SUNSHINE HEALTH
MEDICAID REGULATORY ADDENDUM SUBCONTRACTOR REQUIREMENTS

This Medicaid Regulatory Addendum is incorporated into the Agreement entered into by and between Subcontractor and Health Plan and is applicable to the extent required by state and federal law.

1.1. Subcontractor represents and warrants that it is eligible for participation in the Medicaid program; however, the Subcontractor is not required to participate in the Medicaid program as a provider. Subcontractor represents and warrants that it is not on the State or federal exclusions list. If Subcontractor is involuntarily terminated from the Medicaid program other than for purposes of inactivity, then the Subcontractor is not considered eligible as a subcontractor under this Agreement. Subcontractor acknowledges and agrees that all services and tasks related to the Agreement or this Product Attachment shall be performed in accordance with the terms of the Medicaid Contract.

1.2. Health Plan shall have a contingency plan for each subcontract to provide for continuity of care should the subcontractor cease to provide services that are the subject of the subcontract. If this Agreement or Product Attachment terminates during the course of a Covered Person's treatment by Subcontractor, Subcontractor shall provide for continuity of treatment through completion of treatment of a condition for which Covered Person was receiving care at the time of termination, until the Covered Person selects another treating contracted provider, or during the next open enrollment period. None of the aforementioned may exceed six (6) months after the termination. If a pregnant Covered Person has initiated a course of prenatal care with Contracted Provider, regardless of the trimester in which care was initiated, Health Plan shall allow Covered Person to continue care until completion of postpartum care regardless of Contracted Provider's termination. Notwithstanding the provisions of this Section 1.2, Contracted Provider may refuse to continue to provide care upon termination to a Covered Person who is abusive or noncompliant. During continuation of care following termination, Health Plan and Subcontractor shall continue to abide by the same terms and conditions as existed in the terminated Agreement.

1.3. Subcontractor shall maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Covered Persons. Records shall be maintained for a period not less than ten (10) years from the close of the Medicaid Contract, and shall be retained further if the records are under review or audit until the review or audit is complete. Prior approval for the disposition of records must be requested and approved by the Health Plan if the contract is continuous. Subcontractor acknowledges and agrees that the United States Department of Health and Human Services ("DHHS"), Department of Elder Affairs (DOEA), AHCA, including the Bureau of Medicaid Program Integrity ("MPI"), or Medicaid Fraud Control Unit ("MFCU"), shall have the right to inspect, evaluate, and audit all of the following related to the Medicaid Contract: pertinent books, financial records, medical records, and documents, papers, and records of any provider involving financial transactions or any other records determined to be pertinent to the AHCA Medicaid contract by DOEA, AHCA or DHSS. Upon request, and as required by State and/or federal law, Subcontractor and Contracted Provider shall make available to DOEA, AHCA, MPI, and/or MFCU any and all administrative, contractual, financial and medical records relating to the delivery of items or services for which Medicaid monies are expended. Upon request, and as required by State and/or federal law, Subcontractor and Contracted Provider shall also allow access to DOEA, AHCA, MPI and/or MFCU to any place of business and all medical records. DOEA, AHCA, MPI and/or MFCU shall have access during normal business hours, except under special circumstances when DOEA, AHCA, MPI, and/or MFCU shall have after-hour admission. DOEA, AHCA, MPI and/or MFCU shall determine the need for special circumstances. Subcontractor and Contracted Provider shall provide Covered Services, as set forth in Exhibit 1, Scope of Services, to Covered Persons in accordance with the Medicaid contract.

Subcontractor and Contracted Provider(s) shall comply with audit and record keeping requirements to comply with public record laws as outlined in Section 119.0701, F.S.

1.4. Subcontractor shall comply with Health Plan's cultural competency plan. Health Plan and Subcontractor shall encourage the use of minority business enterprises.

1.5. Subcontractor acknowledges and agrees that any marketing materials related to the Medicaid Contract and distributed by Subcontractor shall be submitted to AHCA for written approval before use. All subcontracts specify that the subcontractor shall comply with the marketing requirements specified in Section IV., Marketing.

1.6. Subcontractor and Contracted Provider(s) shall submit notice of termination at least ninety (90) days before the effective date of such withdrawal.

1.7. Pursuant to 42 CFR 438.224 [Confidentiality], Subcontractor shall safeguard information about Covered Persons. Subcontractor shall also comply with federal HIPAA privacy and security provisions. Health Plan shall document compliance certification testing of transaction compliance with HIPAA for any subcontractor receiving enrollee data.

1.8. Subcontractor acknowledges and agrees that neither Medicaid Recipients nor AHCA shall be held liable for any debts of Subcontractor. This provision shall survive termination of the Agreement and/or this Product Attachment, including termination of the Agreement due to insolvency.

1.9. Subcontractor shall indemnify, defend and hold AHCA, its designees, and the Health Plan's Covered Persons harmless from and against all claims, damages, causes of action, costs or expense, including court costs and reasonable attorney fees to the extent proximately caused by any negligent act or other wrongful conduct. Subcontractor acknowledges that this provision shall survive the termination of the Agreement and/or this Product Attachment. AHCA may waive this requirement for itself, but not Health Plan enrollees, for damages in excess of the statutory cap on damages for public entities, if the subcontractor is a State agency or subdivision as defined by s. 768.28, F.S., or a public health entity with statutory immunity. All such waivers must be approved in writing by AHCA.

1.10. Subcontractor shall secure and maintain during the life of this Agreement and Product Attachment workers' compensation insurance (complying with the Florida's Workers' Compensation Law) for all of its employees connected with the work under the Medicaid Contract unless such employees are covered by the protection afforded by the Health Plan.

1.11. Subcontractor acknowledges and agrees that any provisions of the Agreement that are in conflict with the specifications of the AHCA Medicaid Contract shall be waived as they pertain to Medicaid Recipients.

1.12. In accordance with the requirements of the Standard Contract, Section III., B., Termination, all provider agreements and subcontracts shall contain termination procedures. In addition to any other right to terminate under this Agreement, and not withstanding any other provision of the Medicaid Contract, Subcontractor acknowledges and agrees that AHCA or Health Plan may request immediate termination of this Agreement and/or Product Attachment if, as determined by AHCA, Subcontractor fails to abide by the terms and conditions of this Agreement and Product Attachment, or in the sole discretion of AHCA, Subcontractor fails to come into compliance with this Agreement and Product Attachment within fifteen (15) Calendar Days after receipt of notice from Health Plan specifying such failure and requesting Subcontractor to abide by the terms and conditions thereof.

1.13. Subcontractor shall utilize the applicable appeals procedures outlined in the Agreement if Subcontractor is terminated for any reason. Subcontractor acknowledges and agrees that no additional or separate right of appeal to AHCA or the Health Plan is created as a result of Health Plan's act of terminating, or decision to terminate Provider under the Medicaid Contract.

1.14. Health Plan and Subcontractor shall make prompt submission of information needed to make payment. Subcontractor shall mail or electronically transfer (submit) claims to Health Plan within six (6) months of:

(i) the date of services of discharge from an inpatient setting; or
(ii) the date on which Subcontractor is furnished with the correct name and address of the Covered Person's Health Plan. When Health Plan is the secondary Payor, Subcontractor shall submit the claim to the Health Plan within ninety (90) days of the final determination of the primary Payor. Health Plan agrees to make payment to Participating Health Care Subcontractor and Network in accordance with applicable State and federal laws, rules and regulations, including but not limited to, s.409.967, F.S., s. 409.975(6) F.S., s. 409.982, F.S., s. 641.3155, 42 CFR 238.230 F.S., 42 CFR 447.46, and 42 CFR 447.45(d)(2), (3), (d)(5) and (d)(6). All subcontracts for claims adjudication activities shall comply with 42 CFR 438.8(k)(3).
(iii) In addition to the requirements set forth in Section 1.14 (ii) immediately, above, all model and executed subcontracts and amendments used by the Health Plan under this Agreement and Medicaid Contract shall meet the following requirements: (i) identification of conditions and method of payment; (ii) provide for prompt submission of information needed to make payment; and (iii) provide for full disclosure of the method and amount of compensation or other consideration to be received from the Health Plan; Require any claims processing vendors to maintain accurate enrollee and provider information, including provider agreements reflecting the correct reimbursement rate and provider specialty, to ensure the correct adjudication of claims and proper payment to providers; (iv) require any payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the enrollee's name, the date of service, the procedure code, service units, the amount of reimbursement, and the identification of the Health Plan; (v) require an adequate record system be maintained for recording services, charges, dates and all other commonly accepted information elements for services rendered to the Health Plan.

1.15. Subcontractor acknowledges and agrees this Agreement complies with 42 CFR 438.230, 42 CFR 438.3(k), 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 and all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and Medicaid Contract provisions, and any other applicable State or federal law.

1.16. Health Plan shall assume responsibility for cost avoidance measures for third party collections in accordance with Section XII, Financial Requirements of the AHCA Medicaid contract.

1.17. Subcontractor agrees that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any Health Plan Covered Person. (42 CFR 438.210(e)

1.18. Subcontractor shall comply with the background screening requirements of the Health Plan's contract with AHCA in accordance with s. 408.809, F.S.

1.19. If Subcontractor or Contracted Provider is a Hospital, in addition to the requirements s.409.967 F.S., the rates shall be in accordance with s.409.975(6), F.S.

1.20. Claims or Encounter Submission. Subcontractor or Contracted Provider shall submit to Payor claims or encounters for Covered Services in accordance with the Provider Manual. Payor reserves the right to deny payment to Subcontractor or Contracted Provider if Subcontractor or Contracted Provider fails to submit in accordance with the Provider Manual. If applicable, based on Subcontractor and Contracted Provider's compensation arrangement, Subcontractor or Contracted Provider shall submit encounter data to Payor in a timely fashion, which shall contain such statistical and descriptive medical and patient data and identifying information as specified in the Provider Manual. Encounter Data - All model and executed subcontracts and amendments used by the Health Plan under this Agreement and Medicaid Contract shall require subcontractors

to submit timely, complete and accurate encounter data to the Health Plan in accordance with the requirements of Section X.D., Information Management Systems.

1.21. Health Plan shall delegate those administrative functions outlined in a separate attachment. If such attachment is not executed, no administrative functions shall be deemed as delegated. Initial delegation and delegation renewal will be subject to review, on an ongoing basis, and approval of Subcontractor's performance of delegated administrative functions and compliance by Subcontractor of all Health Plan and regulatory guidelines. Health Plan retains the right to approve, suspend, or terminate delegated functions. Failure of Subcontractor to perform delegated administrative functions, including delegated credentialing activities, in compliance with Health Plan's policies and procedures as determined by AHCA, CMS, or Health Plan, shall result in revocation of delegation or imposition of other sanctions for one or all of the administrative functions that have been delegated. Subcontractor acknowledges and agrees that its agreements with subcontractors are subject to review and approval by Health Plan, CMS, State and other applicable regulatory agencies. Any services or other activity performed by related entity, contractor, subcontractor, or first-tier or downstream entity of the Subcontractor, in accordance with this contract, are consistent and comply with the Health Plan's contractual obligations.

The Health Plan shall maintain ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this Agreement and Medicaid Contract, and may, delegate performance of work required under this Agreement and Medicaid Contract to a subcontractor. The Health Plan shall submit any proposed delegation to AHCA for prior written approval. The Health Plan shall submit all subcontracts for Agency review at least ninety (90) days before the proposed effective date of the subcontract or change. If the submission is for management of a covered service, the Health Plan shall include the following in its submission to AHCA in a manner prescribed by AHCA:

(i) Draft subcontract that complies with subcontract requirements specified in this section, AHCA Standard Contract, 42 CFR 438.230(c)(1)(i), and 42 CFR 438.3(k);
(ii) Test PNV file as proof of provider network adequacy;
(iii) Copy of applicable licensure, if appropriate;
(iv) Enrollee materials;
(v) Population covered by the subcontract;
(vi) Provider materials;
(vii) Model provider agreement template as specified in Section VIII., Provider Services; and
(viii) Approximate number of impacted enrollees.

1.22 No subcontract that the Health Plan enters into with respect to performance under the contract shall, in any way, relieve the Health Plan of any responsibility for the performance of duties under this contract. The Health Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of this Medicaid Contract and shall provide AHCA with its monitoring schedule for all Agency-approved subcontractors by December 1 of each Contract year. All executed subcontracts and amendments used by the Health Plan under this contract shall be in writing, signed, and dated by the Health Plan. The Health Plan shall identify the service(s) and/or goods covered by the subcontract, as applicable. The Health Plan shall identify in its subcontracts any aspect of service that may be further subcontracted by the subcontractor.

1.23 If AHCA determines, at any time, that a subcontract is not in compliance with a Medicaid Contract requirement, the Health Plan shall promptly revise the subcontract into compliance. In addition, the Health Plan may be subject to sanctions pursuant to Section XI, Sanctions, and/or liquidated damages pursuant to Section XII, Liquidated Damages, as determined by AHCA.

1.24 Subcontractor to comply with Section 274A (e) of the Immigration and Nationality Act, AHCA will consider the employment of any contractor of unauthorized aliens a violation of this Act. If the

Subcontractor knowingly employs unauthorized aliens, such a violation shall be cause for unilateral cancellation of this Agreement and Medicaid Contract. The Subcontractor shall be responsible for including this provision in all subcontracts with private organizations issued as a result of this Agreement and Medicaid Contract.

1.25 Subcontractor to comply with The Immigration Reform and Control Act of 1986, which prohibits employers from knowingly hiring illegal workers. The Subcontractor shall only employ individuals who may legally work in the United States (U.S.) - either U.S. citizens or foreign citizens who are authorized to work in the U.S. The Subcontractor shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification system, https://e-verify.uscis.gov/emp, to verify the employment eligibility of all new employees hired by the Subcontractor during the term of this Agreement and Medicaid Contract and shall also include a requirement in its subcontracts that the subcontractor utilize the E-Verify system to verify the employment eligibility of all new employees hired by the subcontractor performing work or providing services pursuant to this Agreement and Medicaid Contract.

1.26 The Health Plan shall not delegate provider network management to a subcontractor that meets both of the following: (i) the subcontractor is owner or has controlling interest in any provider(s) included in the network; and (ii) the subcontractor limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.

1.27 Subcontractor to comply with reporting its financial status (i.e. periodic financial reporting, financial statements) to the Health Plan through quarterly unaudited and annually audited financial statements. The quarterly unaudited financial statements shall be submitted to the Health Plan within sixty (60) days of the end of the quarter and annual audited financial statements shall be submitted within one hundred twenty (120) days of the end of the year.

Health Plan's contract with AHCA requires that Health Plan provide, upon request, copies of the financial statements, including documentation of the Health Plan's financial review. Failure to obtain required financial statement shall result in liquidated damages as specified in Section XIV, Liquidated Damages.

1.28 Require, if the subcontractor is at financial risk and/or is delegated to process and pay claims, the subcontractor shall maintain a surplus account to meet its obligations.

1.29 Require that the subcontractor timely notify the Health Plan of changes in directory information.

1.30 Monitoring and Inspections. All model and executed subcontracts and amendments used by the Health Plan under this Agreement and Medicaid Contract shall meet the following requirements with respect to provisions for monitoring and inspections:

(i) Provide that AHCA, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the subcontractor, or of the subcontractor's subcontractor, pertaining to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's Contract with the State. In accordance with 42 CFR 438.230(c)(3)(iii), the subcontractor shall agree that the right to audit exists through ten (10) years from the final date of this Agreement and Medicaid Contract period or from the date of completion of any audit, whichever is later;
(ii) Provide that the subcontractor shall make available for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid enrollees pertinent to this Agreement and Medicaid Contract by AHCA, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS; (42 CFR 438.3(h); s. 1903(m)(2)(A)(iv) of the Social Security Act)

(iii) Require full cooperation in any investigation by AHCA, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, DOEA, or other State or federal entity or any subsequent legal action that may result from such an investigation.
(iv) In addition to record retention requirements for practitioner or provider licensure, require subcontractors to retain, as applicable, the following information in accordance with 42 CFR 438.3(u): enrollee grievance and appeal records in 42 CFR 438.416; base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period not less than ten (10) years from the close of this Agreement and Medicaid Contract and retained further if the records are under review or audit until the review or audit is complete. (Prior approval for the disposition of records must be requested and approved by the Health Plan if the subcontract is continuous.); (42 CFR 438.3(h))
(v) Provide for monitoring and oversight by the Health Plan and the subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Health Plan's and AHCA's credentialing requirements as found in Section VIII., Provider Services, if the Health Plan has delegated the credentialing to a subcontractor;
(vi) Provide for monitoring of services rendered to Health Plan enrollees through the subcontractor.

1.31 All subcontracts must contain provisions wherein the subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with Section XVI., Reporting Requirements, and the SMMC Report Guide.

1.32 Provide that the subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the subcontractor's ability to meet its obligations.

1.33 Health Plan shall immediately advise AHCA of the insolvency of a subcontractor or of the filing of a petition in bankruptcy by or against a principal subcontractor. Subcontractor and Contracted Provider(s) shall comply with the aforementioned requirement by immediately notifying the Health Plan pursuant to all of the applicable terms and conditions of the Agreement.

1.34 Subcontractor and Contracted Provider(s) shall comply with and be obligated to cooperate with recovery efforts, including participating in audits and repay overpayments.

2. If Subcontractor is delegated for credentialing, Subcontractor agrees to implement processes to ensure that new contracted providers will be fully credentialed, contracted and made participating within sixty (60) calendar days. This is calculated from the date a fully completed contracted provider enrollment or credentialing application is received to the date that the Agency for Health Care Administration (AHCA) receives the name of that contracted provider on Health Plan's Provider Network Verification file. In order to meet this standard, Subcontractor will establish processes and reports to monitor the status of a contracted providers credentialing participation status. Subcontractor will submit the newly credentialed and contracted provider to Health Plan in the file format specified by Health Plan by day thirty (30) so the contracted provider can be added to Health Plan's Provider Network Verification file.

Should AHCA modify the Provider Network Verification file specifications, Health Plan will provide those to Subcontractor within fifteen (15) calendar days of receipt from AHCA. Subcontractor will implement the changes within thirty (30) calendar days.

Within thirty (30) days of execution of this contract, Subcontractor will provide to Health Plan the process to collect this information and the specifications of how each of these reports are calculated. Health Plan must approve the methodology. In the event that Subcontractor anticipates any system changes that may impact the methodology or specifications approved by Health Plan, those changes must be submitted to Health Plan at least thirty (30) days prior to the change, for review and approval.

3. FALSE CLAIMS ACT INFORMATION

Employees, subcontractors, providers and agents of the Subcontractor must comply with the Federal False Claims Act ("FCA"). The following sets out information regarding the FCA, penalties for violating the FCA, protections for "whistleblowers" under the FCA, and the law's role in preventing and detecting fraud, waste and abuse and the responsibility of all employees, subcontractors, providers and agents of the Provider relating to detection and prevention of FCA violations.

Summary of the FCA. The federal False Claims Act ("FCA") is one of several laws the federal government has implemented to prevent and detect fraud, abuse and waste in federal health care programs (31 U.S.C. 3729 through 3733). The FCA applies to claims presented to federal health care programs for payment and permits the government to bring civil actions to recover damages and penalties when healthcare providers submit false claims. The FCA provides that anyone who "knowingly" presents, or causes to be presented, a "false or fraudulent claim" is liable for damages up to three (3) times the amount of the erroneous payment, mandatory penalties for each claim submitted, and administrative remedies such as exclusion from future participation in government health care programs. The FCA prohibits retaliation against any teammate that reports any actual or potential violation of the FCA.

What the FCA Prohibits. The FCA prohibits persons from making any type of fraudulent claim for payment to the federal government. Specifically, the False Claims Act prohibits persons from:

(i) Knowingly presenting, or causing the presentation of, a false or fraudulent claim for payment or approval by the federal government (including any federal health care program);
(ii) Knowingly making, using, or causing a false record or statement to get a false or fraudulent claim paid or approved by the federal government;
(iii) Conspiring to defraud the federal government by getting a false or fraudulent claim allowed or paid; or
(iv) Knowingly making, using, or causing a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the federal government.

For purposes of the FCA, "knowing" and "knowingly" mean that a person, with respect to information:

(i) has actual knowledge of the information;
(ii) acts in deliberate ignorance of the truth or falsity of the information; or
(iii) acts in reckless disregard of the truth or falsity of the information.

While the FCA imposes liability only when the claimant acts "knowingly," it does not require that the person submitting the claim have actual knowledge that the claim is false, and no proof of specific intent to defraud is required. A person who acts in "reckless disregard" or in "deliberate ignorance" of the truth or falsity of the information also can be found liable under the FCA. In sum, the FCA imposes liability on any person who submits a claim to the federal government or to the state Medicaid program (including Health Plan) when the person knows (or should know) the claim is false. An example may be a physician who submits a bill to Medicare for medical services he/she knows has not been provided.

The FCA also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. An example of this may include a government contractor, such as Health Plan, or its subcontracted vendors who submits records that he/she knows (or should know) are false and that indicate compliance with certain contractual or regulatory requirements.

The third area of liability includes those instances in which someone may obtain money from the federal government or the Health Plan program to which he may not be entitled, and then uses false statements or records in order to retain the money.

Penalties for Violations of the FCA. Each false claim violation under the FCA may be punishable by civil penalties between $11,000 and $23,000, plus three times the amount of the damages sustained by the government.

Information Regarding State and Federal Whistleblower Protections. Any employee who is discharged, demoted, suspended, threatened, harassed, or in any other manner discriminated against with respect to the terms and conditions of employment as a result of initiating a qui tam relator action under the False Claims Act, or otherwise assisting in the investigation or litigation of a False Claims Act violation, may be entitled to certain remedies from his or her employer. Such remedies include reinstatement at the same seniority status that such employee would have had but for the allegedly discriminatory actions of the employer; payment of twice the amount of backpay accrued by the employee; and compensation for any special damages sustained by the employee as a result of the discrimination, including litigation costs and reasonable attorney's fees.

Preventing, Detecting and Reporting Fraud, Waste, and Abuse. Health Plan is strongly committed to detecting and preventing fraud, waste, and abuse. To this end, Health Plan has adopted an active Compliance and Ethics Program and operates under a code of conduct. The Health Plan compliance program requires compliance with both legal requirements and ethical standards and is composed of the following key elements:

(i) Support for the program comes from the highest levels of the organization.
(ii) A Compliance Officer leads Health Plan's compliance efforts.
(iii) A Compliance and Ethics Program sets forth Health Plan's expectations concerning compliant behavior and there are policies and procedures that support the compliance effort and address key compliance areas.
(iv) The program provides for safe, secure, and confidential reporting mechanisms to report employee concerns (anonymously, if requested) and to seek guidance on compliance issues.
(v) The program provides for training employees, providers, subcontractors, and related parties on the elements of the program.
(vi) There is an effective system of internal controls to monitor compliance efforts.
(vii) The program calls for an on-going compliance risk assessment and annual assessment and renewal of the compliance program.

All Health Plan employees, subcontractors, providers and agents are required to act in a manner consistent with the requirements of the Health Plan Compliance and Ethics Program and to review the Health Plan Code of Conduct issued by the Health Plan Compliance Office, the principles and requirements of which apply to all dealings with Health Plan.

Should any Health Plan employee, subcontractor, provider or agent (or employee of the same) obtain information that reasonably leads it, him, or her to believe there has or may have been a violation of law or of Health Plan's compliance program by Health Plan or any of its employees, subcontractors, providers or agents, such person must promptly report and disclose the same to the Health Plan Compliance Office and provide such office with all information related to such belief. Such person also must cooperate with the Compliance Office in any audit or investigation instituted by Health Plan related to any compliance matters or other actions taken pursuant to Health Plan's compliance program. Health Plan prohibits any form of retaliatory conduct or action against any employee or person who reports any compliance violation or concern pursuant to Health Plan's compliance program.

The Health Plan Compliance Office has a toll-free hotline for compliance reporting and for reporting potential fraud, abuse and waste. Any report maybe made anonymously, if desired. All reports to the Health Plan Compliance Office are treated as confidential to the greatest extent possible. Further, all forms of information received, transmitted, discussed, or archived by the Health Plan Compliance Office, including but not limited to, verbal and written communications, documents, reports, correspondence, network transmissions, and

electronically or magnetically stored data are treated as confidential information.

3.1 Subcontractor Responsibilities. Subcontractor shall ensure that Health Plan policies related to this Amendment are available to all employees, including management, as well as all subcontractors, providers and agents. Should any Subcontractor employee, subcontractor, provider or agent (or employee of the same) obtain information that reasonably leads it, him, or her to believe there has or may have been a violation of the FCA or of Health Plan's compliance program by Subcontractor or any of its employees, subcontractors, providers or agents, such person must promptly report and disclose the same to the appropriate individual at the Subcontractor, who shall report the same, along with all information related to such belief, to the Health Plan. Provider also must cooperate with the Health Plan in any audit or investigation instituted by Health Plan related to any compliance matters or other actions taken pursuant to Health Plan's compliance program. Health Plan prohibits any form of retaliatory conduct or action against any employee or person who reports any compliance violation or concern pursuant to the program.

In addition to the False Claims Act Information provisions set forth above, with respect to Section 6032 of the federal Deficit Reduction Act of 2005, the following are required (42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act):

(i) Program integrity requirements under the contract (438.608(a)(6)).

Administrative and management arrangements or procedures to detect and prevent fraud, waste and abuse. The State, through its contract with the MCO, PIHP or PAHP, must require that the MCO, PIHP, or PAHP, or subcontractor to the extent that the subcontractor is delegated responsibility by the MCO, PIHP, or PAHP for coverage of services and payment of claims under the contract between the State and the MCO, PIHP, or PAHP, implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. The arrangements or procedures must include the following: In the case of MCOs, PIHPs, or PAHPs that make or receive annual payments under the contract of at least $5,000,000, provision for written policies for all employees of the entity, and of any contractor 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 rights of employees to be protected as whistleblowers.

(ii) State plans for medical assistance 42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act).

A State plan for medical assistance must provide that any entity that receives or makes annual payments under the State plan of at least $5,000,000, as a condition of receiving such payments, shall:

(i) establish written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code[33], any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs(as defined in section 1128B(f));

(ii) include as part of such written policies, detailed provisions regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

(iii) include in any employee handbook for the entity, a specific discussion of the laws described in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

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

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

HEALTH PLAN:	**PROVIDER:**
Sunshine State Health Plan, Inc.	(Legibly Print Name of Provider)
Authorized Signature:	Authorized Signature:
Print Name: William Kruegel	Print Name:
Title: Chief Operating Officer	Title:
Signature Date:	Signature Date:
ECM #:	Tax Identification Number:
To be completed by Health Plan only:	State Medicaid Number:
Effective Date:	Billing National Provider Identifier:

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