**HUMANA**

**ANCILLARY PARTICIPATION AGREEMENT**

**State: WI**

**COVER SHEET**

| Creation Date: February 16, 2016 |
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| Emptoris Contract Number: 25063 |
| Provider Name:<br>Legal Name: Racine County<br>DBA Name: Ridgewood Care Center |

| Federal Tax ID:<br>EIN: 396005734 |
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| Optional Information: | |
|---|---|
| NPI: 1649275991 | Specialty: SNF-SKILLED NURSING FACILITY |

| Contract Contact Information:<br>Name: Jenny Druktenis |
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| Address Line 1: 3205 WOOD RD | |
|---|---|
| Address Line 2: ________ | |
| City: RACINE | State: WI Zip: 534065048 |
| County: RACINE | FIPS: 55101 |
| Phone: 2625546440 ext ________ | Fax: 2625040052 |
| Email: jenny.druktenis@goracine.org | |

| Address for Notice<br>Name: Jenny Druktenis |
|---|

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| City: RACINE | State: WI Zip: 534065048 |
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| Phone: 2625546440 ext ________ | Fax: 2625040052 |
| Email: jenny.druktenis@goracine.org | |

| Contractor Information:<br>Name: Mark S. Bennehoff | Market: Milwaukee-WI |
|---|---|
| Address Line 1: N19W24133 RIVERWOOD DR | |
| Address Line 2: STE 300 | |
| City: WAUKESHA | State: WI Zip: 53188-1145 |
| County: WAUKESHA | FIPS: ________ |
| Phone: 2624084414 ext ________ | Fax: 9206321331 |
| Email: MBennehoff@humana.com | |

## ANCILLARY PARTICIPATION AGREEMENT

This **Provider** Participation Agreement ("**Agreement**") is made and entered into by and between **Racine County** (hereinafter referred to as "**Provider**") and Humana Insurance Company, Humana Wisconsin Health Organization Insurance Corporation, and their affiliates that underwrite or administer health plans (hereinafter referred to as "**Humana**").

### 1. RELATIONSHIP OF THE PARTIES

1.1 In performance of their respective duties and obligations hereunder, **Humana** and **Provider**, and **Provider's** respective employees and agents, are at all times acting and performing as independent contractors, and neither party, nor their respective employees and agents, shall be considered the partner, agent, servant, employee of, or joint venturer with, the other party. Unless otherwise agreed to herein, the parties acknowledge and agree that neither **Provider** nor **Humana** will be liable for the activities of the other nor the agents and employees of the other, including but not limited to, any liabilities, losses, damages, suits, actions, fines, penalties, claims or demands of any kind or nature by or on behalf of any person, party or governmental authority arising out of or in connection with: (i) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (ii) any negligent act or omission or other misconduct; (iii) the failure to comply with any applicable laws, rules or regulations; or (iv) any accident, injury or damage to persons or property. Notwithstanding anything to the contrary contained herein, **Provider** further agrees to and hereby does indemnify, defend and hold harmless **Humana** from any and all claims, judgments, costs, liabilities, damages and expenses whatsoever, including reasonable attorneys' fees, arising from any acts or omissions in the provision by **Provider** of Health Care Services to Members. This provision shall survive termination or expiration of this Agreement.

1.2 The parties agree that **Humana's** affiliates whose Members receive services hereunder do not assume joint responsibility or liability between or among such affiliates for the acts or omissions of such other affiliates.

### 2. SERVICES TO MEMBERS

2.1 Subject at all times to the terms of this Agreement, **Provider** agrees to provide or arrange for professional medical service and/or related Health Care Services to individuals designated by Humana (herein referred to as "Members") with an identification card or other means of identifying them as Members covered under a self-funded or fully insured health benefits plan to which **Provider** has agreed to participate as set forth in the product participation list attachment.

2.2 **Provider** agrees to provide Health Care Services to individuals covered under other third party payors' (hereinafter referred to as "Payor" or "Payors") health benefits contracts (hereinafter referred to as "Plan" or "Plans") and agrees to comply with such Payors' policies and procedures. For Covered Services rendered to such individuals, **Provider** acknowledges and agrees that all rights and responsibilities arising with respect to benefits to such individuals shall be subject to the terms of the Payor Plan covering such individuals. Individuals covered under such Plans will have an identification card as a means of identifying the Payor Plan which provides coverage. Such identification cards will display the Humana logo and/or name.

2.3 For Covered Services provided to those individuals identified in Section 2.2 above, Payor will make payments for Covered Services directly to **Provider** in accordance with the terms and conditions of this Agreement and the rates set forth in the Payment Attachment applicable to the Plan type of such individual. **Provider** agrees that in no event, including, but not limited to, nonpayment by Payor, or Payor's insolvency, shall **Provider** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Humana for services provided by **Provider** to Plans' Members. This provision shall not prohibit collection by **Provider** from Plans' Members for non-covered services and/or Member cost share amounts in accordance with the terms of the applicable Member Plan. Payors Plans will provide

appropriate steerage mechanisms including benefit designs and/or physician directory and web site listings to ensure their covered individuals will have incentives to utilize **Provider's** services. All obligations of **Provider** under this Agreement with respect to Humana's Members shall equally apply to the individuals identified in Section 2.2 above.

## 3. THIRD PARTY BENEFICIARIES

3.1 Except as is otherwise specifically provided in this Agreement, the parties have not created and do not intend to create by this Agreement any rights in other parties as third party beneficiaries of this Agreement, including, without limitation, Members.

## 4. SCOPE OF AGREEMENT

4.1 This Agreement sets forth the rights, responsibilities, terms and conditions governing: (i) the status of **Provider** and **Provider's** employees, subcontractors and independent contractors as health care providers (hereinafter referred to as "**Participating Providers**") providing those services and supplies that a health care provider is licensed to provide, and which are normally provided to individuals ("**Health Care Services**"); and (ii) **Provider's** provision of medical or related Health Care Services (hereinafter referred to as "**Provider Services**") to Members. All terms and conditions of this Agreement which are applicable to "**Provider**" are equally applicable to each Participating Provider, unless the context requires otherwise.

4.2 **Provider** acknowledges and agrees that its Participating Providers will abide by the terms and conditions of this Agreement. The parties acknowledge and agree that nothing contained in this Agreement is intended to interfere with or hinder communications between **Provider** and Members regarding the Members' medical conditions or treatment options, and **Provider** acknowledges that all patient care and related decisions are the sole responsibility of **Provider** and **Humana** does not dictate or control clinical decisions with respect to the medical care or treatment of Members. **Provider** agrees to provide **Humana**, upon request, with copies of orders from Member's attending physician.

4.3 **Provider** acknowledges and agrees that with respect to self-funded groups, unless otherwise provided herein, **Humana's** responsibilities hereunder are limited to provider network administration and/or claims processing.

## 5. ACQUISITIONS

5.1 This Section applies to any **Provider** acquisition through any means including, but not limited to, asset or stock purchase, merger, or consolidation (collectively, "**Acquisition**") of an ownership interest in a facility or other provider of whatever type or construction including, but not limited to, a (i) hospital, (ii) free standing ambulatory surgery center, (iii) radiology center, (iv) sleep center; or (v) physician, physician group, Independent Practice Association or Physician Hospital Organization (collectively, "**Entity**"). In the event of **Provider's** Acquisition of an Entity and such Entity has an agreement in effect with **Humana** for the provision of Health Care Services, then such Entity shall not become a participating provider with **Humana** under this Agreement but, rather, the existing separate agreement between **Humana** and such Entity will control for its duration. Furthermore, **Provider** shall not exercise any termination or nonrenewal right which may exist in the agreement between **Humana** and such Entity for a period of twelve (12) months subsequent to the effective date **Provider** acquires its ownership interest in such Entity.

5.2 In the event **Provider's** ownership, separate existence or entity construction (e.g., corporation, limited liability company, etc.) is altered or affected in any way as a result of acquisition, merger, consolidation or through any other means whatsoever (including, but not limited to, being merged into an affiliated entity), then this Agreement shall continue to control with respect to **Provider's** provision of Health Care Services to **Humana's** Members notwithstanding any contrary outcome which may otherwise be allowed or required by law. Furthermore, **Provider** agrees that it shall not exercise any termination or nonrenewal right which may otherwise exist in this Agreement for a period of twelve (12) months subsequent to the effective date of such transaction event.

## 6. TERM AND TERMINATION

6.1

The term of this Agreement shall commence on _______ __________________, 20__. (The "**Effective Date**") The initial term of this Agreement shall be for One (1) year(s). This Agreement shall automatically renew for subsequent One (1) year terms unless either party provides written notice of non-renewal to the other party at least ninety (90) days prior to the end of the initial term or any subsequent renewal terms.

6.2 Notwithstanding anything to the contrary herein, either party may terminate this Agreement without cause at any time following the initial term of this Agreement by providing to the other party ninety (90) days prior written notice of termination.

6.3 **Humana** may terminate this Agreement immediately upon written notice to **Provider**, stating the cause for such termination, in the event: (i) **Provider's** or any Participating Provider's continued participation under this Agreement may adversely affect the health, safety or welfare of any Member or brings **Humana** or its health care networks into disrepute; (ii) **Provider** or any Participating Provider fails to meet **Humana's** credentialing or re-credentialing criteria; (iii) **Provider** or any Participating Provider is excluded from participation in any federal health care program; (iv) **Provider** voluntarily or involuntarily seeks protection from creditors through bankruptcy proceedings or engages in or acquiesces to receivership or assignment of accounts for the benefit of creditors; or (v) **Humana** loses its authority to do business in total or as to any limited segment of business, but then only as to that segment.

6.4 In the event of a breach of this Agreement by either party, the non-breaching party may terminate this Agreement upon at least sixty (60) days prior written notice to the breaching party, which notice shall specify in detail the nature of the alleged breach; provided, however, that if the alleged breach is susceptible to cure, the breaching party shall have thirty (30) days from the date of receipt of notice of termination to cure such breach, and if such breach is cured, then the notice of termination shall be void of and of no effect. If the breach is not cured within the thirty (30) day period, then the date of termination shall be that date set forth in the notice of termination. Notwithstanding the foregoing, any breach related to credentialing or re-credentialing, quality assurance issues or alleged breach regarding termination by Humana in the event that **Humana** determines that continued participation under this Agreement may affect adversely the health, safety or welfare of any Member or bring **Humana** or its health care networks into disrepute, shall not be subject to cure and shall be cause for immediate termination upon written notice to **Provider.**

6.5 **Provider** agrees that the notice of termination or expiration of this Agreement shall not relieve Provider of its obligation to provide or arrange for the provision of Provider Services through the effective date of termination or expiration of this Agreement.

6.6 **Provider** agrees that **Humana** may terminate **Provider** or an individual Participating Provider's participation from one or more line(s) of business and/or provider network(s) covered by this Agreement by providing ninety (90) day's prior written notice to Provider. In such event, the affected **Provider** or Participating Provider(s) shall remain participating with respect to all other line(s) of business, if any, and/or provider network(s) covered by this Agreement.

## 7. POLICIES AND PROCEDURES

7.1 **Provider** agrees to comply with **Humana's** quality assurance, quality improvement, accreditation, risk management, utilization review, utilization management, clinical trial and other administrative policies and procedures established and revised by **Humana** from time to time and, in addition, those policies and procedures which are set forth in **Humana's** Provider Manual for Physicians, Hospitals, and Other Health Care Providers, or its successor (hereinafter referred to as the "**Manual**"), and bulletins or other written materials that may be promulgated by **Humana** from time to time to supplement the Manual. The Manual and updated policies and procedures may be issued and distributed by **Humana** in electronic format. Paper copies may be obtained by **Provider** upon written request. Revisions to such policies and procedures shall become binding

upon **Provider ninety (90)** days after such notice to **Provider** by mail or electronic means, or such other period of time as necessary for **Humana** to comply with any statutory, regulatory and/or accreditation requirements.

7.2 **Humana** shall maintain an authorization procedure for **Provider** to verify coverage of Members under a **Humana** health benefits contract.

7.3 Notwithstanding anything to the contrary in this Agreement or in the Member's health benefits contract, **Provider** shall obtain authorization from **Humana** prior to the provision of those services for which **Humana** requires prior authorization. Prior to rendering any non-emergent service, **Provider** is responsible for determining if such service requires prior authorization by reviewing **Humana's** prior authorization requirements posted on http://www.humana.com/providers/ (or any subsequent location as may be specified in the Manual or otherwise by written notice) or by contacting **Humana's** customer service phone number, as indicated on Member's identification card. **Provider's** failure to obtain required prior authorization may result in a fifty percent (50%) reduction of the amount, if any, that would otherwise be due under this Agreement for the service. With respect to the amount by which the payment was reduced, **Provider** shall not under any circumstance bill, charge, seek, receive and/or retain payment from Member. Further, in the event the reduction described herein is effected, **Provider** shall refund any excess Copayment amounts collected from Member.

**8. CREDENTIALING AND PROFESSIONAL LIABILITY INSURANCE**

8.1 Participation under this Agreement by **Provider** and Participating Providers is subject to the satisfaction of all applicable credentialing and re-credentialing standards established by **Humana**. **Provider** shall provide **Humana**, or its designee, information necessary to ensure compliance with such standards at no cost to **Humana** or its designee. **Provider** agrees to use electronic credentialing and recredentialing processes when administratively feasible.

8.2 **Provider** shall maintain, at no expense to **Humana**, policies of comprehensive general liability, professional liability, and workers' compensation coverage, insuring **Provider** and **Provider's** employees and agents against any claim or claims for damages arising as a result of injury to property or person, including death, occasioned directly or indirectly in connection with the provision of Health Care Services contemplated by this Agreement and/or the maintenance of **Provider's** facilities and equipment. Upon request, **Provider** shall provide **Humana** with evidence of said coverage. **Provider** shall within ten (10) business days following service upon **Provider**, or such other period of time as may be required by any applicable law, rule or regulation, notify **Humana** in writing of any Member lawsuit alleging malpractice involving a Member.

**9. PROVISION OF MEDICAL SERVICES**

9.1 **Provider** shall provide Members all available Health Care Services within the normal scope of and in accordance with **Provider's** licenses, certifications and privileges to provide certain services as delineated by **Humana**. **Provider** agrees to comply with all requests for information related to **Humana** determination of **Provider's** privileging status. **Provider** shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts related to the provision of Provider Services for which privileges have not been granted to **Provider** by **Humana**.

9.2 **Provider** shall maintain all medical equipment including, but not limited to, imaging, diagnostic and/or therapeutic equipment (hereinafter referred to as "**Equipment**") in acceptable working order and condition and in accordance with the Equipment manufacturer's recommendations for scheduled service and maintenance. Such Equipment shall be located in areas that promote patient and employee safety. **Provider** shall provide **Humana** or its agents with access to such Equipment for inspection and an opportunity to review all records reflecting Equipment

maintenance and service history. Such Equipment shall only be operated by qualified technicians with appropriate training and required licenses and certifications.

9.3 Equipment owned and/or operated by **Provider** shall comply with all standards for use of such Equipment and technician qualifications established by **Humana**. **Provider** agrees to comply with all requests for information related to Equipment and **Provider's** and/or **Provider's** staff, qualifications for use of same. In the event: (i) **Provider's** Equipment fails to meet **Humana's** standards; or (ii) **Provider** declines to comply with **Humana's** standards for use of Equipment, **Provider** agrees that it will not use such Equipment while providing Health Care Services to Members and shall not bill, charge, seek payment or have any recourse against **Humana** or Members for any amounts for Health Care Services with respect to such Equipment.

**10. STANDARDS OF PROFESSIONAL PRACTICE**

10.1 Health Care Services shall be made available to Members without differentiation or discrimination on the basis of type of health benefits plan, source of payment, employment status, socioeconomic status, sex, sexual preference, age, race, ethnicity, religion, national origin, health status, disability, military service, or veterans' status. **Provider** shall provide Health Care Services to Members in the same manner as provided to their other patients and in accordance with prevailing practices and standards of the profession.

**11. QUALITY AND UTILIZATION REVIEW DATA REQUESTED BY HUMANA**

11.1 **Provider** agrees to participate in **Humana's** utilization review program, whether performed internally or by an external vendor of **Humana's** choosing, and to provide data requested by **Humana** to conduct quality and utilization review activities concerning **Humana** Members.

11.2 **Provider** agrees to obtain from Members authorization for **Humana's** review personnel to have access to Members during their term of treatment and to Members' medical records, and pursuant to such authorization, provide **Humana's** review personnel such access. **Provider** further agrees to furnish **Humana's** review personnel access to **Provider** and **Provider's** personnel during the term of a Member's treatment.

**12. MEDICAL RECORDS**

12.1 **Provider** shall prepare, maintain and retain as confidential the medical records of all Members receiving Health Care Services, and Members' other personally identifiable health information received from **Humana**, in a form and for time periods required by applicable state and federal laws, licensing requirements, accreditation and reimbursement rules and regulations to which **Provider** is subject, and in accordance with accepted medical practice. **Provider** shall obtain authorization of Members permitting **Humana** or its designee, and/or any state or federal agency as permitted by law, to obtain a copy and have access, upon reasonable request, to any medical record of Member related to Health Care Services provided by **Provider** pursuant to applicable state and federal laws. Copies of such records for the purpose of claims processing shall be made and provided by Provider at no cost to **Humana** or the Member.

12.2 Upon request from **Humana** or a Member, **Provider** shall transfer a complete copy of the medical records of any Member transferred to another physician and/or facility for any reason, including termination or expiration of this Agreement. The copy and transfer of medical records shall be made at no cost to **Humana** or the Member and shall be made within a reasonable time following the request, but in no event more than five (5) business days, except in cases of emergency where the transfer shall be immediate. **Provider** agrees that such timely transfer of medical records is necessary to provide for the continuity of care for Members. **Provider** agrees to pay court costs and/or legal fees incurred by Humana or the Member to enforce the terms of this provision.

**12.3** **Provider** and **Humana** agree, and **Humana** will require its designee to agree, to maintain the confidentiality of information maintained in the medical records of Members, and information

obtained from **Humana** through the verification of Member eligibility, as required by law. This **Section 12.3** shall survive any expiration or termination of this Agreement, regardless of the cause.

## 13. GRIEVANCE AND APPEALS PROCESS/BINDING ARBITRATION

13.1 Grievance and Appeals Internal Administrative Review: **Provider** shall cooperate and participate with **Humana** in grievance and appeals procedures to resolve disputes that may arise between **Humana** and its Members. **Provider** and **Humana** further agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Provider** will first exhaust any internal **Humana** administrative review or appeal procedures prior to submitting any matters to binding arbitration.

13.2 Agreement to Arbitrate: The parties agree that any dispute arising out of their business relationship which cannot be settled by mutual agreement shall be submitted to final and binding arbitration under the Health Care Payor Provider Arbitration Rules of the American Arbitration Association ("AAA"), including disputes concerning the scope, validity or applicability of this agreement to arbitrate ("**Arbitration Agreement**"). The parties agree that this Arbitration Agreement is subject to, and shall be interpreted in accordance with, the Federal Arbitration Act, 9 U.S.C. §§ 1-16. No claim or allegation shall be excepted from this Arbitration Agreement, including alleged breaches of the Agreement, alleged violations of state or federal statutes or regulations, tort or other common law claims, and claims of any kind that a party to the Agreement has conspired or coordinated with, or aided and abetted, one or more third parties in violation of law. Without limiting the foregoing, this Arbitration Agreement requires arbitration of disputes involving antitrust, racketeering and similar claims. This Arbitration Agreement supersedes any prior arbitration agreement between the parties. The parties agree to arbitrate disputes arising from the parties' business relationship prior to the effective date of the Agreement under the terms of this arbitration provision. This Arbitration Agreement, however, does not revive any claims that were barred by the terms of prior contracts, by applicable statutes of limitations or otherwise.

13.3 Arbitration Process: The arbitration shall be conducted by one neutral arbitrator selected by the parties from the AAA National Health Care Panel of arbitrators. The arbitrator shall have prior professional, business or academic experience in health care, managed care or health insurance matters. In the event of an arbitration of antitrust claims, the arbitrator shall have prior professional, business or academic experience in antitrust matters. The arbitration shall be conducted in a location selected by mutual agreement or, failing agreement, at a location selected by the AAA that is no more than fifty (50) miles from **Provider's** place of business. The cost of any arbitration proceeding(s) hereunder shall be borne equally by the parties. Each party shall be responsible for its own attorneys' fees and such other costs and expenses incurred related to the proceedings, except to the extent the applicable substantive law specifically provides otherwise.

13.4 Joinder; Class Litigation: Any arbitration under this Arbitration Agreement shall be solely between **Humana** and **Provider**, shall not be joined with another lawsuit, claim, dispute or arbitration commenced by any other person, and may not be maintained on behalf of any purported class.

13.5 Expense of Compelling Arbitration: If either party commences a judicial proceeding asserting claims subject to this Arbitration Agreement or refuses to participate in an arbitration commenced by the other party, and the other party obtains a judicial order compelling arbitration of such claims, the party that commenced the judicial proceeding or refused to participate in an arbitration in violation of this Arbitration Agreement shall pay the other party's costs incurred in obtaining an order compelling arbitration, including the other party's reasonable attorneys' fees.

13.6 <u>Judgment on the Decision and Award:</u> Judgment upon the decision and award rendered by an arbitrator under this Arbitration Agreement may be entered in any court having jurisdiction thereof.

## 14. USE OF PROVIDER'S NAME

14.1 **Humana** may include the following information in any and all marketing and administrative materials published or distributed in any medium: **Provider's** name, the names of all Participating Providers, **Provider's** and Participating Providers' telephone numbers, addresses, available services, and **Provider's** Internet web-site address. **Humana** will provide **Provider** with access to such information or copies of such administrative or marketing materials upon request.

14.2 **Provider** may advertise or utilize marketing materials, logos, trade names, service marks, or other materials created or owned by **Humana** after obtaining **Humana's** written consent. **Provider** shall not acquire any right or title in or to such materials as a result of such permissive use.

14.3 **Provider** agrees to allow **Humana** to distribute a public announcement of **Provider's** affiliation with **Humana**.

## 15. PAYMENT

15.1 **Provider** shall accept payment from **Humana** for those Health Care Services provided to Members for which benefits are payable under a Member's health benefits contract (herein referred to as "**Covered Services**") provided to Member in accordance with the reimbursement terms in the Payment Attachment. **Provider** shall collect directly from Member any co-payment, coinsurance, or other Member cost share amounts (hereinafter referred to as "**Copayments**") applicable to the Covered Services provided and shall not waive, discount or rebate any such Copayments. Payments made in accordance with the Payment Attachment less the Copayments owed by Members pursuant to their health benefits contracts shall be accepted by **Provider** as payment in full from **Humana** for all Covered Services. This provision shall not prohibit collection by **Provider** from Member for any services not covered under the terms of the applicable Member health benefits contract. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service.

15.2 **Provider** agrees that payment may not be made by **Humana** for Health Care Services rendered to Members which are determined by **Humana** not to be Medically Necessary. "Medically Necessary" (or "Medical Necessity"), unless otherwise defined in the applicable Member health benefits contract, means services or supplies provided by a licensed, certified or approved, as applicable, hospital, physician or other health care provider to identify or treat a condition, disease, ailment, sickness or bodily injury and which, in the opinion of **Humana**, are: (i) consistent with the symptoms, diagnosis and treatment of the condition, disease, ailment, sickness or bodily injury; (ii) appropriate with regard to standards of accepted medical practice; (iii) not primarily for the convenience of the patient or the hospital, physician, or other health care provider; (iv) the most appropriate and cost-effective supply, setting, or level of service which safely can be provided to the patient; and (v) substantiated by records and documentation maintained by the provider of services. When applied to an inpatient, it further means that the patient's symptoms or condition requires that the services or the supplies cannot be provided safely to the patient as an outpatient. Notwithstanding anything to the contrary in this Agreement, **Provider** agrees that in the event of a denial of payment for Provider Services rendered to Members determined not to be Medically Necessary by **Humana**, that **Provider** shall not bill, charge, seek payment or have any recourse against Member for such services. Notwithstanding the immediately preceding sentence, **Provider** may bill the Member for services determined not to be Medically Necessary if **Provider** provides the Member with advance written notice that: (a) identifies the proposed services, (b) informs the Member that such services may be deemed by **Humana** to be not Medically Necessary, and (c) provides an estimate of the cost to the Member

for such services and the Member agrees in writing in advance of receiving such services to assume financial responsibility for such services.

15.3 **Provider** agrees that **Humana** may recover overpayments made to **Provider** by **Humana** by offsetting such amounts from later payments to **Provider**, including, without limitation, making retroactive adjustments to payments to **Provider** for errors and omissions relating to data entry errors and incorrectly submitted claims or incorrectly applied discounts. **Humana** shall provide **Provider** thirty (30) days advance written notice of **Humana's** intent to offset such amounts prior to deduction of any monies due. If **Provider** does not refund said monies or request review of the overpayments described in the notice within thirty (30) days following receipt of notice from **Humana**, **Humana** may without further notice to **Provider** deduct such amounts from later payments to **Provider**. **Humana** may make retroactive adjustments to payments for a period not to exceed eighteen (18) months from original date of payment or such other period as may be required or allowed by applicable law.

15.4 In the event **Humana** has access to **Provider's**, or a Participating Provider's, services through one or more other agreements or arrangements in addition to this Agreement, **Humana** will determine under which agreement payment for Covered Services will be made.

15.5 Nothing contained in this Agreement is intended by **Humana** to be a financial incentive or payment that directly or indirectly acts as an inducement for **Provider** to limit Medically Necessary services.

15.6 Notwithstanding any other reimbursement terms specified in this Agreement, for all Covered Services rendered to Medicare Advantage Members (including but not limited to Members enrolled in Medicare-Medicaid alignment plans or their equivalent) the reimbursement for which under this Agreement is determined in whole or in part by a Medicare reimbursement methodology, the final payment amount to **Provider** as determined under this Agreement shall be reduced in the same manner as the reduction in the final payment amount that CMS is applying to provider payments in Medicare Parts A and/or B pursuant to the Balanced Budget and Emergency Deficit Control Act of 1985, as amended by the Budget Control Act of 2011, or any successor legislation ("Sequestration"). This provision is effective April 1, 2013 and shall apply for the duration of the time in which Sequestration reductions apply to provider payments under Medicare Parts A and/or B.

## 16. SUBMISSION OF CLAIMS

16.1 **Provider** shall submit all claims and encounters to **Humana** or its designee, as applicable, using the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") compliant 837 electronic format, or a UB-04 and/or a CMS 1500 paper format, or their successors. Claims and encounters will utilize HIPAA compliant Code Sets for all coded values. Claims shall include the **Provider's** NPI and the valid taxonomy code that most accurately describes the Health Care Services reported on the claim. Claims shall be submitted within ninety (90) days from the later of: (i) the date of service; or (ii) the date of the **Provider's** receipt of the explanation of benefits from the primary payor when **Humana** is the secondary payor; provided, however, all claims under the self-insured plans must be submitted within ninety (90) days of the date of service. **Humana** may, in its sole discretion, deny payment for any claim(s) received by **Humana** after the later of the dates specified above. **Provider** acknowledges and agrees that at no time shall Members be responsible for any payments to **Provider** except for applicable Copayments and non-covered services provided to such Members.

16.2 **Humana** will process **Provider** claims which are accurate and complete in accordance with **Humana's** normal claims processing procedures and applicable state and/or federal laws, rules and regulations with respect to the timeliness of claims processing. Such claims processing procedures and edits may include, without limitation, automated systems applications which identify, analyze and compare the amounts claimed for payment with the diagnosis codes and which analyze the relationships among the billing codes used to represent the Health Care

Services provided to Members. These automated systems may result in an adjustment of the payment to the **Provider** for the Health Care Services or in a request, prior to payment, for the submission for review of medical records that relate to the claim. **Provider** may request reconsideration of any adjustments produced by these automated systems by submitting a timely request for reconsideration to **Humana**. A reduction in payment as a result of claims policies and/or processing procedures is not an indication that the service provided is a non-covered service. In no event may Physician bill a Member for any amount adjusted in payment.

16.3 Unless applicable law mandates submission may be in paper format, **Provider** shall submit all claims, encounters, and clinical data to **Humana** by electronic means available and accepted as industry standard, which may include claims clearinghouses or electronic data interface companies used by **Humana**. **Provider** acknowledges that **Humana** may market certain products that will require electronic submission of claims and clinical data in order for **Provider** to participate. **Provider** shall notify **Humana** when they have completed their transition to Electronic Medical Records and agrees to provide information on the status to **Humana** upon request. Unless applicable law mandates submission may be in paper format, **Provider** shall submit to **Humana** all **Humana** required clinical data (including, but not limited to, laboratory data) by available electronic means within thirty (30) days of the date of service or within the time specified by applicable law.

## 17. COORDINATION OF BENEFITS

17.1 When a Member has coverage, other than with **Humana**, which requires or permits coordination of benefits from a third party payor in addition to **Humana**, **Humana** will coordinate its benefits with such other payor(s). In all cases, **Humana** will coordinate benefits payments in accordance with applicable laws and regulations and in accordance with the terms of its health benefits contracts. When permitted to do so by such laws and regulations and by its health benefits contracts, **Humana** will pay the lesser of: (i) the amount due under this Agreement; (ii) the amount due under this Agreement less the amount payable or to be paid by the other payor(s); or (iii) the difference between the primary Payor's allowed amount and the amount paid by the other payor(s). In no event, however, will **Humana**, when its plan is a secondary payor, pay an amount, which, when combined with payments from the other payor(s), exceeds the rates set out in this Agreement; provided, however, if Medicare is the primary payer, **Humana** will, to the extent required by applicable law, regulation or Centers for Medicare and Medicaid Services ("**CMS**") Office of Inspector General ("**OIG**") guidance, pay **Provider** an amount up to the amount **Humana** would have paid, if it had been primary, toward any applicable unpaid Medicare deductible or coinsurance.

## 18. NO LIABILITY TO MEMBER FOR PAYMENT

18.1 **Provider** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Provider** or any Participating Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Health Care Services provided by **Provider**. This provision shall not prohibit collection by **Provider** from Member for any non-covered service and/or Copayments in accordance with the terms of the applicable Member health benefits contract.

18.2 **Provider** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Provider** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Provider**, and **Provider** shall obtain from such persons specific agreement to this provision.

18.3 Any modification to this **Section 18** shall not become effective unless approved by the Commissioner of Insurance, in the event such approval is required by applicable state law or regulation, or such changes are deemed approved in accordance with state law or regulation.

**19. ACCESS TO INFORMATION**

19.1 **Provider** agrees that **Humana** or its designee, or any state or federal regulatory agency as required by law, shall have reasonable access and an opportunity to examine **Provider's** financial and administrative records as they relate to Health Care Services provided to Members during normal business hours, on at least **seventy-two (72) hours** advance notice, or such shorter notice as may be imposed on **Humana** by a federal or state regulatory agency or accreditation organization.

**20. NEW PRODUCT INTRODUCTION**

20.1 From time to time during the term of this Agreement, **Humana** may develop or implement new products. Should **Humana** offer participation in any such new product to **Provider**, **Provider** shall be provided with ninety (90) days' written notice prior to the **implementation** of such new product. If **Provider** does not object in writing to its participation in such new product within such ninety (90) day notice period, **Provider** shall be deemed to have accepted participation in the new product. In the event **Provider** objects to its participation in a new product, the parties shall confer in good faith to reach agreement on the terms of **Provider's** participation. If agreement on such new product cannot be reached, such new product shall not apply to this Agreement.

20.2 **Humana** may in its discretion, establish, develop, manage and market provider networks in which **Provider** may not be selected to participate. In addition, **Provider** agrees to participate as a network provider in health benefits plans that **Humana** may establish, develop and/or manage that have varying Member Copayment obligations on services provided by **Humana** participating providers, including **Provider.**

**21. ASSIGNMENT AND DELEGATION**

21.1 The assignment by **Provider** of this Agreement or any interest hereunder shall require notice to and the written consent of **Humana**. As used in this paragraph, the term "assignment" shall also include a change of control in **Provider's** practice by merger, consolidation, transfer, or the sale of thirty-three percent (33%) or more stock or other ownership interest in **Provider's** practice. Any attempt by **Provider** to assign this Agreement or any interest hereunder without complying with the terms of this paragraph shall be void and of no effect, and **Humana**, at its option, may elect to terminate this Agreement upon thirty (30) days written notice to **Provider**, without any further liability or obligation to **Provider**. **Humana** may assign this Agreement in whole or in part to any purchaser of or successor to the assets or operations of **Humana**, or to any affiliate of **Humana**, provided that the assignee agrees to assume **Humana's** obligations under this Agreement. Upon notice of an assignment by **Humana**, **Provider** may terminate this Agreement upon thirty (30) days written notice to Humana.

**22. COMPLIANCE WITH REGULATORY REQUIREMENTS**

22.1 **Provider** acknowledges, understands and agrees that this Agreement may be subject to the review and approval of state regulatory agencies with regulatory authority over the subject matter to which this Agreement may be subject. Any modification of this Agreement requested by such agencies or required by applicable law or regulations shall be incorporated herein as provided in **Section 24.10** of this Agreement.

22.2 **Provider** and **Humana** agree to be bound by and comply with the provisions of all applicable state and/or federal laws, rules and regulations. The alleged failure by either party to comply with applicable state and/or federal laws, rules or regulations shall not be construed as allowing either party a private right of action against the other in any court, administrative or arbitration proceeding in matters in which such right is not recognized or authorized by such law or regulation. **Provider** and Participating Providers agree to procure and maintain for the term of

this Agreement all license(s) and/or certification(s) as is required by applicable law and **Humana's** policies and procedures. **Provider** shall notify **Humana** immediately of any changes in licensure or certification status of **Provider** or Participating Providers. If **Provider** or any individual Participating Provider violates any of the provisions of applicable state and/or federal laws, rules and regulations, or commits any act or engages in conduct for which **Provider's** or Participating Providers' professional licenses are revoked or suspended, or otherwise is restricted by any state licensing or certification agency by which **Provider** or Participating Providers are licensed or certified, **Humana** may immediately terminate this Agreement or any individual Participating Provider.

**23. DISPUTE RESOLUTION/LIMITATIONS ON PROCEEDINGS**

23.1 **Provider** and **Humana** agree that in the event they are unable to resolve disputes that may arise with respect to this Agreement, **Provider** will first exhaust any internal **Humana** administrative review or appeal mechanisms prior to submitting any matters to binding arbitration.

**23.2** **Provider** may contest the amount of the payment, denial or nonpayment of a claim only within a period of eighteen (18) months following the date such claim was paid, denied or not paid by the required date by **Humana**. In order to contest such payments, **Provider** shall provide to **Humana**, at a minimum, in a clear and acceptable written format, the following information: Member name and identification number, date of service, relationship of the Member to the patient, claim number, name of the provider of the services, charge amount, payment amount, the allegedly correct payment amount, difference between the amount paid and the allegedly correct payment amount, and a brief explanation of the basis for the contestation. **Humana** will review such contestation(s) and respond to **Provider** within sixty (60) days of the date of receipt by **Humana** of such contestation.

**24. MISCELLANEOUS PROVISIONS**

24.1 **SEVERABILITY.** If any part of this Agreement should be determined to be invalid, unenforceable, or contrary to law, that part shall be reformed, if possible, to conform to law, and if reformation is not possible, that part shall be deleted, and the other parts of this Agreement shall remain fully effective.

24.2 **GOVERNING LAW.** This Agreement shall be governed by and construed in accordance with the applicable laws of the state in which Health Care Services are provided. The parties agree that applicable state and/or federal laws and/or regulations may make it necessary to include in this Agreement specific provisions relevant to the subject matter contained herein. Such state law provisions, if any, are set forth in the state law coordinating provisions attachment hereto. Such federal law provisions, if any, are set forth in the Medicare Advantage provisions attachment hereto. The parties agree to comply with any and all such provisions and in the event of a conflict between the provisions in the state law coordinating provisions attachment and/or the Medicare Advantage provisions attachment and any other provisions in this Agreement, the provisions in those attachments, as applicable, shall control. In the event that state and/or federal laws and/or regulations enacted after the Effective Date expressly require specific language be included in this Agreement, such provisions are hereby incorporated by reference without further notice by or action of the parties and such provisions shall be effective as of the effective date stated in such laws, rules or regulations.

24.3 **WAIVER.** The waiver, whether expressed or implied, of any breach of any provision of this Agreement shall not be deemed to be a waiver of any subsequent or continuing breach of the same provision. In addition, the waiver of one of the remedies available to either party in the event of a default or breach of this Agreement by the other party shall not at any time be deemed a waiver of a party's right to elect such remedy at any subsequent time if a condition of default continues or recurs.

24.4 **NOTICES.** Any notices, requests, demands or other communications, except notices of changes in policies and procedures pursuant to **Section 7**, required or permitted to be given under this

Agreement shall be in writing and shall be deemed to have been given: (i) on the date of personal delivery, or (ii) provided such notice, request, demand or other communication is received by the party to which it is addressed in the ordinary course of delivery: (a) on the third day following deposit in the United States mail, postage prepaid or by certified mail, return receipt requested; (b) on the date of facsimile transmission, or (c) on the date following delivery to a nationally recognized overnight courier service, each addressed to the other party at the address set forth below their respective signatures to this Agreement, or to such other person or entity as either party shall designate by written notice to the other in accordance herewith. **Humana** may also provide such notices to **Provider** by electronic means to the email address of **Provider** set forth on the Cover Sheet to this Agreement or to other email addresses **Provider** provides to **Humana** by notice as set forth herein. Unless a notice specifically limits its scope, notice to any one party included in the term **"Provider"** or **"Humana"** shall constitute notice to all parties included in the respective terms.

24.5 **CONFIDENTIALITY.** **Provider** agrees that the terms of this Agreement and information regarding any dispute arising out of this Agreement are confidential, and agrees not to disclose the terms of this Agreement nor information regarding any dispute arising out of this Agreement to any third party without the express written consent of **Humana**, except pursuant to a valid court order, or when disclosure is required by a governmental agency. Notwithstanding anything to the contrary herein, the parties acknowledge and agree that **Provider** may discuss the payment methodology included herein with Members requesting such information.

24.6 **COUNTERPARTS, HEADINGS AND CONSTRUCTION.** This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, and all of which together constitute one and the same instrument. The headings in this Agreement are for reference purposes only and shall not be considered a part of this Agreement in construing or interpreting any of its provisions. Unless the context otherwise requires, when used in this Agreement, the singular shall include the plural, the plural shall include the singular, and all nouns, pronouns and any variations thereof shall be deemed to refer to the masculine, feminine or neuter, as the identity of the person or persons may require. It is the parties desire that if any provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is to be construed against its drafter shall not apply to the interpretation of the provision.

24.7 **INCORPORATION OF ATTACHMENTS.** All attachments attached hereto are incorporated by reference.

24.8 **FORCE MAJEURE.** Neither party to this Agreement shall be deemed to breach its obligations under this Agreement if that party's failure to perform under the terms of this Agreement is due to an act of God, riot, war or natural disaster.

24.9 **ENTIRE AGREEMENT.** This Agreement, including the attachments, addenda and amendments hereto and the documents incorporated herein, constitutes the entire agreement between **Humana** and **Provider** with respect to the subject matter hereof, and it supersedes any prior or contemporaneous agreements, oral or written, between **Humana** and **Provider**.

24.10 **MODIFICATION OF AGREEMENT.** This Agreement may be amended in writing as mutually agreed upon by Provider and **Humana**. In addition, **Humana** may amend this Agreement upon ninety (90) days' written notice to **Provider**. Failure of **Provider** to object in writing to such amendment during the ninety (90) day notice period shall constitute acceptance of such amendment by **Provider**.

**IN WITNESS WHEREOF**, the parties have the authority necessary to bind the entities identified herein and have executed this Agreement to be effective as of the Effective Date.

**ANCILLARY/AUTHORIZED SIGNATORY**

| | |
|---|---|
| Legal Entity: Racine County | |
| Provider DBA Name: Ridgewood Care Center | |
| Signature: [signature] | |
| Printed Name: JONATHAN DELAGRAVE RACINE COUNTY EXECUTIVE | |
| Title: | |
| Date: 3-29-2016 | |
| Tax ID: 396005734 | |

**Humana**

| | |
|---|---|
| Signature: [signature] | |
| Printed Name: Ryan O. Castignani | |
| Title: VP | |
| Date: 4/8/2016 | |

**Address For Notice:**

**PROVIDER:**

| Provider : |
|---|
| Jenny Druktenis |
| 3205 WOOD RD |
| ——— |
| RACINE WI 534065048 |

**Humana:**

| Copy to: |
|---|
| Humana Inc |
| Attn: Law Department |
| P.O. Box 1438 |
| Louisville, Kentucky 40201-1438 |

Date 3/21/16
Certified to be correct as to form
By [signature]
Racine County Corporation Counsel

REVIEWED BY FINANCE DIRECTOR

[signature] 3/24/16
Sign Date

Russell A. Clark
Racine County Board Chairman
[signature] -3-29-16

HUM Anc 10-2007 WI

**Provider Affiliated Billing Entities Attachment**

| TAX ID | Provider's Name | Provider's DBA Name |
| --- | --- | --- |
| 396005734 | Racine County | Ridgewood Care Center |

## PRODUCT PARTICIPATION LIST

## ATTACHMENT

**Provider** agrees to participate in the health benefits plan(s) selected below, whether self-funded or fully insured, that are offered or administered by **Humana**.

**Health Benefits Plan** **(Check only those which apply)**

| | |
|---|---|
| Commercial PPO Plans | X |
| Commercial HMO Plans | X |
| Commercial POS Plans | X |
| Commercial EPO Plans | X |
| Medicare PPO Plans | X |
| Medicare POS Plans | X |
| Medicare Network PFFS Plans | X |
| Medicare HMO Plans | X |

## HUMANA'S UTILIZATION REVIEW PROGRAM

## ATTACHMENT

**Humana** interventions can occur throughout the continuum of care. The channels for that engagement can include telephone, on-site engagement and written communication. **Provider** agrees to participate in and cooperate with **Humana's** utilization review program that includes, but is not limited to, the following processes:

1. **Provider** agrees to verify that the Member's physician has obtained pre-authorization approval of the admission from **Humana** for all non-emergency admissions and surgical cases.

2. **Provider** agrees to notify **Humana's** admission review department of all admissions within twenty-four (24) hours of admission.

3. **Provider** agrees to notify **Humana** on a daily basis, of Members who have been discharged or transferred from **Provider.**

4. **Provider** agrees to obtain authorization from Members at time of admission for the **Provider** to release medical records to **Humana** and for **Humana's** review personnel to review the Member's medical records during hospitalization and after discharge.

5. **Provider** agrees to allow **Humana** review personnel to have access to Member's medical records and to Members to undertake concurrent review. This access can be either telephonic or on site.

6. **Provider** agrees to cooperate with **Humana's** review personnel in discharge planning for Members.

7. **Provider** agrees to make adequate space available, when needed, in the medical records department for **Humana's** review personnel to carry out review activities or cooperate with telephonic reviews. **Provider** agrees to allow **Humana** access to electronic records when that is the only way to view a medical record.

8. Upon discharge of Members, **Provider** agrees to submit a completed claim form, in the format specified in the Agreement for each Member to **Humana** with the admitting and discharge diagnosis recorded and coded.

9. **Provider** agrees to allow **Humana's** review personnel to photocopy any portion of the medical records of Members.

10. **Provider** agrees to release copies of medical records to **Humana** of Members who have been discharged from **Provider** for retrospective review and special studies.

## STATE LAW COORDINATING PROVISIONS

## ATTACHMENT

## WISCONSIN

**Humana** and **Provider** agree that the following provisions are incorporated into the Agreement solely to the extent specifically required to ensure compliance with applicable Wisconsin laws, rules and/or regulations. To the extent this Agreement covers any Medicare Advantage line(s) of business, the parties further agree that none of the provisions of this attachment apply to same.

### I. CONTINUITY OF CARE

**Humana** and **Provider** agree the following continuity of care provision is added to the Agreement as follows:

**MEMBERS WHOSE HEALTH BENEFITS PLANS ARE NOT SUBJECT TO OPEN ENROLLMENT:**

**Provider** shall continue to provide or arrange for the provision of Covered Services to Member(s) whose health benefits plan is not subject to open enrollment for the time period set forth in Section A or B below, as applicable, if the Member(s) was informed through **Humana's** marketing materials provided or available to Member(s) at the time of the Member's enrollment or most recent coverage renewal, whichever is later, that **Provider** and/or its Participating Provider(s) was, or would be, a participating provider with **Humana**.

**MEMBERS WHOSE HEALTH BENEFITS PLANS ARE SUBJECT TO OPEN ENROLLMENT:**

**Provider** shall continue to provide or arrange for the provision of Covered Services to Member(s) whose health benefits plan is subject to open enrollment for the time period set forth in Section A or B below, as applicable, if the Member(s) was informed through **Humana's** marketing materials provided or available to Member(s) during the most recent open enrollment period that **Provider** and/or its Participating Provider(s) was, or would be, a participating provider with **Humana**.

**A. PARTICIPATING PROVIDERS WHO ARE PRIMARY CARE PHYSICIANS:**

In the event of termination or expiration of this Agreement for any reason, other than for reasons of quality of care or misconduct, **Provider** shall continue to provide or arrange for the provision of Covered Services by its Participating Provider(s) who are primary care physicians under Wisconsin law for the following periods of time: (i) for those Members whose plan is not subject to open enrollment, continuation of care is required until the end of the current plan year; or (ii) for those Members whose plan is subject to open enrollment, continuation of care is required until the end of the plan year in which **Humana** represented that such Participating Provider(s) was, or would be, a participating provider with **Humana**.

**B. PARTICIPATING PROVIDERS WHO ARE NOT PRIMARY CARE PHYSICIANS:**

In the event of termination or expiration of this Agreement for any reason, other than for reasons of quality of care or misconduct, **Provider** shall continue to provide or arrange for the provision of Covered Services to a Member undergoing a course of treatment with a Participating Provider who is not a primary care physician under Wisconsin law for the following periods of time: (i) the remainder of the course of treatment; or (ii) ninety (90) days from the effective date of termination or expiration, whichever is less; except that, in no event, is the continuation of care required to extend beyond the current plan year for those Members whose plan is not subject to open enrollment; and for those Members whose plan is subject to open enrollment, continuation of care is not required to extend beyond the plan year in which **Humana** represented that such Participating Provider was, or would be, a participating provider with **Humana**. If maternity care is the course of treatment and the Member is in the second or third trimester at the time of termination or expiration of this Agreement, such Participating Provider shall continue the Member's course of treatment until the completion of postpartum care for the Member and the infant.

**PAYMENT:**

Payment by **Humana** to **Provider** for the continued provision of Covered Services hereunder is subject to any and all Medical Necessity determinations of which **Humana** is allowed to undertake pursuant to this Agreement. **Provider** agrees to accept as payment in full the rates set forth in this Agreement for all Covered Services provided to **Humana's** Members under this continuity of care provision. Notwithstanding anything to the contrary herein, **Humana** is not required to reimburse **Provider** hereunder, nor is **Provider** required to comply with this continuity of care provision, in the event **Provider** no longer practices or arranges for the provision of services in **Humana's** geographic service area.

**MEMBER HOLD HARMLESS:**

**Provider** agrees that **Provider** is bound by the provisions of Wis. Stat. §609.91 in relation to the provision of Covered Services under this continuity of care provision, regardless of whether or not the Member's plan is a health maintenance organization plan and regardless of whether **Provider** is a participating provider with **Humana** at the time services are rendered hereunder.

## II. COMPLAINTS AND GRIEVANCES

**Provider** agrees to promptly respond to complaints and grievances filed with **Humana**. **Provider** further agrees to include in its subcontracts, if any, affecting the provision of services under this Agreement a requirement that the subcontractor will promptly respond to complaints and grievances filed with **Humana**. Notwithstanding the foregoing, in the event the affected Member's health benefits plan is a commercial PPO plan and this Agreement covers commercial PPO plans, **Provider** agrees to: (i) promptly provide to **Humana** any information necessary for **Humana** to respond to such Member complaints and grievances; and (ii) include in its subcontracts, if any, affecting the provision of services under this Agreement a requirement that the subcontractor will promptly provide to **Humana** any information necessary for **Humana** to respond to such Member complaints or grievances.

## III. SPECIALISTS TERMINATIONS

In the event any Participating Provider is a specialist, **Provider** shall require such Participating Provider(s) to post a notification of any termination of this Agreement in their office on the earlier of: (i) thirty (30) days prior to the effective date of termination; or (ii) fifteen (15) days following **Humana's** receipt of **Provider** notice of termination, as applicable.

## IV. SERVICES TO MEMBERS

Subsequent to the termination or expiration of this Agreement for any reason, **Provider** shall continue to provide or arrange for the provision of Covered Services to Member(s) whose provider network was guaranteed for the renewing health benefits Plan year for the greater of the following time periods: (i) the period required by applicable law; or (ii) for the entirety of the Member's renewing health benefits plan year.

## ATTACHMENT

## PROVIDER REIMBURSEMENT

## SKILLED NURSING FACILITY

**Commercial and Medicare Advantage Plan(s):**

### INPATIENT SERVICES SNF/SNU SERVICES – SNF PPS Methodology

**Provider** agrees to accept as payment in full from **Humana** for Covered Services provided to **Humana's** Medicare Advantage Members and Commercial Members, covered under such Plans offered by **Humana** with access to **Humana**, ninety percent (90%) of Provider's Medicare allowable amount in effect as of the date such services are rendered in accordance with Medicare Advantage laws, state laws, rules and regulations, less any co-payments, co-insurance, deductibles or other cost-share amounts due from such Members.

### OUTPATIENT SNF/ SNU SERVICES – OPPS Methodology

**Provider** agrees to accept as payment in full from **Humana** for Covered Services provided to **Humana's** Medicare Advantage Members and Commercial Members covered under such Plans offered by **Humana** with access to **Humana**, ninety percent (90%) of Provider's Medicare allowable amount in effect as of the date such services are rendered in accordance with Medicare Advantage laws, state laws, rules and regulations, less any co-payments, co-insurance, deductibles or other cost-share amounts due from such Members.

## ANCILLARY SERVICES

**Provider** agrees to provide only those laboratory, injectable, infusion therapies, durable medical equipment, radiology, nuclear medicine, physical therapy and other ancillary health care services which **Provider** is qualified to provide by license, certification, and state and/or federal law.

## PROVIDER LOCATIONS

## ATTACHMENT

(To be provided by Provider prior to execution of this Agreement.)

The following is a list of **Provider's** locations, including address, telephone and fax numbers, tax identification number, National Provider Identifier ("**NPI**"), contact person, office hours, specialty services available for each service location included in this Agreement and other **Provider** personnel who will be providing services to **Humana** Members under this Agreement. **Provider** shall provide **Humana** with no less than sixty (60) days prior written notice of any addition, change or closing of a location. **Provider** will provide updates of this listing to **Humana** on a quarterly basis.

## MEDICARE ADVANTAGE PROVISIONS

## ATTACHMENT

The following additional provisions relate specifically to Medicare Advantage products and plans and are hereby incorporated by reference into the Agreement.

a) **Provider** agrees to: (i) abide by all state and federal laws regarding confidentiality, privacy and disclosure of medical records or other health and enrollment information, (ii) ensure that medical information is released only in accordance with applicable state and/or federal law, or pursuant to court orders or subpoenas, (iii) maintain all Member records and information in an accurate and timely manner, and (iv) allow timely access by Members to the records and information that pertain to them.

b) **Humana** and **Provider** agree that **Humana** will process all claims for Covered Services which are accurate and complete within thirty (30) days from the date of receipt.

c) **Provider** agrees that in no event, including, but not limited to, nonpayment by **Humana**, **Humana's** insolvency or breach of this Agreement, shall **Provider** bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than **Humana** (or the payor issuing the health benefits contract administered by **Humana**) for Covered Services provided by **Provider** for which payment is the legal obligation of **Humana**. This provision shall not prohibit collection by **Provider** from Member for any non-covered service and/or Copayments in accordance with the terms of this Agreement and the applicable Member health benefits contract. **Provider** further agrees that: (i) this provision shall survive the expiration or termination of this Agreement regardless of the cause giving rise to expiration or termination and shall be construed to be for the benefit of the Member; (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between **Provider** and Member or persons acting on their behalf; and (iii) this provision shall apply to all employees, agents, trustees, assignees, subcontractors, and independent contractors of **Provider**, and **Provider** shall obtain from such persons specific agreement to this provision.

d) **Provider** agrees to cooperate with and assist **Humana** in its efforts to comply with its Medicare Advantage contract(s) and/or Medicare Advantage rules and regulations and to assist **Humana** in complying with corrective action plans necessary for **Humana** to comply with such rules and regulations.

e) **Provider** agrees that nothing in the Agreement shall be construed as relieving **Humana** of its responsibility for performance of duties agreed to through its Medicare Advantage contracts existing now or entered into in the future with CMS.

f) **Provider** agrees to comply with and be subject to all applicable Medicare program laws, rules and regulations, reporting requirements, and CMS instructions as implemented and amended by CMS. This includes, without limitation, state and federal laws regulatory agencies' including, but not limited to, HHS, the Comptroller General or their designees rights to evaluate, inspect and audit **Provider's** operations, books, records, and other documentation and pertinent information related to **Provider's** obligations under the Agreement, as well as all other state and federal laws, rules and regulations applicable to individuals and entities receiving federal funds. **Provider** further agrees HHS', the Comptroller General's, or their designees right to inspect, evaluate and audit any pertinent information for any particular contract period will exist through ten (10) years from the final date of the contract period between **Humana** and CMS or from the date of completion of any audit, whichever is later, and agrees to cooperate, assist and provide information as requested by such entities.

g) **Provider** agrees to retain all contracts, books, documents, papers and other records related to the provision of services to Medicare Advantage Members and/or as related to **Provider's** obligations under the Agreement for a period of not less than ten (10) years from: (i) each successive December 31; or (ii) the end of the contract period between **Humana** and CMS; or (iii) from the date of completion of any audit, whichever is later.

h) **Provider** agrees in the event certain identified activity(ies) have been delegated to **Provider** under the Agreement, any sub-delegation of the noted activity(ies) by **Provider** requires the prior written approval of **Humana**. Notwithstanding anything to the contrary in the Agreement, **Humana** will monitor **Provider's** performance of any delegated activity(ies) on an ongoing basis and hereby retains the right to modify, suspend or revoke such delegated activity(ies) in the event **Humana** and/or CMS determines, in their discretion, that **Provider** is not meeting or has failed to meet its obligations under the Agreement related to such delegated activity(ies). In the event that **Humana** has delegated all or any part of the claims payment process to **Provider** under the Agreement, **Provider** shall comply with all prompt payment requirements to which **Humana** is subject. **Humana** agrees that it shall review the credentials of **Provider** or, if **Humana** has delegated the credentialing process to **Provider**, **Humana** shall review and approve **Provider's** credentialing process and audit it on an ongoing basis.

i) **Provider** agrees to comply with **Humana's** policies and procedures.

j) **Provider** agrees to maintain full participation status in the federal Medicare program. This also includes all of **Provider's** employees, subcontractors, and/or independent contractors who will provide services, including, without limitation, health care, utilization review, medical social work, and/or administrative services under the Agreement.

k) **Provider** agrees that payment from **Humana** for services rendered to **Humana's** Medicare Advantage Members is derived, in whole or in part, from federal funds received by **Humana** from CMS.

l) **Provider** agrees to disclose to **Humana**, upon request and within thirty (30) days or such lesser period of time required for **Humana** to comply with all applicable state and/or federal laws, all of the terms and conditions of any payment arrangement that constitutes a "physician incentive plan" as defined by CMS and/or any federal law or regulation. Such disclosure should identify, at a minimum, whether services not furnished by the physician/provider are included, the type of incentive plan including the amount, identified as a percentage, of any withhold or bonus, the amount and type of any stop-loss coverage provided for or required of the physician/provider, and the patient panel size broken down by total group or individual physician/provider panel size, and by the type of insurance coverage (i.e., Commercial HMO, Medicare Advantage HMO, Medicare PPO, and Medicaid HMO).

m) **Provider** agrees that in the event of **Humana's** insolvency or termination of **Humana's** contract with CMS, benefits to Members will continue through the period for which premium has been paid and benefits to Members confined in an inpatient facility will continue until their discharge.

n) **Provider** agrees to provide or arrange for continued treatment, including, but not limited to, medication therapy, to Medicare Advantage Members upon expiration or termination of the Agreement. In accordance with all applicable state and federal laws, rules and/or regulations, treatment must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Medicare Advantage Member's course of treatment, or until **Humana** has made arrangements for substitute care for the Medicare Advantage Member; and (ii) until the date of discharge for Medicare Advantage Members hospitalized on the effective date of termination or expiration of the Agreement. **Provider** agrees to accept as payment in full from **Humana** for Covered Services rendered to **Humana's** Medicare Advantage Members, the rates set forth in the Payment Attachment(s) which are applicable to such Member.

o) **Provider** agrees to cooperate with the activities and/or requests of any independent quality review and improvement organization utilized by and/or under contract with **Humana** as related to the provision of services to Medicare Advantage Members.

p) **Provider** agrees to cooperate with **Humana's** health risk assessment program.

q) **Provider** agrees to provide to **Humana** accurate and complete information regarding the provision of Covered Services by **Provider** to Members ("**Data**") on a complete CMS 1500 or UB 92 form, or their respective successor forms as may be required by CMS, or such other form as may be required by law when submitting claims and encounters in an electronic format, or such other format as is mutually agreed upon by both parties. The Data shall be provided to **Humana** on or before the last day of each month for encounters occurring in the immediately preceding month, or such lesser period of time as may be required in the Agreement, or as is otherwise agreed upon by the parties in writing. The submission of the Data to **Humana** and/or CMS shall include a certification from **Provider** that the Data is accurate, complete and truthful. In the event the Data is not submitted to **Humana** by the date and in the form specified above, **Humana** may, in its sole option, withhold payment otherwise required to be made under the terms of the Agreement until the Data is submitted to **Humana**.

r) **Provider** agrees not to collect or attempt to collect copayments, coinsurance, deductibles or other cost-share amounts from any **Humana** Medicare Advantage Member who has been designated as a Qualified Medicare Beneficiary ("**QMB**") by CMS.

s) **Provider** agrees to maintain written agreements with employed and contracted health care providers and health care professionals providing services under the Agreement in a form comparable to, and consistent with, the terms and conditions of the Agreement. **Provider's** downstream provider agreements shall include terms and conditions which comply with all applicable requirements for provider agreements under state and federal laws, rules and regulations including, without limitation, the Medicare Advantage rules and regulations to which **Humana** is subject. In the event of a conflict between the language of the downstream provider agreements and the Agreement, the language in the Agreement shall control.

t) With respect to any Members who are eligible for both Medicare and Medicaid, **Provider** agrees that such Members will not be held liable for Medicare Part A and Medicare Part B cost sharing when the State is responsible for paying such amounts. Further, with respect to such Members, **Provider** agrees to: (i) accept the payment amount from **Humana** as payment in full, or (ii) bill the appropriate State source.

## HMO PROVISIONS

## ATTACHMENT

**The following provisions apply to HMO products and plans, as applicable.**

I. **Services to Members**. In the event **Provider** provides a Member a non-covered service or refers a Member to an out-of-network provider without pre-authorization from **Humana**, **Provider** shall, prior to the provision of such non-covered service or out-of-network referral, inform the Member: (i) of the service(s) to be provided or referral(s) to be made; (ii) that **Humana** will not pay or be liable financially for such non-covered service(s) or out-of-network referral(s); and (iii) that Member will be responsible financially for non-covered service(s) and/or out-of-network referral(s) that are requested by the Member.

II. **Continuity of Care**. Subject to and in accordance with all applicable state and/or federal laws, rules and/or regulations, treatment following termination or expiration of this Agreement must continue until the Member: (i) has been evaluated by a new participating provider who has had a reasonable opportunity to review or modify the Member's course of treatment, or until **Humana** has made arrangements for substitute care for the Member; and (ii) until the date of discharge for Members hospitalized on the effective date of termination or expiration of this Agreement. **Provider** agrees to accept as payment in full from **Humana** for Covered Services rendered to such Members, the rates set forth in the Payment Attachment, less any Copayments due from such Members.

III. **Provider Responsibilities**.

A. **Services**
**Provider** agrees to be responsible twenty-four (24) hours a day, seven (7) days a week for providing Covered Services for Members.

B. **Specific Referrals**
Except in the case of a medical emergency, **Provider** agrees to use its best efforts to admit, refer, and cooperate with the transfer of Members for Covered Services only to providers designated, specifically approved by or under contract with **Humana**.

In addition, **Provider** acknowledges and agrees that certain Members may have health benefits contracts that limit coverage to certain types of participating providers. For such Members, referrals are required to be made to specific providers designated by **Humana**.

C. **Disease/Case Management Programs**
**Provider** agrees to participate in **Humana's** disease/case management programs as they are developed and implemented.

D. **Hospitalist Programs**
**Provider** agrees to cooperate with and participate in **Humana's** hospitalist programs where applicable, as they are developed and implemented.

E. **Transplant Programs**
Upon request by **Humana**, **Provider** agrees to cooperate with and participate in **Humana's** organ and tissue transplant programs as they are developed and implemented.

F. **Humana First**
**Provider** agrees to participate in **Humana's** twenty-four (24) hours nurse call program, HumanaFirst, or any such successor program.

G. **Health Improvement Studies**

**Provider** agrees to participate in **Humana's** health improvement studies as they are developed and implemented.

H. **Quality Improvement Activities**

**Provider** agrees to cooperate with **Humana's** quality improvement activities and, upon request by **Humana**, to participate in **Humana's** quality improvement activities as they are developed and implemented.

## Ins 9 Appendix C

## NOTICE

**THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HEALTH MAINTENANCE ORGANIZATION INSURER ENROLLEES FOR PAYMENT FOR SERVICES**

Section 609.94, Wis. Stat., requires each health maintenance organization insurer ("HMO insurer"), to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§609.91 to 609.935, and §609.97(1), Wis. Stats.

### SUMMARY

Under Wisconsin law a health care provider may not hold HMO insurer enrollees or policyholders ("enrollees") liable for costs covered under an HMO insurer policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold harmless statutes only if the provider voluntarily "opts-in." An HMO insurer may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form in order to be effective.

### HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not effect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issue by the HMO insurer.

A. MANDATORY FOR HOLD HARMLESS.

An enrollee of an HMO insurer is not liable to a health care provider for health care costs which are covered under a policy issued by that HMO insurer if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO insurer, owns at least 5% of the voting securities of the HMO insurer, is directly or indirectly involved with the HMO insurer through direct or indirect selection of or representation by one or more board Members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO insurer board Members who directly or indirectly represent one or more IPAs or affiliates of IPAs.
2. Care is provided by a provider under a contract with or through Membership in an organization identified in 1.
3. To the extent the charge exceeds the amount the HMO insurer has contractually agreed to pay the provider for that health care service.
4. The care is provided to an enrolled medical assistance recipient under a Department of Health and Family Services prepaid health care policy.
5. The care is required to be provided under the requirements of s. Ins 9.35, Wis. Adm. Code.

B. "OPT-OUT" HOLD HARMLESS

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA.

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO insurer or are provided by a provider selected by the HMO insurer.
3. Provided by a provider, other than a hospital, under a contract with or through Membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its Member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT-IN" HOLD HARMLESS

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO insurer. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

**CONDITIONS NOT AFFECTING IMMUNITY**

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO insurer, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute).
2. A breach of or default on any agreement by the HMO insurer, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.
3. The insolvency of the HMO insurer or any person contracting with the HMO insurer, or the commencement of insolvency, delinquency or bankruptcy proceedings involving the HMO insurer or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless.
4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable.
5. Failure by the HMO insurer to provide notice to providers of the statutory hold-harmless provisions.
6. Any other conditions or agreement existing at any time.

**EXEMPTIONS AND ELECTIONS**

Hospitals, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO insurer, the provider must within thirty (30) days after entering into that contract provide a notice to OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.
2. If the hospital, IPA, or other provider does not have a contract with an HMO insurer, the provider must notify OCI that it intends to be exempt with respect to a specific HMO insurer and must provide that notice for the period January 1, 1990, to December 21, 1990, at least sixty (60) days before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least 90 days in advance.
3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.
4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through Membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions or the failure of the clinic to elect to be exempt applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.
5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO insurer or if the physician is a selected provider for the

HMO insurer, unless the services are provided by a physician for a hospital, IPA or clinic which is subject to the statutory hold-harmless "opt-out" provision.

## NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation or change in control of the provider, HMO insurer, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

P.O. Box 7873, Madison, WI 53707-7873

## HMO INSURER CAPITAL AND SECURITY SURPLUS

Each HMO insurer is required to meet minimum capital and surplus standard ("compulsory surplus requirements"). These standards are higher if the HMO insurer has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, beginning January 1, 1992, the compulsory surplus requirements shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO insurer must also maintain a security surplus in the amount set by the Commissioner of Insurance.

## FINANCIAL INFORMATION

An HMO insurer is required to file financial statements with OCI. You may request financial statements from the HMO insurer. OCI also maintains files of HMO insurer financial statements that can be inspected by the public.