable for the remainder of the charges. Enrollees shall remain responsible for any applicable Copayment. Insurer shall include such a prohibition in all Provider contracts for Insurer's Florida Healthy Kids network.

Insurer shall indemnify, defend, and hold Enrollees harmless from all financial loss caused by Insurer's failure to comply with this Contract or state or federal laws or regulations.

9.4 Third Party Liability

9.4.1 Subrogation Rights

In the event Insurer provides a Covered Service to an Enrollee for which a third party is liable, and the Enrollee received third-party payment for those medical expenses, Insurer shall seek reimbursement from the third party or Enrollee for the actual cost of benefits provided.

Insurer is not entitled to reimbursement in excess of the Enrollee's monetary recovery for medical expenses provided from the third party.

9.4.2 Coordination of Benefits

In accordance with Section 624.91(5)(c), Florida Statutes, Florida Healthy Kids insurers are the payers of last resort.

Insurer shall coordinate benefits with any other third-party payer that may be liable for an Enrollee's medical care. Insurer shall adhere to the third-party liability requirements at 1902(a)(25) of the Act and section 53102 of the Bipartisan Budget Act of 2018, including cost avoidance and "pay and chase" requirements.

Insurer shall notify FHKC of any Enrollees Insurer identifies as covered under other health insurance by the fifteenth (15^{th}) day of each month. At a minimum, Insurer shall include the Enrollee's name, Florida Healthy Kids member ID, identification of the other carrier, and the effective and termination dates of the other coverage, if available. Insurer shall identify any Enrollees as having other coverage through Florida Medicaid separately.

Insurer shall coordinate benefits with any insurer under contract with FHKC to provide comprehensive dental care benefits to Enrollees, including the provision of prescription coverage for prescriptions prescribed by the Enrollee's dental Provider.

9.5 Medical Loss Ratio

The minimum medical loss ratio (MLR) for each rating period is eighty-five percent (85%).

Likewise, the maximum non-benefit premium component for each rating period shall not exceed fifteen percent (15%). Insurer shall identify what components and subcomponents have been included in its non-benefit expenses, as required by FHKC.

The MLR shall be calculated in accordance with 42 CFR 457.1203, which incorporates 42 CFR 438.8.

FHKC may issue additional written guidance on the definition of medical expense or non-benefit expense to Insurer. Federal and state regulations impacting the calculation of MLRs or non-benefit expense requirements may also be applicable. To the extent permissible by law, FHKC may choose to adopt such regulations early or adopt such regulations that would not otherwise be applicable. Should such guidelines be applied, FHKC shall notify Insurer in writing.

In the event Insurer achieves an MLR less than eighty-five percent (85%) for the rating period, Insurer shall return one hundred percent (100%) of the difference between the actual MLR and the minimum MLR to FHKC. Insurer's MLR rebate shall include both Insurer's Title XXI Enrollees and Insurer's Full-pay Enrollees in the Service Area; however, Insurer shall report the portion of the rebate attributable to the Title XXI Enrollees and the Full-pay Enrollees based on the respective proportion of Enrollee member months for the rating period.

9.5.1 MLR Reporting Requirements

Insurer shall provide a quarterly MLR report to FHKC in the format established by FHKC. The format established by FHKC shall include claims runout periods. The quarterly MLR report is an ongoing report. As such, Insurer shall update the report each quarter to include any additional claims information received since the prior report.

The quarterly MLR report is due as follows:

Reporting Quarter	**Due Date**
July 1 – September 30	November 30
October 1 – December 31	February 28
January 1 – March 30	May 31
April 1 – June 30	August 31

Insurer shall provide an updated annual MLR report with Insurer's premium rate adjustment request. Insurer shall also identify all non-benefit and medical expense payments to affiliate and subsidiary companies, including an explanation of the relationship.

9.5.2 Experience Adjustment Report

In addition to the quarterly and annual MLR report, Insurer shall provide an experience adjustment report for each Contract Year. The experience adjustment report due date is June 30th the following year.

The MLR rebate, if any, shall be calculated and provided based on the data included in this report. If any MLR rebate is owed to FHKC, Insurer shall remit such payment to FHKC no later than August 1st.

The experience adjustment report shall be in a format established by FHKC and include sufficient documentation, as determined by FHKC, to support Insurer's MLR calculation and to allow FHKC to evaluate the component and subcomponent expenses included. FHKC shall determine the adequacy of the information supplied and whether the MLR calculation is accurate.

Section 10: Record Retention

Insurer shall retain all records associated with this Contract for at least ten (10) years following the Contract Term or the completion of any audit, whichever is later. Such records include Enrollee Grievance and Appeal records described in 42 CFR 438.416, base data described in 42 CFR 438.5(c), medical loss ratio reports and data, and information and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608 and 42 CFR 438.610, as referenced in 42 CFR 438.3(u) incorporated by 42 CFR 457.1201(q).

Insurer shall maintain records and documentation in accordance with generally acceptable accounting principles sufficient to substantiate all administrative and Medical Services expenditures under this Contract.

Insurer shall securely store such records as appropriate for the contents of the record. Insurer is responsible for all storage costs associated with record maintenance under this Contract. Destruction of records is Insurer's responsibility.

Insurer shall retain the physical record for at least 90 days for any record converted into an electronic format, which shall be retained in accordance with the retention schedule.

At the end of the record retention period, Insurer shall consult with FHKC as necessary to assure an appropriate means of return and/or destruction of all records, including PHI and PII, and shall notify FHKC in writing when such destruction is complete. If PHI or PII is to be returned, the Parties shall document when all information has been received by FHKC.

Before Insurer returns and/or destroys records, Insurer shall provide such detail as requested by FHKC. In the event Insurer determines that returning or destroying records is not feasible,

Insurer shall provide to FHKC notification of the conditions that make return or destruction not feasible, and Insurer shall:

- Retain only those records necessary for Insurer to continue its proper management and administration or to carry out its legal responsibilities;
- Return to FHKC (or, if agreed to by FHKC, destroy) the remaining records that the BA still maintains in any form;
- Continue to use appropriate safeguards and comply with the HIPAA Security Rule with respect to PHI to prevent Access, acquisition, use, or disclosure of the PHI, other than as provided for in this section, for as long as Insurer retains the PHI;
- Not use or disclose PHI or PII retained by BA other than for the purposes for which such information was retained and subject to the same conditions set forth in Attachment B, Section 7, which applied prior to termination or expiration of the Contract; and
- Return to FHKC (or, if agreed to by FHKC, destroy) PHI or PII retained by Insurer when it is no longer needed by Insurer for its proper management and administration or to carry out its legal responsibilities.

At the end of the applicable retention period, Insurer shall return or destroy all records at FHKC's sole discretion. Destruction of records is Insurer's responsibility.

Failure to comply with this section may constitute an Event of Default and renders this Contract subject to termination by FHKC, at FHKC's sole discretion. Section 10 survives termination or expiration of the Contract.

Section 11: Audit Rights

FHKC, AHCA, AHCA's Office of Inspector General, CMS, HHS, HHS's Office of Inspector General, the Comptroller General of the U.S. and their designees, any insurer contracted with FHKC, or any state or federal agency authorized by law have authority to perform audits, investigations, inspections, and reviews. These entities may, at any time, inspect the premises, physical facilities, and equipment where and on which work related to this Contract is conducted.

All entities shall have access to electronic and physical records and Data in the possession of Insurer or its Subcontractors related to, or created as a result of, this Contract to fulfill their audit, investigation, inspection, and review responsibilities. The following records are specifically excluded from inspection, copying, and audit rights under this Contract, unless those documents would be required to be produced for inspection and copying under the

requirements of chapter 119, Florida Statutes; any other provision of the Florida Statutes, or Article I, Section 24, of the Florida Constitution; or any other state or federal law:

a. Financial and other internal company records of the Insurer or its Subcontractors that are not created or received in connection with this Contract;
b. Documents that are confidential attorney work product or subject to attorney-client privilege; and
c. Information of the Insurer or its agents, affiliates, or Subcontractors (to include any of their other customers) that is confidential, proprietary, or trade secret.

Insurer shall be responsible for the costs associated with the audits, investigations, inspections, and reviews. If practical, FHKC will use reasonable efforts to minimize the number and duration of such audits, investigations, inspections, and reviews and to conduct such audits, investigations, inspections, and reviews in a manner that will minimize the disruption to the Insurer's or its affiliates', agents', or Subcontractors' business operations.

FHKC agrees to share any of its audit findings with Insurer, and Insurer agrees to respond to audit findings within twenty (20) Business Days of receipt of the audit findings. FHKC may extend the date for responding to audit findings if Insurer is acting diligently and requests additional time.

Insurer shall cooperate in any evaluative efforts conducted by FHKC, FHKC's contracted Insurers, or authorized state or federal agencies during the Contract Term and for a period of at least ten (10) years following the Contract Term. These efforts may include a post-Contract audit. In the event records must be sent to FHKC, Insurer is responsible for production, delivery, and associated costs.

Under section 20.055(5), Florida Statutes, Insurer agrees and shall ensure its Subcontractors agree to cooperate with the inspector general in any investigation, audit, inspection, review, or hearing.

Insurer shall require any Subcontracts associated with this Contract to include this provision.

Failure to comply with this provision may constitute an Event of Default and may render this Contract subject to unilateral cancellation by FHKC as determined by FHKC in its sole discretion.

11.1 Audit Reports

At a minimum, FHKC shall conduct periodic audits of the accuracy, truthfulness, and completeness of encounter data and financial data submitted by, or on behalf of, Insurer. The results of such audits will be made available on FHKC's public website in accordance with 42 CFR 457.1285, which incorporates 42 CFR 438.602(g).

Insurer shall ensure an annual SOC 2 Type II audit is performed on its application hosting center and based upon the security requirements as outlined in section 5 of the Contract. Insurer shall provide a copy of the most recent audit report to FHKC by the date established in the approved implementation plan and annually thereafter by the date required by FHKC.

Section 12: Contract Management; Monitoring

Insurer shall comply with all provisions of this Contract and its amendments, if any, and shall act in good faith in the performance of the Contract. FHKC, in its sole discretion, may assess Insurer Financial Consequences up to five hundred dollars ($500) per incident of noncompliance. Such Financial Consequences shall not be assessed if other applicable Financial Consequences are assessed for the incident.

Insurer shall utilize written policies and procedures to implement all provisions of this Contract.

Insurer shall provide education and training to its staff, as appropriate and applicable to the staff members' duties, including education and training regarding advance directive policies and procedures. Insurer shall allow FHKC to participate in its formal training modules or sessions upon request.

12.1 FHKC Information and Access

Upon execution of the Contract, FHKC will, in accordance with this Contract, provide Insurer with timely information and access to operating guidelines, policies, procedures, information systems and databases, FHKC leadership, management, and employees in order for Insurer to perform the services contemplated in this Contract, including providing the reports and other documents specified in the Contract.

12.2 Meetings

Meetings between the Parties shall be held at the FHKC offices in Tallahassee, Florida, or via conference call, as determined by FHKC. Insurer shall be available to attend meetings or present requested information to other stakeholders, as directed by FHKC. Insurer shall not be entitled to additional compensation for any meeting preparation or attendance, including travel.

Upon FHKC request, Insurer shall provide to FHKC for approval a proposed agenda in advance of scheduled meeting dates. Insurer shall publish and distribute the approved agenda and related documents and/or handouts within the timeframe specified by FHKC. Insurer shall provide detailed and well-documented minutes of meetings as required by FHKC. Within three (3) Business Days after the meetings, Insurer shall provide draft meeting minutes to the contract manager for review, any correction, and approval.

12.3 Implementation; Readiness Assessment

Insurer shall ensure all resources needed for a timely and complete implementation are available so that all Covered Services will be fully provided, as determined by FHKC.

Insurer shall provide a final implementation plan for approval to FHKC within five (5) Business Days after Contract execution. Insurer may submit the implementation plan in Microsoft Excel or Microsoft Project.

At a minimum, the implementation plan shall include:

a. Each task necessary to fully implement this Contract;

b. The start and end dates for each task;

c. Any task dependencies;

d. Identification of key milestones;

e. The responsible Party for each task; and

f. Insurer's resource allocation for each task.

Insurer shall update the implementation plan weekly, or as specified by FHKC, until implementation is complete and accurate, as determined by FHKC. If FHKC determines the implementation plan is not complete or accurate, as determined by FHKC, Insurer shall have three (3) Business Days from notification of disapproval to submit a revised implementation plan for approval. The required frequency of the updated implementation plan submission may be changed with approval or direction from FHKC. Changes to task due dates require written approval from FHKC.

Insurer shall be liable for Financial Consequences equal to one thousand dollars ($1,000) per Calendar Day the implementation plan is late. Financial Consequences apply to each Calendar Day beyond the due date until provided to FHKC. Financial Consequences apply to the initial due date and to subsequent due dates should the implementation plan require revisions prior to FHKC approval and are limited to a total of fifteen thousand dollars ($15,000).

12.4 Account Management Team

Insurer shall assign an account management team to act as primary contacts for FHKC. The account management team shall include:

- An executive sponsor;
    - The executive sponsor must have decision-making authority for Insurer.

- The executive sponsor shall not be the same individual as the contract manager.

- A contract manager;
- A member services manager;
    - Insurer shall provide FHKC with a designated contact for escalated Enrollee issues. If Insurer chooses to designate an individual other than the member service manager as the designated contact, such individual shall be considered part of the account management team.
- A clinical specialist, clinical manager or medical director;
- A compliance manager;
- A finance senior manager, director or officer; and
- Other individuals identified as necessary by the Parties.

Insurer shall provide the name, email address, office telephone number, and business mailing address for each person on the account management team to FHKC at the time of Contract execution.

Insurer shall provide written notice to FHKC of any changes to the account management team designations or contact information no later than one (1) Business Day for the executive sponsor and contract manager and five (5) Business Days for any other individual.

Each member of the account management team shall:

a. Be knowledgeable about Insurer's operations relating, directly or indirectly, to Insurer's obligations under this Contract, insofar as such operations relate to his or her job duties.

b. Be knowledgeable about and able to coordinate with other Insurer contacts for work that falls outside of his or her responsibilities or scope of expertise;

c. Dedicate the time and resources necessary to manage FHKC's account, including reasonable availability for and responsiveness to telephonic and email communication and onsite meetings.

At a minimum, Insurer's contract manager, member services manager, and designated contact for escalated Enrollee issues shall provide a secondary contact and the secondary contact's information, including name, email address, and phone number, when the primary contact is out of the office or unavailable for extended periods.

This section is intended to provide FHKC with primary contacts for key Contract functions and shall not limit either Party from working with, directly or indirectly, additional individuals.

12.5 Contract Managers

Each Party shall designate a contract manager who will oversee the Party's performance of its obligations during the term of this Contract.

Each Party shall provide the name, email address, direct office telephone number and business mailing address to the other Party and maintain such information with the Contract. The Parties shall provide this information at the time of Contract execution.

Each Party shall provide written notice to the other Party of any changes to the contract manager designation or the contract manager's contact information no later than one (1) Business Day of the change. The Parties shall maintain the revised contract manager information with the Contract.

12.6 Monitoring

FHKC shall monitor, directly and indirectly, Insurer for compliance with this Contract, applicable federal and state laws and regulations, and the performance of the Insurer in relation to the Program.

In addition to the Data, documentation, and information specified in this Contract, Insurer must submit any other Data, documentation or information relating to the performance of Insurer's obligations under this Contract required by FHKC or the secretary of HHS.

Insurer shall regularly monitor its own performance under this Contract and the performance of any of its Subcontractors and Providers. Insurer's monitoring shall include:

a. Compliance with Insurer's obligations under this Contract; and

b. Insurer's performance, distinct from compliance, under this Contract related to:

    i. Financial management;

    ii. Management of care, including health outcomes, quality of care, case and disease management programs, and utilization review;

    iii. Satisfaction, including Enrollees and Providers;

    iv. Administrative processes, including claims processing and call center performance; and

    v. Quality improvement, including cultural competency, performance improvement projects, performance measures, and training provided to employees and, if applicable, Providers.

Insurer shall provide a quarterly report that includes cost and utilization information for key metrics identified by FHKC, including potentially preventable events. Insurer and FHKC shall

conduct quarterly meetings via conference calls (unless otherwise required by FHKC) to discuss the key metrics and performance guarantees. Insurer shall make staff with the appropriate knowledge and expertise available during these meetings and shall be prepared to discuss the report in detail as well as discuss any other relevant topics such as barriers to care, emerging trends and anticipated legislative actions.

12.7 Corrective Action Plans

FHKC may require Insurer to propose and implement a Corrective Action Plan (CAP) to address and correct the cause of deficiencies in Insurer's performance under this Contract, including failure to meet the performance guarantees in Attachment C and findings from the EQRO compliance validation. If Insurer's performance falls below the minimum level of performance for the same performance guarantee set forth in this Contract for three (3) or more consecutive measurement periods, Insurer shall provide a CAP to remediate the performance and prevent it from occurring in the future. This does not prevent FHKC from requiring a CAP prior to three (3) consecutive failures to meet a PG.

Insurer shall submit a CAP to FHKC for approval within seven (7) Business Days of such request from FHKC, unless FHKC requests another timeframe. The timeframe to provide the corrective action plan is inclusive of the date of request.

If the CAP is not subsequently approved by FHKC, Insurer shall submit a revised CAP within three (3) Business Days from the notification of FHKC's disapproval.

At a minimum, CAPs shall include a description of the problem being corrected, a description of the solution, and an implementation plan detailing the implementation of the solution with anticipated completion dates.

Insurer shall be liable for Financial Consequences of five hundred dollars ($500) per Calendar Day, limited to fifteen thousand dollars ($15,000) per incident for CAP-submission timeliness failures. Financial Consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the day provided to FHKC. Financial Consequences apply to the initial due date and to subsequent due dates should the CAP require revisions prior to FHKC approval.

Insurer shall submit CAP updates on a routine basis. The schedule for such updates shall be established individually for each CAP. Unless otherwise required by FHKC, Insurer shall recommend an update schedule for the CAP to FHKC for approval. Insurer shall be liable for Financial Consequences of one thousand dollars ($1,000) per Calendar Day, limited to thirty thousand dollars ($30,000) per incident, for failure to complete implementation of the approved CAP by the date established in the CAP schedule. Financial Consequences apply to each Calendar Day beyond the due date until the CAP is implemented, inclusive of the day implementation is complete.

12.8 Contract Termination or Expiration Transition Plan

Upon the termination or expiration of this Contract, Insurer shall ensure a smooth transition to any other insurer or contract.

Insurer shall provide a transition plan to FHKC for approval within ninety (90) Calendar Days before the termination or expiration date of this Contract. In the event the Contract terminates prior to the expiration date and Insurer is not given more than ninety (90) Calendar Days' Notice, Insurer shall provide a transition plan by the date specified by FHKC or, if no date is specified, within five (5) Business Days of Insurer's receipt of the termination Notice.

If the transition plan is not subsequently approved by FHKC, Insurer shall submit a revised transition plan within five (5) Business Days from the notification of FHKC's disapproval.

Insurer's failure to provide a timely transition plan acceptable to FHKC or failure to timely implement such transition plan, in whole or in part, shall be considered an Event of Default and failure to perform.

In such event Insurer shall be responsible for Financial Consequences in the amount of $1,000.00 (one thousand dollars) per day, as determined by FHKC. FHKC may also withhold payment to Insurer for nonperformance or unsatisfactory performance of the terms of this Contract.

This section survives termination or expiration of this Contract.

12.9 Performance Guarantees

Insurer's performance under this Contract is subject to the performance guarantees, including reporting requirements, and associated Financial Consequences established in Attachment C.

The inclusion of performance guarantees and the related Financial Consequences in this Contract is intended to address unsatisfactory performance in the context of ongoing operations without resort to the Event of Default remedies set forth in section 44.10. If Insurer's performance falls below the minimum level of performance for the same performance guarantee set forth in this Contract for three (3) consecutive measurement periods or fails to meet a total of five (5) or more performance standards in six (6) out of twelve (12) months (regardless of standard), and such failure is not otherwise excused, then FHKC may follow the process outlined in section 44.6 in lieu of accepting any Financial Consequences.

12.10 Financial Consequences

Insurer agrees the services provided under this Contract are critical to the success of FHKC's provision of quality services to Enrollees and the administration of the Program. Likewise, Insurer's performance of its obligations under this Contract in a timely and reliable manner and to a high-quality standard is significant to FHKC and FHKC's mission.

Insurer may be subject to Financial Consequences as described in this Contract for failure to perform its obligations as required. Financial Consequences are not liquidated damages and shall be assessed at FHKC's sole discretion. FHKC shall inform Insurer in writing of any Financial Consequences incurred. In accepting any Financial Consequences, FHKC does not waive its right to pursue a Corrective Action Plan as set forth in section 12.7 or other remedies for costs and damages not covered by any Financial Consequences.

Insurer may dispute or request a waiver of any Financial Consequences assessed by submitting such request in writing to FHKC's contract manager within five (5) Business Days of receipt of the Financial Consequences assessment. Requests shall clearly identify the Financial Consequences being assessed, provide a narrative describing Insurer's reasoning for the dispute or waiver request and include any supporting documentation. FHKC shall review and make a recommendation to the appropriate committee, if required, and respond to the request in writing. FHKC's decision shall be the final determination.

Insurer shall pay any Financial Consequences within forty-five (45) Calendar Days of notice of assessment. FHKC reserves the right to offset any Financial Consequences owed by Insurer from any payments owed to Insurer in the event Insurer fails to make timely payment.

Financial Consequences shall be capped at no more than ten percent (10%) of the premiums paid to Insurer in the month in which the Financial Consequences are assessed.

FHKC may waive Financial Consequences, in whole or in part, for any reason in its sole discretion. The waiver of Financial Consequences in one instance does not provide Insurer any right or expectation to future waived Financial Consequences under the same or any other circumstances.

12.11 Intermediate Sanctions

FHKC may impose intermediate sanctions in accordance with 42 CFR 438.700. In the event FHKC makes any of the following determinations based on findings from onsite surveys, complaints by Enrollees and others, financial status or any other source, sanctions may be imposed as listed. FHKC may impose any or all of the potential sanctions listed for a determination.

a. Insurer fails substantially to provide Medically Necessary services that Insurer is required to provide, under law or under this Contract, to an Enrollee.

    i. Potential Sanctions:

        1. Civil money penalties limited to twenty-five thousand dollars ($25,000) for each determination.

        2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.

3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.

4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

ii. FHKC may recommend that CMS impose denial of payment to the state for new Enrollees of Insurer. Such denial of payment from CMS automatically results in a denial of payment for such Enrollees from FHKC.

b. Insurer imposes premiums or charges on Enrollees that are in excess of the premiums or charges permitted under the Program.

i. Potential Sanctions:

1. Civil money penalties limited to the greater of twenty-five thousand dollars ($25,000) or double the amount of the excess charges.

2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.

3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.

4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

c. Insurer acts to discriminate among Enrollees or potential Enrollees on the basis of their health status or need for health care services, including termination of the enrollment or refusal to reenroll an Enrollee, except as permitted under this Contract, or any practice that would reasonably be expected to discourage enrollment by potential Enrollees whose medical condition or history indicates probable need for substantial future Covered Services.

i. Potential Sanctions:

1. Civil money penalties limited to fifteen thousand dollars ($15,000) for each person FHKC determines was not enrolled because of a discriminatory practice subject to an overall limit of one hundred thousand dollars ($100,000) for each determination.

2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.

3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.

4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

d. Insurer misrepresents or falsifies information that it furnishes to FHKC, the State of Florida, or CMS.

   i. Potential Sanctions:

      1. Civil money penalties limited to one hundred thousand dollars ($100,000) for each determination.

      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.

      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.

      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

e. Insurer misrepresents or falsifies information that it furnishes to an Enrollee, potential Enrollee, or Provider.

   i. Potential Sanctions:

      1. Civil money penalties limited to twenty-five thousand dollars ($25,000) for each determination.

      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.

      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.

      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

f. Insurer fails to comply with the requirements for physician incentive plans as required by law.

   i. Potential Sanctions:

1. Civil money penalties limited to twenty-five thousand dollars ($25,000) for each determination.
2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

g. Insurer has distributed directly, or indirectly through any agent or Subcontractor, Marketing materials that have not been approved by FHKC or that contain false or misleading information.

   i. Potential Sanctions:

      1. Civil money penalties limited to twenty-five thousand dollars ($25,000) for each determination.
      2. Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
      3. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      4. Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

h. Insurer has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.

   i. Potential Sanctions:

      1. Granting and notifying Enrollees the right to terminate enrollment with Insurer without cause.
      2. Suspension of new enrollment, including default enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
      3. Suspension of payment for Enrollees enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

Section 13: Force Majeure

Neither Party shall be responsible for delays or failure to perform its obligations under this Contract resulting from acts beyond the control of the Party. Such acts include blackouts, riots, acts of war, terrorism, epidemics, fire, communication line failure, power failure or shortage, fuel shortages, hurricanes, or other natural disasters.

Insurer remains responsible for delays or failures caused or contributed to by the fault or negligence of Insurer or its employees, agents, or Subcontractors even when such delay occurred during or because of an act beyond the control of Insurer, to the extent the delay was under the control of Insurer, its employees, agents, or Subcontractors.

For any delay of Insurer's performance, Insurer must provide Notice to FHKC that describes the cause of the delay or potential delay within the following timeframe, whichever occurs first: (i) five (5) Calendar Days after the cause or event first arose that creates the delay; (ii) five (5) Calendar Days after Insurer's knowledge of the cause or event that will create the delay, if Insurer could reasonably foresee that a delay could occur as a result; or (iii) if delay is not reasonably foreseeable, within five (5) Calendar Days after the date Insurer first had reason to believe that a delay could result.

If Insurer believes that any delay of its performance is attributable to an act or omission of FHKC, Insurer must provide Notice to FHKC that describes the cause of the delay within the following timeframe, as applicable: (i) five (5) Calendar Days after the cause that creates or will create the delay first arose, if Insurer could reasonably foresee that a delay could occur as a result, or (ii) if delay is not reasonably foreseeable, within five (5) Calendar Days after the date Insurer first had reason to believe that a delay could result.

Insurer's provision of Notice in strict accordance with this section 13 and section 38 is a condition precedent to any remedy. Insurer will not assert any claim for damages against FHKC arising from the delay events described above. Insurer's sole remedy for such delays shall be an extension of time, and Insurer shall not be entitled to an increase in the Contract price or payment of any kind from FHKC for direct, indirect, or consequential damages or expenses, impact costs, or other costs, including costs of acceleration or inefficiency, arising because of delay, disruption, interference, or hindrance from any such delay event. THE FOREGOING SHALL CONSTITUTE INSURER'S SOLE REMEDY OR EXCUSE WITH RESPECT TO DELAYS SET FORTH IN THIS SECTION.

Section 14: Waiver

A Party's delay or failure to exercise or enforce any of its rights under this Contract shall not constitute or be deemed a waiver of the Party's right thereafter to enforce those rights. Any single or partial exercise or enforcement of a right shall not preclude any other or further exercise or enforcement of such right or the exercise or enforcement of any other right.

FHKC maintains the right to waive, in whole or in part, any of Insurer's obligations under this Contract unless such waiver would result in unapproved noncompliance with any state or federal law or regulation or FHKC's contract with AHCA.

Section 15: Indemnification

Insurer shall indemnify, defend, and hold harmless FHKC and its FHKC's officers, directors, and employees and agents from and against any third-party claims, suits, proceedings of any kind, demands, losses, damages, costs, or expenses (including attorneys' fees, outside counsel attorneys' fees, and court costs) relating to acts or omissions bodily injury or death of any person or damage to real and/or tangible personal property directly caused or alleged to be caused by Insurer or its employees, principals, partners, agents, Subcontractors, and/or network Providers, whether acting alone or in collusion with others, in connection with the performance of this Contract.

FHKC agrees to provide written notice to Insurer of any demand for indemnity under this section. If a suit or proceeding is initiated for which Insurer must indemnify FHKC, then FHKC will reasonably cooperate with Insurer's defense of such suit or proceeding. Insurer may settle any claim, suit, or proceeding (at Insurer's sole expense) without FHKC's approval provided the settlement does not include any obligation and/or admission of FHKC. FHKC shall be entitled to attorneys' fees and court costs under this section.

Section 16: Liability

Except as otherwise set forth in this Contract, (i) neither FHKC nor Insurer shall be liable to the other Party or to any third party for any lost profits or any loss of business or any consequential, special losses, or damages of any kind; and (ii) the sole and exclusive remedy of Insurer and FHKC for any claim, loss, or damages in any way related to, or arising out of, this Contract or any services provided or anticipated to be provided shall be limited to such Party's actual, direct damages. None of the limitations expressed in (i) and (ii) shall preclude FHKC from seeking injunctive relief.

Section 17: Marketing

Insurer shall not engage in the Marketing of Insurer's Florida Healthy Kids plan without prior written approval from FHKC.

Insurer shall ensure Marketing materials meet the requirements of 42 CFR 457.1207, which incorporates 42 CFR 438.10.

Retention efforts directed at Enrollees are subject to all the requirements of this section. Retention efforts do not include activities conducted in the normal course of business, to

maintain or improve health outcomes, to maintain or improve quality of care, or to measure Enrollee satisfaction.

17.1 Florida KidCare Marketing

Insurer consents to the use of its name in any Marketing and advertising or media presentations describing Florida KidCare that are developed and disseminated by FHKC. Insurer consents to FHKC's use of a third-party Marketing representative as set forth in section 624.91(7)(a), Florida Statutes, applies to this Contract.

Insurer shall submit to FHKC all press releases and other publicity matters relating to this Contract or mentioning or referencing FHKC or any FHKC personnel. Insurer shall not publish or use press releases or publicity matters without obtaining FHKC's written consent, which will not be unreasonably withheld or delayed. This provision shall not apply to Insurer's marketing materials that merely list FHKC as a client.

Insurer shall not utilize the Marketing materials, logos, trade names, service marks, or other materials belonging to FHKC without FHKC's written consent. Written authorization must be received for each individual use or activity prior to use. As required by FHKC, Insurer agrees to cobrand marketing materials using logos, trade names, service marks, and other materials belonging to FHKC in conjunction with Insurer's own materials.

Insurer shall not utilize any Marketing materials, logos, trade names, service marks or other materials identifying Florida KidCare without obtaining prior written authorization from the state agency holding the rights to such names or marks.

17.2 Prohibited Statements

Insurer shall not make any written or oral statements suggesting that Enrollees or potential Enrollees must enroll with Insurer to obtain or retain Florida KidCare benefits.

Insurer shall not make any written or oral statements suggesting that Insurer is endorsed by FHKC, AHCA, CMS, or any other similar entity, including city or county governments.

Insurer shall not use superlatives (e.g., "the best," "highest ranked," "rated number 1") in Marketing materials unless such use is substantiated with supporting data provided to FHKC as a part of the Marketing activities review process.

Insurer shall not use superlatives in its logos or product tag lines (e.g., "XYZ Plan means the first in quality care," "XYZ Plan means the best in managed care"). This requirement does not prevent Insurer from using other statements in its logos or product tag lines (e.g., "Your health is our major concern," "Quality care is our pledge to you").

Insurer shall not compare itself to another insurer or health plan unless:

a. An independent study makes the comparison;

b. Insurer has received written agreement from all other insurers or health plans being compared; and

c. Insurer provides a complete copy of the independent study and written agreements.

17.3 Professional Integrity

At a minimum, Insurer shall maintain industry standards of professional integrity in conducting Marketing activities.

Insurer shall not distribute inaccurate, false, or misleading Marketing materials.

Insurer shall not use Marketing materials with negative statements about any other Florida Healthy Kids insurer or Insurer.

Insurer may not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

Insurer shall not require network Providers or facilities to distribute Marketing materials nor shall Insurer require or allow network Providers or facilities to distribute Marketing materials for Insurer at the exclusion of any other Florida Healthy Kids insurer with which the Provider or facility participates. Insurer shall not compensate any network Provider or facility for distributing Marketing materials.

17.4 Cold-call Marketing

Insurer shall not directly or indirectly engage in cold-call Marketing activities, including door-to-door contact, telephonic contact, email, or text message. This provision does not prohibit Insurer from communicating via these mediums in the course of business activities that are not cold-call Marketing activities.

If a person provides Insurer with permission to contact him or her, Insurer shall not interpret such permission as open-ended permission to contact the person:

a. After the initial inquiry has been resolved;

b. About topics outside the scope of the original inquiry; or

c. In a manner outside the scope of the original permission.

17.5 Geographic Distribution

Insurer shall not advertise outside its Service Area unless such advertising is unavoidable. For situations in which this is unavoidable, Insurer shall clearly disclose its Service Area.

Insurer shall distribute any approved Marketing materials to its entire Service Area. In the event Insurer’s responsibility to provide culturally competent services and communications

necessitates variations in Marketing materials among Regions in Insurer's Service Area, Insurer may make those changes necessary for a particular Marketing material to fulfill its cultural competency obligations without being considered noncompliant with this requirement.

17.6 Endorsements and Testimonials

Insurer may use product endorsements and testimonials, subject to the following limitations:

a. The speaker must identify Insurer by name;

b. If an individual is paid to portray a real or fictitious situation, the Marketing material must clearly state, "Paid endorsement";

c. Insurer shall not use quotes from Providers;

d. Insurer shall not use negative testimonials about other Florida Healthy Kids insurers or vendors;

e. Insurer shall not compensate potential enrollees for endorsement or promotion; and

f. Enrollees may endorse Insurer only if the Enrollee is currently enrolled with Insurer and voluntarily chooses to provide the endorsement.

Republication of a user's social media or other electronic media content or comment promoting is considered an endorsement or testimonial and is subject to the terms of this provision.

17.7 Marketing Events

Marketing events are subject to the approval of FHKC. Unless otherwise required by FHKC, prior approval from FHKC is waived for the following types of events:

a. Public events sponsored by a local government or state government;

    i. This includes events held primarily for participants of a city, county, or state-run program, such as sports clubs, art programs, and school-sponsored events.

b. Events held by non-profit youth organizations;

    i. Such organizations shall be approved for this waiver on an individual basis and may be approved at the national level.

    ii. Insurer shall submit a written request for approval for each youth organization Insurer would like to include in this waiver. Approval of a waiver for another Florida Healthy Kids insurer does not provide automatic waiver of the same organization for Insurer.

c. Events held by Providers in Insurer's network so long as Insurer ensures the Provider has extended the same invitation to all other Florida Healthy Kids insurers for which the Provider is a network Provider;

d. Other organizations approved by FHKC.

    i. Such organizations shall be approved for this waiver on an individual basis.

    ii. Insurer shall submit a written request for approval for each organization Insurer would like to include in this waiver. Approval of a waiver for another Florida Healthy Kids insurer does not provide automatic waiver of the same organization for Insurer.

    iii. Insurer shall submit the name, location and a description of the organization and their activities, whether such organization is non-profit or for-profit, a description of the events Insurer expects to attend, whether the events are open to the public or limited in any way, and any other information FHKC deems necessary.

Insurer shall only distribute FHKC-approved Marketing materials at events.

Insurer shall provide a quarterly report listing all events attended and events Insurer intended to attend, but which were cancelled or Insurer otherwise did not attend. At a minimum, such reports shall include:

a. Event name;

b. Date of event;

c. Location of event;

d. Host organization;

e. Anticipated participant attendance;

f. Actual participant attendance, if available; and

g. Indication that Insurer did not attend, as applicable, and the reason for non-attendance.

Insurer shall provide an annual report assessing Insurer's Marketing events. The annual Marketing events assessment shall include:

a. A summary breakdown of the types of events attended by:

    i. Organization type;

    ii. Region;

    iii. Overall event purpose; and

iv. Seasonal trends, if any.

b. An assessment of the Marketing events contribution to enrollment growth or maintenance;

c. A high-level summary of lessons learned; and

d. Any other information required by FHKC.

17.8 Nominal Gifts

Insurer may distribute nominal gifts to Applicants, Enrollees, or potential Enrollees so long as such gifts are:

a. Provided regardless of enrollment;

b. Valued at no more than fifteen dollars ($15) per item;

c. Valued at no more than seventy-five dollars ($75) in the aggregate per Enrollee on an annual basis; and

d. Not in the form of cash, gift cards, gift certificates, or other monetary rebates.

Nominal gifts require approval from FHKC prior to distribution.

17.9 Marketing Review Process

17.9.1 Marketing Materials

Insurer shall submit Marketing materials to FHKC for approval no less than thirty (30) Calendar Days prior to Insurer's intended utilization date, unless otherwise approved by FHKC. The total Marketing material review time from initial submission to final determination is dependent on multiple factors, including the condition of the original submission, the time Insurer takes to make any requested changes, and the size and complexity of the materials. This provision in no way guarantees a final determination within the thirty (30) Calendar Days.

For Marketing materials with multiple versions, Insurer shall submit a copy of each version with the request.

Insurer shall be responsive to FHKC's comments, questions, requests for more information, and other such requests. Failure to be responsive to such requests or failure to provide sufficient information or appropriate changes may result in delay or denial of Insurer's Marketing materials.

Insurer shall provide Marketing materials in the intended final format, including quality of images used and removal of watermarks from stock photos. Insurer may submit Marketing materials that include such marks as stock photo watermarks during the review period but must provide a copy of the final Marketing material with all such marks removed. Such

Marketing materials are not considered approved until the submission of the unmarked form to FHKC regardless of any approval of the draft, marked material.

Insurer shall provide Marketing materials electronically and in a format in which FHKC may use standard software functionality to create redlines or insert comments. FHKC may require Insurer to submit any Marketing materials in a different format than the original submission if needed to effectively and efficiently review and provide feedback on the material.

17.9.2 Marketing Events

Insurer shall submit all events subject to prior approval to FHKC for review at least seven (7) Calendar Days prior to the event. If Insurer is invited to attend the event fewer than seven (7) Calendar Days in advance, Insurer shall submit the event to FHKC for approval as soon as reasonably possible.

Insurer shall submit all events to FHKC's public outreach calendar at least seven (7) Calendar Days prior to the event. If Insurer is invited to attend the event fewer than seven (7) Calendar Days in advance, Insurer shall submit the event to FHKC's public outreach calendar the same day the event invitation is accepted if the event does not require prior approval, or the same date the event is approved by FHKC if prior approval is required. Insurer shall inform FHKC if such an event is cancelled or Insurer is unable to attend as expected.

Section 18: Eligibility and Enrollment

18.1 Eligibility

FHKC is the sole authority for determining eligibility for Florida Healthy Kids. Insurer shall cooperate with any changes to eligibility and enrollment-related processes implemented by FHKC.

Insurer shall, without restriction, accept Enrollees FHKC identifies to Insurer for coverage. Insurer shall not refuse to provide coverage to any Enrollee on the basis of past or present health status or need for healthcare services.

Insurer shall not refuse to provide coverage to, or use any policy or practice that has the effect of discriminating against, any Enrollee on the basis of race, color, national origin, sex, sexual orientation, gender identity, disability, or whether or not an Enrollee has executed an advance directive.

Insurer shall inform FHKC of information Insurer receives about changes in an Enrollee's circumstances that may affect the Enrollee's eligibility, including changes in Enrollee's residence and the death of the Enrollee, within five (5) Business Days of receipt of such information.

18.2 Requests for Eligibility Review

If Insurer has reasonable cause to believe that an Enrollee is not eligible for the Program, (e.g., Insurer believes an Enrollee should be placed in a different state or federal program for which eligibility would render that Enrollee ineligible for the Program), Insurer shall provide a written eligibility review request to FHKC.

Insurer's written eligibility review request shall include:

a. The reason for the eligibility review request;

b. How the relevant considerations were discovered;

c. Confirmation that no other considerations influenced Insurer's decision to request the review, including (specifically, but without limitation):

   i. An adverse change in the Enrollee's health status;

   ii. Utilization of services;

   iii. The Enrollee's diminished mental capacity; or

   iv. Uncooperative or disruptive behavior resulting from the Enrollee's special needs.

FHKC shall review the eligibility request and provide its findings to Insurer, to the extent permitted by law.

In the event Insurer disputes FHKC's determination of a written eligibility request and the request is based upon the Enrollee's eligibility for another state or federal program that would make the Enrollee ineligible for Florida Healthy Kids coverage, FHKC will seek an eligibility determination from the entity administering the federal or state program for which Insurer alleges the Enrollee is eligible. The Parties shall be bound by the entity's response to the eligibility review request. The rights and remedies provided under this section are exclusive to such eligibility disputes.

18.3 Enrollment

FHKC is the sole authority for assigning enrollees to Florida Healthy Kids plans.

An Enrollee's coverage is effective at 12:00 a.m. on the first day of the Enrollee's first Coverage Month, as determined by FHKC.

18.4 Enrollment Files

FHKC shall provide Insurer all enrollment information necessary for Insurer to provide the services under this Contract. The enrollment information shall identify Enrollees who have been

identified as American Indian or Alaskan Native, the Enrollees who are Title XXI eligible, and the Enrollees who are enrolled in the Full-pay Plan.

FHKC shall provide enrollment information as follows:

a. FHKC shall provide Insurer an enrollment file on the 15th of the month prior to the start of the Coverage Month.

b. FHKC shall provide Insurer a supplemental enrollment file each Business Day until the day before the regular enrollment file is generated for the next month's coverage. Coverage for Enrollees identified on the supplemental enrollment file is effective retroactive to the first day of the Coverage Month. The supplemental enrollment file will also include disenrollments and updates to demographic data.

c. FHKC may provide manual enrollment updates for reinstatements or terminations at any time. Coverage for Enrollees identified on manual enrollment updates is effective on the first of the identified Coverage Month.

d. FHKC shall notify Insurer in advance of any planned deviations from the enrollment file timeframes listed herein. Insurer shall accept these planned deviations as well as any unplanned deviations regardless of whether FHKC provided prior notification.

Insurer shall maintain an information system capable of electronically receiving and updating enrollment data as provided by FHKC. Insurer shall accept enrollment data in the format required by FHKC. Insurer shall accurately and timely process enrollment changes in accordance with this section and Attachment C.

The enrollment file format is subject to change and shall not require a Contract amendment.

18.5 Enrollment File Discrepancy Reports

Insurer shall assess the preliminary and supplemental enrollment files each month and provide a discrepancy report to FHKC. Insurer shall report discrepancies on the enrollment file discrepancy report, such as duplicate records, address errors, records rejected by Insurer's system, and other errors that call the data into question. Discrepancy reports shall be provided to FHKC within five (5) Business Days of receipt of the supplemental enrollment file.

Insurer shall timely make any corrections to the Data required after FHKC's review of the discrepancy reports.

18.6 Enrollment Reconciliation

FHKC shall provide a monthly capitation file that includes all enrollment changes related to Insurer that have occurred in the month and the amount FHKC paid or offset for each Enrollee listed.

Insurer shall accept the monthly capitation file in the format FHKC requires. The file format is subject to change and shall not require a Contract amendment.

Insurer shall use the monthly capitation file as the source for reconciling enrollment and premium payments. Insurer shall reconcile enrollment and premiums received and provide the results of such reconciliation to FHKC quarterly.

18.7 Enrollee Assignment Process

During the first Contract Year, FHKC shall auto-assign potential enrollees to available insurers on a one-to-one (1:1) basis, upon application approval. Beginning with the second Contract Year, FHKC may choose to:

a. Continue assigning potential enrollees to available plans on a one-to-one (1:1) basis; or

b. Modify the auto-assignment process to an assignment ratio other than one-to-one (1:1) to the benefit of higher performing Florida Healthy Kids insurers. FHKC may consider performance measure results, provision of obligations in compliance with this Contract, quality assessment and performance improvement execution or any other aspect or aspects, in whole or in part, of Insurer's obligations under this Contract, subject to FHKC's sole discretion.

At initial enrollment, Enrollees are provided a free-look period in which the Enrollee has ninety (90) Calendar Days to enroll with another insurer without cause. Enrollees are provided a free-look period annually. Enrollees may only request a change in insurers outside of a free-look period as provided in this section.

FHKC is responsible for notifying enrollees of their right to request an enrollment change outside of the free-look period, if such choice is available in their Region, as follows:

a. For cause:

    i. The Enrollee has moved out of Insurer's service area;

    ii. The Enrollee has an active relationship with a health care Provider who is not in Insurer's network but is in the network of another available insurer;

    iii. Insurer no longer participates in the Region in which the Enrollee resides;

    iv. The Enrollee's insurer is under a quality improvement plan or corrective action plan relating to quality of care intermediate sanctions with FHKC; or

    v. Other reasons, including poor quality of care, lack of access to services, or lack of access to providers experienced in providing care needed by Enrollee.

b. Without cause, determined on a case-by-case basis by FHKC.

18.8 Enrollment Procedures

18.8.1 Primary Dental Provider Assignment

Insurer shall offer each Enrollee a choice of Primary Dental Providers (PDPs) who meet the credentialing, access, and appointment standards of this Contract. In addition to offering Enrollees a choice of PDPs, Insurer shall ensure each Enrollee is assigned to a PDP who acts as an appropriate ongoing source of care and is primarily responsible for coordinating the services accessed by the Enrollee.

Insurer may auto-assign Enrollees to PDPs, but Enrollees must be permitted to select another PDP. Should Insurer choose to auto-assign Enrollees to PDPs, Insurer may consider provider quality metrics and outcomes and shall consider the following when making such assignments:

a. The Enrollee's last PDP assignment, if known;

b. Time and distance from the Enrollee's home address;

c. Sibling assignments; and

d. The Enrollee's age and any age limitations with the PDP.

18.8.2 Enrollment Package

Insurer shall provide an enrollment package to new Enrollees within five (5) Business Days' receipt of the enrollment information. The enrollment package shall include or make reference to the following items in accordance with the terms of section 21.3, Enrollee Materials:

a. Member identification card;

b. PDP assignment and contact information or PDP selection instructions;

c. Member handbook; and

d. Provider directory.

18.9 Disenrollment

An Enrollee's coverage shall terminate on the last day of the Coverage Month in which the Enrollee:

a. Ceases to be eligible to participate;

b. Establishes residence outside of the Service Area; or

c. Is determined to have engaged in Fraud.

Insurer may not request disenrollment of an Enrollee for any reason.

Termination of coverage and the effective date of such termination shall be determined solely by FHKC.

Section 19: Enrollee Rights

Insurer shall comply with all applicable state and federal laws pertaining to Enrollee rights and shall ensure that Insurer's network Providers observe and protect those rights.

Insurer shall maintain written policies regarding Enrollee rights. Insurer shall provide a copy of such policies to FHKC during implementation of the Contract and by the date established in the approved implementation plan. Insurer shall also provide a copy of its Enrollee rights policies for review prior to the effective date of any change to such policies.

Insurer shall provide education and training on Enrollee rights to its staff.

An Enrollee's exercise of his or her rights shall not adversely affect the way Insurer, or Insurer's network Providers, treat the Enrollee. At a minimum, Insurer must adhere to the Enrollee rights listed in this provision.

In accordance with 42 CFR 457.1220, which incorporates 42 CFR 438.100, Enrollees have the right to:

a. Receive information in accordance with 42 CFR 438.10;

b. Be treated with respect and consideration for his or her dignity and privacy;

c. Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

d. Participate in decisions regarding his or her health care, including the right to refuse treatment;

e. Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in federal regulations on the use of restraints and seclusion;

f. Request and receive a copy of his or her medical records and request that such medical records be amended or corrected; and

g. Receive health care services in accordance with 42 CFR 438.206- 438.210.

Section 20: Cultural Competency

Insurer shall provide services, including oral and written communication to Enrollees, in a culturally competent manner appropriate for the population, including those with limited

English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

Insurer shall maintain a comprehensive written cultural competency plan describing how Insurer, its Providers, employees, and systems will effectively provide services to Enrollees of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and respects the worth of the Enrollee and protects and preserves the dignity of each.

Insurer shall submit its initial cultural competency plan for approval by FHKC by the date established in the approved implementation plan and annually thereafter by November 1st.

Section 21: Enrollee Services

Insurer shall maintain an enrollee service unit to provide Enrollee-related customer service. The enrollee service unit shall have the ability to answer Enrollee inquiries by telephone, electronic communication, and written communication. The enrollee service unit shall be accessible by a toll-free telephone number during the hours of 7:30 a.m. to 7:30 p.m. Eastern Time, Monday through Friday, except on FHKC-recognized holidays.

Insurer shall utilize automatic call distribution equipment and enrollee services representatives staffing sufficient to handle the expected volume of calls. Insurer shall also provide a telecommunication device for the deaf (TTY/TDD) and access to interpreter services. Insurer shall ensure enrollee services representatives are satisfactorily trained and capable of resolving Enrollee and potential Enrollee inquiries in all areas related to Florida Healthy Kids. Insurer's enrollee services representatives shall be familiar with the basic eligibility requirements for the Florida Healthy Kids Program, but shall refer or transfer individuals with detailed questions or concerns to the Florida KidCare call center. Insurer shall monitor the enrollee services line to ensure Insurer meets certain performance standards and for quality assurance, including recording calls, conducting routine audits, and other monitoring activities. Insurer shall meet the performance guarantees related to enrollee services included in Attachment C.

Insurer shall provide a publicly available website with access to Florida Healthy Kids information. The publicly available website shall include:

a. The Enrollee handbook,

b. A printable provider directory,

c. A searchable electronic provider directory,

d. A link to FHKC's Florida Healthy Kids website, and

e. Any other information that may be needed by Enrollees or potential Enrollees.

Insurer's publicly available website is subject to FHKC approval.

Insurer shall also provide a non-public website with secure access for Enrollees that shall include:

a. The ability for Enrollees to print a temporary ID card,

b. The ability for Enrollees to request a new ID card, and

c. Enrollee educational materials (unless Insurer chooses to make such materials available on the publicly available website).

Insurer's non-public website is subject to FHKC's approval.

21.1 Escalated Enrollee Issues

FHKC sometimes receives Enrollee complaints or concerns directly from Enrollees or forwarded from state agencies, legislative offices, and others. FHKC may forward such issues to Insurer for research and resolution. An escalated Enrollee issue may be designated by FHKC as an urgent escalated Enrollee issue based upon factors such as the Enrollee's health status. All other escalated Enrollee issues are considered routine escalated Enrollee issues.

Insurer shall acknowledge receipt of the escalated Enrollee issue within two (2) hours for urgent escalated Enrollee issues and by close of business for routine escalated Enrollee issues unless a different timeframe is specified by FHKC.

Insurer shall provide regular status updates to FHKC on any activities and progress underway, including when further action and progress are temporarily halted. In the event progress is temporarily halted, Insurer shall allow no more than two (2) Business Days or three (3) Calendar Days between updates, whichever is earlier. Insurer shall not wait to be prompted for status updates by FHKC to provide such updates.

To the extent reasonable and unless otherwise required by FHKC, Insurer shall resolve routine escalated Enrollee issues within five (5) Business Days and urgent escalated Enrollee issues within two (2) Business Days, unless the Enrollee's health requires faster resolution. In the event the expected resolution timeframe is not reasonable to resolve the escalated Enrollee issue, Insurer shall inform FHKC in writing and provide an expected timeframe for resolution and the basis for the extended timeframe, subject to FHKC approval.

Escalated Enrollee issues are not intended to take the place of or circumvent any aspect of the Grievance or Appeal process. The Parties shall act in good faith in the performance of this provision.

21.2 Translation Services; Alternative Formats

Insurer shall provide oral translation services to any Enrollee who speaks any non-English language. Insurer shall notify Enrollees of the availability of oral interpretation services and inform Enrollees how to access such services.

Insurer shall make all written materials available in English, Spanish, and all prevalent non-English languages in Insurer's Service Area spoken by approximately five percent (5%) or more of Insurer's Florida Healthy Kids population.

Insurer shall provide translation services to Enrollees at no cost.

21.3 Enrollee Materials

Insurer is responsible for all preparation, cost, and distribution of Enrollee materials.

Insurer shall provide all materials to Enrollees and potential Enrollees in a manner and format that may be easily understood and is readily accessible in accordance with 42 CFR 457.1207, which incorporates 42 CFR 438.10. Insurer agrees to follow best practices related to accessibility of materials insofar as such best practices are reasonable and practicable.

Insurer shall use a font size no smaller than 12-point in all written materials.

Insurer shall make all written materials available in alternative formats and in a manner that takes into consideration the Enrollees' special needs, including those who are visually impaired or have limited reading proficiency. Such alternative formats shall include auxiliary aids and services, oral interpretation in any language, and written interpretation in the language(s) prevalent in the Service Area. Insurer shall notify all Enrollees that information is available in alternative formats upon request at no cost. Insurer shall also inform Enrollees how to access such services.

Written materials shall include a notice of nondiscrimination and taglines explaining the availability of written or oral translation in the prevalent non-English languages in the Service Area, as required by Section 1557 of the Affordable Care Act, as well as in large print, which means printed in a font size no smaller than 18-point. Insurer shall use the top fifteen (15) prevalent non-English languages determined by HHS unless otherwise approved by FHKC to use another source Insurer believes is more accurate.

Insurer shall inform FHKC of the intended method(s) Insurer will use to distribute Enrollee materials. FHKC may require Insurer use or refrain from using certain method(s).

Insurer shall make good faith efforts to contact or provide materials through alternate, allowable, methods to Enrollees when mail or other communication is returned undeliverable.

21.3.1 Specified Enrollee Materials

At a minimum, Insurer must provide the Enrollee materials specified in this section. As directed by FHKC, Insurer shall coordinate with FHKC and its vendors to promote consistency in messaging to Enrollees.

A. Enrollee Identification (ID) Card.

Insurer shall mail each Enrollee a hardcopy of his or her Enrollee ID card without requiring that the Enrollee first request such hardcopy. The Enrollee ID card shall include Insurer's name, the Enrollee's name, ID number, effective date of coverage, and Insurer's contact information. The Enrollee ID card shall identify the Enrollee as a Florida Healthy Kids member and shall not contain any potentially misleading information, such as references not related to the Program, including references to Medicaid.

B. Enrollee Handbook.

Insurer shall provide an Enrollee handbook based on the model Enrollee handbook provided by FHKC. Insurer shall customize such material to the extent permitted or required by FHKC. The handbook shall include the following elements:

a. A description of benefits and any associated cost sharing sufficient to ensure that Enrollees understand the benefits covered by this Contract, including the scope, amount, duration, and limitations associated with a Covered Service.

b. A description of how to access services, including any requirements for prior authorization of any services, referrals for specialty care, or any other restrictions on choice among network Providers.

c. Disclosure of any services Insurer does not cover because of moral or religious objections and instructions about how to obtain information from FHKC about how to access any such services.

d. The extent to which, and how, Enrollees may obtain Covered Services.

e. A description of Emergency Medical Conditions and services, including post-stabilization services, including what constitutes an emergency, the fact that prior authorization is not required, and that Enrollee has a right to use any hospital or setting for emergency care.

f. The process for selecting and changing the Enrollee's PDP;

g. A description of the Grievance and Appeal process, including the right to file and the availability of assistance in the filing process;

h. A description of the Enrollee's rights and responsibilities;

i. How to access auxiliary aids and services, including accessing information in alternative formats or languages;

j. The toll-free telephone number for Enrollee services and any other unit providing services directly to Enrollees;

k. How to report suspected Fraud or Abuse; and

l. Any other information required by FHKC.

C. Provider directory.

Insurer shall make a Provider directory available on Insurer's website in a machine-readable file and format, as specified by the Secretary of HHS, as well as in paper form upon request. Insurer shall also make a searchable electronic Provider directory available on Insurer's website.

Information included in a hardcopy Provider directory or a printable electronic Provider directory must be updated at least monthly. Searchable electronic Provider directories must be updated no later than thirty (30) Calendar Days after Insurer receives updated Provider information.

At a minimum, the Provider directory must contain the following information for each PDP, orthodontist, and specialist:

a. Provider name;

b. Provider group affiliation, if any;

c. Specialty, as appropriate;

d. Street Address(es);

e. Telephone number(s);

f. Website URL, if any;

g. Office hours;

h. Age limitations, if any;

i. Non-English languages, including American Sign Language, spoken by the Provider or a skilled medical interpreter at the Provider's office;

j. Whether Provider has completed cultural competency training;

k. Whether Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms, and equipment; and

l. Whether the Provider is accepting new patients.

D. Enrollee Handbook notice of Change.

Insurer shall provide Enrollees with a notice of change for any significant changes, as determined by FHKC, made to the Enrollee handbook. Any such notices must be provided to Enrollees at least thirty (30) Calendar Days prior to the effective date of such change.

E. Notice of Network Provider Termination.

Insurer shall notify Enrollees who received services from a terminating network Provider within the past six (6) months of such termination at least sixty (60) Calendar Days before the effective date of the termination. When such notice is not possible, Insurer shall make a good-faith effort to provide written notice to Enrollees who received primary or regular care from a terminating network Provider within fifteen (15) Calendar Days of receipt or issuance of the Provider termination notice.

F. Certificates of Creditable Coverage.

Insurer is responsible for issuing certificates of creditable coverage to Enrollees upon the Enrollee's request.

21.3.2 Enrollee Material Review Process

All Enrollee materials must be approved by FHKC prior to distribution.

Insurer shall submit Enrollee materials to FHKC for approval no less than thirty (30) Calendar Days prior to Insurer's intended publication or utilization date, unless otherwise approved or required by FHKC. The total Enrollee material review time from initial submission to final determination is dependent on multiple factors, including the condition of the original submission, the time Insurer takes to make any requested changes, and the length and complexity of the materials. This provision in no way guarantees a final determination within the thirty (30) Calendar Days.

For Enrollee materials with multiple versions, Insurer shall submit a copy of each version with the request.

Insurer shall be responsive to FHKC's comments, questions, requests for more information, and other such requests. Failure to be responsive to such requests or failure to provide sufficient information or appropriate changes may result in denial of Insurer's Enrollee materials.

Insurer shall provide Enrollee materials in the intended final format, including quality of images used and removal of watermarks from stock photos. Insurer may submit Enrollee materials that include marks such as stock photo watermarks during the review period, but must subsequently provide a copy of the final Enrollee material with all such marks removed. Such Enrollee materials are not considered approved until the submission of the unmarked form to FHKC, regardless of any approval of the draft, marked material.

Insurer shall provide Enrollee materials electronically and in a format in which FHKC may use standard software functionality to create redlines or insert comments. FHKC may require Insurer to submit any Enrollee materials in a different format than the original submission if needed to effectively and efficiently review and provide feedback on the material.

Section 22: Benefits

Insurer shall provide the Covered Services described in Attachment A. In the event Insurer requires clarification about any coverage or cost-sharing requirement, Insurer shall consult with FHKC. Insurer shall have mechanisms in place to help Enrollees and potential Enrollees understand the requirements and benefits of the Plan.

Insurer shall not avoid costs for services covered under this Contract by referring Enrollees to publicly supported health care resources and requiring the Enrollee to utilize those resources.

Insurer shall ensure that services provided are sufficient in amount, duration, and scope to reasonably achieve the purpose for which the services are furnished. Insurer shall not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or Enrollee condition. This provision does not prohibit Insurer from placing appropriate limits on services or implementing utilization management controls.

22.1 Utilization Management

Insurer shall establish utilization management controls to ensure Enrollees receive appropriate care. Insurer's utilization management controls shall allow for consideration of factors specific to individual Enrollees such as age and medical history.

Insurer shall not compensate individuals or entities conducting utilization management activities in a way that provides incentives for the individual or entity to deny, limit or discontinue Medically Necessary services to an Enrollee.

Utilization management activities, including prior authorization reviews, shall be conducted by individuals with clinically appropriate backgrounds in a manner that results in interrater reliability sufficient to indicate the appropriateness and validity of the process, including the training given to the reviewers.

22.2 Mental Health and Substance Use Disorder Parity

Insurer shall comply with the requirements of 42 CFR 457.496. Insurer shall assist and cooperate with FHKC as needed to ensure the Program is in compliance with parity requirements. In the event Insurer is directly or indirectly preventing the Program from meeting parity requirements, Insurer shall implement appropriate, timely changes to allow the Program to become compliant.

22.3 Telehealth

FHKC considers telehealth to be a modality of care and not a separate form of health care practice. As such, all requirements applicable to Providers delivering in-person services apply to Providers delivering telehealth services, including standards of care and medical record requirements. Insurer shall not apply any policies or procedures to telehealth services that are

significantly more restrictive or stringent than those applied to in-person services unless such differences are required to maintain the intent and functionality of a policy or procedure that applies to in-person services.

Insurer shall cover benefits for services provided by telehealth to the extent the same services are provided in-person, when possible and appropriate. Insurer shall cover store-and-forward and remote patient monitoring services telehealth modalities, as appropriate.

Telephone conversations (without two-way, real-time audio and visual components), chart review, email, and facsimile transmissions are not considered telehealth.

22.4 Benefit Determinations; Practice Guidelines

Insurer shall consult with the requesting Provider when making benefit determinations, as appropriate.

Insurer shall follow written policies and procedures and practice guidelines, for making benefit determinations, including processing requests for initial and continuing authorization for services.

Insurer shall adopt practice guidelines:

a. That are based on valid, reliable clinical evidence of Providers in the relevant field;

b. Consider the needs of Enrollees; and

c. In consultation with contracting health care professionals.

Insurer shall review and periodically update its practice guidelines, as appropriate.

Decisions related to utilization management, Enrollee education, coverage of services, and other relevant areas shall be consistent with Insurer's adopted practice guidelines. Insurer shall provide any practice guidelines used for the Plan to Enrollees, potential Enrollees, and network Providers, upon request.

22.4.1 Adverse Benefit Determinations

Insurer shall provide timely and adequate written notice of an Adverse Benefit Determination. The benefit determination and any notice of Adverse Benefit Determination must be provided within the following timeframes in accordance with 42 CFR 457.1260 and to the extent it incorporates 42 CFR part 438 subpart F:

a. For termination, suspension, or reduction of previously approved services, the notice must be provided at least ten (10) Calendar Days before the date of action except when:

    i. Insurer has information confirming the death of the Enrollee;

ii. Insurer receives a clear signed written statement from the Enrollee stating that the Enrollee no longer wishes to receive services, or the Enrollee gives information that requires termination or reduction of services and the Enrollee indicates understanding that termination or reduction of services must be the outcome of providing such information;

iii. The Enrollee has been admitted to an institution which causes ineligibility under the plan for further services;

iv. The Enrollee's whereabouts are unknown and the United States Postal Service returns Insurer's mail to the Enrollee with no forwarding address;

v. Insurer establishes that the Enrollee is enrolled in Florida Healthy Kids with another insurer;

vi. A change in the level of medical care is prescribed by the Enrollee's physician;

vii. The notice involves an Adverse Benefit Determination made with regard to the preadmission screening requirements of section 1919(e)(7) of the Act;

viii. In accordance with 42 CFR 431.213(h); and

ix. Insurer has facts, verified through secondary sources when possible, indicating that action should be taken because of probable Fraud by the Enrollee. In such instances the notice must be provided at least five (5) Calendar Days before the date of action.

b. For denial of payment, the notice must be provided at the time of any action affecting the claim;

c. For standard service authorization decisions that deny or limit services, within fourteen (14) Calendar Days following receipt of request for service, except that Insurer may extend the timeframe up to an additional fourteen (14) Calendar Days if the Enrollee or Provider requests extension or Insurer is able to justify to FHKC a need for additional information and that the extension is in the Enrollee's interests so long as:

i. Insurer gives the Enrollee written notice of the reason for the decision to extend the timeframe and inform the Enrollee of the right to file a Grievance; and

ii. Insurer issues and carries out the determination as expeditiously as the Enrollee's health condition requires, but no later than the date the extension expires.

d. For service authorization decisions not reached within the timeframes required by 42 CFR 438.210(d), which constitutes a denial and thus is an Adverse Benefit Determination, Insurer must provide the notice on the date the timeframe expires; or

e. For expedited service authorization decisions, Insurer must provide notice as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours after receipt of the request, except that Insurer may extend the timeframe up to an additional fourteen (14) Calendar Days if the Enrollee or Provider requests extension or Insurer is able to justify to FHKC a need for additional information and that the extension is in the Enrollee's interests.

A notice of Adverse Benefit Determination must include:

a. The Adverse Benefit Determination the Insurer made;

b. The reason for the Adverse Benefit Determination;

c. The Enrollee's right to be provided, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to the Adverse Benefit Determination, including Medical Necessity criteria and processes, strategies or evidentiary standards used in setting coverage limits;

d. The Enrollee's right to request an Appeal, including information on exhausting the Appeal process and the right to request an independent review;

e. The procedures for exercising these rights; and

f. The circumstances under which an Appeal can be expedited and how the Enrollee can request an expedited Appeal.

22.5 Value-add Services

Insurer may offer value-add services at no cost to FHKC or Enrollees. Insurer shall offer any value-add services proposed during the ITN process and listed in Attachment A.

Insurer shall submit any proposed value-add services, including a description of the eligible population and any limitations, to FHKC for approval.

Insurer must request and receive FHKC approval to discontinue any value-add services. Unless approved by FHKC in writing, value-add services shall be offered for at least one (1) complete Contract Year and shall not be discontinued during a Contract Year.

Any value-add services proposed during the ITN and included in this Contract are considered material to the competitive ITN process. As such, Insurer shall not discontinue these value-add services without replacing the value-add service with an equivalent value-add service, subject to FHKC approval. An equivalent value-add service must be relevant to the Program and must be expected to fulfill similar needs for Enrollees regarding the number of Enrollees potentially impacted and the level of care.

Requests for changes to value-add service shall be submitted to FHKC for consideration annually on July 1. Insurer shall provide Enrollees with notice of any value-add service changes at least ninety (90) Calendar Days in advance of such changes.

If a value-added service is provided in lieu of a Covered Service or setting required in this Contract:

a. Such service is subject to FHKC's determination that the alternative service or setting is medically appropriate and cost effective;

b. Enrollees are not required to use the alternative service or setting;

c. The alternative services or setting are authorized and identified in this Contract; and

d. The utilization and actual cost of the alternative services or setting are taken into account when developing the premium rates in accordance with 42 CFR 457.1201(e) and 42 CFR 438.3(e)(2)(iv).

Insurer shall include all value-add services in Insurer's Enrollee handbook.

22.6 Additional Service Commitments

Insurer shall provide any additional service commitments specified in Attachment A. Insurer shall also make available to Enrollees any materials or services generally available to Insurer's other clients, such as educational material, access to relevant websites, or assistance finding and accessing community support services.

The provision of an additional service commitment does not guarantee access or availability of the specified additional service commitment to any Enrollee; access and availability may be dependent upon a variety of variables including location and eligibility requirements.

Insurer shall inform FHKC in writing of any substantial changes to any additional service commitments at least sixty (60) Calendar Days in advance unless otherwise specified.

22.7 Social Determinants of Health

Insurer shall have a mechanism to address social services needs of Enrollees through available community-based social service resources. Insurer shall not require Enrollees to access community-based social service resources instead of covered benefits.

22.8 Case Management

Insurer shall provide case management services. Insurer shall provide FHKC a list of case management programs, to the extent any case management is condition-specific, by the date established in the approved implementation plan. Insurer shall inform FHKC of any addition or removal of such programs sixty (60) Calendar Days prior to the change.

Insurer shall have policies and procedures in place for identifying and enrolling Enrollees likely to benefit from such services.

Insurer shall provide a quarterly case management report that includes the number of Enrollees identified as eligible for case management, the number of Enrollees enrolled in the quarter, the percentage of eligible Enrollees engaged in case management, Insurer's definition of "engagement" and a breakdown of such information by program, as applicable.

22.9 Coordination; Transition of Care

Insurer shall coordinate, or provide for the coordination of, services between settings of care, including appropriate discharge planning for short and long-term hospital and institutional stays, with services Enrollees receive from other health care coverage or liable third parties and with services Enrollees receive from community and social support Providers.

Insurer shall implement a transition of care policy consistent with the transition of care policy adopted by FHKC. FHKC's transition of care policy shall be made publicly available. Insurer will provide a copy of Insurer's transition of care policy to FHKC by the date established in the approved implementation plan and prior to any proposed changes. Changes to Insurer's transition of care policy are subject to FHKC's approval. Summaries of the transition of care policy shall be included in the Enrollee handbook and relevant notices.

Notwithstanding any other provision of this Contract, as of the Effective Date of Services, Insurer shall be liable for the cost of any previously authorized, ongoing course of treatment provided to an Enrollee by any provider, regardless of whether such provider has a contract with Insurer, without any further authorizations, for an additional sixty (60) Calendar Days after termination or expiration of any prior insurer's contract covering such Enrollees.

Insurer shall comply with the requirements of 42 CFR 457.1216.

22.10 Medical Coordination

Insurer shall coordinate care with Enrollees' other Florida Healthy Kids health insurance carriers. Insurer shall enter into Data sharing agreements and shall exchange Data with FHKC's other insurance carriers as directed by FHKC.

Section 23: Grievances and Appeals

Insurer shall have a Grievance and Appeal system in place for Enrollees in compliance with 42 CFR 457.1260. The Grievance and Appeal system shall be the same for Title XXI Enrollees and Full-pay Plan Enrollees. Insurer shall establish and maintain policies and procedures for the Grievance and Appeal system, including procedures for expedited Appeals.

Insurer shall provide its Grievance and Appeal policies and procedures to FHKC by the date established in the approved implementation plan and at least sixty (60) Calendar Days prior to

any proposed changes. The initial policy and procedures and any subsequent changes are subject to approval by FHKC. Insurer shall provide its Grievance and Appeal policies and procedures to Providers and Subcontractors when Insurer engages with such entities or individuals and after any approved changes.

Insurer shall ensure individuals making decisions about Grievances and Appeals:

a. Were not involved in any previous level of review or decision-making and are not the subordinate of any such individual;

b. Have the appropriate clinical expertise in treating the Enrollee's condition or disease when:

    i. An Appeal is based on lack of Medical Necessity;

    ii. A Grievance is about the denial of an expedited resolution of an Appeal; and

    iii. A Grievance or Appeal involves clinical issues.

c. Take all comments, documents, records, and other information submitted by the Enrollee or Enrollee's representative into account without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

Insurer shall maintain a record of all Grievances and Appeals that includes the following information for each Grievance and Appeal:

a. Date received;

b. Date of each review or review meeting, as applicable;

c. Enrollee name;

d. Nature or general description of the reason for the Grievance or Appeal;

e. Disposition of each level of the Grievance and Appeal process, as applicable;

f. Date of resolution at each level, as applicable; and

g. Documents relevant to each Grievance and Appeal.

Insurer shall accurately maintain these records in a manner accessible to FHKC and, upon request, CMS.

Insurer shall provide FHKC with a quarterly Grievances and Appeals report. The Grievances and Appeals report shall include:

a. A summary analysis of the Grievances and Appeals that includes:

i. Appeal response timeliness as a percentage of Appeals in the reporting quarter that were closed timely. Appeals closed in the quarter includes Appeals that were received in a different quarter and closed in the reporting quarter.

ii. Grievance response timeliness as a percentage of Grievances in the reporting quarter that were closed timely. Grievances closed in the quarter includes Grievances that were received in a different quarter and closed in the reporting quarter.

b. Line item records of Grievances and Appeals received in the quarter that includes:

i. The date received;

ii. Identification as a Grievance or an Appeal;

iii. Nature or general description of the reason for the Grievance or Appeal;

iv. The disposition, as applicable;

v. The date of the disposition, as applicable;

vi. If a Subcontractor handles the Grievance or Appeal, the name of the Subcontractor responsible; and

vii. An indicator showing whether the Grievance or Appeal is for a Title XXI Enrollee or a Full-pay Plan Enrollee.

c. Line item records of Grievances and Appeals closed in the quarter that includes:

i. The date received;

ii. Identification as a Grievance or an Appeal;

iii. Nature or general description of the reason for the Grievance or Appeal;

iv. The disposition;

v. The date of the disposition;

vi. If a Subcontractor handles the Grievance or Appeal, the name of the Subcontractor responsible; and

vii. An indicator showing whether the Grievance or Appeal is for a Title XXI Enrollee or a Full-pay Plan Enrollee.

Insurer shall provide an annual summary analysis Grievance and Appeals report that includes:

a. Appeal response timeliness as a percentage of Appeals in the reporting Contract Year that were closed timely. Appeals closed in the Contract Year includes Appeals that were

received in a different Contract Year for this Contract and closed in the reporting Contract Year.

b. Grievance response timeliness as a percentage of Grievances in the reporting Contract Year that were closed timely. Grievances closed in the Contract Year includes Grievances that were received in a different Contract Year for this Contract and closed in the reporting Contract Year.

c. Summary of any Appeal trends. At a minimum Insurer shall consider whether any trends may be found regarding benefits appealed, Provider specialty types involved (as a function of the benefit, not related to Provider involvement in the Appeal process), and similarities in overturned Appeals.

d. A description of activities Insurer has taken to address avoidable Appeals as well as any planned activities.

e. Summary of any Grievance trends. At a minimum Insurer shall consider whether any trends may be found regarding Grievance topic and Providers involved (as a component of the Grievance, not related to Provider involvement in the Grievance process).

f. A description of activities Insurer has taken to address avoidable Grievances as well as any planned activities.

Insurer shall provide this information in the aggregate and broken out in the manner requested by FHKC. Insurer's performance is subject to the performance guarantees established in Attachment C.

Insurer shall provide Enrollees with reasonable assistance completing forms and taking other procedural steps related to Grievances and Appeals, upon request. Such assistance shall include providing auxiliary aids and services, interpretation services and toll-free numbers with TTY/TTD and interpreter capability. Insurer shall follow the requirements of 42 CFR 457.1207 and 42 CFR 438.10 and any method(s) established by FHKC when notifying Enrollees about any aspect of the Grievance and Appeal process.

An Enrollee's authorized representative, including Providers, may file Grievances and Appeals on the Enrollee's behalf with the written consent of the Enrollee. Insurer shall not take punitive action against any Provider for filing an Appeal, requesting an expedited Appeal, or supporting an Enrollee's request for an expedited Appeal.

23.1 Grievances

Enrollees may file a Grievance with Insurer orally or in writing at any time. Insurer shall acknowledge receipt of the Grievance in writing within five (5) Business Days.

Insurer shall provide Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments.

Insurer shall resolve each Grievance, and provide notice of the resolution, as expeditiously as the Enrollee's health condition requires within the timeframes required in this Contract and 42 CFR 457.1260. Standard resolution and notice of Grievances shall not exceed ninety (90) Calendar Days from the date of Grievance receipt, unless extended appropriately.

The standard resolution timeframe for a Grievance may be extended by up to fourteen (14) Calendar Days if:

a. The Enrollee requests the extension; or

b. Insurer shows that there is need for additional information and that such an extension is in the Enrollee's interest. FHKC may choose to request the basis for Insurer's decision to extend the timeframe. In such instances, the basis for Insurer's decision is subject to FHKC's satisfaction.

If a Grievance timeframe has been extended other than at the request of an Enrollee, Insurer shall make reasonable efforts to give the Enrollee:

a. Prompt oral notice of the delay;

b. Written notice of the decision to extend the timeframe within two (2) Calendar Days; and

c. Notice of the Enrollee's right to file a Grievance regarding this decision.

Insurer shall resolve the Grievance as expeditiously as the Enrollee's health condition requires, but no later than the date the extension expires.

23.2 Appeals

Enrollees may file an Appeal orally or in writing within sixty (60) Calendar Days of the date of notification of an Adverse Benefit Determination. Oral requests for Appeal must be followed by a signed, written Appeal unless the request is for an expedited Appeal. Such oral requests shall be used to establish the earliest possible filing date for the Appeal. Insurer shall acknowledge receipt of the Appeal in writing within five (5) Business Days. Appeals are limited to a single level. Enrollees wishing to further appeal Insurer's decision to uphold an Appealed decision may proceed to the independent external review process.

Insurer shall provide Enrollees a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. Such reasonable opportunity includes informing the Enrollee of the limited time available for these actions sufficiently in advance of the resolution timeframes for Appeals. Insurer shall also provide Enrollees with the Enrollee's case file, including medical records, other documents and records and any new or

additional evidence considered, relied upon or generated by Insurer in connection with the Appeal of the Adverse Benefit Determination, free of charge and sufficiently in advance of the resolution timeframe for Appeals.

Insurer shall resolve each Appeal, and provide notice, as expeditiously as the Enrollee's health condition requires within the timeframes required in this Contract and 42 CFR 457.1260.

a. Standard resolution and notice of Appeals shall not exceed thirty (30) Calendar Days from the date of Appeal receipt, unless extended appropriately.

b. Expedited resolution and notice of Appeals shall not exceed seventy-two (72) hours from the Appeal receipt, unless extended appropriately.

When an Enrollee requests an expedited Appeal, Insurer shall determine whether taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. Providers may also request, or support an Enrollee's request for, an expedited Appeal.

The standard resolution timeframe for an Appeal may be extended by up to fourteen (14) Calendar Days if:

a. The Enrollee requests the extension; or

b. Insurer shows that there is need for additional information and that such an extension is in the Enrollee's interest. FHKC may choose to request the basis for Insurer's decision to extend the timeframe. In such instances, the basis for Insurer's decision is subject to FHKC's satisfaction.

If an Appeal timeframe has been extended other than at the request of an Enrollee, Insurer shall make reasonable efforts to give the Enrollee:

a. Prompt oral notice of the delay;

b. Written notice of the decision to extend the timeframe within two (2) Calendar Days; and

c. Notice of the Enrollee's right to file a Grievance regarding this decision.

Insurer shall resolve the Appeal as expeditiously as the Enrollee's health condition requires, but no later than the date the extension expires.

Insurer shall provide written notice of resolution for Appeals and shall additionally make reasonable efforts to provide oral notice of resolution of an expedited Appeal. Appeal determination notices must include:

a. The result of the Appeal process;

b. The date the Appeal was resolved;

c. For Appeal determinations not wholly in the Enrollee's favor, the right to request an independent external review, and instructions on how to make such a request.

In the event Insurer fails to adhere to the Appeal decision or notice requirements, the Enrollee shall be deemed to have exhausted the Appeal process and may request an independent external review.

In the event Insurer overturns an Adverse Benefit Determination, Insurer shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the Appeal resolution date.

23.3 Independent External Review

Enrollees may request an independent external review within one hundred twenty (120) Calendar Days of notification that an appealed Adverse Benefit Determination has been upheld or when the Appeal process has been deemed exhausted by way of Insurer's failure to adhere to the notification and timing requirements of 42 CFR 457.1260 which incorporates 42 CFR 438.408.

Insurer shall maintain a contract with an Independent Review Organization (IRO) for the provision of Enrollees' option to have a post-appeal independent review. Such contract shall specify and meet all state and federal laws, regulations and guidance applicable to CHIP Grievance and Appeal process requirements and subcontractor requirements, including FHKC's audit rights.

Insurer shall provide a quarterly report listing all independent reviews the IRO handled in the quarter, including the date the independent review was requested, the date the IRO made a final decision, the outcome of the review, whether Insurer has since received any Grievances related to the independent review and any other information requested by FHKC.

Enrollees and the Enrollee's representative or the legal representative of a deceased Enrollee's estate shall be included as parties to the review.

In the event the independent external review overturns an Adverse Benefit Determination, Insurer shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the independent external review determination date.

Insurer is responsible for the full cost of all independent reviews.

Section 24: Access to Care

24.1 General Network Requirements

Insurer shall maintain a network of Providers sufficient to meet the requirements of this Contract and to adequately serve the needs of the Enrollees. Insurer shall allow Enrollee choice of network Providers to the extent possible and appropriate.

Insurer's Provider network shall be supported by written agreements.

Insurer shall establish mechanisms to:

a. Ensure network Provider compliance with required terms;

b. Monitor Providers regularly to determine compliance;

c. Take corrective action should a network Provider fail to comply; and

d. Handle Provider complaints.

Insurer shall not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification, including Providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision does not:

a. Require Insurer to contract with Providers beyond the number necessary to meet the needs of the Enrollees;

b. Preclude Insurer from using different reimbursement amounts for different specialties or different Providers of the same specialty; or

c. Preclude Insurer from establishing measures designed to maintain quality of services or control costs and are consistent with Insurer's responsibilities to Enrollees.

Insurer shall promptly notify FHKC when Insurer receives information about a change in a network Provider's information that may affect the Provider's eligibility to participate in the Program.

Insurer shall provide FHKC with a monthly list of Providers leaving and entering the network the previous month. The monthly network change report shall include each Provider's NPI, name, address(es), specialty type, telephone number, whether the Provider is entering or leaving the network, an indicator showing whether the Provider should appear in the Provider directory or be suppressed, and indicators for any Providers removed from the network for ineligibility to participate in Medicare, Medicaid, or CHIP or for Fraud or Abuse.

Upon FHKC request, Insurer shall provide its complete network Provider data in the format, timeframe and frequency required by FHKC.

Insurer shall provide FHKC with sixty (60) Calendar Days advance written notice of any anticipated termination of large Provider groups, hospitals, or any independently practicing Provider if the independently practicing Provider has at least fifty (50) Enrollees on its patient panel.

24.2 Provider Credentialing

Insurer shall establish and follow policies and procedures for credentialing and recredentialing Providers. Such policies and procedures shall, at a minimum, comply with the uniform credentialing and recredentialing policy adopted by FHKC. Insurer may adopt credentialing and recredentialing policies and procedures that are more robust than FHKC's uniform credentialing and recredentialing policy requires.

In the event Insurer terminates a contract or declines to contract with a Provider or Provider group, Insurer shall provide FHKC and affected Providers with written notice of the reason for Insurer's decision.

24.3 Participating Provider Requirements

Insurer shall require each network Provider to have a National Provider Identifier (NPI).

Insurer shall ensure all network Providers have an active Medicaid ID.

In the event a network Provider is unwilling to obtain a Medicaid ID, Insurer shall enroll the Provider directly with FHKC by requiring the Provider to sign an FHKC Provider agreement in addition to Insurer's Provider agreement. Insurer is responsible for providing all relevant information and documents to the Provider and submitting to FHKC all relevant information and documents, including the executed FHKC Provider agreement. If the Provider is already enrolled directly with FHKC, Insurer shall submit all relevant information to FHKC; however, the Provider is not required to sign another FHKC Provider agreement. As required by the FHKC Uniform Credentialing Policy, Insurer is responsible for all credentialing and recredentialing activities for network Providers regardless of enrollment status with FHKC.

Insurer's network shall not include any Providers excluded for participation by Medicare, Medicaid, or CHIP. Insurer shall not enter into or authorize any agreements with such excluded Providers that would otherwise require Insurer to pay for out-of-network services, except for Emergency Services.

Insurer shall ensure that all network Providers are enrolled in Medicaid or CHIP consistent with the Provider disclosure, screening, and enrollment requirement of 42 CFR part 455, subparts B and E as incorporated in 42 CFR 438.608(b). Insurers may execute temporary Provider contracts pending the outcome of the Medicaid or CHIP provider enrollment process of up to one

hundred twenty (120) Calendar Days but must terminate a network Provider immediately upon notification that the network Provider cannot be enrolled, or the expiration of one (1) 120 Calendar Day period without enrollment of the Provider. Insurer shall provide assistance to AHCA, FHKC, and any other agency as requested to facilitate the enrollment process.

Insurer shall ensure that its network Providers and Subcontractors are required to submit encounter data within a timeframe that allows Insurer to comply with the requirements of 42 CFR 457.730.

24.4 Medical Records

Insurer shall require Providers to maintain and share, as appropriate, medical records for each Enrollee in accordance with professional standards and applicable federal and state law.

24.5 Health Information Technology Participation

24.5.1 Electronic Notification System

Insurer shall participate in the Event Notification System (ENS) of the Florida Health Information Exchange. Insurer shall use the hospital encounter Data it receives through the ENS in its case and disease management and care coordination programs to identify, develop, and implement interventions that reduce avoidable emergency department visits for its Enrollees. Insurer shall also implement programs to share its ENS encounter data with its network Providers to collaborate on these same goals.

24.5.2 Electronic Health Records

Throughout the Contract Term, Insurer shall monitor, promote, and support the use of electronic health records (EHRs) by its network Providers.

By June 30, 2023 and annually thereafter, Insurer shall report to FHKC results of Insurer's efforts at promoting and monitoring the adoption of EHRs among network Providers. In the event use of EHRs by Insurer's network Providers does not increase from the previous Contract Year, the report shall include changes Insurer has made to its policies and procedures that support the adoption of EHRs.

This provision does not require Insurer's Providers meeting EHR use standards to participate in or receive incentives from the Florida Medicaid EHR Incentive Program.

24.6 Facility Standards

Network facilities shall meet applicable accreditation, licensure requirements, and regulations specified by AHCA.

24.7 Federally Qualified Health Centers; Rural Health Centers

A Federally Qualified Health Center (FQHC) is an entity that is receiving a grant under Section 330 of the Public Health Service Act and Section 1905(1)(2)(B) of the Social Security Act.

A Rural Health Clinic (RHC) is a facility meeting the requirements of section 1861(aa)(2) of the Social Security Act, 42 CFR 405.2401 and 42 CFR 491.2.

Insurer shall reimburse FQHCs and RHCs at or above the reimbursement amounts provided under the Medicaid Prospective Payment System for such entities.

No supplemental payments from FHKC will be provided for these payments under any circumstances. Insurer is responsible for the entire amount.

Insurer shall provide a quarterly report identifying all network FQHCs and RHCs and attesting to Insurer's compliance with these reimbursement requirements.

This provision does not require Insurer to contract with FQHCs or RHCs.

24.8 Indian Health Care Providers

Insurer shall maintain sufficient numbers of Indian Health Care Providers (IHCPs) in Insurer's Provider network to ensure timely access to services from such Providers to those Enrollees eligible to receive such services. Insurer shall provide a quarterly attestation and supporting documentation to FHKC demonstrating compliance with this requirement.

Insurer shall allow any Enrollee who is eligible to receive services from a network IHCP to choose the IHCP as his or her PCP so long as the IHCP has the capacity to provide the services. Insurer must also allow any Enrollee who is eligible to receive services from an IHCP to obtain services covered under the Contract from an out-of-network IHCP. Insurer shall allow out-of-network IHCPs to refer Enrollees to a network Provider.

Should there be too few IHCPs in the State to ensure timely access to Covered Services, Enrollees who are eligible to receive such services shall be permitted to access out-of-state IHCPs.

Insurer shall pay for Covered Services provided to eligible Enrollees by IHCPs, whether participating in the network or not, at either the rate negotiated between Insurer and the IHCP or at a rate not less than the level and amount of payment Insurer would make for services to a non-IHCP network Provider. Insurer shall make all payments to network IHCPs in a timely manner, as required by 42 CFR 447.45 and 447.46.

When an IHCP is also an FQHC, but is not a network Provider, Insurer shall pay the IHCP an amount equal to the amount Insurer would pay a participating FQHC that is not an IHCP.

When an IHCP is not an FQHC, regardless of network participation status, the IHCP has the right to receive its applicable encounter rate published annually in the Federal Register by the Indian Health Service, or in the absence of such published encounter rate, the amount it would receive if the services were provided by the State's Medicaid fee for service payment methodology.

Insurer shall pay IHCPs the full amount an IHCP is eligible to be paid. No supplemental payments from FHKC will be provided for these payments under any circumstances. Insurer is responsible for the entire amount.

24.9 Network Adequacy

Insurer shall maintain and monitor a Provider network sufficient to meet Enrollee needs and the requirements of this Contract. Insurer shall take into consideration Enrollees with limited English proficiency, physical and mental disabilities, or other barriers to care and Insurer's ability to meet such needs through the Provider network when determining network adequacy.

Insurer shall provide a certification attesting to, and documentation supporting, Insurer's capacity to serve the expected enrollment in its service area in accordance with the terms of this Contract. Supporting documentation must demonstrate that Insurer offers an appropriate range of preventive, primary care, and specialty services for the anticipated number of Enrollees in the Service Area and that Insurer maintains a network of Providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated Enrollees. Insurer shall submit this documentation in the format specified by FHKC.

Documentation shall be submitted when:

a. Insurer enters into this Contract with FHKC;

b. On an annual basis, when submitting the annual premium report; and

c. Any time there has been a significant change in Insurer's operations that may affect the adequacy of capacity and services, including changes in:

    i. Services;

    ii. Benefits;

    iii. Geographic service area;

    iv. Composition of Provider network;

    v. Payments to Provider network; or

    vi. Enrollment of a new population in plan.

Insurer understands and agrees that such documentation may be posted on FHKC's website in accordance with 42 CFR 457.1285.

Insurer shall also provide any documentation needed by FHKC's EQRO to conduct an annual network adequacy validation or any other activity required by FHKC.

FHKC may add network access requirements, such as Provider to Enrollee ratios, urgent care center or telehealth services access requirements, or revise existing network access requirements to meet Enrollee needs, reflect Enrollee utilization patterns, reflect availability of Providers, or for other similar reasons.

Failure to provide access as required in this Contract may constitute an Event of Default, as determined by FHKC in its sole discretion, and shall entitle FHKC to unilaterally terminate the Contract pursuant to section 44.6 Termination for Lack of Performance or Breach.

24.9.1 Geographical Access

Insurer shall maintain a network that meets the following standards:

Provider Type	**Time (in minutes)**		**Distance (in miles)**	
	Rural	**Urban**	**Rural**	**Urban**
PCP	30	20	30	20
Specialist	40	20	30	20
Orthodontist	70	30	50	20
Telehealth	Report			

For telehealth services, Insurer shall report Enrollee's access to telehealth services in the manner and format determined by FHKC. FHKC may choose to use such reports and other information available to create access standards for telehealth services or to create a methodology to supplement the geographic network access standards.

"Specialist" includes any dental provider not included in the PCP or Orthodontist categories. Providers may not be counted twice between categories (except for telehealth reporting).

Insurer shall provide FHKC with a quarterly geographic access report demonstrating Insurer's compliance with these requirements and the performance guarantees in Attachment C.

24.9.2 Geographic Access Exemptions

Insurer may request a waiver for the time and/or distance network adequacy standards for a given geographical area. To request a service area exemption, Insurer must submit a written request for an exemption accompanied by supporting documentation. These requests shall include:

a. Identification of the service area, provider type(s), and specific standard(s) the request for exemption covers;

b. The reason for the request, which may include:

    i. No providers exist in the area.

    ii. No providers exist in the area that are able to pass Insurer's credentialing or recredentialing standards.

    iii. Limited providers exist in the area and all refuse to contract with Insurer despite Insurer's documented good faith efforts to contract.

c. The number of providers in the area;

d. The distance to the nearest Provider;

e. Documentation of Insurer's efforts to find providers in the area as well as proof of existing providers' inability to be credentialed/recredentialed or proof of Insurer's failed good faith efforts to contract, as appropriate. Insurer must provide the practice address and phone number of any provider refusing to contract;

f. Certification attesting that documentation is complete and accurate;

g. Insurer's plan to monitor the area and take action should any change occur;

h. Explanation of how Insurer will provide timely services to enrollees in the area; and

i. Any other information FHKC deems necessary to make a determination.

Once a service area exemption has been granted, Insurer must monitor and report on Enrollee access to the relevant provider type as well as activity relating to Insurer's monitoring plan on a quarterly basis.

Exemptions expire and must be re-approved every two (2) years unless withdrawn by Insurer or revoked by FHKC. Exemptions may be revoked for the following reasons:

a. The situation in the area has changed and Insurer can reasonably be expected to meet access requirements;

b. Failure to provide continuing evidence that the exemption is appropriate; and

c. Failure to adequately monitor, take action or report as required by Insurer's documented plan, the contract, or state or federal law.

Information regarding service area exemptions may be reported to CMS as required by federal law.

24.9.3 Appointment Access

Insurer shall require network Providers to offer hours of operation and appointment times that are no less than the hours of operation and appointment times offered to commercial enrollees.

Insurer shall provide timely treatment for Enrollees in accordance with the following standards:

a. Emergency care shall be provided immediately.

b. Urgently needed care shall be provided within twenty-four (24) hours.

c. Routine sick visit care shall be provided within seven (7) Calendar Days of the Enrollee's request for services.

d. Routine preventive care visits shall be provided within four (4) weeks of the Enrollee's request.

e. Follow-up care shall be provided as medically appropriate.

Insurer shall report on network Providers offering routine After-hours Services as required by FHKC.

24.9.4 Out-of-Network Access

In the event an Enrollee requires access to Covered Services and Insurer has failed to provide adequate access to such Covered Services, as determined by FHKC or Insurer, Insurer shall provide access to the relevant Covered Services outside the network. In the event Insurer has materially failed to provide adequate access for an Enrollee's ongoing health care needs, including access to an out-of-network Provider, FHKC may direct Enrollees to seek related Covered Services from an out-of-network Provider. Should FHKC direct such action, Insurer shall be financially responsible for such services to the extent Insurer would be responsible if the services had been provided by a network Provider.

24.10 Physician Incentive Plans

Insurer shall comply with 42 CFR 457.1201(h), 42 CFR 438.3(i), 42 CFR 422.208, and 42 CFR 422.210, as well as any other applicable federal or state laws and regulations related to physician incentive plans.

Insurer shall not make specific payment(s), directly or indirectly (including offerings of monetary value measured in the present or future), to a physician or physician group as an inducement to reduce or limit Medically Necessary services furnished to an Enrollee.

If a physician incentive plan places a physician or physician group at substantial financial risk for services that the physician or physician group does not furnish itself, Insurer shall ensure that

all physicians and physician groups at financial risk have sufficient aggregate or per-patient stop-loss protection.

Substantial financial risk is determined as defined in 42 CFR 422.208 and this Contract. Substantial financial risk is when risk is based on the use or costs of referral services and that risk exceeds the risk threshold of twenty-five percent (25%) of potential payments. Payments based on other factors are not considered in determining whether substantial financial risk exists.

The following arrangements cause substantial financial risk to exist for physicians or physician groups with patient panel sizes not greater than twenty-five thousand (25,000) patients:

a. Withholds greater than twenty-five percent (25%) of potential payments;

b. Withholds less than twenty-five percent (25%) of potential payments if the physician or physician group is potentially liable for amounts exceeding twenty-five percent (25%) of potential payments;

c. Bonuses that are greater than thirty-three percent (33%) of potential payments minus the bonus;

d. Withholds plus bonuses if the withholds plus bonuses equal more than twenty-five percent (25%) of potential payments. The threshold bonus percentage for a particular withhold percentage may be calculated using the formula described in 42 CFR 422.208(d)(3)(iv);

e. Capitation arrangements if the difference between the maximum potential payments and the minimum potential payments is more than twenty-five percent (25%) of the maximum potential payments or the maximum and minimum potential payments are not clearly explained in the contract with the physician or physician group; and

f. Any other incentive arrangements that have the potential to hold the physician or physician group liable for more than twenty-five percent (25%) of potential payments.

Stop-loss protection required for physicians and physician groups at substantial financial risk must cover ninety percent (90%) if aggregate stop-loss protection is used. If per-patient stop-loss protection is used, the stop-loss limit per patient must be determined based on the size of the patient panel in accordance with 42 CFR 422.208(g) and must cover ninety percent (90%) of the costs of referral services that exceed the per patient Deductible limit in accordance with 42 CFR 422.208(f)(2)(iii).

Insurer shall provide Enrollees with a disclosure that includes whether the Insurer uses a physician incentive plan that affects the use of referral services, the type of incentive arrangement and whether stop-loss protection is provided, upon request.

Insurer shall notify FHKC of any physician incentive plans used for Healthy Kids Enrollees and provide documentation to FHKC assuring that insurer is meeting contractual and regulatory requirements. Such documentation shall also include a copy of the Enrollee disclosure notice Insurer intends to provide to Enrollees.

24.11 Integrity of Professional Advice to Enrollees

Insurer shall comply with 42 CFR 457.985 prohibiting Insurer from interfering with the advice of health care professionals to Enrollees and requiring that professionals engaged in the performance of Insurer's duties under this Contract give information about treatments to Enrollees as provided by law.

Insurer shall not prohibit, or otherwise restrict, a Provider acting within the lawful scope of practice from advising or advocating on behalf of an Enrollee who is his or her patient regarding:

a. The Enrollee's health status, medical care or treatment options, including any alternative treatment that may be self-administered;

b. Any treatment the Enrollee needs to decide among all relevant treatment options;

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

d. The Enrollee's right to participate in decisions regarding his or her health care, including the right to refuse treatment and to express preference about future treatment decisions.

Insurer shall be subject to intermediate sanctions, as described in 42 CFR Part 457, Subpart I, for any violations of this prohibition.

24.12 Provider Payments

24.12.1 Claims

Insurer shall provide FHKC with the address from which claims are paid.

Insurer shall receive and process claims in accordance with the terms of this Contract and industry best practices and nationally recognized standards, including the use of electronic transmission of claims, payments and related documents.

Insurer shall pay clean claims submitted electronically within fifteen (15) Calendar Days of receipt. For all other claims submitted electronically, Insurer shall deny or request any additional information needed to process the claim within fifteen (15) Calendar Days and deny or pay within ninety (90) Calendar Days of claim receipt.

Insurer shall pay clean claims not submitted electronically within twenty (20) Calendar Days of receipt. For all other claims not submitted electronically, Insurer shall deny or request any

additional information needed to process the claim within fifteen (15) Calendar Days and ultimately deny or pay within ninety (90) Calendar Days of receipt.

Insurer shall also process and pay claims in accordance with the performance guarantees required in Attachment C.

A clean claim is a claim completed in accordance with Insurer's guidelines, accompanied by all documentation required for payment and that may be processed and adjudicated without obtaining additional information from the Provider or a third party or Medical Necessity review. Claims from Providers under investigation for Fraud, Abuse, or violation of state or federal laws or regulations are not considered clean claims.

Information pertaining to claims and payment data provided to FHKC shall be accompanied by an attestation attesting to the accuracy, completeness and truthfulness of the data under penalty of perjury.

24.12.2 Capitated Arrangements

Insurer shall monitor and assess any capitated arrangements in place on a routine basis to ensure that such arrangements continue to provide appropriate value in cost savings or avoidance.

Annually, or upon request, Insurer shall provide FHKC with a report listing the types of services provided under capitated arrangements, the percent of encounters that are capitated, the total amount paid for capitated services broken out as required by FHKC and, for those services provided by a mix of capitated and other payment arrangements, the percentage of providers under a capitated agreement.

24.12.3 Provider Overpayments

Insurer shall provide an annual report listing all overpayments to Providers, including overpayments made related to Fraud, Waste and Abuse and all other overpayments.

a. Such policies and procedures must include:

    i. A mechanism for a network Provider to report in writing to Insurer that an overpayment has been received and the reason why the overpayment was received; and

    ii. Require Provider to return the overpayment to Insurer within sixty (60) Calendar Days after the date on which the overpayment was identified.

Section 25: Fraud and Abuse

Insurer shall have administrative and management arrangements and procedures to detect and prevent Fraud, Waste, and Abuse that comply with all state and federal laws and regulations, including 42 CFR 457.1285.

Insurer's arrangements and procedures shall include:

a. A compliance program that includes:

   i. Written policies, procedures and standards of conduct detailing Insurer's commitment to comply with all applicable requirements and standards;

   ii. A compliance officer responsible for developing and implementing the policies, procedures and practices designed to ensure compliance with the Contract. The compliance officer shall have sufficient experience in healthcare and shall report directly to the CEO and Insurer's board of directors;

   iii. A regulatory compliance committee on the board of directors and at the senior management level charged with overseeing Insurer's compliance program and its compliance with the Contract;

   iv. A system for training and educating the compliance officer, senior management and Insurer's employees about state, federal, and contractual requirements;

   v. Effective lines of communication between the compliance officer and Insurer's employees, as evidenced by some formal policy;

   vi. Enforcement of standards through well-publicized disciplinary guidelines;

   vii. Non-retaliation policies against any individual that reports violations of Insurer's Fraud and Abuse policies and procedures or suspected Fraud and Abuse; and

   viii. A system, and related procedures, with dedicated staff for routine internal monitoring, auditing of compliance risks, prompt response to, investigation of, and correction of compliance issues, actions to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements of the Contract.

b. A method used to verify services that were represented to have been delivered by network Providers were received by Enrollees. Such verification process shall be conducted on a regular basis;

c. The distribution of written policies to Insurer's employees, and of any Subcontractor or agent, that provide detailed information about the False Claims Act and other federal

and state laws described in section 1902(a)(68) of the Act, including information about the rights of employees to be protected as whistleblowers;

d. Prompt reporting to FHKC of information Insurer obtains indicating Fraud or potential Fraud by a Provider, Subcontractors, Applicant, or Enrollee;

e. Suspension of payments to a network Provider when FHKC or AHCA determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23; and

f. Policies and procedures to maintain adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist Insurer with preventing and detecting potential Fraud and Abuse activities.

Insurer shall provide its Fraud, Waste, and Abuse policies to FHKC for approval during implementation of this Contract, by the date established in the approved implementation plan, and prior to any changes. Changes to Insurer's Fraud, Waste, and Abuse policies are subject to FHKC approval.

Insurer shall provide FHKC with a quarterly Fraud, Waste, and Abuse report detailing prevention activities conducted by Insurer, potential offenses being investigated and any confirmed instances of Fraud or Abuse. Insurer may report information on violations of law by Subcontractors, Providers, Enrollees or other relevant individuals to FHKC and/or to CMS, as appropriate. Insurer may only report such information regarding Enrollees when the information pertains to enrollment in the plan or Covered Services.

Insurer shall cooperate in any investigation by FHKC or any state or federal entities and any subsequent legal action that may result from such an investigation.

Section 26: Quality Management

26.1 Accreditation

Insurer shall inform FHKC of any accreditations received by a private independent accrediting entity. Insurer shall authorize the private independent accrediting entity to provide FHKC with a copy of its most recent accreditation review. Such review includes the following information:

a. Accreditation status

b. Accreditation survey type

c. Accreditation level, as applicable

d. Accreditation results, including:

    i. Recommended actions or improvements

    ii. Corrective action plans; and

iii. Summaries of findings

e. Expiration date of the accreditation

In accordance with the requirements of 42 CFR 457.1240(c), FHKC will make Insurer's accreditation status available on the Florida Healthy Kids website. Such accreditation status will include the name of the accrediting entity, accreditation program and accreditation level, as applicable.

Insurer shall provide FHKC with a report listing the accrediting entity, accreditation program and accreditation level of all accreditations during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by December 15th. Insurer shall inform FHKC of any change in accreditation status within thirty (30) Calendar Days of such change.

26.2 Quality Assessment and Performance Improvement

Insurer shall maintain a quality assessment and performance improvement (QAPI) program that objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes.

At a minimum, the QAPI program shall include:

a. Performance improvement projects (PIPs) focusing on clinical and non-clinical areas;

b. Collection and submission of performance measurement data;

c. Mechanisms to detect underutilization and overutilization of services;

d. Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs;

e. Written policies and procedures that address components of effective health care management including anticipation, identification, monitoring, measurement, evaluation of Enrollees' health care needs, and effective action to promote quality of care; and

f. Any performance measures and PIPs that are required by CMS during the term of this Contract.

Insurer's QAPI shall incorporate an annual quality improvement plan (QIP). Insurer's QIP shall:

a. Include an executive summary describing the structure of Insurer's QAPI, Insurer's approach to quality improvement and how Insurer evaluates the QIP and QAPI to determine new or improved quality improvement activities;

b. Define and implement improvements in processes that enhance clinical efficiency, provide effective utilization, and focus on improved outcome management achieving the highest-level of success;

c. Implement specific interventions to better manage Enrollee care and promote improved health outcomes; and

d. Identify performance goals supporting the QAPI program.

Insurer shall submit its QIP to FHKC during implementation of the Contract, by the date established in the approved implementation plan, and annually thereafter by July 1st. Insurer's QIP is subject to FHKC approval. Insurer shall use the results of the QIP to assess and report on the overall QAPI program to FHKC annually.

Insurer shall have a quality improvement committee that develops and is responsible for the oversight of the QIP. The quality improvement committee shall be chaired or co-chaired by Insurer's medical director, meet at least quarterly and include provider representation.

26.3 External Quality Review

FHKC contracts with an EQRO to conduct annual external quality review activities during the Contract term.

Insurer shall cooperate in all such activities. Cooperation with EQR-activities includes, but is not limited to:

a. Responsiveness to requests for discussion and feedback, including requests for PIP-topic preferences;

b. Provision of data, documentation and other information in an accurate and timely manner;

c. Reviews and evaluation of Insurer's PIPs, whether such review is a review of the format and initial methodology, progress review or the EQRO's validation review;

d. Participation in any EQR-related training made available to Insurer by FHKC;

e. Monitoring of activities by FHKC; and

f. Corrective action plans or quality improvement activities required of Insurer by FHKC as a result of EQR-activity findings.

Insurer shall calculate results for and report the performance measures identified by FHKC on an annual basis as part of FHKC's external quality review activities. Insurer shall also provide FHKC with data, as specified by FHKC, which enables FHKC to validate or calculate Insurer's performance using the standard measures. FHKC may choose to independently calculate, or have calculated, the performance measures. Insurer remains responsible for calculating the

performance measures regardless of whether FHKC is independently calculating these performance measures.

Insurer shall conduct PIPs as part of the QAPI program in accordance with the written guidance for PIPs released by CMS. Each PIP must be designed to:

a. Achieve significant improvement, sustained over time, in health outcomes and/or Enrollee satisfaction; and

b. Must include measurement of performance using:

    i. Objective quality indicators;

    ii. Implementation of interventions to achieve improvement in access and quality of care;

    iii. Evaluate the effectiveness of the interventions; and

    iv. Planning and initiation of activities for increasing or sustaining improvement.

PIPs specific to Insurer and/or to the overall Program resulting from FHKC's monitoring, the EQR-activities or industry trends or emerging issues may also be required from Insurer. FHKC may choose to either dictate any or all of the PIP topics or allow Insurer to choose any or all of its PIP topics, subject to FHKC approval.

26.4 Managed Care Quality Rating System

FHKC may adopt the quality rating system developed by CMS or may adopt an alternative quality rating system as allowed in 42 CFR 457.1240 which incorporates 42 CFR 438.334. FHKC will notify Insurer of any such quality rating system.

Insurer shall cooperate with FHKC in the implementation and maintenance, including data submission, of such quality rating system.

26.5 CAHPS Survey

Insurer shall conduct NCQA's Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 5.0H, or its successor, or a modified CAHPS dental survey approved by FHKC annually for its Florida Healthy Kids population. At its sole discretion, FHKC may reject any modified CAHPS survey and require the use of the unmodified CAHPS Health Plan Survey. Insurer shall conduct the annual CAHPS survey in a manner that allows Insurer to report on the Florida Healthy Kids results separately from the results of any other group. FHKC may publish Insurer's Florida Healthy Kids CAHPS survey results.

26.6 FHKC Quality Initiatives

FHKC may implement quality initiatives other than those types of quality activities considered in this Contract and may require Insurer to participate in such initiatives. In the event a quality initiative requires substantial and material efforts by Insurer beyond the scope of the Contract, FHKC shall amend the Contract to include the quality initiative. The Parties agree to negotiate such amendments in good faith.

Insurer shall engage in preliminary discussions, research assistance, basic consultation and other activities of a similar nature and such activities shall not require a Contract amendment.

26.6.1 Value-Based Payments

Insurer shall report on its value-based payment arrangements, including Provider participation, Enrollee participation, type of value-based payment and planned contracting activities as required by FHKC. FHKC may require Insurer to implement a value-based payment arrangement development plan. The value-based payment arrangement development plan, including measure indicators and outcome targets, shall be subject to approval by FHKC.

Section 27: Reporting Requirements

Insurer shall comply with all reporting requirements under this Contract in the manner and timeframes specified in the Contract or as otherwise required by FHKC. For this section, the term “reports” encompasses reports, documents, deliverables, and other information provided to FHKC.

Insurer shall provide reports to FHKC electronically. Insurer shall provide physical copies upon request.

Reports submitted to FHKC must be clearly named and must include, at a minimum, Insurer’s name and a short descriptive document title. Such descriptive document titles should be intelligible by an individual familiar with CHIP and general health insurance, but unfamiliar with Insurer and Insurer’s internal document management system and processes. FHKC may occasionally dictate a specific naming convention for certain documents. Insurer shall adhere to any prescribed naming convention.

In the event a routine report is required for which Insurer has no data to report for the reporting period, Insurer shall populate relevant fields in the report with a statement indicating the lack of reportable information. Insurer shall not fail to submit any report because of lack of reportable data.

Insurer may be required to provide FHKC information or data that is not specified under this Contract. Insurer shall have at least thirty (30) Calendar Days to fulfill such ad hoc reporting requests unless otherwise required by FHKC.

Insurer shall provide supporting evidentiary documentation with all reports unless otherwise required by FHKC.

Insurer shall provide reports in accordance with the requirements described in this Contract or requested by FHKC. Insurer shall be liable for Financial Consequences in the amount of five hundred dollars ($500) per Calendar Day, limited to fifteen thousand dollars ($15,000) per incident, for failure to provide reports in an acceptable format by the required due date. Financial Consequences apply to each Calendar Day beyond the due date until provided to FHKC, inclusive of the day provided to FHKC. Financial Consequences apply to the initial due date and to subsequent due dates should the report require revisions prior to FHKC approval.

Insurer shall be liable for Financial Consequences in the amount of five hundred dollars ($500) per incident for failure to adhere to any reporting requirement other than timeliness.

FHKC shall not assess both Calendar Day and per incident Financial Consequences for the same instance of noncompliance nor shall FHKC assess such Financial Consequences when FHKC has assessed other Financial Consequences for an equivalent reason for the instance of noncompliance.

Section 28: Warranty

Insurer shall provide the Services in a professional, workmanlike manner in accordance with the requirements of this Contract and the standards and quality prevailing among first-rate, nationally recognized firms in the industry and warrants that it will remain in such condition during the Contract Term. If FHKC discovers that the reports and other documents and services are not in such condition during the Contract Term, Insurer shall promptly correct, cure, replace, or otherwise remedy the condition at no cost to FHKC. This provision does not affect any other rights or remedies of FHKC, including FHKC's right to terminate all or a portion of the Contract for breach or default.

Section 29: Further Assurances

Subsequent to the execution of the Contract by both Parties, the Parties will execute and deliver any further legal instruments and perform any acts that are or may become necessary to effectuate the purposes of this Contract.

Section 30: Good standing

Insurer must maintain good standing as a Florida or foreign profit or non-profit corporation, partnership, limited liability company, or other recognized business entity authorized to transact business pursuant to the laws of Florida. Insurer shall submit a certified copy of a Certificate of Status from the Secretary of State, Division of Corporations, to FHKC concurrent with the execution of this Contract.

Section 31: Representation of Ability to Perform

Insurer represents that there is no pending or threatened action, suit, proceeding, inquiry, or investigation at law or equity before or by any court, governmental agency, public board, or other body that would materially prohibit, restrain, or enjoin the execution or delivery of Insurer's obligations, diminish Insurer's obligations, or diminish Insurer's financial ability to perform the terms of this Contract. During the term of this Contract, if any of the aforementioned events occur, Insurer shall immediately notify FHKC in writing. Insurer shall remain adequately capitalized during the term of this Contract. Insurer's failure to comply with this section constitutes an Event of Default and shall be grounds for termination of this Contract, in FHKC's sole discretion.

Section 32: Other Compliance Requirements

Each Party shall comply with all federal, state, and local laws, ordinances, rules, and regulations applicable to such Party in its performance under this Contract.

Insurer shall notify FHKC within ten (10) Business Days of any change to federal, state, or local laws, ordinances, rules, or regulations pertaining to Insurer's performance under this Contract. AHCA, DOH, and FHKC retain sole responsibility for interpreting, establishing, and administering federal and state policies, rules, procedures, and directives. FHKC does not delegate any authority or discretion to Insurer in regards thereto.

Insurer shall provide an affidavit of compliance substantially in the form provided in Attachment B for itself and all Subcontractors approved under section 4 prior to the Effective Date of Services and annually thereafter. The certification must be signed by the executive officer and properly notarized. Insurer shall provide the signed certification to FHKC. As part of the certification process, Insurer and all approved Subcontractors shall undertake to review all requirements under this Contract and investigate and confirm compliance with all Contract requirements.

If during that process (or at any other time), Insurer or any approved Subcontractor discovers that it is not in compliance with the Contract obligations, Insurer and Subcontractor shall immediately take corrective action. As part of the corrective action, Insurer and the Subcontractor shall, within three (3) Business Days, or sooner if required elsewhere in the Contract, of discovering the noncompliance, notify FHKC of the particulars and shall provide to FHKC a corrective action plan in accordance with section 12.7 that details the actions to be taken to comply with the Contract requirements.

Section 33: Encounter Data

Insurer shall provide a quarterly encounter and claims data for all services rendered under this Contract. Insurer shall submit the encounter and claims data using a format and following a process established by FHKC. The quarterly encounter and claims data shall include the level of detail specified by FHKC using standardized ASC X12N 837, NCPDP formats and the ASC X12N 835 or another standardized format, as required by FHKC. Encounter data reports must comply with HIPAA security and privacy standards and shall be submitted in a format required by the Medicaid Statistical Information System or successor system.

FHKC anticipates requiring Insurer to submit the quarterly encounter and claims data to FHKC's contracted EQRO and AHCA's contracted Insurer responsible for the annual Florida KidCare Evaluation Report.

Insurer shall provide the quarterly Encounter and Claims Data by the due dates listed in the following chart:

Encounters and Claims Processed During:	**Data Due to AHCA's Contracted vendor by:**	**Data Due to FHKC by:**
July 1-September 30	October 15	November 15
October 1-December 31	January 15	February 15
January 1-March 31	April 15	May 15
April 1-June 30	July 15	August 15

FHKC may amend the process, format, or other requirements during the Contract term without amending this Contract. Insurer shall implement such changes by the date required by FHKC.

Insurer shall be liable for Financial Consequences in the amount of one thousand dollars ($1,000) per Calendar Day for failure to provide a complete file of all claims/encounter data to FHKC's contracted EQRO and/or AHCA's contracted Insurer on a quarterly basis in the format and timeframe specified by FHKC. Financial Consequences apply to each Calendar Day beyond the due date until such complete file is submitted to FHKC's EQRO and/or AHCA's contracted Insurer in the format specified, inclusive of the date Insurer provides the file.

Insurer shall assist FHKC in complying with any state or federal encounter data reporting requirements, including correcting accuracy, completeness or other compliance issues.

Access to Enrollee claims data by FHKC, the State of Florida, the federal Centers for Medicare and Medicaid Services, and the Department of Health and Human Services Inspector General shall be allowed to the extent permitted by law.

Section 34: Attestations

Insurer shall provide a written attestation signed by Insurer's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual reporting directly to the CEO or CFO with delegated authority to sign for the CEO or CFO. The attestation shall certify based on best information, knowledge and belief, that the Data, documentation or information provided is accurate, complete and truthful when submitting the information listed in this provision.

The CEO or CFO is ultimately responsible for attestations provided by an individual with delegated authority. Insurer shall provide an organizational chart upon execution of this Contract and within one (1) week of any changes.

This provision is applicable to the following specified Data, documentation and information:

a. Encounter Data;

b. Data FHKC may use to determine Insurer's compliance with MLR requirements;

c. Data FHKC may use to determine Insurer has made adequate provision against the risk of insolvency;

d. Documentation related to Insurer's compliance with requirements for availability and accessibility of services, including Provider network adequacy;

e. Information on ownership and control of Insurer and Subcontractors;

f. Annual overpayment recoveries report; and

g. Any other Data, documentation or information for which FHKC requests an attestation.

Attestations must be submitted concurrently with the submission of Data, documentation, or information.

Insurer shall attest to the accuracy, completeness and truthfulness of claims and payment data submitted to FHKC under penalty of perjury.

Section 35: Governing Law

Insurer shall comply with all applicable federal and state laws and regulations, including:

a. Title VI of the Civil Rights Act of 1964, as amended, 42 U.S.C. 2000d et seq.;

b. Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. 794;

c. Title IX of the Education Amendments of 1972, as amended 20, U.S.C. 1681 et seq.;

d. The Age Discrimination Act of 1975, as amended, 42 U.S.C. 6101 et seq.;

e. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 U.S.C. 9849;

f. The American Disabilities Act of 1990, P.L. 101-336;

g. Section 274A (e) of the Immigration and Nationalization Act;

h. Title XXI of the federal Social Security Act;

i. HIPAA, and any other federal or state laws regarding disclosure of protected health information as specified in Attachment B;

j. The Immigration Reform and Control Act of 1986;

k. The drug free workplace program as defined in section 287.087, Florida Statutes;

l. All applicable federal and state laws regarding advertising, marketing and promotional activities of health care services or otherwise related to the offering of health care services and items and services including: (i) the Federal Anti-Kickback Law, 42 U.S.C. § 1320a-7b; (ii) the Civil Monetary Penalty Law, 42 U.S.C. § 1320a-7a; (iii) the Civil and Criminal False Claims Acts, 31 U.S.C. §§ 3729-3733; (iv) the Stark Law, 42 U.S.C. §1395nn; (v) the Health Care Fraud Statute, 18 U.S.C. § 1347; and (vi) to the extent applicable, the respective state law counterparts of any of the federal laws described in (i) through (v) above; and

m. All applicable state and federal laws and regulations governing FHKC.

Insurer further agrees that all Subcontractors, sub-grantees, or others with whom it arranges to provide goods, services, or benefits in connection with any of its programs and activities are not discriminating against either those whom they employ nor those to whom they provide goods, services, or benefits in violation of the above statutes, regulations, guidelines, and standards.

It is expressly understood that evidence of Insurer's refusal or failure to substantially comply with this section or such failure by Insurer's subcontractors or anyone with whom Insurer affiliates in performing under this Contract shall constitute an Event of Default and renders this Contract subject to unilateral cancellation by FHKC, at FHKC's sole discretion.

Section 36: Americans with Disabilities Act/Unauthorized Aliens

Insurer assumes the sole responsibility for compliance with all laws, rules, and regulations stated in the Americans with Disabilities Act.

Insurer acknowledges and affirms that the employment of unauthorized aliens by Insurer may be considered a violation of Section 247A of the Immigration and Nationality Act. By execution of this Contract, Insurer affirms to the best of its knowledge that it is not in violation of either law at the time of execution.

The Parties agree that failure to comply with this section may constitute an Event of Default and may be grounds for termination of this Contract in accordance with section 44 at FHKC's discretion.

36.1 Non-Discrimination and Equal Opportunity

Insurer agrees to not discriminate on the basis of race, religion, sex, creed, national origin, disability, age, marital status, or veteran's status in its employment practices. Insurer agrees to comply with the laws of Florida and of the U.S., regarding such non-discrimination and equality of opportunity, which are applicable to Insurer. Furthermore, in accordance with section 287.134, Florida Statutes, an entity or affiliate who has been placed on the discriminatory vendor list may not submit a bid on a contract to provide goods or services to a public entity and may not be awarded or perform work as an Insurer, supplier, subcontractor, or consultant under contract with any public entity, and may not transact business with any public entity. Insurer shall ensure that it and its Subcontractors are, to the best of their knowledge, not in violation of any laws referenced in this section as of the Effective Date of Services. The Parties agree that failure to comply with this section may constitute an Event of Default and may be grounds for termination of this Contract in accordance with section 44.

Section 37: Clean Air Act

Insurer agrees to comply with all applicable standards, orders, or regulations issued pursuant to the Clean Air Act (42 U.S.C. §§7401-7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. §§1251-1387).

Section 38: Notices

Insurer shall prepare any Notices under this Contract on Insurer's letterhead, signed by an executive officer, and serve such Notices upon FHKC by email attachment (read receipt requested) to FHKC's chief operational officer and contract manager, by certified mail (return receipt requested), or personal delivery to:

Florida Healthy Kids Corporation
1203 Governor's Square Blvd
Suite 400
Tallahassee, FL 32301

All Notices under this Contract to be served upon Insurer shall be served by email attachment (read receipt requested), certified mail (return receipt requested), or personal delivery to:

Managed Care of North America, Inc. d/b/a MCNA
200 West Cypress Creek Road, Suite 500
Fort Lauderdale, FL 33309

The Parties agree that any change in the above-referenced address or name of the contact person shall be submitted in a timely manner to the other Party. All Notices under this Contract shall be deemed duly given: (i) when delivered in person to the recipients named above, (ii) upon personal delivery to the intended recipients, (iii) when delivered by certified U.S. mail, return receipt requested, postage prepaid, addressed by name and address to the Party intended, or (iv) delivered by email attachment read receipt requested.

38.1 Notification Requirements

Insurer shall notify FHKC in writing within one (1) Business Day, of:

a. Any judgment, decree or order rendered by any court of any jurisdiction or Florida administrative agency enjoining Insurer from the sale or provision of services.

b. Any petition by Insurer in bankruptcy or for approval of a plan of reorganization or arrangement under the Bankruptcy Act; Chapter 631, Florida Statutes; or any other Florida Statute; or an admission seeking relief provided therein.

c. Any petition or order of rehabilitation or liquidation as provided in chapters 631 or 641, Florida Statutes, or any other Florida Statute.

d. Any order revoking Insurer's Certificate of Authority or license issued by an agency of the State of Florida.

e. Any administrative action taken by the Department of Financial Services, Office of Insurance Regulation, or the Agency for Health Care Administration regarding Insurer.

f. Any medical malpractice action filed in a court of law in which an Enrollee is a party (or in which Enrollee's allegations are to be litigated).

g. The filing of an application for merger or other change in structure or ownership.

h. Any pending litigation or commencement of legal action involving Insurer in which liability for or Insurer's obligation to pay could exceed five hundred thousand dollars ($500,000.00) or ten percent (10%) of Insurer's surplus, whichever is lower.

Section 39: Administrative and Legal Proceedings

"Legal action" is defined to include administrative proceedings.

39.1 Venue

Without limiting the dispute resolution process set forth in section 40, the exclusive forum and venue for any legal action that arises out of or relates to the Contract for which there is no administrative remedy shall be a State court of competent jurisdiction in Leon County, Florida, or, on appeal, the First District Court of Appeal. Florida law will apply to any legal action,

without giving effect to Florida's choice of law principles. Further, any hearings and depositions for any legal action shall be held in Leon County, Florida. FHKC, in its sole discretion, may waive this venue for depositions.

39.2 Attorney Fees

In the event of any legal action, dispute, litigation, or other proceeding in relation to this Contract, FHKC is entitled to recover its attorney fees (including attorneys' fees for outside counsel) and other costs incurred from Insurer, whether or not suit is filed, and if filed, at both trial and appellate levels.

The Parties agree the intent of this provision is to protect the Enrollees who receive medical benefits through Florida KidCare and rely upon the continuation of FHKC's duties authorized in section 624.91, Florida Statutes.

Section 40: Dispute Resolution

Any conflict or dispute between FHKC and Insurer relating to the Contract will be resolved in accordance with the procedures specified in this Contract, which will be the sole and exclusive procedures for the resolution of any such disputes prior to litigation. Negotiations and mediation as herein prescribed are conditions precedent to litigation; however, this section will not apply in the case of Termination for Convenience as provided in section 44.3.

40.1 Informal Negotiations/Information Resolution

Whenever FHKC and Insurer have a dispute related to the Contract, the contract manager for each Party will immediately attempt to resolve the dispute, subject to the approval of the authorized signatory of the Parties or their designees.

40.2 Informal Executive-Level Negotiations

If the dispute is not resolved pursuant to section 40, Insurer and FHKC will attempt in good faith to resolve any dispute promptly by negotiation between executives of FHKC and Insurer or their designees having authority to settle the controversy, and who are at a higher level of management than persons with direct responsibility for the administration of the services at issue. Either Party may declare the informal negotiation process terminated by delivering Notice thereof to the other Party.

40.3 Mediation

Within five (5) Business Days after delivery of the Notice declaring the informal negotiation process terminated, either Party may initiate a mediation proceeding by a request in writing. The mediation is a condition precedent to filing any action by either Party.

40.3.1 Mediation Procedure

All mediation proceedings will be conducted in accordance with the Contract, the Florida Rules for Certified and Court-Appointed Mediators, and applicable Florida Statutes.

40.3.2 Selection of a Neutral Mediator

If FHKC and Insurer do not agree on the selection of a neutral mediator within ten (10) Calendar Days of the request for mediation, then FHKC will unilaterally select the mediator, who must be a Florida certified mediator. Both Parties will promptly cooperate with the appointed mediator to effectuate mediation.

40.3.3 Location of Mediation

Unless otherwise agreed in writing by FHKC and Insurer, mediation sessions will occur in Tallahassee, Florida.

40.3.4 Mediation Period

Mediation pursuant to this section will be conducted over a period of forty-five (45) Calendar Days following the appointment of a mediator, unless otherwise agreed upon by the Parties. If the dispute cannot be resolved by the mediation deadline or by the end of any mutually agreed continuation thereof, FHKC, Insurer, or the mediator may give Notice declaring the mediation process terminated.

40.4 Obligation to Mediate

The Parties regard the obligation to mediate as an essential provision and one that is legally binding on each. Either Party may bring an action to enforce this obligation in the circuit court of Leon County, Florida.

40.5 Performance to Continue

Subject to the termination rights specified in section 44, each Party will continue to perform its obligations under this Contract pending final resolution of any dispute arising out of this Contract.

40.6 Confidentiality

The Parties agree to maintain the confidentiality of any mediation regarding disputes arising under this Contract, which shall be treated as compromise and settlement negotiations.

40.7 Notice of Decision

If the procedures outlined above do not resolve the dispute, the dispute will be decided by FHKC's Chief Operating Officer, who will reduce the decision to writing and serve a copy to Insurer. The decision of FHKC's Chief Operating Officer will be final and conclusive unless

Insurer files an action in circuit court within twenty-one (21) Calendar Days from the date of receipt of the contract manager's decision. Exhaustion of administrative remedies is an absolute condition precedent to Insurer's ability to pursue any action in circuit court.

Section 41: Severability

If any term or provision of this Contract is found by a court of competent jurisdiction to be invalid, illegal, or otherwise unenforceable, the same shall not affect the other terms or provisions hereof or the whole of the Contract, but such term or provision shall be deemed to be modified to the extent necessary to render such term or provision enforceable, and the rights and obligations of the Parties shall be construed and enforced accordingly, preserving to the fullest permissible extent the intent of the Parties.

Section 42: Survival Clause

All provisions in the Contract that expressly or customarily survive the termination or expiration of the Contract shall continue in effect after the Contract is terminated or expires.

Section 43: Taxes

FHKC does not pay federal excise and sales taxes on direct purchases of tangible personal property. If applicable, FHKC will provide Insurer a tax-exempt certificate for sales of tangible personal property to FHKC by Insurer or purchases of tangible personal property made by Insurer on behalf of FHKC in connection with this Contract, where the title vests in FHKC; however, Insurer acknowledges and agrees that FHKC is without liability to Insurer in the event the Florida Department of Revenue or other regulatory agency denies any such claimed exemption.

Section 44: Termination, Default, Remedies

The Contract may be terminated as set forth in this section. In its sole discretion, FHKC may extend the effective date of any termination to allow for transition under section 45.

44.1 Termination for Cause

FHKC has the right to terminate the Contract in the event of an uncured Event of Default as specified in section 44.10 or an Event of Default that is not subject to cure.

44.2 Termination for Non-Appropriation of Funds

FHKC may, in its sole discretion, terminate this Contract by providing thirty (30) Calendar Days Notice to Insurer if the State of Florida and/or United States fails to appropriate sufficient funds to perform FHKC's obligations under this Contract. The Contract shall terminate on the last day

of the fiscal year in which sufficient funds were appropriated, subject to the terms in this Contract.

The effective date of the termination may be extended to allow for transition under section 45, if adequate funds are appropriated to cover any fees and costs FHKC will incur during such transition.

44.3 FHKC's Right to Terminate for Convenience

FHKC may terminate the Contract for convenience, in whole or in part, upon thirty (30) Calendar Days Notice to Insurer when FHKC determines, in its sole discretion, that it is in its interest to do so. Insurer will not furnish any services under the Contract after the date of termination, except as necessary to complete the continued portion of the Contract, if any. Insurer will not be entitled to recover any cancellation charges, consequential damages, or lost profits. Insurer's sole and exclusive remedy is recovery of direct costs actually incurred for authorized services satisfactorily performed prior to the termination or its monthly payment pursuant to section 2.4, whichever is less.

44.4 Termination for Lack of Payment

In the event FHKC fails to make payments in accordance with the schedule included in this Contract, Insurer may suspend work and pursue the appropriate remedies for FHKC's breach of its payment obligations. Insurer shall provide FHKC at least thirty (30) Calendar Days written Notice of its intent to suspend work because of lack of payment and allow FHKC an opportunity to correct the default prior to suspension of work.

44.5 Termination for Insolvency or Bankruptcy

In the event of Insurer's insolvency or filing a petition for bankruptcy, FHKC may immediately terminate this Contract, either in its entirety or any part herein, at its sole discretion. Insurer will not furnish any services under the Contract after the date of termination, except as necessary to complete the continued portion of the Contract, if any. Insurer shall notify FHKC within one (1) Business Day of the Insolvency or the filing of a petition for bankruptcy. Consistent with section 15 above, in no event shall FHKC or Enrollees be held liable for Insurer's debt.

44.6 Termination for Lack of Performance or Breach

The continuation of this Contract is contingent upon the satisfactory performance of Insurer. If Insurer commits an Event of Default or fails to adequately meet the terms of this Contract, FHKC reserves the right to terminate this Contract, or any part herein, at its discretion. Such termination shall be effective on the date determined by FHKC and provided by written Notice to Insurer. FHKC, in its sole discretion, may allow Insurer to cure any performance deficiencies prior to termination of the Contract. Insurer will not furnish any services under the Contract

after the date of termination, except as necessary to complete the continued portion of the Contract, if any.

44.7 Termination upon Revision of Applicable Law

In the event federal or state revisions of any applicable laws or regulations restrict FHKC's ability to comply with the Contract, make such compliance impracticable, frustrate the purpose of the Contract, or place the Contract in conflict with FHKC's ability to adhere to its statutory purpose, FHKC may unilaterally terminate this Contract. FHKC shall provide Insurer a Notice of termination at least thirty (30) Calendar Days prior to the termination date. Insurer will not furnish any services under the Contract after the date of termination, except as necessary to complete the continued portion of the Contract, if any.

44.8 Termination upon Mutual Agreement

Upon mutual agreement of the Parties, this Contract, or any part herein, may be terminated on an agreed date prior to the end of the Contract without penalty to either Party.

44.9 Right to Equitable Relief

In lieu of terminating the Contract upon the occurrence of an Event of Default, FHKC may institute legal proceedings to compel performance of any obligation required to be performed by Insurer hereunder including, where appropriate, actions for specific performance, and injunctive relief. Insurer agrees that it does not have any right to equitable relief against FHKC and will not attempt to institute any proceeding for equitable relief against FHKC.

44.10 Events of Default

Each of the following constitutes an Event of Default by Insurer:

a. Breach of a material obligation under this Contract;

b. The occurrence of any one or more of the following events:

    1. Insurer fails to pay any sum of money due hereunder;

    2. Insurer fails to provide the reports and other documents specified in this Contract, including Attachment D, or the services as required under the Contract;

    3. Insurer employs an unauthorized alien in the performance of any work required under the Contract;

    4. Insurer fails to correct work that FHKC has rejected as unacceptable or unsuitable;

5. Insurer discontinues the performance of the work required under the Contract;

6. As specified by FHKC, Insurer fails to resume work that has been discontinued;

7. Insurer abandons the project;

8. Insurer becomes insolvent or is declared bankrupt;

9. Insurer files for reorganization under the bankruptcy code;

10. Insurer commits any act of bankruptcy or insolvency, either voluntarily or involuntarily;

11. Insurer fails to promptly pay any and all taxes or assessments imposed by and legally due FHKC;

12. Insurer makes an assignment for the benefit of creditors without the approval of FHKC;

13. Insurer made or has made a material misrepresentation or omission in any materials provided to FHKC;

14. Insurer fails to furnish and maintain the bonds required by this Contract;

15. Insurer fails to procure and maintain the required insurance policies and coverages required by this Contract;

16. FHKC determines that the surety issuing a bond securing Insurer's performance of its obligations hereunder becomes insolvent or unsatisfactory;

17. A change in Insurer's ownership, structure, or control in violation of the Contract;

18. Insurer utilizes a Subcontractor in the performance of the work required by the Contract which has been placed on a state or federal convicted vendor's list;

19. Insurer is suspended or is removed as an authorized insurer by any state or federal agency or Insurer is convicted of a felony;

20. Insurer refuses to allow FHKC access to all equipment, documents, papers, letters, or other material subject to the audit terms of this Contract;

21. Insurer refuses to allow auditor access as required by the Contract;

22. Insurer permits PII or PHI Data to be transmitted, viewed, or Accessed outside of the continental U.S., except as otherwise allowed in this Contract;

23. Insurer's engagement of a Subcontractor in violation of the Contract;

24. For any other cause whatsoever that Insurer fails to perform in an acceptable manner as determined by FHKC, including failure to meet the performance guarantees set forth in Attachment C, pay associated Financial Consequences, or pay liquidated damages;

25. Failure to timely notify FHKC upon discovery of problems or issues impacting an information technology system;

26. Failure to comply with the requirements of section 36; or

27. Any other occurrence identified as an Event of Default in this Contract.

c. Continuous Performance Default – Regarding the performance guarantees set forth in Attachment C, the following will constitute a Continuous Performance Default unless otherwise excused or cured as provided in this Contract:

    1. Insurer fails to meet the same performance standard for at least three (3) consecutive measurement periods; or

    2. Insurer fails to meet a total of five (5) or more performance guarantees in six (6) out of twelve (12) consecutive months.

d. For any other reason identified elsewhere in the Contract as an Event of Default.

44.11 Opportunity to Cure Default

If Insurer has an Event of Default, FHKC will provide Insurer Notice of the Event of Default and request that such default be cured ("Cure Notice"), except in those circumstances specified in this Contract for which the ability to cure is not available. If Insurer fails to cure the specified Event of Default within forty-five (45) Calendar Days of receipt of the Cure Notice (or such other mutually agreed upon time) and the Parties have completed the dispute resolution process in section 40 without resolution ("Default"), then FHKC shall have the right to initiate transition as set forth in section 45. The transition provisions set forth in section 45 will commence upon thirty (30) Calendar Days Notice to Insurer of the termination, unless otherwise agreed to by the Parties, subject to any continuing rights or obligations hereunder. FHKC's right to terminate this Contract or commence the transition provisions shall automatically expire if Insurer has cured the Event of Default prior to Insurer's receipt of the Notice of termination.

In the instance of a Continuous Performance Default as set forth in section 44.10, FHKC must provide a Cure Notice to Insurer within one hundred twenty (120) Calendar Days after FHKC receives a performance standard report indicating Continuous Performance Default. FHKC's

right to terminate the Contract under this provision shall be in addition to any other rights and remedies at law or in equity.

44.12 Consequences of Termination

If FHKC terminates this Contract prior to expiration of the Contract, Insurer shall assist FHKC as set forth in section 45. Nothing in this section shall preclude either Party from asserting any rights to seek damages incurred (including without limitation FHKC's costs to replace the Covered Services to the extent those costs exceed what FHKC would have paid for the Covered Services under the Contract). The limitations of liability in section 16 and all other provisions intended to survive termination shall continue in effect.

44.13 FHKC's Default

Upon material breach by FHKC, Insurer will give FHKC Notice of the breach and request that such default be cured ("Cure Notice"). If FHKC fails to cure the specified breach within forty-five (45) Calendar Days of receipt of the Cure Notice (or such other mutually agreed upon time) and the Parties have completed the dispute resolution process in section 40 without resolution ("Default"), then Insurer shall be entitled to pursue compensation due for reports and other documents specified in Attachment D and services as provided in this Contract. Insurer will not, however, discontinue or terminate its services or work. Insurer is not entitled to, and will not seek, any compensation or damages other than the compensation provided for in section 2.4. Insurer will not be entitled to consequential damages, lost profits, lost business opportunity, or any damages other than the compensation provided for in section 2.4.

44.14 Rights Cumulative, No Waiver

The rights and remedies provided and available to FHKC and Insurer in this Contract are distinct, separate, and cumulative remedies, and no one of them, whether or not exercised by a Party, shall be deemed to be in exclusion of any other. The election of one remedy shall not be construed as a waiver of any other remedy or of any rights and remedies either Party may have in law or equity.

44.15 FHKC's Rights Upon Uncured Insurer Default

If Insurer commits an uncured Event of Default under this Contract, FHKC may perform or engage a third party to perform the uncured services at the reasonable expense of Insurer. Insurer shall repay FHKC for all costs and expenses incurred, subject to the limitations of liability contained herein, together with a rate of interest pursuant to section 55.03(1), Florida Statutes. The rate of interest shall be measured from the date Insurer receives Notice from FHKC that such payment is due until Insurer pays or credits such amount to FHKC.

44.16 Third-party Satisfaction

In the event FHKC issues a termination Notice because of Insurer's Event of Default, Insurer shall satisfy all undisputed obligations to its Subcontractors providing services and all other third parties before FHKC shall pay Insurer for services rendered.

IN WITNESS WHEREOF, the Parties have caused this Contract to be executed by their undersigned officials as duly authorized.

Section 45: Transition

Upon termination or the anticipated expiration of the Contract, Insurer shall provide all services under the Contract in order to ensure a smooth transition to FHKC or an alternative Insurer. FHKC has the right to commence transition for up to two (2) years prior to Contract expiration or in anticipation of Contract termination for such time as determined by FHKC.

In the event FHKC requires additional work from Insurer after the termination date or expiration date of the Contract, FHKC may extend the Contract, in whole or in part, upon written notice to Insurer. Insurer shall provide staff, services, consultation, and any other resources in order to complete the transition of the Contract, as requested by FHKC. In such an event, FHKC's payment to Insurer shall be prorated and limited to the actual staff, services, and/or other resources provided by Insurer and requested by FHKC. Insurer must itemize with specificity as to time, date, purpose, number of hours, staff, services, and/or other resources provided. Further, FHKC's payment shall only be made to the extent any such transition is elected by FHKC and not caused by any fault or delay by Insurer, as determined by FHKC. Unless otherwise agreed to in writing or extended pursuant to this section, all necessary provisions of this Contract shall remain in effect (including performance guarantees, Financial Consequences, and liquidated damages) until the date FHKC (or its alternative Insurer) takes over the provision of Covered Services, subject to any obligations that survive the Contract.

This section survives termination or expiration of this Contract.

Section 46: Entire Understanding

This Contract embodies the entire understanding of the Parties relating to the subject matter hereof and supersedes all other agreements, negotiations, understanding, or representations, whether verbal or written, between the Parties relative to the subject matter hereof.

Section 47: Execution in Counterparts

This Contract may be executed in counterparts, each of which shall be an original and all of which shall constitute one and the same instrument.

FOR
FLORIDA HEALTHY KIDS CORPORATION:

Signed: _____

Name: Ryan West

Title: Chief Executive Officer

Date: 3/9/2022

FOR
MANAGED CARE OF NORTH AMERICA, INC.
D/B/A MCNA:

Signed: _____

Name: Shannon Turner

Title: Executive Vice President

Date: 3/28/22

Attachment A: Benefit Schedule

Dental Benefits Overview

In accordance with section 409.815(2)(q), Florida Statutes, dental benefits provided by the Florida Healthy Kids Corporation ("FHKC") are those dental benefits provided to children by the Florida Medicaid program under section 409.906(6), Florida Statutes, and as required by federal law.

Incorporation by Reference

The following rules are hereby incorporated by reference to the extent they govern benefit coverage, limitations, and exclusions related to the Benefits Schedule:

a. Rule 59G-4.002, F.A.C., Dental General Fee Schedule; Practitioner Fee Schedule; Prescribed Drugs (not reviewed by the pharmaceutical and therapeutics committee) Fee Schedule; Prescribed Drug Fee Schedule; Federally Qualified Health Center Billing Codes; and County Health Department Billing.
b. Rule 59G-4.055, F.A.C.
c. Rule 59G-4.060, F.A.C.
d. Rule 59G-4.100, F.A.C.
e. Rule 59G-4.207, F.A.C.
f. Rule 59G-4.250, F.A.C.

However, the incorporation of these rules does not include coverage for Early and Periodic Screening, Diagnosis, and Treatment services and does not expand the scope of coverage beyond the dental benefits provided to children under section 409.906(6), Florida Statutes, and as required by federal law.

Cost Sharing

Enrollees are not subject to any cost-sharing.

Covered Services

Adjunctive General Services

Covered services include:

a. Behavioral management; up to three times per 366-day period.
b. Intravenous/Non-intravenous Sedation; up to three times per 366-day period.
c. Palliative Treatment

Diagnostic Services

Covered services include:

a. Oral evaluations

    i. One comprehensive evaluation every three years
    ii. Limited evaluations, as medically indicated
    iii. One periodic evaluation every 181 days
    iv. One assessment (D0191) every 181 days
    v. One screening (D0190) every 181 days

b. Diagnostic imaging
    i. Bitewing radiograph(s) every 181 days
    ii. One complete series of intraoral radiographs every three years
    iii. One panoramic radiograph every three years

The following are not covered:

a. Dental screenings or assessments performed by a registered dental hygienist on the same date of service as an evaluation performed by a dentist.
b. Individual periapical radiograph(s) on the same date of service when the reimbursement amount exceeds that of a complete series.
c. Intraoral-complete series and panoramic film on the same date of service.

Endodontic Services

Covered services include services to treat the dental pulp and surrounding tissues.

Orthodontic Services

Covered services include orthodontic services for enrollees with handicapping malocclusions, limited to:

a. Up to 24 units within a 36-month period, including the removal of appliances and retainers at the end of treatment
b. One replacement retainer(s) per arch, per lifetime

Periodontal Services

Covered services include services to diagnose and treat the diseases of the supporting and surrounding tissues of the teeth.

Full mouth scaling performed on the same date of service as root planing or periodontal scaling is not covered.

Preventive Services

Covered services include:

a. One oral prophylaxis once every 181 days
b. Topical fluoride application
    i. Varnish:
        1. Once every 90 days for enrollees under age six
        2. Once every 181 days for enrollees age six and older
    ii. Non-varnish fluoride applications once every 181 days
    iii. Silver diamine fluoride once every 181 days per tooth
c. Sealants, limited to one application per tooth (permanent molar) every three years

Prosthodontic Services

Covered services include those services to diagnose, plan, rehabilitate, fabricate, and maintain dentures as follows:

a. One of the following per enrollee
    i. One upper set
    ii. One lower set
    iii. One complete set of full dentures
    iv. Removable partial dentures
b. One reline, per denture, per 366-day period
c. One all-acrylic interim partial (flipper) for the anterior teeth

Restorative Services

Covered services include all-inclusive restorative services as follows:

a. Restorations
    i. Anesthesia is covered for restorative services only when not billed separately
b. Crowns

Surgical Procedures and Extractions

Covered services include:

a. Surgical procedures and extraction services
b. Emergency dental services to alleviate pain and/or infection
c. Procedures essential to prepare the mouth for dentures
a. Surgical and adjunctive treatment of diseases, injuries, deformities, and defects of the oral and maxillofacial areas

Exclusions

The following services are excluded from coverage:

a. Services that do not meet the requirements of Medical Necessity
b. Services that unnecessarily duplicate another provider's service
c. Experimental or investigational drug, biological product, device, medical treatment, or procedure that meets any of the following criteria, as determined by Insurer:
    i. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the Enrollee's circumstances is the subject of ongoing phase I, II, or III clinical trials;

    ii. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the Enrollee's circumstances is under study with a written protocol to determine maximum tolerated dose, toxicity, safety, or efficacy in comparison to conventional alternatives; or

    iii. Reliable evidence shows the drug, biological product, device, medical treatment, or procedure when applied to the Enrollee's circumstances is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board as required and defined by federal regulations, particularly those of the U.S. Food and Drug Administration or the Department of Health and Human Services.

d. Prescription drugs and services provided in a hospital, urgent care center, or emergency department (these are benefits covered by the Enrollee's Florida Healthy Kids health plan).
e. Early and Periodic Screening, Diagnosis, and Treatment services.

Attachment B: Business Associate Agreement

THIS BUSINESS ASSOCIATE AGREEMENT ("AGREEMENT") is entered into by and between Florida Healthy Kids Corporation, a Florida non-profit corporation, ("FHKC" or "Covered Entity") and Managed Care of North America, Inc. d/b/a MCNA (the "BA") (collectively referred to as the "Parties"), and is incorporated in the contract for Dental Services and Coverage between FHKC and BA (hereby referred to as the "Contract" for purposes of this Agreement).

Section 1. HIPAA Compliance

FHKC and BA agree to comply with the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, codified at 42 U.S.C. §1320d through d-9, as amended from time to time ("HIPAA") and the Health Information Technology for Economic and Clinical Health Act ("HITECH"). BA recognizes and agrees that it is directly obligated by law, through the Contract, and through any other written agreement and this Agreement to comply with the provisions of HIPAA and HITECH applicable to BA pursuant to its performance of Services.

Section 2. Definitions for Use in this Agreement

Terms used but not otherwise defined in this Agreement or the Contract shall have the same meaning as those terms in 45 C.F.R. Parts 160, 162, and 164, as modified or supplemented herein.

"Access" means to review, inspect, approach, instruct, communicate with, store Data in, retrieve Data from, or otherwise make use of any Data, regardless of type, form, or nature of storage. Access to a computer, network, or peripherals includes local and remote access.

Section 3. Obligations and Activities of BA (Privacy Rule)

3.1 Operation on Behalf of FHKC

The BA shall use and disclose Protected Health Information ("PHI") only as shall be permitted by the Contract, this Agreement, any other agreement(s) or as required by law. BA shall have the same duty to protect FHKC's PHI as such term is defined in the Contract and/or under HIPAA, and in furtherance of the duties therein.

3.2 Compliance with the Privacy Rule

BA agrees to fully comply with the requirements under the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E ("Privacy Rule") applicable to "business associates," as that term is defined in the Privacy Rule, and not use or further disclose PHI other than as permitted or required by the Contract, this Agreement, or as required by law.

BA shall create and/or adopt policies and procedures to periodically audit BA's adherence to all HIPAA regulations. BA acknowledges and promises to perform such audits pursuant to the terms and conditions set out herein. BA shall make such audit policies and procedures available to FHKC for review.

To the extent BA is to carry out one or more of FHKC's obligations under the Privacy Rule, BA agrees to comply with the requirements of the Privacy Rule that apply to FHKC in the performance of such obligations. Except as otherwise allowed in this Agreement and under HIPAA, BA shall not directly or indirectly receive remuneration in exchange for any PHI of an Individual unless the Individual has provided a valid authorization compliant with HIPAA and state law.

3.3 Privacy Safeguards and Policies

BA agrees to use appropriate safeguards to prevent Use or Disclosure of PHI other than as provided for by the Contract, this Agreement, or any other agreement(s) or as required by law.

3.4 Mitigation of Harmful Effect of Violations

BA agrees to inform FHKC without unreasonable delay and mitigate, to the extent practicable, any harmful effect that is known to BA resulting from Access, acquisition, Use, or Disclosure of PHI by BA, or by a subcontractor or agent of BA, resulting from a violation of the requirements of this Agreement.

3.5 Privacy Obligations regarding Breaches and Security Incidents

3.5.1 Privacy Breach

BA will report to FHKC, immediately following discovery and without unreasonable delay, any Access, acquisition, Use, or Disclosure of FHKC's PHI not permitted by HIPAA, the Contract, this Agreement, or in writing by FHKC. In addition, BA will report, immediately following discovery and without unreasonable delay, but in no event later than five (5) Business Days following discovery, any Breach of Unsecured Protected Health Information, notwithstanding whether BA has made an internal risk assessment and determined that no notification is required. BA shall cooperate with FHKC in investigating the Breach and in meeting FHKC's obligations under HIPAA and any other security breach notification laws. In the event of a Breach, BA and FHKC will work together in good faith to comply with any required regulatory filings due to the Breach.

Any such report shall include the identification (if known) of each Individual whose Unsecured PHI has been, or is reasonably believed by BA to have been, Accessed, acquired, Used, or Disclosed during such Breach. BA will make the report to FHKC's Privacy Officer not more than five (5) Business Days after BA discovers such non-permitted Access, acquisition, Use, or Disclosure.

Regarding any items not known at the time of the initial report, BA will subsequently report to FHKC as answers are determined. All elements will be reported no later than thirty (30) days after the date of the initial report, or as soon as feasible, whichever is sooner.

BA shall track all Breaches and shall periodically report such Breaches in summary fashion as may be requested by FHKC, but not less than annually within sixty (60) days of each anniversary of this Agreement.

3.5.2 Access of Individual to PHI and other Requests to Business Associate

If BA receives PHI from FHKC in a Designated Record Set, BA agrees to provide access to such PHI to FHKC in order for FHKC to meet its requirements under 45 CFR § 164.524. If BA receives a request from an Individual for a copy of the Individual's PHI, and the PHI is in the sole possession of the BA, BA will provide the requested copies to the Individual in compliance with 45 CFR § 164.524 and notify FHKC of such action within five (5) Business Days of completion of the request. If BA receives a request for PHI in the possession of FHKC or receives a request to exercise other individual rights as set forth in the Privacy Rule, BA shall promptly forward the request to FHKC within two (2) Business Days. BA shall then assist FHKC as necessary in responding to the request in a timely manner. If a BA provides copies of PHI to the Individual, it may charge a reasonable fee for hard copies as the regulations shall permit. If requested, BA shall provide electronic copies as required by law.

3.5.3 Recording of Designated Disclosures of PHI

BA agrees to maintain and make available information required to provide an accounting of disclosures to FHKC as necessary to satisfy FHKC's obligations under 45 CFR § 164.528. BA agrees to provide to FHKC, within fifteen (15) days and in a secure manner, information collected in accordance with this provision, to permit FHKC to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528 and applicable state law.

3.5.4 Requests to Make an Amendment to the PHI

BA agrees to make any amendments to PHI maintained by BA in a Designated Record Set as agreed to by FHKC pursuant to 45 CFR § 164.526 or take other measures as necessary to satisfy FHKC's obligations under 45 CFR § 164.526.

3.5.5 Security and Privacy Compliance Review upon Request

HHS Inspection BA shall make its internal practices, books, and records relating to the Access, acquisition, Use, and Disclosure of PHI available to the HHS for purposes of determining Covered Entity's compliance with HIPAA. Except to the extent prohibited by law, BA agrees to notify FHKC of all requests served upon BA for information or documentation by or on behalf of the HHS. BA shall provide to FHKC a copy of any PHI that BA provides to the HHS concurrently with providing such PHI to the HHS.

3.5.6 FHKC Inspection

Upon written request, BA agrees to make available to FHKC during normal business hours BA's internal practices, books, and records relating to the use and disclosure of PHI or Electronic Protected Health Information ("EPHI") received from, or created or received on behalf of, FHKC in a time and manner designated by FHKC for the purposes of FHKC determining compliance with the HIPAA Privacy and Security Requirements.

Section 4. Obligations and Activities of BA (Security Rule)

4.1 Compliance with Security Rule

BA shall ensure compliance with the HIPAA Security Standards for the Protection of EPHI, 45 C.F.R. Part 160 and Part 164, Subparts A and C (the "Security Rule"), with respect to EPHI covered by the Contract and this Agreement. Further, at least once every three (3) years, BA shall conduct a risk analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of EPHI.

4.2 Security Safeguards and Policies

BA agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of FHKC as required by the Security Rule. The BA will maintain appropriate documentation of its compliance with the Security Rule. These safeguards include:

- Annual training to relevant employees, contractors, and subcontractors on preventing improper Access, acquisition, Use, or Disclosure of PHI, updated as appropriate;
- Adopting policies and procedures regarding the safeguarding of PHI, updated and enforced as necessary; and
- Implementing appropriate technical and physical safeguards to protect PHI, including access controls, transmission security, workstation security, etc.

4.3 Security Provisions in Business Associate Contracts

In accordance with 45 CFR §§ 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, BA shall ensure that any subcontractors that create, receive, maintain, or transmit PHI on behalf of BA agree in writing to the same restrictions and conditions that apply to BA with respect to such information.

4.4 Reporting Security Incidents and Breaches to FHKC

BA shall track all Security Incidents and shall periodically report such Security Incidents in summary fashion as may be requested by FHKC, but not less than annually within sixty (60) days of each anniversary of this Agreement. The BA shall reasonably use its own vulnerability assessment of damage potential and monitoring to define levels of Security Incidents and responses for BA's operations.

The BA shall promptly and, with every commercially reasonable effort, within 15 hours of discovery, notify FHKC's Privacy Officer of any Security Incident, including any Breach of Security under section 501.171, Florida Statutes, in a preliminary report , with a full report of the incident within five (5) Business Days of the time it became aware of the incident.

The BA shall likewise notify FHKC in a preliminary report within two (2) Business Days of any unauthorized Access or acquisition, including but not limited to internal User Access to non-test records reported to BA's privacy manager, and any Use, Disclosure, modification, or destruction

of PHI by an employee or otherwise authorized User of its system of which it becomes aware with a full report of the incident within five (5) Business Days from the time it became aware of the incident.

BA shall identify in writing key contact persons for administration, Data processing, marketing, information systems and audit reporting within thirty (30) days of the execution of this Agreement. BA shall notify FHKC of any reduction of in-house staff during the term of this Agreement, in writing, within ten (10) Business Days.

When reporting any Security Incident or Breach, BA shall use the "Notification to FHKC of Security Incident or Breach of Protected Health Information" form attached hereto.

4.5 Unsecured Protected Health Information

For all Unsecured PHI maintained or transmitted by BA or BA's subcontractors, BA shall notify each Individual whose Unsecured PHI has been Accessed, acquired, Used, or Disclosed in a manner not permitted under the HIPAA Privacy Rule which compromises the security and privacy of the PHI, except when law enforcement requires a delay pursuant to 45 CFR § 164.412. If BA cannot identify the specific Individuals whose Unsecured PHI may have been Accessed, BA shall notify all persons whose Unsecured PHI reasonably may have been Accessed.

On behalf of FHKC, BA shall notify such Individuals without unreasonable delay, and in no case later than sixty (60) days after discovery of the Breach. The Notice required under HIPAA shall be made as follows:

- By written Notice in plain language including, to the extent possible:
    - A brief description of what happened, including the date of the Breach and the date of the discovery of the Breach, if known;
    - A description of the types of Unsecured PHI involved in the Breach (including but not limited to items such as whether full name, social security number, date of birth, home address, Family Account number, diagnosis, disability code, or other types of information were involved);
    - Any steps Individuals should take to protect themselves from potential harm resulting from the Breach;
    - A brief description of what BA and FHKC are doing to investigate the Breach, to mitigate the harm to Individuals, and to protect against further Breaches; and
    - Contact procedures for Individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an email address, website or postal address.

- BA must use a method of notification that meets the requirements of 45 CFR 164.404(d).

Further, BA must provide Notice to the media when required under 45 CFR 164.406 and to HHS pursuant to 45 CFR 164.408.

BA also agrees to comply with any similar state laws, such as section 501.171, Florida Statutes, that govern breaches.

BA agrees to pay all costs of notification and any associated mitigation as a result of a Breach or breach of state law, including the provision of, at a minimum, two years of credit monitoring and identity theft protection for such affected Individuals. FHKC, in its sole discretion, shall determine if the Breach or breach of state law is significant enough to warrant such measures and the length of time such mitigation measures shall be offered to the affected Individuals.

In the event of the unpermitted Access, acquisition, Use, or Disclosure of Unsecured PHI, BA shall pay for and maintain a prompt mechanism on the existing toll-free telephone line, email link, and fully functioning web page to respond to any Enrollee's or Applicant's concerns about security, Breach, unauthorized Access, acquisition, Use, or Disclosure, or any credible allegations or suspicions of the above.

4.6 Additional Consumer Protections

For purposes of this paragraph, the terms and definitions set forth in section 501.171, Florida Statutes, govern over any other conflicting definitions specified in this Agreement. BA understands that FHKC or its customers may be a Covered Entity (as may be BA) under the terms of section 501.171. The reporting requirements set forth in Section 4.4 of this Agreement apply to any Breach of Security. In the event of a Breach of Security, the BA shall indemnify and hold FHKC harmless for expenses and/or damages related to the Breach of Security. Such obligation shall include, but is not limited to, the mailed notification to a governmental agency and any individual in Florida whose Personal Information is reasonably believed to have been Accessed as a result of the Breach of Security. In the event that the BA discovers circumstances requiring notification of more than one thousand (1,000) persons at one time, BA shall also notify, without unreasonable delay, all consumer reporting agencies that compile and maintain files on consumers on a nationwide basis, as in the Fair Credit Reporting Act, 15 U.S.C. § 1681a(p), of the timing, distribution and content of the Notices. Substitute Notice, as specified in section 501.171(4)(f), Florida Statutes, shall not be permitted except as approved in writing in advance by FHKC. The Parties agree that PHI includes Data elements in addition to those included described as Personal Information under section 501.171 and agree that BA's responsibilities under this paragraph shall include all PHI or EPHI. BA agrees to pay all costs of any associated mitigation as a result of a Breach of Security, including the provision of, at a minimum, one (1) year of credit monitoring and identity theft protection for such affected individuals. FHKC, in its sole discretion, shall determine if the Breach of Security is significant enough to warrant such measures and the length of time such mitigation measures shall be offered to the affected individuals.

Section 5. Electronic Transaction and Code Sets

To the extent that the services performed by BA pursuant to the Agreement involve transactions that are subject to the HIPAA Standards for Electronic Transactions and Code Sets, 45 C.F.R. Parts 160 and 162, with respect to EPHI covered by the Contract and this Agreement, BA shall conduct such transactions in conformance with such regulations as amended from time to time. Without limiting the generality of the foregoing, BA also agrees that it will, in accordance with 45 C.F.R. § 162.923(c), comply with all applicable requirements of 45 C.F.R. Part 162, and require any agent or subcontractor to comply with all applicable requirements of 45 C.F.R. Part 162.

Section 6. Permitted Uses and Disclosures by BA – General Use and Disclosure Provisions

6.1 Use of PHI for Operations on Behalf of FHKC

BA shall conduct all activities in compliance with 45 CFR 164 Subpart C to ensure data security, including, but not limited to encryption of all information that is confidential under Florida or federal law, while in transmission and while resident on portable electronic media storage devices. Encryption is required and shall be consistent with Federal Information Processing Standards, and /or the National Institute of Standards and Technology publications regarding cryptographic standards.

Except as otherwise limited by this Agreement, BA may Use or Disclose PHI to perform functions, activities, or services for, or on behalf of, FHKC as specified in the Contract and this Agreement, provided that such Use or Disclosure would not violate HIPAA if done by FHKC or other policies and procedures of FHKC. BA may Use or Disclose PHI as required by law.

Except as otherwise provided in the Contract or this Agreement, BA is prohibited from further using or disclosing any information received from FHKC, or from any other business associate of FHKC for any commercial purposes of the BA, including, by way of example, “Data mining.”

BA shall only request, use and disclose the minimum amount of PHI necessary to accomplish the purposes of the request, use or disclosure.

6.2 No Offshoring

Except as may be expressly authorized in the Contract between FHKC and BA, BA and any of its subcontractors and agents are prohibited from (a) performing any services under the Contract or this Agreement outside of the continental U.S.; (b) sending, transmitting, or maintaining PHI or Individually Identifiable Health Information outside of the continental U.S.; or (c) allowing PHI or Individually Identifiable Health Information to be Accessed from or maintained outside the continental U.S.

Section 7. Permitted Uses and Disclosures by BA – Specific Use and Disclosure Provisions

7.1 Proper Management and Administration of BA

BA may use PHI for the proper management and administration of BA or to carry out BA's responsibilities under the Contract and/or this Agreement.

7.2 Third-Party Disclosure Confidentiality

Except as otherwise limited in the Contract or this Agreement, BA may disclose PHI for the proper management and administration of the BA or to carry out the legal responsibilities of BA, provided that disclosures are required by law or, if permitted by law, this Agreement, the Contract, and any Ancillary Agreements, provided that, if BA discloses any PHI to a third party for such a purpose, BA shall enter into a written agreement with such third party requiring the third party to: (a) maintain the confidentiality, integrity, and availability of PHI and not to use or further disclose such information except as required by law or for the purpose for which it was disclosed, and (b) notify BA of any instances in which it becomes aware in which the confidentiality, integrity, and/or availability of the PHI is breached in a preliminary report within two (2) Business Days with a full report of the incident within five (5) Business Days from the time it became aware of the incident.

7.3 Data Aggregation Services

Except as otherwise limited in this Agreement, BA may use PHI to provide Data Aggregation Services to FHKC as permitted by 42 CFR § 164.504I(2)(i)(B).

Section 8. Provisions for FHKC to Inform BA of Privacy Practices and Restrictions

8.1 Notice of Privacy Practices

FHKC shall provide BA with the Notice of Privacy Practices produced by FHKC or provided to FHKC as a result of FHKC's obligations with other organizations in accordance with 45 CFR § 164.520, as well as any changes to such Notice.

8.2 Notice of Changes in Individual's Access or PHI

FHKC shall provide BA with any changes in, or revocation of, permission by an Individual to use or disclose PHI, if such changes affect BA's permitted or required uses.

8.3 Notice of Restriction in Individual's Access or PHI

FHKC shall notify BA of any restriction to the use or disclosure of PHI that FHKC has agreed to in accordance with 45 CFR § 164.522, to the extent that such restriction may affect BA's use of PHI.

Section 9. Term and Termination

9.1 Term

The Term of this Agreement shall be effective concurrent with the Contract, and shall terminate when all of the PHI provided by FHKC to BA, or created or received by BA on behalf of FHKC, is destroyed or returned to FHKC, or, if it is not feasible to return or destroy PHI, protections are extended to such information in accordance with the termination provisions in this section.

9.2 Termination for Cause

FHKC has the right to immediately terminate this Agreement in the event BA fails to comply with or violates a material provision of this Agreement or any provision of the Privacy and Security Rules. Notwithstanding the aforementioned, BA shall not be relieved of liability to FHKC for damages sustained by virtue of any breach of this Agreement by BA.

9.3 Effect of Termination; Return of Protected Health Information

Upon termination of this Agreement for any reason, except as provided in subsections below, BA shall, at its own expense, either return and/or destroy all PHI and other Individually Identifiable Health Information received from FHKC or created or received by BA on behalf of FHKC. This provision applies to all Individually Identifiable Health Information regardless of form, including but not limited to electronic or paper format. This provision shall also apply to PHI and other Individually Identifiable Health Information in the possession of subcontractors or agents of BA.

The BA shall consult with FHKC as necessary to assure an appropriate means of return and/or destruction of PHI and Individually Identifiable Health Information, and shall notify FHKC in writing when such destruction is complete. If PHI or Individually Identifiable Health Information is to be returned, the Parties shall document when all information has been received by FHKC.

The BA shall notify FHKC whether it intends to return and/or destroy the PHI or Individually Identifiable Health Information with such additional detail as requested. In the event BA determines that returning or destroying the PHI and Individually Identifiable Health Information received by or created for FHKC at the end or other termination of this BAA is not feasible, BA shall provide to FHKC notification of the conditions that make return or destruction not feasible, and BA shall:

a) Retain only that PHI and Individually Identifiable Health Information that is necessary for BA to continue its proper management and administration or to carry out its legal responsibilities;

b) Return to FHKC (or, if agreed to by FHKC, destroy) the remaining PHI that the BA still maintains in any form;

c) Continue to use appropriate safeguards and comply with the Security Rule with respect to EPHI to prevent use or disclosure of the PHI and Individually Identifiable Health Information, other than as provided for in this section, for as long as BA retains the PHI;

d) Not use or disclose the PHI or Individually Identifiable Health Information retained by BA other than for the purposes for which such information was retained and subject to the same conditions set out under "Permitted Uses and Disclosures by BA – Specific Use and Disclosure Provisions" which applied prior to termination; and

e) Return to FHKC (or, if agreed to by FHKC, destroy) the PHI and Individually Identifiable Health Information retained by BA when it is no longer needed by BA for its proper management and administration or to carry out its legal responsibilities.

Section 10. Miscellaneous

10.1 Breach of Agreement

BA's failure to perform the obligations in this Agreement shall be a breach of this Agreement and/or the Contract and will entitle FHKC to recover any damages it incurs arising from a failure to perform the obligations in this Agreement, including any actual out-of-pocket expenses incurred by FHKC to investigate and remediate the violation, reimbursement for any assessments against FHKC by AHCA due to BA's failure, and/or to pursue injunctive relief.

10.2 Severability

If any of the provisions of this Agreement shall be held by a court of competent jurisdiction to be no longer required by HIPAA, the Parties shall exercise their best efforts to determine whether such provisions shall be retained, replaced, or otherwise modified.

10.3 Cooperation

The Parties agree to cooperate and to comply with procedures mutually agreed upon to facilitate compliance with HIPAA, including procedures designed to mitigate the harmful effects of any improper Access, acquisition, Use, or Disclosure of PHI.

10.4 Regulatory Reference

Any reference in this Agreement to a section in the HIPAA regulations means those provisions currently in effect or as may be amended in the future.

10.5 Modification and Amendment

This Agreement may be modified only by express written amendment executed by all Parties hereto. The Parties agree to take such action to amend this Agreement from time to time as is necessary for FHKC to comply with the requirements of HIPAA and applicable state law.

10.6 Survival

The respective rights and obligations of BA under "Term and Termination" of this Agreement shall survive the termination of this Agreement and the Contract.

10.7 Interpretation

Any ambiguity in this Agreement or the Contract shall be resolved so as to permit FHKC to comply with HIPAA.

10.8 No Third-Party Rights/Independent Contractors

The Parties to this Agreement do not intend to create any rights in any third parties. The Parties agree that they are independent contractors and not agents of each other, except nothing herein affects whether BA is an "agent" for purposes of compliance with 42 CFR § 1001.952(d).

10.9 State Law

BA acknowledges and agrees that it has implemented and will maintain appropriate privacy and security measures to protect personal information consistent with state laws and regulations to the extent those state laws and regulations are applicable to the PHI. The confidentiality obligations hereunder are independent of and do not limit or otherwise affect the Parties' other confidentiality obligations under this Agreement.

10.10 Governing Law

To the extent not preempted by federal law, this Agreement shall be governed and construed in accordance with the State of Florida without regard to conflicts of law provisions that would require application of the law of another state.

10.11 Assignment, Binding Nature, and Benefits

This Agreement binds and benefits the Parties, their respective successors, and their permitted assigns. BA may not assign or subcontract rights or obligations under this Agreement without the express written consent of FHKC. FHKC may assign its rights and obligations under this Agreement under this Agreement to any successor or affiliated entity.

10.12 Counterparts

This Agreement may be executed in multiple counterparts, which shall constitute a single agreement, and by facsimile or PDF signatures, which shall be treated as originals.

REMAINDER OF THIS PAGE LEFT INTENTIONALLY BLANK
SIGNATURE PAGE TO FOLLOW

IN WITNESS WHEREOF, the Parties have caused this BUSINESS ASSOCIATE AGREEMENT, to be executed by their undersigned officials as duly authorized.

FOR

FLORIDA HEALTHY KIDS CORPORATION:

Signed: _____

Name: Ryan West

Title: Chief Executive Officer

Date: 3/9/2022

FOR

MANAGED CARE OF NORTH AMERICA, INC. D/B/A MCNA:

Signed: _____

Name: Shannon Turner

Title: Executive Vice President

Date: 3-23-22

NOTIFICATION TO FHKC OF SECURITY INCIDENT OR BREACH OF PROTECTED HEALTH INFORMATION

Contract Information	
Contract Number	Contract Title

Contract Contact Information	
Contact Person for This Incident:	
Contact Person's Title:	
Contact's Address	
Contact's Email:	
Contact's Telephone No:	

Business Associate hereby notifies FHKC that there has been a Security Incident or Breach of Protected Health Information (collectively referred to as a "Breach" for purposes of this Notification) that Business Associate has used or has had access to under the terms of the Business Associate Agreement, as described in detail below:

Detail of the Security Incident or Breach	
Date of Security Incident or Breach	Date of Discovery of Security Incident or Breach
Information about the Breach or Security Incident	
Type of Breach or Security Incident: Lost or stolen laptop, computer, flash drive, disk, etc. Stolen password or credentials Unauthorized Access by an employee or contractor Unauthorized Access by an outsider	

Other (describe)
Detailed Description of the Breach or Security Incident
Types of Protected Health Information involved in the Breach or Security Incident (such as Full Name, SSN, Date of Birth, Address, Family Account Number, Disability Code, etc.)

Personal Information: Name Address Date of birth Social Security number Driver's license or identification card number Financial insurance information (credit card number, bank account number, etc.) Health insurance information (insurance carrier, insurance card number, etc.) Other Personal or Health Information (describe):	Health Information: Basic information (age, sex, height, etc.) Disease or medical conditions Medications Treatments or procedures Immunizations Allergies Information about children Test results Hereditary conditions Mental health information Information about diet, exercise, weight, etc.) Correspondence between patient, or medical power of attorney Organ donor authorization

What steps are being taken to investigate the Security Incident or Breach, mitigate losses, and protect against any further Security Incidents or Breaches?

List any law enforcement agencies you've contacted about the Security Incident or Breach

Number of Individuals Impacted	If over 500, do individuals live in multiple states?	
	Yes	No

Breach or Security Incident Notification		
Have you made the Security Incident or Breach public?		If YES, when did you make it public
Yes	No	

Have you notified the people whose information was Breached or impacted?

YES. We notified them on:

Attach a copy of the letter to this form. Don't include any Individually Identifiable Health Information, other than your own contact information.

NO. Our investigation isn't complete.

Comments

Submitted By: Date of Submission:

_____ _____

Attachment C: Performance Guarantees

Insurer agrees the services provided under this Contract are critical to the success of FHKC's provision of quality services to Enrollees and the administration of the Program as part of Florida's CHIP and the Full-pay Plan.

The failure to meet the following performance guarantees (PGs) shall be deemed a default. For each such default, Insurer shall be liable to FHKC for financial consequences in addition to any other remedies available under the Contract. FHKC shall inform Insurer in writing, by email or mail, of any financial consequences incurred and how the amounts owed to FHKC should be remitted.

FHKC may waive financial consequences, in whole or in part, for any reason in its sole discretion. The waiver of financial consequences in one instance does not provide Insurer any right or expectation to future waived financial consequences under the same, or any other, circumstances.

When reporting PG results, Insurer shall round the results at the tenth decimal place to the nearest whole number.

- For percentages with numbers zero through four (0-4) in the tenth decimal place, round down.
- For percentages with numbers five through nine (5-9) in the tenth decimal place, round up.

PG-1: Average Speed to Answer

Ninety percent (90%) of inbound calls received by Insurer's enrollee services call center shall be answered by a live agent within thirty (30) seconds.

Reporting Frequency: Monthly

Financial Consequences: five hundred dollars ($500) per percentage point below guarantee.

Calculation Methodology

- The answer time measurement threshold begins when the call is presented in the call queue for an agent to answer.
    - The time the caller spends navigating any automated systems is not included in the measurement time.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of inbound calls answered within thirty (30) seconds. Performance reported in any other manner, including the average

number of seconds for ninety percent (90%) of inbound calls to be answered is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 21

PG-2: Call Abandonment Rate

The percentage of calls received that are terminated by the caller before a live person answers shall not exceed three percent (3.0%).

Reporting Frequency: Monthly

Financial Consequences: five hundred ($500) per percentage point below guarantee.

Calculation Methodology

- The abandonment measurement threshold begins when the call is presented in the call queue for an agent to answer.
    - Callers who terminate while navigating any automated systems are not included in the measurement.

Related Contract Reference: Section 21

PG-3: Blocked Calls

The percentage of inbound calls blocked from entering the call center system and those that are forced disconnects shall be zero percent (0.0%).

Reporting Frequency: Monthly

Financial Consequences: five hundred dollars ($500) per percentage point above the guarantee.

Calculation Methodology

- The percentage of blocked calls shall be calculated by the number of calls blocked by Insurer's telecom provider and the number of calls that are forced disconnects divided by the total number of calls.

Related Contract Reference: Section 21

PG-4: First Call Resolution

Insurer's enrollee service representatives shall ensure that at least eighty-five percent (85%) of calls are resolved within the first call during the first Contract Year and at least ninety percent (90%) thereafter.

Reporting Frequency: Monthly

Financial Consequences: two hundred fifty dollars ($250) per percentage point below the guarantee

Calculation Methodology

- Insurer shall audit a statistically valid random sample of all Florida Healthy Kids calls each quarter.
    - Insurer shall determine if the call is the first call the caller has made about the issue and if the enrollee services representative answering the call resolved the call during that initial call.
    - Resolution includes providing complete and clear information to the extent a call or other communication back to or from the caller is not needed. Insurer shall also review the caller's record to ensure no follow up calls were placed to Insurer about the same issue.

Related Contract Reference: Section 21

PG-5: Call Quality Assurance Monitoring

Insurer shall ensure that the average call quality monitoring score resulting from call monitoring of all call center enrollee service representatives working on the Florida Healthy Kids account is at least ninety-five percent (95%).

Reporting Frequency: Monthly

Financial Consequences: two hundred fifty dollars ($250) per percentage point below the guarantee

Calculation Methodology

- Insurer shall conduct quality assurance monitoring of all call center enrollee service representatives working on the Florida Healthy Kids account each month using an established review methodology for which the highest score possible is one hundred percent (100%). Insurer shall divide the sum of all quality assurance monitoring review scores by the total number of quality assurance monitoring reviews conducted during the month.

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report performance based on the average score. Performance reported in any other manner, including the number of quality assurance monitoring reviews to meet ninety-five percent (95%) is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 21

PG-6: Enrollment Files

Insurer shall accurately process one hundred (100%) of enrollment files, including supplemental enrollment files within two (2) Business Days of receipt.

Reporting Frequency: Monthly

Financial Consequences: one thousand dollars ($1,000) per Calendar Day

Calculation Methodology

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of enrollment files accurately processed within two (2) Business Days of receipt.
- Financial Consequences apply to each Calendar Day beyond the due date until accurately processed, inclusive of the date processed.

Related Contract Reference: Section 18

PG-7: Ad hoc Enrollment Data

Insurer shall accurately process one hundred percent (100%) of ad hoc enrollment requests, including changes in demographic information, within one (1) Business Day of request.

Reporting Frequency: Monthly

Financial Consequences: one thousand dollars ($1,000) per incident per Calendar Day

Calculation Methodology

- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of enrollment files accurately processed within one (1) Business Day of request.
- Financial Consequences apply to each Calendar Day beyond the due date until accurately processed, inclusive of the date processed for each ad hoc enrollment request.

Related Contract Reference: Section 18

PG-8: Enrollment Packages

Insurer shall provide complete enrollment packages, including ID cards, to one hundred percent (100%) of new Enrollees within five (5) Business Days of receipt of the enrollment information.

Reporting Frequency: Monthly

Financial Consequences: two thousand dollars ($2,000) per percentage point below guarantee.

Calculation Methodology

- "Provide" is used in the same manner as 42 CFR 438.10(g)(3) except that a physical ID card must be mailed to each Enrollee.
- Enrollment packages returned undeliverable due to no fault of Insurer are not included in the measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of enrollment packages provided to Enrollees within five (5) Business Days. Performance reported in any other manner, including the number of days to process one hundred percent (100%) of enrollment packages is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 18

PG-9: Appeal and Grievance Resolution Timeframe

Insurer shall resolve one hundred percent (100%) of Appeals and Grievances within the timeframes below. Any of the timeframes below may be extended by fourteen (14) Calendar Days if the conditions of 42 CFR 438.408(c) are met.

- Standard Grievances: Ninety (90) Calendar Days
- Standard Appeals: Thirty (30) Calendar Days
- Expedited Appeals: Seventy-two (72) hours

Reporting Frequency: Quarterly

Financial Consequences: two thousand five hundred dollars ($2,500) per percentage point below guarantee.

Calculation Methodology

- When determining the percentage of Appeals and Grievances resolved timely, the denominator includes all Appeals and Grievances received for which the latest acceptable resolution date fell within the reporting period, regardless of when the Appeal or Grievance was actually resolved. For example, an Appeal or Grievance for which the latest acceptable resolution date falls in quarter B shall be included in the

denominator for quarter B regardless of the quarter during which the Appeal or Grievance was resolved.

  - The "latest acceptable resolution date" includes the fourteen (14) Calendar Days extension only if the required conditions were met **and** the extension was taken for the Appeal or Grievance.

- When determining the percentage of Appeals and Grievances resolved timely, the numerator includes all Appeals and Grievances included in the denominator that were resolved timely.

Related Contract Reference: Section 23

PG-10: Independent Review Timeframes

Insurer shall ensure that Insurer's contracted IRO completes one hundred percent (100%) of the independent reviews within the timeframes below.

- Standard Review: forty-five (45) Calendar Days
- Expedited Review: Seventy-two (72) hours

Reporting Frequency: Quarterly

Financial Consequences: two thousand five hundred dollars ($2,500) per percentage point below guarantee.

Calculation Methodology

- When determining the percentage of reviews resolved timely, the denominator includes all reviews received for which the latest acceptable resolution date fell within the reporting period, regardless of when the review was actually resolved. For example, a review for which the latest acceptable resolution date falls in quarter B shall be included in the denominator for quarter B regardless of the quarter during which the review was resolved.
- When determining the percentage of reviews resolved timely, the numerator includes all reviews included in the denominator that were resolved timely.

Related Contract Reference: Section 23

PG-11: Electronic Claims Processing

Insurer shall process ninety percent (90%) of electronic claims within fifteen (15) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: five hundred ($500) per percentage point below guarantee.

Calculation Methodology

- The measurement for electronic claims includes clean claims and claims for which all information requested by Insurer to continue processing the claim has been received.
- The measurement begins on the date a clean claim is received or on the date stamped on information received for non-clean claims. The measurement ends on either the date a payment is made, as indicated by the date on the payment, or the date the claim is denied, as indicated by the date on the denial notice.
- Claims currently pending response from Providers are not included in this measurement.
- Claims related to investigations for potential fraud, waste or abuse are not included in this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of electronic claims processed within fifteen (15) Calendar Days. Performance reported in any other manner, including the number of days to process ninety percent (90%) of electronic claims is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-12: Paper Claims Processing

Insurer shall process ninety percent (90%) of paper claims within twenty (20) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: five hundred ($500) per percentage point below guarantee.

Calculation Methodology

- The measurement for paper claims includes clean claims and claims for which all information requested by Insurer to continue processing the claim has been received.
- The measurement begins on the date a clean claim is received or on the date stamped on information received for non-clean claims. The measurement ends on either the date a payment is made, as indicated by the date on the payment, or the date the claim is denied, as indicated by the date on the denial notice.

- Claims currently pending response from Providers are not included in this measurement.
- Claims related to investigations for potential fraud, waste or abuse are not included in this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of paper claims processed within twenty (20) Calendar Days. Performance reported in any other manner, including the number of days to process ninety percent (90%) of paper claims is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-13: Claims Payment Financial Accuracy

Ninety-eight percent (98%) of claims Insurer audits in a statistically valid quarterly audit of Florida Healthy Kids claims using representative sampling shall be free from financial errors.

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars ($500) per percentage point below guarantee.

Calculation Methodology

- Financial accuracy shall be measured as (the number of claims free from financial error divided by the number of claims in the audit sample) multiplied by (the number of claims in the strata population divided by the number of claims in the population).
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of claims free from financial error. Performance reported in any other manner, including the percentage of paid dollars that were for claims free from financial error is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-14: Non-financial Claims Processing Accuracy

Ninety-five percent (95%) of claims Insurer audits in a statistically valid quarterly audit of Florida Healthy Kids claims using representative sampling shall be free from non-financial errors.

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars ($500) per percentage point below guarantee.

Calculation Methodology

- Non-financial claims processing accuracy shall be measured as (the number of claims free from non-financial error divided by the number of claims in the audit sample) multiplied by (the number of claims in the strata population divided by the number of claims in the population).
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of claims free from non-financial error. Performance reported in any other manner, including the percentage of paid dollars that were for claims free from non-financial error is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-15: Provider Overpayment Recovery

Insurer shall recover eighty percent (80%) of overpayments to Providers within sixty (60) Calendar Days of discovery.

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars ($500) per percentage point below guarantee.

Calculation Methodology

- The measurement timeframe begins the date a payment is determined to be an overpayment and ends the date Insurer receives full compensation for the overpaid amount.
- When determining the percentage of overpayments recovered timely, the denominator includes all identified overpayments for which the latest acceptable recovery date fell within the reporting period regardless of when the overpayment was actually recovered.
    - The “latest acceptable recovery date” means sixty (60) Calendar Days from the date the overpayment was identified.

- Overpayments recovered by netting the overpaid amount from amounts owed to a Provider may be considered recovered only if payments of funds owed to the Provider sufficient to recover the entire overpaid amount have been fully processed by Insurer.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of overpayments recovered from Providers within sixty (60) Calendar Days. Performance reported in any other manner, including the number of Calendar Days to recover eighty percent (80%) of Provider overpayments is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-16: Standard Prior Authorization Processing Timeliness

Insurer shall process 100 percent (100%) of all standard prior authorizations within fourteen (14) Calendar Days.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement begins from the date Insurer receives the request and ends the date Insurer makes a final decision and communicates such decision to the requesting Provider.
    - Requests for prior authorization pending additional information from the requesting Provider are not included in the measurement so long as the prior authorization was extended appropriately as described in 42 CFR 438.210.
    - Prior authorizations for which Insurer extended beyond the fourteen (14) Calendar Days as permitted by law are excluded from this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of prior authorizations processed within fourteen (14) Calendar Days. Performance reported in any other manner, including the number of Calendar Days to process one hundred percent (100%) of prior authorizations is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-17: Expedited Prior Authorization Processing Timeliness

Insurer shall process 100 percent (100%) of all expedited prior authorizations within seventy-two (72) hours.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee.

Calculation Methodology

- The measurement begins from the date and time Insurer receives the request and ends the date and time Insurer makes a final decision and communicates such decision to the requesting Provider.
    - Requests for prior authorization pending additional information from the requesting Provider are not included in the measurement so long as the prior authorization was extended appropriately as described in 42 CFR 438.210.
    - Prior authorizations for which Insurer extended beyond the seventy-two (72) hours as permitted by law are excluded from this measurement.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of prior authorizations processed within seventy-two (72) hours. Performance reported in any other manner, including the number of Calendar Days or hours to process one hundred percent (100%) of prior authorizations is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-18: Systems Availability

Insurer shall maintain availability, which includes standard accessibility, of systems critical to Enrollees and Providers, including the public and private plan website(s), any Provider portal or website, and enrollment system, twenty-four hours a day, seven days a week (24/7) except during scheduled maintenance. Insurer shall resolve unscheduled unavailability of these systems within forty-eight (48) hours of identification of the unavailability, when such unavailability is within Insurer's direct or indirect control.

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per Calendar Day

Calculation Methodology

- Financial Consequences apply to each Calendar Day beyond the allowable forty-eight (48) hours, including the date the systems regain availability.

Related Contract Reference: Sections 5, 21, and 24

PG-19: Network Access

Insurer shall provide ninety percent (90%) of Enrollees residing in Insurer's Service Area with access to one Provider for each of the provider types below within the timeframe and distance listed for rural and urban counties.

Provider Type	**Time (in minutes)**		**Distance (in miles)**	
	Rural	**Urban**	**Rural**	**Urban**
PDP	30	20	30	20
Specialist	40	20	30	20
Orthodontist	70	30	50	20
Telehealth	Report			

Reporting Frequency: Quarterly

Financial Consequences: five hundred dollars ($500) per percentage point below guarantee per measurement.

Enrollment	Quarterly Financial Consequences Cap
<25K	$20,000
25-50K	$30,000
50-75K	$40,000
75K+	$50,000

Calculation Methodology

- Network access shall be calculated separately for each provider type and access type (time or distance) and geographical location type (rural or urban).
    - This PG requires twelve (12) separate measurements.
    - Financial Consequences shall be assessed for each of the twelve (12) measurements, including each access and geographical type and for each Provider type, for which Insurer fails to meet the guarantee.
    - Insurer shall be assessed total financial consequences for the PG based on the sum of the financial consequences for provider type, access type, and geographical location type measurements.
    - The quarterly financial consequences cap applies to the PG and not the twelve (12) separate measurements.
- The most recent U.S. census data available is used to determine whether a county is rural or urban.

- For rural measurements, all rural counties in Insurer's Service Area are included in the measurement, regardless of whether the counties are all in the same Region.
- For urban measurements, all urban counties in Insurer's Service Area are included in the measurement, regardless of whether the counties are all in the same Region
- Insurer shall use estimates of actual driving time and actual driving distance to determine access.
    - Insurer may not use "as-the-crow-flies" methodology for determining driving time or mileage.
- The measurements should exclude geographical areas for which Insurer has a current network access waiver for the specified provider type.
- For purposes of determining compliance with this PG and for determining any financial consequences, Insurer shall report the percentage of Enrollees with access within the standard. Performance reported in any other manner, including the percentage or number of Providers within the access standard for ninety percent (90%) of Enrollees is insufficient to meet the requirements of this PG.

Related Contract Reference: Section 24

PG-20: Appointment Access Standards

Ninety percent (90%) of network Providers maintain appointment availability within the timeframes required below:

Type of Care	**Timeframe**
Emergency	Immediately
Urgent	Within twenty-four (24) hours
Routine sick visit care	Seven (7) Calendar Days
Routine preventive care	Within four (4) weeks of request

Reporting Frequency: Quarterly

Financial Consequences: one thousand dollars ($1,000) per percentage point below guarantee per measurement.

Calculation Methodology

- Appointment access shall be determined by Insurer's internal audit and quality assurance activities, using appropriate stratification to avoid over or under representation of any appointment type.
- Appointment access shall be calculated by dividing the sum of network Providers maintaining appointments within the specified timeframes by the total number of

network Providers evaluated. This measure is a single calculation encompassing all appointment types.

Related Contract Reference: Section 24

Attachment D: Reports and Deliverables

The following reports and deliverables are due from Insurer to FHKC by the dates indicated in the chart below. This chart is not an exhaustive list of reports and deliverables required by the Contract. In the event of any conflict between Attachment D and the Contract, the Contract supersedes.

Report/Deliverable Name	**Contractual Reference**	**Frequency and Due Dates**
Implementation plan	12.3	One-time; within five (5) Business Days of Contract execution
Premium rate adjustment request package	2.10.1	Annually; December 1
Prohibited affiliations disclosure	3.4	Annually; July 15
Ownership and control disclosures	3.7	Upon Contract execution, renewal or extension Within thirty-five (35) Calendar Days of any change in ownership
Conflict of interest disclosure form	3.9	Within five (5) Business Days of Insurer's receipt of executed Contract Within ten (10) Business Days after becoming aware of any potential conflicts of interest Annually; July 15
Lobbying disclosure	3.10	Upon Contract execution Annually; July 15
Proof of insurance coverage	3.13	Within ten (10) Business Days of Contract execution Annually; December 31 or by certificate of insurance expiration date
Subcontractor requests	4	Date established in approved implementation plan

		90 Calendar Days prior to proposed effective date
Subcontractor monitoring schedule	4.2	Date established in approved implementation plan Annually; June 1
Subcontractor contingency plan	4.2	Date established in approved implementation plan Upon submission of new Subcontractor requests
NIST compliant information security risk assessment attestation	5	One-time; June 30, 2022
Audited financial statements	9.1	Annually; July 1
Other coverage liability report	9.4.2	Monthly; by the 15th
MLR report	9.5.1	Quarterly; see section 9-5-1 for specific dates
Annual MLR report	9.5.1	Annually; July 1
Experience adjustment report	9.5.2	Annually; June 30, beginning on June 30, 2023
SOC 2 Type II	11.1	Date established in approved implementation plan Annually; date required by FHKC
Account management team contact information	12.4	Upon Contract execution
Key experience metrics report	12.6	Quarterly; by the 15th of the second month following the reporting quarter.
Contract termination transition plan	12.8	90 Calendar Days' prior to Contract termination
Quarterly marketing event report	17.7	Quarterly; 15th of the month following the reporting quarter

Annual marketing event report	17.7	Annually; August 31
Enrollment file discrepancy report	18.5	Monthly; 5 Business Days after receipt of supplemental enrollment file
Enrollee rights policies	19	Date established in approved implementation plan
Cultural competency plan	20	Date established in approved implementation plan Annually; July 1
Disease and case management report	22.9	Quarterly; by the 15th of the second month following the reporting quarter.
Transition of care policy	22.10	Date established in approved implementation plan
Grievances and Appeals Report	23	Quarterly; 15th of the month following the reporting quarter
Network add/term report	24.1	Monthly; 5th of the month following the reporting month
Electronic health record meaningful use report	24.5.2	Annually; July 1, beginning July 1 2023
FQHC/RHC report	24.7	Quarterly; 15th of the month following the reporting quarter
IHCP report	24.8	Quarterly; 15th of the month following the reporting quarter
Adequate capacity to serve	24.9	Upon Contract execution Annually; July 1 Upon significant change in Insurer's operations
Geographic network access report	24.9.1	Quarterly; by the 15th of the second month following the reporting quarter.

Service area exemption reports	24.9.2	Quarterly; 20th of the month following the reporting quarter
Claims payment address(es)	24.12.1	Date established in approved implementation plan
Claims processing report	24.12.1	Quarterly; 15th of the month following the reporting quarter
Capitated arrangements report	24.12.2	Annually; August 1
Provider overpayment report	24.12.3	Annually; July 1 beginning 2023
Fraud and Abuse policies	25	Date established in approved implementation plan
Fraud and Abuse report	25	Quarterly; 15th of the month following the reporting quarter
Accreditation report	26.1	Date established in approved implementation plan Annually; December 15
Quality Improvement Plan	26.2	Date established in approved implementation plan Annually; July 1
Quality Improvement Plan Assessment	26.2	Annually; July 1, beginning Jul 1, 2023
Encounter and claims data	33	Quarterly; see section 33 for specific dates
Attestation organizational chart	34	Upon Contract execution; within 1 week of any changes
Encounter data attestation	34	Concurrent with submission of encounter data
MLR-related attestation	34	Concurrent with submission of documentation FHKC may use to determine Insurer's

		compliance with MLR requirements
Financial solvency-related attestation	34	Concurrent with submission of documentation FHKC may use to determine Insurer has made adequate provision against the risk of insolvency
Availability and accessibility of services attestation	34	Concurrent with submission of documentation related to Insurer's compliance with requirements for availability and accessibility of services, including Provider network adequacy
Ownership and control disclosures attestation	34	Concurrent with submission of documentation
Annual overpayment recoveries report attestation	34	Concurrent with submission of annual overpayment recoveries report