AMENDMENT NO. 3 TO DENTAL SERVICES CONTRACT BETWEEN THE FLORIDA HEALTHY KIDS CORPORATION AND DENTAQUEST OF FLORIDA, INC.

This AMENDMENT No. 3, entered into between the Florida Healthy Kids Corporation ("FHKC") and DentaQuest of Florida, Inc. ("INSURER"), and effective as of July 1, 2018 ("Effective Date"), amends that certain Dental Services Contract between FHKC and INSURER effective July 1, 2016 ("Contract").

WHEREAS, the Contract allows for amendments by mutual written consent of the parties; and

WHEREAS, the parties have agreed upon certain revisions to the Contract, to be effective as of July 1, 2018; and

WHEREAS, the parties desire to amend the Contract as provided in this Amendment;

NOW, THEREFORE, in consideration of the mutual promises and agreements herein contained, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties agree as follows:

1. Section 1 of the Contract is hereby revised by adding the following definitions:

1-27 "Act" means the Social Security Act.

1-28 "Adverse Benefit Determination" means the denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; the reduction, suspension or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the FHKC; the failure of Insurer to act within the timeframes required by law for standard resolution of Grievances and Appeals; and the denial of an Enrollee's request to dispute a financial liability, including cost sharing, copayments, premiums and other Enrollee financial liabilities.

1-29 "Agency for Health Care Administration" or "AHCA" means the lead state agency for Title XXI of the Social Security Act for purposes of receipt of federal funds, for reporting purposes, and for ensuring compliance with federal and state regulations and rules.

1-30 "Appeals" means a review by Insurer of an Adverse Benefit Determination.

1-31 "Centers for Medicare and Medicaid Services" or "CMS" means the federal agency responsible for administering the Children's Health Insurance Program.

1-32 "Grievance" means an expression of dissatisfaction about any matter other than an Adverse Benefit Determination and that is not resolved within 24 hours of receipt. Grievances may include, but are not limited to, the quality of care or services provided,

and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's rights regardless of whether remedial action is requested. Grievances also include an Enrollee's right to dispute an extension of time proposed by Insurer to make an authorization decision.

1-33 "U.S. Department of Health and Human Services" or "HHS" means the federal department responsible for operating CMS.

2. Section 2-3 of the Contract is hereby revised by adding the following sub-section:

2-3-1 Overpayments

Insurer agrees to return to FHKC any overpayments due to unearned funds or funds disallowed pursuant to the terms of this Contract that were paid under this Contract. Insurer shall return any such funds to FHKC within forty-five (45) calendar days of identification by FHKC or Insurer.

Premiums payments may only be retained by Insurer for eligible enrollees. Premium payments made for enrollees determined to be ineligible for coverage must be returned to FHKC.

3. Section 2-5 of the Contract is hereby revised by adding the following sentence:

In addition to the data, documentation and information specified in this Contract, Insurer must submit any other data, documentation or information relating to the performance of Insurer's obligations under this Contract required by FHKC or the secretary of U.S. Department of Health and Human Services (HHS).

4. Section 2 of the Contract is hereby revised by adding the following section:

2-6 Intermediate Sanctions

FHKC may impose intermediate sanctions in accordance with 42 CFR 457.1270. Sanctions may be imposed as listed should FHKC make any of the following determinations based on findings from onsite surveys, complaints by Enrollees and others, financial status or any other source. FHKC may impose any or all of the potential sanctions listed for a determination.

- Insurer fails substantially to provide medically necessary services that Insurer is required to provide, under law or under this Contract, to a covered Enrollee.
    - Potential Sanctions:
        - Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
        - Civil money penalties limited to $25,000 for each determination.

        - Suspension of new enrollment, including auto-assigned enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
        - Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
    - FHKC may request AHCA recommend that CMS impose denial of payment to the state for new enrollees of Insurer. Such denial of payment from CMS automatically results in a denial of payment for those same enrollees from FHKC.

- Insurer imposes on Enrollees premiums or charges in excess of the premiums or charges permitted under the program.
    - Potential Sanctions:
        - Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
        - Civil money penalties limited to the greater of $25,000 or double the amount of the excess charges.
        - Suspension of new enrollment, including auto-assigned enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
        - Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Insurer acts to discriminate among Enrollees on the basis of their health status or need for health care services, including termination of the enrollment or refusal to reenroll an Enrollee, except as permitted under this Contract, or any practice that would reasonably be expect to discourage enrollment by potential Enrollees whose medical condition or history indicates probably need for substantial future medical services.
    - Potential Sanctions:
        - Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
        - Civil money penalties limited to $15,000 for each Enrollee FHKC determines was not enrolled because of a discriminatory practice subject to an overall limit of $100,000 for each determination.

        - Suspension of new enrollment, including auto-assigned enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
        - Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

- Insurer misrepresents or falsifies information that it furnishes to FHKC, the state or CMS.
    - Potential Sanctions:
        - Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
        - Civil money penalties limited to $100,000 for each determination.
        - Suspension of new enrollment, including auto-assigned enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
        - Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Insurer misrepresents or falsifies information that it furnishes to an Enrollee, potential Enrollee or health care provider.
    - Potential Sanctions:
        - Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
        - Civil money penalties limited to $25,000 for each determination.
        - Suspension of new enrollment, including auto-assigned enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
        - Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Insurer fails to comply with the requirements for Provider incentive plans as required by law.
    - Potential Sanctions:

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

- Insurer has distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by FHKC or that contain false or misleading information.
    - Potential Sanctions:
        - Granting and notifying Enrollees of the right to terminate enrollment with Insurer without cause.
        - Civil money penalties limited to $25,000 for each determination.
        - Suspension of new enrollment, including auto-assigned enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
        - Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- Insurer has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations.
    - Potential Sanctions:
        - Granting and notifying Enrollees the right to terminate enrollment with Insurer without cause.
        - Suspension of new enrollment, including auto-assigned enrollment, after the date FHKC or the Secretary of HHS notifies Insurer of this determination.
        - Suspension of payment for beneficiaries enrolled after the effective date of the sanction and until FHKC or CMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.

5. Section 3-1 is hereby revised by adding the following sentence at the end of the paragraph:

Insurer must provide education and training to its staff, as appropriate and applicable to the staff members' duties, including but not limited to, enrollee rights.

6. Section 3-1 is hereby revised by adding the following sub-section:

3-1-1 Location; Entities Outside the United States

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

7. Section 3-2 is hereby revised by deleting the second and third paragraphs in their entirety and substituting the following language:

INSURER shall meet or exceed the appointment and geographic access standards for pediatric dental care existing in the community and as specifically provided in this Contract.

INSURER shall maintain and monitor a medical network, under staff or contract, sufficient to permit reasonably prompt medical services to all Enrollees, including those with limited English proficiency and those with physical and mental disabilities, in accordance with the terms of this Contract. Insurer shall allow Enrollees choice of network Providers to the extent possible and appropriate.

Upon Enrollee request, Insurer must provide a second opinion from a network Provider, or arrange for a second opinion from an out-of-network Provider, at no cost to the Enrollee.

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

- Insurer enters into this Contract with FHKC;
- On an annual basis when submitting the annual premium report; and
- Any time there has been a significant change in Insurer's operations that may affect the adequacy of capacity and services, including changes in:
    - Services;
    - Benefits;
    - Geographic service area;
    - Composition of Provider network;

- Payments to Provider network; or
- Enrollment of a new population in plan.

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

INSURER may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable state law, solely on the basis of that license or certification, including Providers that serve high-risk populations or specialize in conditions that require costly treatment. This provision does not require Insurer to contract with Providers beyond the number necessary to meet the needs of the Enrollees, preclude Insurer from using different reimbursement amounts for different specialties or different Providers of the same specialty, or preclude Insurer from establishing measures designed to maintain quality of services or control costs and are consistent with Insurer's responsibilities to Enrollees.

Insurer must provide affected Providers with written notice of the reason for Insurer's decision to decline to include individual Providers or groups of Providers in its Provider network.

Insurer must comply with any additional requirements established by FHKC.

8. Sub-Section 3-2-1 is hereby revised by adding the following paragraph before the first paragraph:

Insurer must ensure each Enrollee has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the Enrollee. Insurer shall ensure Enrollees are provided information on how to contact their designated person or entity.

9. Sub-Section 3-2-2 is hereby revised by adding the following paragraph before item A. Primary Care Dental Providers:

The Provider network must be supported by written agreements. Insurer must establish mechanisms to ensure network Provider compliance with required terms, monitor Providers regularly to determine compliance and take corrective action should a network Provider fail to comply. Insurer must follow a documented process for credentialing and recredentialing Providers. Such process must be in compliance with the uniform credentialing and recredentialing policy adopted by FHKC.

10. Sub-Section 3-2-2 is hereby revised by adding item C, as follows:

C. Indian Health Care Providers

Insurer must maintain sufficient numbers of Indian Health Care Providers (IHCPs) in Insurer's Provider network to ensure timely access to services from such Providers to Enrollees eligible to

receive such services. Insurer must provide a quarterly attestation and supporting documentation to FHKC demonstrating compliance with this requirement.

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

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

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

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

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

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

11. Sub-Section 3-2-3 is hereby revised by adding the following language and chart before item A:

Insurer shall maintain a network that meets the following standards:

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

12. Sub-Section 3-2-4 is hereby revised by adding the following sentence before the first sentence in item B:

Insurer shall require network Providers to offer hours of operation and appointment time that are no less that the hours of operation and appointment times offered to individuals enrolled in commercial insurance plans.

13. Section 3-2 is hereby revised by adding the following new sub-section:

3-2-5 Network Adequacy Exceptions

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

- Identification of the service area, provider type(s), and specific standard(s) the request for exemption covers;
- The reason for the request, which may include:
    - No providers exist in the area.
    - No providers exist in the area that are able to pass Insurer's credentialing or recredentialing standards.
    - Limited providers exist in the area and all refuse to contract with Insurer despite Insurer's documented good faith efforts to contract.
- The number of providers in the area;
- The distance to the nearest network provider;
- Documentation of Insurer's efforts to find providers in the area as well as proof of existing providers' inability to be credentialed/recredentialed or proof of Insurer's failed good faith efforts to contract, as appropriate. Insurer must provide the practice address and phone number of any provider refusing to contract;
- Certification attesting that documentation is complete and accurate;
- Insurer's plan to monitor the area and take action should any change occur;
- Explanation of how Insurer will provide timely services to enrollees in the area; and
- Any other information FHKC deems necessary to make a determination.

Once a service area exemption has been granted, Insurer must monitor and report on enrollee access to the relevant provider type as well as activity relating to Insurer's monitoring plan on a quarterly basis.

Exemptions expire and must be re-approved every two years unless withdrawn by Insurer or revoked by FHKC. Exemptions may be revoked for the following reasons:

- The situation in the area has changed and Insurer can reasonably be expected to meet access requirements;
- Failure to provide continuing evidence that the exemption is appropriate; and
- Failure to adequately monitor, take action or report as required by Insurer's documented plan, the contract or state or federal law.

Information regarding service area exemptions may be reported to CMS as required by federal law.

14. Section 3-2 is hereby revised by adding the following sub-section:

3-2-6 Coordination of Care

Insurer must coordinate, or provide for the coordination of, services between settings of care, with services Enrollees receive from other dental care coverage, other liable third-parties, and with services Enrollees receives from community and social support Providers.

15. Section 3-2 is hereby revised by adding the following sub-section:

3-2-7 Transition of Care

Insurer must implement a transition of care policy consistent with the transition of care policy adopted by FHKC. FHKC's transition of care policy shall be made publicly available. Insurer will provide a copy of Insurer's transition of care policy to FHKC during implementation of the Contract and prior to any changes. Summaries of the transition of care policy will be included in the Enrollee handbook and relevant notices.

16. Section 3-4 is hereby revised by deleting the last paragraph in its entirety and substituting the following:

Insurer will be subject to intermediate sanctions, as described in 42 CFR Part 457, Subpart I, for any violations of this prohibition.

Likewise, INSURER agrees to comply with 42 CFR, Section 438.3(i), and any other applicable federal or state laws and regulations related to Provider incentive plans including any disclosure requirements related to such incentive plans. Insurer must notify FHKC of any Provider incentive plans used for Healthy Kids Enrollees and provide documentation to FHKC assuring

that insurer is meeting contractual and regulatory requirements. Such documentation shall also include a copy of the Enrollee disclosure notice Insurer intends to provide to Enrollees.

17. Section 3-5 is hereby revised by adding the following language between the first and second paragraphs:

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

Insurer shall have mechanisms in place to provide Enrollees determined to have special health care needs with direct access to a specialist in a manner that is appropriate for the Enrollee's condition and identified needs. Direct access may include, but is not limited to, a standing referral or an approved number of visits). To prevent duplication of work, assessments related to an Enrollee's special health care needs and direct access determinations must be provided to FHKC or another Title XXI insurer. Insurer will accept such information as assessed by another insurer in the Program from FHKC. For purposes of this provision, "special health care needs" means health care needs sufficient to meet the clinical eligibility criteria for Children's Medical Service Network.

Insurer must follow written policies and procedures and practice guidelines, for making benefit determinations, including processing requests for initial and continuing authorization for services. Practice guidelines, including medical coverage guidelines, adopted by Insurer must be based on valid, reliable clinical evidence of Providers in the relevant field, must consider the needs of Enrollees, must be adopted in consultation with contracting health care professionals and must be reviewed and updated periodically, as appropriate. Decisions related to utilization management, Enrollee education, coverage of services and other relevant areas must be consistent with the practice guidelines. Insurer shall provide any practice guidelines used for the Plan to Enrollees, potential Enrollees and network Providers, upon request.

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

Insurer also agrees utilization management activities, such as prior authorization reviews, will be conducted by individuals with clinically appropriate backgrounds in a manner that results in interrater reliability sufficient to indicate the appropriateness and validity of the process. The process includes the training given to the reviewers.

When appropriate, Insurer will consult with the requesting Provider when making benefit determinations.

Insurer must provide timely and adequate written notice of an Adverse Benefit Determination. The benefit determination and any notice of Adverse Benefit Determination must be provided within the following timeframes:

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

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

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

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

    iv. The Enrollee's whereabouts are unknown and the post office returns Insurer's mail directed towards the Enrollee indicating no forwarding address;

    v. Insurer establishes that the Enrollee is enrolled in the Program in another region;

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

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

    viii. When the date of action will occur in less than ten (10) Calendar Days in accordance with 42 CFR 431.213(h); and

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

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

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

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

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

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

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

A notice of Adverse Benefit Determination must include:

a. The Adverse Benefit Determination Insurer has made;

b. The reason for the Adverse Benefit Determination;

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

d. The Enrollee's right to request an appeal, including information on exhausting the Appeal process and the right to request a SAP, or successor, hearing;

e. The procedures for exercising these rights;

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

18. Section 3-6 is hereby revised by adding the following sentence after the first paragraph:

Information pertaining to claims and payment data provided to FHKC must be accompanied by an attestation attesting to the accuracy, completeness and truthfulness of the data under penalty of perjury.

19. Section 3-9 is hereby revised by adding the following language to the end of the first paragraph:

Insurer may not request disenrollment of an Enrollee for any reason other than as detailed in item B, request for eligibility review, below.

20. Item B of section 3-9 is hereby revised by deleting the paragraph in its entirety and substituting the following:

If Insurer has reasonable cause to believe that an Enrollee is not eligible for the Program because that Enrollee should be placed in a different state or federal program for such services which eligibility would render that Enrollee ineligible for the Program, Insurer may request in writing that FHKC review the eligibility of that Enrollee. Insurer must provide the reason for the eligibility review request, including how the relevant considerations were discovered. Insurer must confirm no other considerations influenced Insurer's decision to request the review, including an adverse change in the Enrollee's health status, utilization of services, the Enrollee's diminished mental capacity, or uncooperative or disruptive behavior resulting from the Enrollee's special needs. FHKC shall ensure that all records and findings maintained by FHKC concerning a particular eligibility determination will be made available to Insurer with reasonable promptness to the extent permitted under sections 624.91 and 409.821, F.S., regarding confidentiality of information held by FHKC and the Florida KidCare program.

21. Item B of section 3-11 is hereby revised by deleting the first sentence and substituting the following:

An Enrollee handbook, based on the model Enrollee handbook provided by FHKC, that complies with any federal or state requirements, and has been approved by FHKC.

22. Section 3-11 is hereby revised by adding the following after item C:

D. Information about Insurer's formulary.

23. Section 3-13-2 is hereby revised by deleting the section in its entirety and substituting the following:

INSURER shall have in place appropriate preventative and detection measures which ensure against fraud and abuse as defined in this Contract that complies with all state and federal laws and regulatory requirements, including the applicable provisions of 42 CFR 438.608, 42 CFR 4559(a)(2) and Section 409.814, F.S.

FHKC shall have access to monitor such fraud and abuse prevention activities conducted by INSURER. If INSURER obtains information demonstrating or indicating fraud, or potential fraud, by Providers, subcontractors, Applicants or Enrollees, INSURER shall report its findings to FHKC for investigation. Insurer must provide FHKC with a fraud, waste and abuse report on a quarterly basis detailing prevention activities conducted by Insurer, potential offenses being investigated and any confirmed instances of Fraud or Abuse.

Insurer may report information on violations of law by Subcontractors, Providers, Enrollees or other relevant individuals to FHKC and/or to CMS, as appropriate. For Enrollees, such reports only apply to information on violations of law pertaining to enrollment in the plan and the provision of, or payment for, health services.

At a minimum, INSURER'S fraud and abuse compliance program shall include:

A. A regulatory compliance committee on the board of directors and at the senior management level charged with overseeing Insurer's compliance program, including compliance with the Contract;

B. A compliance officer with sufficient experience in health care, who shall have the responsibility and authority for developing and carrying out the provisions of the Fraud and Abuse policies of procedures of INSURER and compliance with the contract. The compliance officer must report directly to the CEO and the board of directors.

C. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring, auditing of compliance risks, prompt response to, investigation of, and correction of compliance issues, actions to reduce the potential for recurrence of compliance issues, and ongoing compliance with the requirements of the Contract.

D. A policy or procedure detailing the method used to verify services that network Providers represented were received by Enrollees and the application of such verification process on a regular basis.

E. A policy or procedure for suspending payments to a network Provider for which FHKC or AHCA determines there is a credible allegation of fraud in accordance with 42 CFR 455.23.

F. Policies and procedures for recovering overpayments made to Providers, not including amounts recovered under False Claims Acts cases or other investigations. Such policies and procedures must include:

    i. A mechanism for a network Provider to report in writing to Insurer that an overpayment has been received and the reason why the overpayment was received; and

    ii. Require Provider to return the overpayment to Insurer within sixty (60) Calendar Days after the date on which the overpayment was identified.

G. Adequate staffing and resources to investigate unusual incidents and to develop corrective action plans to assist INSURER with preventing and detecting potential Fraud and Abuse activities.

H. Effective lines of communication between the compliance officer and Insurer's employees, as evidenced by some formal policy;

I. Submission of INSURER's Fraud and Abuse policies to FHKC within thirty (30) calendar days of initial execution of this Contract and then annually thereafter by July 1st.

J. Internal controls and written policies, ~~and~~ procedures, and standards of conduct that are designed to prevent, detect, and report known or suspected Fraud and Abuse activities and that detail Insurer's compliance with all applicable requirements and standards.

K. A system for training and educating the compliance officer, senior management and Insurer's employees about state, federal and contractual requirements;

L. Enforcement of standards through well-publicized disciplinary guidelines; and

M. Provisions for the investigation and follow-up of any reports notification to FHKC of, including but not limited to, any fraud by subcontractors, Applicants, or Enrollees.

N. Cooperation in any investigation by FHKC, state, or Federal entities or any subsequent legal action that may result from such an investigation.

O. Non-retaliation policies against any individual that reports violations of INSURER's Fraud and Abuse policies and procedures or suspected Fraud and Abuse.

P. Distribute written Fraud and Abuse policies to its employees in accordance with Section 6032 of the federal Deficit Reduction Act of 2005, including the rights of employees to be protected as whistleblowers.

Q. Prompt notification and reporting of the following:

   i. Prompt reporting of all overpayments to Providers identified or recovered. Insurer must specify the overpayments made due to potential Fraud to FHKC.

   ii. Prompt notification to FHKC when Insurer receives information about changes in an Enrollee's circumstances that may affect the Enrollee's eligibility, including, but not limited to, changes in Enrollee's residence and the death of the Enrollee.

   iii. Prompt notification to FHKC when Insurer receives information about a change in a network Provider's information that may affect the Provider's eligibility to participate in the Program, including the termination of the Provider agreement with Insurer. Insurer shall report other changes to a network Provider's information that may affect the Provider's eligibility to participate in the Program in a separate report on a monthly basis.

   iv. Prompt referral of any potential Fraud, waste or Abuse that Insurer identifies, to FHKC.

24. Section 3-14 is hereby revised by deleting the section in its entirety and substituting the following:

Insurer must have a Grievance and Appeal system in place for Enrollees. INSURER agrees to provide the same grievance process for all Enrollees, including, if applicable, any Full Pay

Enrollees. Appeals are limited to one Appeal level. Any such grievance process shall be governed by applicable federal and state laws and regulations.

Insurer is required to follow a method established by FHKC to notify Enrollees of the resolution of a Grievance in accordance with the requirements of 42 CFR 438.10.

Enrollees may file a Grievance orally or in writing at any time. Enrollees, or an Enrollee's authorized representative or Provider acting on behalf of, and with the written consent of, an Enrollee, may file an Appeal orally or in writing within sixty (60) calendar days of the date of notification of an Adverse Benefit Determination. Oral requests for Appeal must be followed by a signed written Appeal unless it is an expedited Appeal. Enrollees may request a statewide standard review within one hundred twenty (120) calendar days of notification that an appealed Adverse Benefit Determination has been upheld or when the Appeal process has been deemed exhausted by way of Insurer's failure to adhere to the notification and timing requirements of 42 CFR 438.408. The statewide standard review is conducted through the Statewide Subscriber Assistance Panel (SAP), or its successor.

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

a. Standard resolution and notice of Grievances may not exceed ninety (90) Calendar Days from the date of Grievance receipt, unless extended appropriately.

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

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

If a Grievance or Appeal timeframe has been extended other than at the request of an Enrollee, Insurer must make reasonable efforts to give the Enrollee prompt oral notice of the delay, give the Enrollee written notice of the decision to extend the timeframe within two (2) Calendar Days, including informing the Enrollee of the right to file a Grievance, and resolve the Appeal or Grievance as expeditiously as the Enrollee's health condition requires, but no later than the date the extension expires.

When an Enrollee requests an expedited Appeal, Insurer must determine whether taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function. Providers may also request, or support an Enrollee's request for, an expedited Appeal. When Insurer denies a request for an expedited Appeal, Insurer must make reasonable efforts to give the Enrollee prompt oral notice of the delay, give the Enrollee written notice of the decision within two (2) Calendar Days, including informing the Enrollee of the right to file a Grievance, and resolve the Appeal as

expeditiously as the Enrollee's health condition requires, but no later than the timeframe for a standard Appeal.

Insurer must ensure no punitive action is taken against any Provider for filing an Appeal, requesting an expedited Appeal, or supporting an Enrollee's request for an expedited Appeal.

Insurer must provide written notice of resolution for Appeals in accordance with the standards described in 42 CFR 438.10 and must make reasonable efforts to provide oral notice of resolution of an expedited Appeal. These notices must include:

a. The result of the Appeal process;

b. The date the Appeal was resolved;

c. For Appeals not wholly in the Enrollee's favor, the right to request a SAP, or successor, hearing, including how to do so;

Insurer must provide Enrollees with reasonable assistance, including auxiliary aids and services, interpretation services and toll-free numbers with TTY/TTD and interpreter capability, in completing forms and taking other procedural steps related to Grievances and Appeals, upon request.

INSURER shall provide to FHKC a copy of INSURER's current grievance process for Enrollees upon execution of this Contract and then annually by July 1st. Insurer must also provide the Grievance and Appeal process and policies to Providers and Subcontractors at the time Insurer enters a contract or agreement with such entities or individuals. Additionally, INSURER shall provide FHKC with advance notice of any proposed changes to the process. Such changes must be reviewed and approved by FHKC prior to implementation.

Insurer's process for handling Grievance and Appeals must:

a. Acknowledge receipt of each Grievance and Appeal;

b. Ensure individuals making decisions about Grievances and Appeals:

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

    ii. Have the appropriate clinical expertise in treating the Enrollee's condition or disease when an Appeal is based on lack of medical necessity, a Grievance regarding denial of an expedited resolution of an Appeal is filed, and when a Grievance or Appeal involves clinical issues; and

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

c. Provide that oral inquiries to Appeal an Adverse Benefit Determination are treated as Appeals to establish the earliest possible filing date for the Appeal and must be confirmed in writing, unless the Enrollee or Provider requests expedited resolution;

d. Establishes and maintains a process for expedited Appeals;

e. Provide the Enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments, including informing the Enrollee of the limited time available sufficiently in advance of the resolution timeframes for Appeals;

f. Provide the Enrollee and Enrollee's representative the Enrollee's case file, including medical records, other documents and records and any new or additional evidence considered, relied upon or generated by Insurer in connection with the Appeal, free of charge and sufficiently in advance of the resolution timeframe for Appeals; and

g. Provide that the Enrollee and Enrollee's representative or the legal representative of a deceased Enrollee's estate are included as parties to the Appeal and SAP, or successor, hearing;

In the case of a reversal of the Adverse Benefit Determination, provide that Insurer authorizes or provides disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours, from the date Insurer's decision to deny, limit or delay services that were not furnished while the Appeal was pending is reversed and, in when the services were not halted pending the outcome of the Appeal, provide that Insurer pays for those services.

INSURER shall maintain a record of all grievances and Appeals that includes the date received; date of each review or review meeting, as applicable; name of the Enrollee; nature or general description of the reason for the Grievance or Appeal; and disposition of each level of the grievance and Appeal process, as applicable; date of resolution at each level, as applicable; and the documents relevant to each Grievance and Appeal. Such records must be accurately maintained in a manner accessible to FHKC and, upon request, CMS. INSURER shall provide FHKC with a quarterly report of all grievances and Appeals received by INSURER involving Enrollees. The report shall include the information listed above, except relevant documentation, and list the number of grievances received during the quarter and the disposition of those grievances and Appeals, and the Appeal response timeliness as a percentage of Appeals in the quarter that were closed timely. Appeals closed in the quarter includes Appeals that were received in a different quarter and closed in the reporting quarter. Insurer agrees to provide information in the aggregate and broken out in the manner requested by FHKC.

INSURER shall also inform FHKC of any Appeals that are referred to the Statewide Subscriber Assistance Panel, or its successor, prior to their presentation at the panel.

A provider, acting on behalf of the Enrollee and with the Enrollee's written consent, may also file an appeal.

25. Section 3-18 is hereby revised by deleting the first paragraph in its entirety and substituting the following:

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

26. Item B of Section 3-18 is hereby revised by deleting the paragraph in its entirety and substituting the following:

INSURER shall maintain all individual medical and other health and enrollment information records with confidentiality and in accordance with state and federal guidelines. INSURER agrees to abide by all applicable state and federal laws governing the confidentiality of minors and the privacy of individually identifiable health information. INSURER's policies and procedures for handling medical records and protected health information shall comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act ("HITECH"), as both may be amended from time to time, all other applicable state and federal statutes and regulations, and shall include provisions for when an Enrollee's protected health information may be used or disclosed without consent or authorization. Insurer shall also make available the purpose for which information is maintained or used and to whom and for what purpose the information will be disclosed outside of FHKC upon an Enrollee's request.

27. Section 3-19 is hereby revised by adding the following sentence before sub-section 3-19-1, as follows:

Insurer must provide all materials to Enrollees or potential Enrollees in a manner and format that may be easily understood and is readily accessible in accordance with 42 CFR 438.10. Insurer agrees to inform FHKC of the intended methodology(ies) to be used to distribute member materials. FHKC may request that Insurer use or refrain from using certain methodologies.

28. Section 3-19-2 is hereby revised by deleting the second paragraph in its entirety and substituting the following:

Information must be in an easily understood language and format, including a font size no smaller than 12 point. INSURER shall make all written materials available in alternative formats and in a manner that takes into consideration the Enrollee's special needs, including those who are visually impaired or have limited reading proficiency. Insurer agrees to follow best practices related to accessibility of materials, including readability and access by those with physical disabilities, insofar as such best practices are reasonable and practicable. INSURER shall notify all Enrollees that information is available at no cost upon request in alternative formats,

including auxiliary aids and services, oral interpretation in any language and written interpretation in the language(s) prevalent in the Service Area, and how to access those formats.

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

At a minimum, Insurer must provide the following member materials:

a. Enrollee Handbook. Insurer must use the model Enrollee handbook, model Enrollee notices and any definitions for managed care terminology FHKC develops. Insurer may customize such material to the extent permitted or required by FHKC. Customized model materials must be approved by FHKC prior to use.

b. Provider directory. Provider directories must be made available on Insurer's website in a machine-readable file and format, as specified by the Secretary of HHS, as well as in paper form. Information included in a paper Provider directory, or a printable electronic Provider directory, must be updated at least monthly. Electronic Provider directories must be updated no later than thirty (30) Calendar Days after Insurer receives updated Provider information. At a minimum, the Provider directory must contain the following information for each PCP and specialist:

- Provider name;
- Provider group affiliation, if any;
- Specialty, as appropriate;
- Street Address(es);
- Telephone number(s);
- Website URL, if any;
- Office hours;
- Age limitations, if any;
- Non-English languages, including American Sign Language, spoken by the Provider or a skilled medical interpreter at the Provider's office;
- Whether Provider has completed cultural competency training;
- Whether Provider's office or facility has accommodations for people with physical disabilities, including offices, exam rooms and equipment; and
- Whether the Provider is accepting new patients.

c. Enrollee notices. Insurer will utilize all model Enrollee notices provided by FHKC. Enrollee notices include, but are not limited to:

    a. Notice of change for any significant changes made the Enrollee handbook. Any such notices must be provided to Enrollees at least thirty (30) calendar days prior to such change.

    b. Notice of network Provider termination. Insurer must make a good faith effort to provide written notice to Enrollees who received primary or regular care from a terminating network Provider within fifteen (15) calendar days of receipt or issuance of the Provider termination notice.

d. Certificates of creditable coverage. Insurer is responsible for issuing certificates of creditable coverage to Enrollees, upon request or upon the Enrollee's coverage termination.

29. Item A of section 3-19-2 is hereby revised by adding the following sentence before the first paragraph:

Insurer will provide services, including oral and written communication to members, in a culturally competent manner appropriate for the population.

30. Item B of section 3-19-2 is hereby revised by adding the following sentence after the last paragraph in item B:

Written materials shall include taglines in the non-English languages prevalent in the service area as well as in large print, which means printed in a font size no smaller than 18 point.

31. Item E of section 3-19-2 is hereby revised by deleting the third paragraph in its entirety and substituting the following:

In any marketing activities, INSURER is required to distribute any approved materials to its entire service area as covered by this Contract. INSURER may not seek to influence enrollment in conjunction with the sale or offering of any private insurance and the INSURER may not engage, directly or indirectly, in door-to-door, telephone or any cold-call marketing activities, including email and text. This provision does not prohibit Insurer from communicating with Enrollees via these mediums in the course of business activities that are not cold-call marketing activities.

Insurer may not use inaccurate, false or misleading materials. Insurer may not make any statements, written or oral, suggesting that Enrollees must enroll with Insurer to obtain or retain benefits or that Insurer is endorsed by CMS, the federal or state government, FHKC or any other similar entity.

32. Section 3-21 is hereby revised by replacing the entirety of the language therein, and substituting as follows:

The premium charged for the provision of Comprehensive Dental Care Services for July 1, 2018 through June 30, 2019 shall be as follows:

Region	PMPM
Statewide	$15.15

33. Section 3-21 is hereby revised by adding the following sub-section:

3-21-1 Medical Loss Ratio

A. Medical Loss Ratio

The medical loss ratio (MLR) for both the Title XXI subsidized program and the Full Pay program shall be eighty-five (85%) percent. The term "medical" as used in this section means "dental."

The medical loss ratio calculations shall include rebates, discounts or other adjustments to the medical costs received by the INSURER. The MLR shall be calculated in accordance with 42 CFR 438.8.

INSURER shall also identify in its annual submission all medical expense payments to affiliated and related companies and explain any such affiliations.

FHKC may issue additional written guidance on the definition of medical expenses to INSURER. Federal and state regulations on the definition of medical loss ratios may also be applicable, once adopted. Should such guidelines be applied, FHKC shall notify INSURER in writing.

B. Maximum Administrative Component

The maximum administrative component shall not exceed fifteen (15%) percent for both the subsidized and Full Pay programs. INSURER shall identify what components and subcomponents have been included in its administrative expenses. FHKC may provide additional written guidance on the definition of administrative expense. Federal and state regulations on the definition of administrative expense may also be applicable once adopted. Should such guidelines be applied, FHKC shall notify INSURER in writing.

34. Section 3-21 is hereby revised by adding the following sub-section:

3-21-2 Experience Adjustment

Insurer is required to submit an annual experience adjustment report. For the Annual Experience Adjustment Report, INSURER shall provide FHKC with a written copy of its findings for each Contract year by the following April 1st (first). If any payments are due under this provision, INSURER shall forward such payment to FHKC no later than May 1st. INSURER may be

subject to audit or verification by FHKC or its designated agents and shall maintain all records necessary to conduct such examinations.

Submission for any Experience Adjustment report shall be in a format established by FHKC and include sufficient documentation, as determined by FHKC, to support the medical loss ratio calculation and to allow FHKC to evaluate the component and subcomponent expenses that have been included in the calculations.

FHKC shall determine the adequacy of the information supplied under this section and whether or not the calculation has been accurately performed.

After receipt of INSURER'S submission, FHKC may request that the calculation also be provided on a regional basis.

INSURER'S submission must include the following minimum information for the subsidized and full pay populations, as may be applicable:

INSURER Name:
Contract Year:
Regions Included in Calculation:

Total Premiums Paid to INSURER during Contract Year:	$
Actual Incurred Claims for Contract Year:	$
Medical Loss Ratio Achieved:	%

Apply adjustment percentage in accordance with Section 3-21-3.

35. Section 3-21 is hereby revised by adding the following sub-section:

3-21-3 Quarterly Medical Loss Ratio Reporting Requirements

Insurer must submit a quarterly medical loss ratio report with results presented by month with claims incurred to date, by region, as well as for Insurer's entire book of business covered under this Contract. The format for the quarterly report shall be established by FHKC.

This ongoing report should be updated each quarter to include any updated claims information received since the prior quarterly report.

The report is due by the end of the second month following the close of the quarter as follows:

January 1 – March 30:	May 31st
April 1 – June 30:	August 31st
July 1 – September 30:	November 30th
October 1 – December 31:	February 28th

If the reporting deadline falls on a holiday or weekend, the report is due on the next business day.

36. Section 3-22-1 is hereby revised by adding the following to the end of the first paragraph:

FHKC may enter into, and initiate, premium rate adjustment negotiations prior to submission of any such request to committee(s) or the Board of Directors. FHKC maintains the right to deny a rate adjustment request, require Insurer decrease rates or require Insurer hold rates flat, based on the data provided and FHKC's analysis. Insurer must respond to FHKC's requests for additional or clarifying information during the rate adjustment process.

37. Section 3-23-1 is hereby revised by deleting the section in its entirety and substituting the following:

INSURER may not knowingly have a relationship with the following:

A. An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549.

B. An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.

"Relationship" is defined as follows:

1. A director, officer, or partner of the INSURER.

2. A person with beneficial ownership of five percent (5%) of more of the INSURER's equity.

3. A network Provider or person with an employment, consulting or other arrangement with the INSURER for the provision of items and services that are significant and material to Insurer's obligations under its contract with FHKC or the State.

4. A Subcontractor

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

Insurer must provide written disclosures of certain information to FHKC upon Contract execution, upon any renewal or extension of the Contract and within thirty-five (35) Calendar Days of any change in ownership of Insurer. Such disclosures include:

a. Any prohibited affiliation under 42 CFR 438.610;

b. Information on ownership and control in accordance with 42 CFR 457.1285 in regards to Insurer and Insurer's Subcontractors, including:

- The name and address of any individual or corporation with an ownership or control interest in Insurer. In the case of a corporation, the address disclosure must include the primary business address, every business location and every P.O. Box address.
- Date of birth and Social Security number or tax identification number, of any individual or corporation, as applicable, with an ownership or control interest in Insurer or in any Subcontractor in which Insurer has a five percent (5%) or more interest.
- Whether the individual or corporation with an ownership or control interest in Insurer is related to another individual or corporation with ownership or control interest in Insurer as a spouse, parent, child or sibling.
- Whether the individual or corporation with an ownership or control interest in any Subcontract in which Insurer has five percent (5%) or more interest is related to another individual or corporation with ownership or control interest in Insurer as a spouse, parent, child or sibling.
- The name of any other disclosing entity, as defined in 42 CFR 455.101 and including fiscal agents and other insurers, in which an owner of Insurer has an ownership or control interest.
- The name, address, date of birth, and Social Security Number of any managing employee, as defined in 42 CFR 455.101 of Insurer.

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

38. Section 3-24 is hereby revised by adding the following language before sub-section 3-24-1:

Insurer must maintain a quality assessment and performance improvement (QAPI) program. At a minimum, the QAPI program must include:

a. Performance improvement projects (PIPs) focusing on clinical and non-clinical areas;

b. Collection and submission of performance measurement data;

c. Mechanisms to detect underutilization and overutilization of services; and

d. Mechanisms to assess the quality and appropriateness of care furnished to Enrollees with special health care needs.

Insurer agrees to include any standard measures and PIPs that are identified and required by CMS during the term of this Contract, unless FHKC is granted an exemption from CMS and instructs Insurer otherwise.

Insurer will assess and report on the overall QAPI program on an annual basis.

39. Section 3-24-3 is hereby revised by adding the following language after the first paragraph:

Cooperation with EQR-activities includes, but is not limited to:

- Provision of data, documentation and other information;
- Reviews and evaluation of Insurer's Performance Improvement Project(s) whether such review is a review of the format and initial methodology, progress review or EQRO's validation review;
- Participation in any EQR-related training made available to Insurer by FHKC;
- Monitoring of activities by FHKC; and
- Corrective action plans or quality improvement activities required of Insurer by FHKC as a result of EQR-activity findings.

Insurer must measure and report the performance measures identified by FHKC on an annual basis as part of FHKC's external quality review activities. Insurer must also provide FHKC with data, as specified by FHKC, which enables FHKC to validate or calculate Insurer's performance using the standard measures. FHKC may choose to independently calculate, or have calculated, the performance measures. Insurer remains responsible for calculating the performance measures regardless of whether FHKC is independently calculating these performance measures.

Insurer must conduct PIPs as part of this program. Each PIP must be designed to:

a. Achieve significant improvement, sustained over time, in health outcomes and/or Enrollee satisfaction; and

b. Must include measurement of performance using:

    i. Objective quality indicators;

    ii. Implementation of interventions to achieve improvement in access and quality of care;

    iii. Evaluate the effectiveness of the interventions; and

    iv. Planning and initiation of activities for increasing or sustaining improvement.

40. Section 3-24 is hereby revised by adding the following sub-section:

3-24-4 Accreditation by Private Independent Accrediting Agency

Insurer must inform FHKC of any accreditations received by a private independent accrediting entity. Insurer must authorize the private independent accrediting entity to provide FHKC with a copy of its most recent accreditation review. Such review includes, but is not limited to, the following information:

a. Accreditation status;

b. Accreditation survey type;

c. Accreditation level, as applicable;

d. Accreditation results, including
    i. Recommended actions or improvements
    ii. Corrective action plans; and
    iii. Summaries of findings

e. Expiration date of the accreditation

In accordance with the requirements of 42 CFR 457.1240(c), FHKC will make Insurer's accreditation status available on the Healthy Kids website. Such accreditation status will include the name of the accrediting entity, accreditation program and accreditation level, as applicable.

Insurer must provide FHKC with a report listing the accrediting entity, accreditation program and accreditation level of all accreditations during implementation of the Contract and annually by September 30th for the term of the Contract. Insurer must inform FHKC of any change in accreditation status, including gain or loss of accreditation, within thirty (30) Calendar Days of such change.

41. Section 3-24 is hereby revised by adding the following sub-section:

3-24-5 Managed Care Quality Rating System

FHKC may adopt the quality rating system developed by CMS, or may adopt an alternative quality rating system as allowed in 42 CFR 438.334. FHKC will notify Insurer of any such quality rating system.

Insurer agrees to cooperate with FHKC in the implementation and maintenance, including data submission, of such quality rating system at no additional cost.

42. Section 3-25 is hereby revised by deleting items B and C in their entirety and substituting the following:

B. INSURER, and Insurer's Subcontractors, shall have all records used or produced in the course of the performance of this Contract available at any time for inspection, review, audit or

copying to FHKC, any vendor contracted with FHKC or any state or federal regulatory agency as authorized by law or FHKC. Additionally, FHKC, AHCA, HHS, CMS, HHS' Office of the Inspector General, the Comptroller General of the United States and their designees may, at any time, inspect the premises, physical facilities and equipment where work related to this Contract is conducted. These records shall be retained for a period of at least ten (10) years following the term of this Contract, from the final date of the Contract period, or if an audit is in progress or audit findings are yet unresolved, from the date all tasks are completed. Such records specifically include, but are not limited to, Enrollee Grievance and Appeal records, base data described in 42 CFR 438.5(c), medical loss ratio reports and data, and information and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608 and 42 CFR 438.610.

C. INSURER agrees to cooperate in any evaluative efforts conducted by FHKC or an authorized subcontractor of FHKC or authorized state or federal agency both during and for a period of at least ten (10) years following the term of this Contract. These efforts may include a post-Contract audit.

43. Section 3-26 is hereby revised by deleting the section in its entirety and substituting the following:

INSURER shall not refuse to provide coverage to any Enrollee on the basis of past or present health status or need for healthcare services. Insurer will not refuse to provide coverage to, or use any policy or practice that has the effect of discriminating against, any Enrollee on the basis of race, color, national origin, sex, sexual orientation, gender identity or disability or whether or not an Enrollee has executed an advance directive.

44. Section 3-27 is hereby revised by deleting the section in its entirety and substituting the following:

INSURER shall comply with all reporting requirements under this Contract in the manner and timeframes specified for each report and as listed under Attachment E, or as otherwise required by FHKC. For this section, the term "reports" encompasses reports, documents, deliverables and other information provided to FHKC. Reports must be provided to FHKC electronically with physical copies provided upon request. Reports submitted to FHKC must be clearly named and must include, at a minimum, Insurer's name and a short descriptive document title. Such descriptive document titles should be intelligible by an individual familiar with CHIP and general health insurance, but unfamiliar with Insurer and Insurer's internal document management system and processes. FHKC may occasionally dictate a specific naming convention for certain documents. Insurer will adhere to any prescribed naming convention.

Insurer shall provide an annual report listing all overpayments to Providers, including overpayments made related to fraud and abuse and all other overpayments.

Insurer must maintain a health information system that collects, analyzes, integrates and reports data, including but not limited to utilization, claims, grievances and appeals and disenrollment for reasons other than loss of eligibility. At a minimum, such health information system must:

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

b. Collect data on Enrollee and Provider characteristics, including any characteristics specified by FHKC, and on all services provided to Enrollees through an encounter data system;

c. Ensure that data received from Providers is accurate and complete by:

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

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

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

d. Make all collected data available to FHKC, AHCA and CMS, upon request.

Insurer must also collect and maintain sufficient encounter data to identify the Provider who delivers any item or service to Enrollees. INSURER shall also provide quarterly encounter and claims data for all services rendered under this Contract including any services provided by contracted Providers. Such data shall be submitted on a quarterly basis utilizing a process and format established by FHKC and shall include the level of detail specified by FHKC using standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 or another standardized format, as required by FHKC. Such encounter data shall include, at a minimum, all Enrollee encounter data FHKC is required to report to CMS in accordance with 42 CFR 438.818. FHKC may amend the process, format or requirements during the Contract term and INSURER shall incorporate any such changes no later than the third (3rd) quarter's report after notification of such changes by FHKC. Encounter data reports must comply with HIPAA security and privacy standards and must be submitted in a format required by the Medicaid Statistical Information System or successor system. Insurer will cooperate with FHKC to enable FHKC to comply with any state or federal encounter data reporting requirements, including correcting accuracy, completeness or other compliance issues.

INSURER is responsible for guaranteeing that all subcontractors comply with these reporting requirements. INSURER also agrees to attest to the accuracy, completeness and truthfulness of claims and payment data that are submitted to FHKC under penalty of perjury. Access to Enrollee claims data by FHKC, the State of Florida, the federal Centers for Medicare and Medicaid Services and the Department of Health and Human Services Inspector General will be allowed to the extent permitted by law.

The timetable for the delivery of quarterly statistical reports is as follows:

Encounters and Claims Processed During:	Claims Data Due to FHKC by:
January 1st – March 31st	April 15th
April 1st – June 30th	July 15th
July 1st – September 30th	October 15th
October 1st – December 31st	January 15th

Failure to provide these reports in a timely manner shall constitute a material breach as defined under Section 4-18(C). Insurer will provide supporting evidentiary documentation with all reports unless otherwise required by FHKC.

INSURER may be required to provide FHKC information or data that is not specified under this Contract in order to comply with federal or state law or regulatory requirements. INSURER shall have at least thirty (30) calendar days to fulfill such ad hoc reporting requests.

45. Section 3-27 is hereby revised by adding the following sub-section:

3-27-1 Attestations

When submitting the information described below, Insurer must provide a written certification signed by Insurer's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual reporting directly to the CEO or CFO with delegated authority to sign for the aforementioned individual, attesting that based on best information, knowledge and belief, the data, documentation or information provided is accurate, complete and truthful. The CEO or CFO is ultimately responsible for certifications provided by an individual with delegated authority. An organizational chart must be provided upon execution of this amendment and within one (1) week of any changes.

Certifications must be submitted concurrently with the submission of data, documentation or information.

This provision is applicable to the following specified data, documentation and information:

a. Encounter Data;

b. Data FHKC may use to determine Insurer's compliance with MLR requirements;

c. Data FHKC may use to determine Insurer has made adequate provision against the risk of insolvency;

d. Documentation related to Insurer's compliance with requirements for availability and accessibility of services, including Provider network adequacy;

e. Information on ownership and control of Insurer and Insurer's Subcontractors;

f. Annual overpayment recoveries report; and

g. Any other data, documentation or information for which FHKC requests a certification.

46. Section 3-30 is hereby revised by deleting item C and substituting the following:

INSURER's Contract with the subcontractor or affiliate fully complies with all terms and conditions of this Contract between INSURER and FHKC and 42 CFR 438.230, including audit-related provisions. Insurer maintains ultimate responsibility for compliance with the terms of the Contract.

47. Section 3-30 is hereby revised by deleting the two paragraphs following item F and substituting the following:

All agreements between INSURER and its subcontractor or affiliates to provide services under this Contract shall be reduced to writing and shall be executed by both parties. Delegated activities, obligations and related reporting requirements must be specified in the written agreement. Such agreement must also provide for the revocation of the delegation of activities or obligations or specify other remedies for instances in which either FHKC or Insurer has determined that the Subcontractor has not performed satisfactorily. All such agreements shall also be available to FHKC within seven (7) business days of request for production.

Should FHKC, the State of Florida, CMS or the HHS Inspector General determine that there is a reasonable possibility of fraud or similar risk, aforementioned entity may inspect, evaluate and audit the Subcontractor at any time.

Failure of INSURER to comply with the provisions of this section shall constitute a material breach as provided under Section 4-18(C) of this Contract.

48. Section 3-31-1 is hereby revised by deleting the second paragraph in its entirety and substituting the following:

If INSURER has granted prior authorization for out of network services that are covered under this Contract or in the case of emergency services, INSURER is responsible for the payment of claims incurred as a result of those services. Insurer must coordinate with any out-of-network Providers to ensure the cost to the Enrollee is no greater than it would be if services were provided by a network Provider for any out-of-network services Insurer is liable for, including but not limited to, emergency services and single-case agreements. Enrollee shall be responsible only for any applicable co-payment as provided for under Attachment D.

49. Attachment E to the Contract, "List of Required Reports," is revised by deleting the provision in its entirety and substituting the revised Attachment E, "Revised List of Required Reports."

50. Except as expressly amended hereby, the Contract shall remain in full force and effect in accordance with its provisions. In the event of any conflict between the Contract and this Amendment, the terms of this Amendment shall govern.

51. This Amendment may be executed in counterparts, each of which shall constitute an original and all of which together shall constitute the same document.

IN WITNESS WHEREOF, the Parties have caused this Amendment No. 3 to be executed by their undersigned officials as duly authorized.

FOR

DENTAQUEST OF FLORIDA, INC.:

NAME: Brett Bostrack

TITLE: Senior Vice President

DATE SIGNED: 6/26/2018

The foregoing instrument was acknowledged me before this 26 day of June, 2018, by Brett Bostrack, as Senior Vice President on behalf of DentaQuest of Florida, Inc. He/She is personally known to me or has produced ✓ as identification.

Signature Christina Marie Kendrick

Notary Public – State of ~~Florida~~ Wisconsin

Christina Marie Kendrick

Print, Type or Stamp Name of Notary Public

My Commission expires: 01/04/2019

CHRISTINA MARIE KENDRICK
Notary Public
State of Wisconsin

FOR:

FLORIDA HEALTHY KIDS CORP.

Rebecca Matthews

Chief Executive Officer

DATE SIGNED: 7/3/18

The foregoing instrument was acknowledged me before this 3 day of JULY, 2018, by Rebecca Matthews, as Chief Executive Officer on behalf of the Florida Healthy Kids Corp. She is personally known to me.

Tracy J Bishop

Signature

Notary Public – State of Florida

Tracy J. Bishop

Print, Type or Stamp Name of Notary Public

My Commission Expires 10/25/2020

TRACY J BISHOP
Commission # GG 42108
My Commission Expires
October 26, 2020

ATTACHMENT E – REVISED LIST OF REQUIRED REPORTS (Dental)

The following chart summarizes the reports required under this Contract according to the frequency of submission. Monthly reports are due on the fifteenth (15th) of each month for the prior month; quarterly reports are due by the fifteenth (15th) of each month following the end of each quarter and annual reports are due by July 1st (first) unless otherwise noted. This chart is provided for reference purposes only; the provisions of the Contract and any reporting requirements included herein will control.

At Contract Execution	Immediately	Monthly	Quarterly	Annually
Insurance Coverages (Section 3-16)	Section 3-20 Requirements (Section 3-20)	Provider Network Changes (Section 3-20)	Statistical Claims Data Reporting (Section 3-28)	Grievance Process (Section 3-14)
Lobbying Disclosures (Section 3-17)	Grievances before the Subscriber Assistance Panel (Section 3-14)		Reports of filed Grievances (Section 3-14)	Lobbying Certification (Section 3-17)
Quality Assurance Plan (Section 3-24)	Termination of subcontractors or affiliates (Section 3-31)		FQHC Attestation (Section 3-31-2)	Audited financial statements (Section 3-25)
Conflicts of Interest Disclosure Form (Section 4-8) (Section 3-23-3) Attachment F	Changes of ownership or controlling interest (Section 4-6)		Network Adequacy Attestations (Section 3-31)	Listing of Subcontractors and affiliates (Section 3-31)
Fraud and Abuse Preventions (Section 3-13)	Changes of Notice and Contract Contact (Section 4-15)		Medical Loss Ratio Reports (Section 3-21-5)	Member materials (Section 3-19-2)
Quality Improvement Plan (Section 3-24)	Changes to Conflicts of Interest Disclosure Form (Section 4-8) (Section 3-23-3) Attachment F		Attestation of Compliance with Reimbursement Requirements	Proof of insurance coverage (3-16)

At Contract Execution	Immediately	Monthly	Quarterly	Annually
Cultural Competency Plan (Section 3-19)	Regulatory Filings (Section 3-27)		Attestation of compliance with IHCP reimbursement requirements (Section 3-2-2)	Fraud and Abuse Preventions (Section 3-13)
HIPAA Compliance/BAA			Service area network adequacy exemption monitoring (Section 3-2-5)	Quality Improvement Plan (Section 3-24-1)
List of Subcontractors and Affiliates (Section 3-31)			Fraud, waste and abuse report (Section 3-13-2)	Cultural Competency Plan (Section 3-19)
Grievance Process (Section 3-14)				Updated Conflict of Interest Form Attachment F (Section 3-23-3) (Section 4-8)
Proof of capacity to serve expected enrollment (Section 3-2)				Experience Adjustment – April 1st (Section 3-21-4)
Disclosures (Section 3-23-1)				Proof of capacity to serve expected enrollment (Section 3-2)
Accreditation (Section 3-24-4)				Accreditation (Section 3-24-4)