Addendum to Account Setup Agreement
Medicare Advantage Programs
Provider Agreement Requirements

To the extent that any LGTC Client offers NET services to Medicare beneficiaries, the Centers for Medicare and Medicaid Services ("CMS") and associated laws, rules and regulations regarding the Medicare Advantage ("MA") Program require that the Client provide for compliance of contracted network providers and their respective employees with certain MA program requirements including, without limitation, inclusion of certain mandatory provisions in MA provider participation agreements and/or associated documents including agreements between LGTC and subcontracted transportation providers, as applicable. A list of some of these requirements can be found in the CMS Managed Care Manual, Chapter 11, Section 100.4, as published by CMS and available on the CMS website. Additionally, revisions to certain applicable regulations can be found in 74 Fed. Reg. 1494 (January 12, 2009) (amending 42 C.F.R. Parts 422 and 423). As such and in addition to the terms and conditions in the Agreement between LGTC and Provider, Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries enrolled in MA health benefit plans. In the event of a conflict between the contract between LGTC and Provider related to services rendered to Medicare beneficiaries and applicable provisions of this Medicare Advantage Program Provider Requirements Addendum ("Addendum"), this Addendum shall control.

II. Definitions. For purposes of this Addendum the following additional terms shall have the meaning set out below:

(1) **"Covered Services"** means those Medically Necessary medical, related health care and other services covered under and defined in accordance with the applicable Medicare beneficiary's MA Plan.

(2) "**Dual Eligible Member"** means a Medicare beneficiary who is also entitled to medical assistance under a state plan under Title XIX ("Medicaid") of the Social Security Act (the "Act").

(3) "**First Tier Entity**" means LogistiCare Solutions, LLC. .

(4) **"Health Plan"** means the entity that offers the MA health benefit plans with which Medicare beneficiaries participate.

(5) "**MA Plan**" means the one or more MA health benefit plans offered or administered by Health Plan(s) for Medicare beneficiaries and under which Provider renders services to Medicare beneficiaries.

(6) "**Medicare Advantage Program or MA Program**" means the federal Medicare managed care program for Medicare Advantage (formerly known as Medicare+Choice) products run and administered by CMS, or CMS' successor.

(7) "**Medicare Contract**" means Health Plan's contract(s) with CMS to arrange for the provision of health care services to certain persons enrolled in an MA Plan who are eligible for Medicare under Title XVIII of the Social Security Act.

(8) "**State"** means the state in which Provider provides the Covered Services.

(9) "**State Medicaid Plan**" the State's plan for medical assistance developed in accordance with Section 1902 of the Act and approved by CMS.

(10) "**Medicare beneficiary**" means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and CMS rules and regulations and enrolled with Health Plan.

II. Additional MA Program Obligations and Requirements. Provider agrees to the following terms and conditions to the extent applicable to NET services rendered to Medicare beneficiaries.

A. Audits; Access to and Record Retention. Provider shall permit audit, evaluation and inspection directly by Health Plan, the Department of Health and Human Services (HHS), the Comptroller General, the Office of the Inspector General, the General Accounting Office, CMS and/or their designees, and as the Secretary of the HHS may deem necessary to enforce the Medicare Contract, physical facilities and equipment and any pertinent information including books, contracts (including any agreements between Provider and its employees, contractors and/or subcontractors providing services related to services provided to Medicare beneficiaries), documents, papers, medical records, patient care documentation and other records and information involving or relating to the provision of services under the Agreement, and any additional relevant information that CMS may require (collectively, "Books and Records"). All Books and Records shall be maintained in an accurate and timely manner and shall be made available for such inspection, evaluation or audit for a time period of not less than ten (10) years, or such longer period of time as may be required by law, from the end of the calendar year in which expiration or termination of the agreement under which Provider renders services to Medicare beneficiaries occurs or from completion of any audit or investigation, whichever is greater, unless CMS, an authorized federal agency, or such agency's designee, determines there is a special need to retain records for a longer period of time, which may include but not be limited to: (i) up to an additional six (6) years from the date of final resolution of a dispute, allegation of fraud or similar fault; (ii) completion of any audit should that date be later than the time frame(s) indicated above; (iii) if CMS determines that there is a reasonable possibility of fraud or similar fault, in which case CMS may inspect, evaluate, and audit Books and Records at any time; or (iv) such greater period of time as provided for by law. Provider shall cooperate and assist with and provide such Books and Records to Health Plan and/or CMS or its designee for purposes of the above inspections, evaluations, and/or audits, as requested by CMS or its designee and shall also ensure accuracy and timely access for Medicare beneficiaries to their medical, health and enrollment information and records. Provider agrees and shall require its employees, contractors and/or subcontractors and those individuals or entities performing administrative services for or on behalf of Provider and/or any of the above referenced individuals or entities: (i) to provide Health Plan and/or CMS with timely access to records,

information and data necessary for: (1) Health Plan to meet its obligations under its Medicare Contract(s); and/or (2) CMS to administer and evaluate the MA program; and (ii) to submit all reports and clinical information required by Health Plan under the Medicare Contract. [42 C.F.R. §§ 422.504(e)(4), 422.504 (h), 422.504(i)(2)(i), 422.504(i)(2)(ii) and 422.504(i)(4)(v)]

B. Privacy and Accuracy of Records. In accordance with the CMS Managed Care Manual and the regulations cited below, Provider agrees to comply with all state and federal laws, rules and regulations, Medicare program requirements, and/or Medicare Contract requirements regarding privacy, security, confidentiality, accuracy and/or disclosure of records (including, but not limited to, medical records), personally identifiable information and/or protected health information and enrollment information including, without limitation: (i) HIPAA and the rules and regulations promulgated thereunder; (ii) 42 C.F.R. § 422.504(a)(13); and (iii) 42 C.F.R. § 422.118; (d) 42 C.F.R. § 422.516 and 42 C.F.R. § 422.310 regarding certain reporting obligations to CMS. Provider also agrees to release such information only in accordance with applicable state and/or federal law, including pursuant to valid court orders or subpoenas.

C. Hold Harmless of Medicare Beneficiaries. Provider hereby agrees: (i) that in no event including, but not limited to, non-payment by Health Plan or First Tier Entity, Health Plan's determination that services were not Medically Necessary, Health Plan's or First Tier Entity's insolvency, or breach of the agreement between Provider and First Tier Entity that is the subject hereof or the agreement between First Tier Entity and Health Plan, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare beneficiary for amounts that are the legal obligation of Health Plan and/or First Tier Entity; and (ii) that Medicare beneficiaries shall be held harmless from and shall not be liable for payment of any such amounts. Provider further agrees that this provision (a) shall be construed for the benefit of Medicare beneficiaries; (b) shall survive the termination of the agreements between Provider and First Tier Entity and First Tier Entity and Health Plan regardless of the cause giving rise to such termination; and (c) supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Medicare beneficiaries, or persons acting on behalf of a Medicare beneficiary. [42 C.F.R. § 422.504(g)(1)(i) and (i)(3)(i)]

D. Hold Harmless of Dual Eligible Members. With respect to those Medicare beneficiaries who are designated as Dual Eligible Members for whom the State Medicaid agency is otherwise required by law, and/or voluntarily has assumed responsibility in the State Medicaid Plan to cover those Medicare Part A and B Member Expenses identified and at the amounts provided for in the State Medicaid Plan, Provider acknowledges and agrees that it shall not bill Medicare beneficiaries the balance of ("balance-bill"), and that such Medicare beneficiaries are not liable for, such Medicare Part A and B Member Expenses, regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept First Tier Entity's payment as payment in full or will bill the appropriate State source if Health Plan has not assumed the State's financial responsibility under an agreement between Health Plan and the State. [42 C.F.R. § 422.504(g)(1)(iii).]

E. Accordance with Health Plan's Contractual Obligations. Provider agrees that any services provided to Medicare beneficiaries shall be consistent with and comply with the requirements of the Medicare Contract. [42 C.F.R. § 422.504(i)(3)(iii).]

F. Prompt Payment of Claims. First Tier Entity will process and pay or deny claims for Covered Services within the timeframe set forth in the agreement between Provider and First Tier Entity . [42 C.F.R. § 422.520(b).]

G. Delegation of Provider Selection. As applicable, Provider understands that if selection of providers who render services to Medicare beneficiaries has been delegated to First Tier Entity by Health Plan, either expressly or impliedly, then Health Plan retains the right to approve, suspend or terminate such downstream or subcontracted arrangements to the extent applicable to Medicare beneficiaries enrolled with Health Plan. [42 C.F.R. § 422.504(i)(5).]

H. Compliance with Health Plan's Policies and Procedures. Provider shall comply with all policies and procedures of Health Plan to the extent applicable to the services rendered by Provider. Such policies may include written standards for the following: (a) timeliness of access to care and member services; (b) policies and procedures that allow for individual medical necessity determinations (e.g., coverage rules, practice guidelines, payment policies); and (c) Health Plan's compliance program which encourages effective communication between Provider and Health Plan's Compliance Officer and participation by Provider in education and training programs regarding the prevention, correction and detection of fraud, waste and abuse and other initiatives identified by CMS. [42 C.F.R. § 422.112; 42 C.F.R. § 422.504(i)(4)(v); 42 C.F.R. § 422.202(b); 42 C.F.R. § 422.504(a)(5); 42 C.F.R. § 422.503(b)(4)(vi)(C) & (D) & (G)(3).]

I. Delegation (Accountability) Provisions. Provider agrees that to the extent Health Plan, in Health Plan's sole discretion, elects to delegate any administrative activities or functions to First Tier Entity, the following shall apply:

(1) Reporting Responsibilities. The Health Plan and First Tier Entity will agree in writing to a clear statement of such delegated activities and reporting responsibilities relative thereto. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(i)]

(2) Revocation. In the event CMS or Health Plan determines that First Tier Entity does not satisfactorily perform the delegated activities and any plan of correction, any and all of the delegated activities may be revoked upon notice by the Health Plan to First Tier Entity. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(ii)]

(3) Monitoring. Any delegated activities will be monitored by the Health Plan on an ongoing basis and formally reviewed by the Health Plan at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iii)]

(4) Credentialing. The credentials of medical professionals, if any, affiliated with Provider and/or First Tier Entity will either be reviewed by Health Plan or, in the event Health Plan has delegated credentialing to First Tier Entity, First Tier Entity's credentialing process will

be reviewed and approved by Health Plan, monitored on an ongoing basis and audited at least annually. [42 C.F.R. § 422.504(i)(3)(ii) and 42 C.F.R. § 422.504(i)(4)(iv)]

(5) No Assignment of Responsibility. Provider understands that Provider and/or First Tier Entity may not delegate, transfer or assign any of Provider's or First Tier Entity's obligations with respect to Medicare beneficiaries or any delegation agreement between Health Plan and Provider and/or First Tier Entity without Health Plan's prior written consent.

J. Compliance with Laws and Regulations. Provider agrees to comply with all applicable Medicare laws, rules and regulations, reporting requirements, CMS instructions, and with all other applicable state and federal laws, rules and regulations, as may be amended from time to time including, without limitation: (a) laws, rules and regulations designed to prevent or ameliorate fraud, waste and abuse including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and/or the anti-kickback statute (section 1128B(b) of the Act); (b) applicable state laws regarding patients' advance directives as defined in the Patient Self Determination Act (P.L. 101-58), as may be amended from time to time; (c) Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) administrative simplification rules found at 45 C.F.R. parts 160, 162, and 164; and (d) laws, rules and regulations and CMS instructions and guidelines regarding marketing. Additionally, and to the extent applicable, Provider agrees to maintain full participation status in the federal Medicare program and shall ensure that none of its employees, contractors, or subcontractors is excluded from providing services to Medicare beneficiaries under the Medicare program. [42 C.F.R. § 422.204(b)(4) and 42 C.F.R. § 422.752(a)(8)]

K. Accountability. Provider hereby acknowledges and agrees that Health Plan oversees the provision of services by Provider to Medicare beneficiaries and that Health Plan shall be accountable under the Medicare Contract for such services regardless of any delegation of administrative activities or functions to Provider or First Tier Entity. [42 C.F.R. § 422.504(i)(1); (i)(4)(iii); and (i)(3)(ii)]

L. Benefit Continuation. Upon termination of Provider's status as a participating provider with Health Plan (unless such termination was related to safety or other concerns), Provider will continue to provide health care benefits/services to Medicare beneficiaries in a manner that ensures medically appropriate continuity of care and for the time period required by applicable law. Specifically, for Medicare beneficiaries who are hospitalized on the date of such termination, services will be provided through the applicable Medicare beneficiary's date of discharge. [42 C.F.R. § 422.504(g)(2)]. The parties acknowledge the provisions set for in this paragraph K are not applicable to NET services.

Execution Page to Follow

Addendum to Account Setup Agreement for Medicare Advantage Program – Execution Page

LOGISTICARE SOLUTIONS, LLC

Printed Name: _____

Title: _____

Signature: _____

Date: _____

PROVIDER: _____

Printed Name: _____

Title: _____

Signature: _____

Date: _____

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