AGREEMENT FOR SERVICES

BETWEEN

CARE WISCONSIN FIRST, INC.

AND

DENTAL PROFESSIONALS OF WISCONSIN-MANAGEMENT SERVICES, LLC

THIS AGREEMENT is made by and between Care Wisconsin Health Plan, Inc., a Wisconsin nonprofit, tax-exempt organization ("Care Wisconsin," or the "Health Plan") and Dental Professionals of Wisconsin-Management Services, LLC ("IPA") as of November 1, 2016 ("Effective Date").

WHEREAS, Care Wisconsin Health Plan, Inc. (the "Health Plan"), a subsidiary of Care Wisconsin, operates Family Care Partnership ("Partnership"), a Fully Integrated Medicare Advantage Special Needs Plan ("SNP," via contracts with the Centers for Medicare and Medicaid services, hereafter "CMS") and Wisconsin Medicaid Program ("WMP," via a Family Care Partnership Contract ("Partnership Contract") with the State of Wisconsin, represented by the Department of Health Services' (hereafter, "DHS") Division of Long Term Care, to provide or arrange for the provision of comprehensive health and long-term care services to eligible persons ("Members").

WHEREAS, Care Wisconsin Health Plan, Inc. (the "Health Plan"), a sole member of Care Wisconsin First, Inc., operates Medicaid SSI, via a contract with the State of Wisconsin, represented by the Department of Health Services' (hereafter, "the Department") Division of Health Care Access and Accountability Managed Care section, to provide or arrange for the provision of comprehensive health and long-term care services to eligible persons ("Members.")

WHEREAS, Participating IPA Providers provide services to patients within the scope of their licensure or accreditation; and

WHEREAS, Health Plan and IPA mutually desire to enter into an arrangement whereby IPA and IPA Participating Providers for the Health Plan and Participating IPA Providers will render Covered Services to Members; and

WHEREAS, in return for the provision of services and other obligations assumed by IPA and Participating IPA Providers under this Agreement, Health Plan will pay Provider for Covered Services and other designated administrative services as outlined in the terms of this Agreement.

NOW THEREFORE, it is agreed as follows:

I. DEFINITIONS

1.1 Agreement. Shall mean this Agreement for Services and all exhibits, attachments, schedules, appendices and amendments hereto.

1.2 Clean Claim. Shall mean a claim that can be processed without obtaining additional information from the provider of the service. A claim is still considered a clean claim if the only error(s) in the submitted information are the result of an error originating in the Department's system or with errors originating from a Health Plan's claims processing system problem, a Health Plan's internal claims or a Health Plan's business process problem. A clean claim does not include a claim that is under review for medical necessity or any claim from a provider who is under investigation for fraud or abuse.

1.3 Covered Services.

1.3.1 For Family Care Partnership, Covered Services include: all Medicaid State Plan services required under WI Stats. S.49.46 (2) and Wisconsin Administrative Code DHS 107 and all Medicaid waiver services required under the s. 1915 © Home and Community-Based Services Waivers titled "Family Care – Aged / Physical Disability Waiver" and "Family Care MR/DD Waiver;" and all Medicare Parts A, B and D services covered under Care Wisconsin's SNP contracts with CMS.

1.3.2 For Medicaid SSI, Covered Services include all Medicaid State Plan services required under WI S under WI Stats. S.49.46 (2), s. 49.471(11), s.49.45(23) and Wisconsin Administrative Code DHS 107.

1.4 Critical Incident. An event, incident, or course of action or inaction that is either:

1.4.1 Associated with suspected abuse, neglect and financial exploitation, other crime, or a violation of member rights,

1.4.2 Or that:

1.4.2.1 Resulted in serious harm to the health or well-being of a member, or

1.4.2.2 Resulted in serious harm to the health or well-being of another person as a result of the member's actions; or

1.4.2.3 Resulted in substantial loss in the value of the personal or real property of a member or of another person as a result of the member's actions, or

1.4.2.4 Resulted in the unexpected death of a member; or

1.4.2.5 Posed an immediate or serious risk to the health, safety, or well being of a member, but did not cause harm because of chance or preventive intervention.

1.5 Downstream Entity. Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a Medicare Advantage organization or applicant and a first tier entity. These written arrangements continue down to the level of ultimate provider of both health and administrative services.

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

1.6.1 Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
1.6.2 Serious impairment to bodily functions.
1.6.3 Serious dysfunction of any bodily organ or part.

1.7 First Tier Entity. Any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.

1.8 Interdisciplinary Team. Shall mean the team that includes the Member, social service care managers and RN care manager, for Family Care, and, for Family Care Partnership, shall mean the team that includes the Member, a nurse practitioner, RN care managers and social services care manager, or other care management staff designated by the Health Plan.

1.9 IPA. Defined in first paragraph of this Agreement.

1.10 IPA Provider. A duly licensed and/or otherwise qualified provider under the laws in the State of Wisconsin who is under contract or on whose behalf a contract has been entered, with Provider.

1.11 Medicaid. Shall mean the WMP operated by the DHS under Title XIX of the Federal Social Security Act, Ch. 49, Wis. Stats. and related state and federal rules and regulations.

1.12 Medicaid Covered Services. Shall mean those services reimbursed for by the WMP for people eligible for Medicaid benefits under §49.46(2), Wis. Stats. and Ch. DHS 107 of the Wisconsin Administrative Code.

1.13 Medicare. Shall mean the health insurance program operated by the U.S. Department of Health and Human Services ("DHHS") under 42 CFR subchapter B, and 1965 Act, Title I of Public Law 89-97, as amended.

1.14 Medicare Advantage ("MA"). An alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

1.15 Medicare Advantage Organization ("MA organization"). A public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

1.16 Medicare Covered Services. Shall mean those services reimbursed by CMS guidelines for people eligible for Medicare benefits.

1.17 Member. Shall mean a person who is enrolled in Family Care Partnership and Medicaid SSI.

1.18 Network Physician. Shall mean a licensed doctor of medicine or osteopathy with which Care Wisconsin has an Agreement for Services for the provision of medical services to Members.

1.19 Primary Care Physician. Shall mean any Network Physician (MD or DO) whose primary care specialty is family practice or general internal medicine and who has agreed to work within the parameters of Care Wisconsin's model of care.

1.20 Provider. (1) Any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by State law or regulation.

1.21 Provider Manual. Shall act as a reference tool for information pertaining to the Care Wisconsin First, Inc. and Care Wisconsin Health Plan programs and their relationship with Providers. When the Provider Manual is referenced in the Agreement (Sections III, V, VIII, IX and XII) it establishes the same terms and conditions for Services and made a part hereof.

1.22 Reasonable Efforts. Shall mean with respect to a given goal, the efforts that a reasonable person in the position of Provider or Health Plan would use so as to achieve that goal as expeditiously as possible.

1.23 Related Entity. Any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

1.24 Special Needs Individual. Shall mean a Medicare Advantage-eligible individual who would benefit from enrollment in a specialized Medicare Advantage plan.

1.25 Special Needs Plan ("SNP"). Shall mean any type of Medicare Advantage Coordinated Care Plan that exclusively enrolls, or enrolls a disproportionate percentage of, Special Needs Individuals.

1.26 Urgent Care. Shall mean medically necessary care that is required by an illness or accidental injury that is not life-threatening and will not result in further disability but has the potential to develop such a threat if treatment is delayed longer than twenty-four (24) hours.

II. SERVICES

Subject to the terms and conditions herein, IPA and IPA Providers:

2.1 Delineates the purpose of the services in Appendix A.

2.2 Will provide to Members the Covered Services defined in Appendix A affixed hereto and made a part hereof.

2.3 Will not create barriers to access to care by imposing requirements on Members that are inconsistent with the provision of necessary Covered Services (e.g., third party liability recovery procedures that delay or prevent care).

2.4 Agrees to cooperate with the Health Plan to ensure that Members receive timely access to Covered Services, that such services meet community standards of quality, and to ensure continuity of care, consistent with the requirements of CMS Guidelines for Access Standards and any other applicable access requirements mandated by law. Health Plan will not be required to use any specific amount of services.

2.5 Agrees to offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service members, if the IPA serves only Medicaid members.

2.6 Agrees to provide members with telephonic member services during normal business hours to provide assistance with gaining access to IPA Providers.

III. TERM AND TERMINATION

3.1 Term. The initial term of this Agreement shall become effective as of the Effective Date and shall continue in effect for one year. Thereafter, this Agreement will automatically renew for periods of one year subject to the terms and conditions of this Agreement unless terminated in accordance with Section 3.2 below.

3.2 Termination or Suspension. This Agreement may be terminated:

3.2.1 Without cause at anytime by either party upon ninety (90) calendar days prior written notice to the other party, and without pursuing dispute resolution as set forth in Section X herein.

3.2.2 With cause if there is any material breach in the performance of the terms and conditions of this Agreement (breach), which breach has not been cured within thirty (30) calendar days following written notice of such breach. Material breaches shall not be subject to the dispute resolution process described in Section X herein.

3.2.3 By Health Plan if IPA or IPA Providers or any of IPA or its IPA Provider's employees or subcontractors:

3.2.3.1 loses any required liability insurance coverage

3.2.3.2 loses any required Medicaid or Medicare certification

3.3.3.3 loses any license(s) required to perform the services to be rendered under this Agreement

Notwithstanding the above, if the cause for termination is due to a loss of insurance coverage, Medicare/Medicaid certification or licenses by an IPA Provider, employee or subcontractor, this Agreement shall continue in full force and effect if the IPA Provider in question is removed from providing services hereunder.

3.2.4 Notwithstanding any other provision herein except 3.2.7, by IPA upon thirty (30) calendar days prior written notice to Health Plan if the Health Plan are unable to pay for services rendered under this Agreement.

3.2.5 The rights of IPA or of any personnel employed or subcontracted by IPA, including if the Health Plan has delegated provider selection to another entity, to provide Covered Services to Members may be reduced, suspended or terminated indefinitely and immediately by Health Plan whenever Health Plan determines that such action may be necessary in order to safeguard the health and welfare of Members, including but not limited to gross misconduct by IPA or IPA Providers, and violations of professional ethics. The Health Plan shall notify IPA of such reduction, suspension or termination of participation in the Health Plan provider network within seven (7) calendar days of the decision by the Health Plan. The Health Plan shall duly consider any objections or concerns that IPA may raise with regard to any such action as soon as reasonably possible, but the decision whether to effect or continue any such action shall rest solely with the Health Plan. If this Agreement is terminated or suspended on this basis, IPA may appeal the termination or suspension decision. The process for filing such an appeal is described in the Care Wisconsin Provider Manual and section 9.2 of this Agreement.

3.2.6 Termination will have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Nothing in this Agreement will be construed to limit either party's lawful remedies in the event of a material breach of this Agreement.

3.2.7 In the event this Agreement is terminated for any reason, IPA agrees to collaborate with the Health Plan to ensure continuity of care for Members receiving services from IPA at the time notice of termination is provided for a reasonable period of time thereafter but not to exceed thirty (30) days, with payment for such services being made to IPA at the same rates as immediately prior to the date of termination of this Agreement.

IV. COMPENSATION

4.1 Services. The Health Plan will reimburse the IPA according to the terms and conditions of Appendix A.

4.2 Rate Negotiation. The Health Plan and IPA reserves the right to renegotiate mutually agreeable rates for services offered under this Agreement.

4.3 Coordination of Benefits. IPA shall submit directly to Health Plan or Health Plan's designee, as specified prior to or when a Member presents for services, all claims for Covered Services rendered to a Member. If applicable to Provider type, IPA agrees to follow Coordination of

Benefits ("COB") procedures established by CMS and WMP, acknowledging that the Health Plan may be the secondary payer in circumstances when a Member is covered by a third-party payer. If the Health Plan is not primary in a COB situation, IPA will bill other primary third-party payers first; in the event that the primary payer denies the claim or makes only a partial payment on the claim, IPA will send invoices to Health Plan or Health Plan's designee within sixty (60) calendar days of receiving the primary payer's denial or partial payment.

4.4 Hold Harmless. The payments required to be made by the Health Plan under Section 4.1 of this Agreement, together with any copayment, deductible or coinsurance for which the Member is responsible, are payment in full for a Covered Service. IPA represents and warrants that IPA agrees not to bill Members and not to accept any payment from a Member or anyone acting on behalf of a Member, in excess of payment in full as provided in this Section 4.4. IPA agrees that in no event, including but not limited to non-payment by Health Plan, insolvency of Health Plan, or breach by Health Plan of this Agreement, will IPA charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or person (other than the Health Plan) acting on behalf of the Member for Covered Services provided under this Agreement including DHS and CMS. The Health Plan and IPA agrees to follow Article VII. J. Department Policy for Member Use of Personal Resources in the contract between DHS and the Health Plan.

This obligation to refrain from billing Members applies even in those cases in which IPA believes that the Health Plan has made an incorrect determination. In such cases, IPA may pursue remedies under this Agreement against the Health Plan, but must still hold the Member harmless.

The provisions of this Section will be construed in favor of the Member, and will survive the termination of this Agreement regardless of the reason for termination and will supersede any oral or written contrary agreement between Provider and Member or the representative of a Member if the contrary agreement is inconsistent with this Section.

4.5 Obligation to Pay. The obligation of the Health Plan or the Member, as the case may be, to pay all amounts owing to IPA under this Agreement shall survive any termination of this Agreement.

4.6 Member Protection. IPA agrees that in the event of the Health Plan's insolvency or other cessation of operations, Provider will continue to provide Covered Services to a Member for the duration of the contract period for which CMS and DHS payments have been made to Health Plan or Health Plan.

V. BILLING AND CLAIMS

5.1 Claims. If applicable to Provider type, IPA will directly bill all insurance in effect that is primary to Medicare and WMP as provided in Section 4.3 herein. IPA will submit all claims payable by the Health Plan under this Agreement to Health Plan's third-party claims processing service ("TPA"), or to Health Plan, as instructed, in standard industry format acceptable to Medicare and/or WMP, or in an alternate format approved by Health Plan. For Medicare Covered Services, Provider will complete the claims in the same manner required for

reimbursement under Medicare, including but not limited to, all appropriate CPT, ICD and related HCPCS codes, except when such codes are not applicable based on the services provided under this Agreement. IPA's claims shall be in compliance with the standards for electronic transactions set forth in 45 CFR 162.

5.2 Timeliness of Claims. A completed claim for which the Health Plan is the primary payer will be submitted following the service being rendered. Providers have ninety (90) days from the date of service to submit claims to the IPA. The IPA shall submit encounter files to the Health Plan within thirty (30) days of receipt of a claim from a Provider.

5.3 Timeliness of Payments. The Health Plan (or the TPA) will make payment to the IPA within thirty (30) calendar days of receiving a Clean Claim. Claims that are not submitted on a claim form approved by the Health Plan and/or are not clean, meaning the claim does not contain all data required by the Health Plan to process the claim and/or the data on the claim is not legible or readable by scanning equipment, will be denied. When claims are denied for the reasons stated in the prior sentence, IPA will be required to submit a corrected claim in order to receive reimbursement.

5.4 Adjustments. All claims will be considered final unless IPA requests an adjustment in writing within sixty (60) calendar days after receipt of payment.

5.5 Claim Denial and Appeal Process. IPA may submit an appeal within 60 calendars days of the initial denial or partial payment to the Health Plan if the Health Plan denies payment in full or in part for services rendered by IPA. The Health Plan must inform IPA in writing of the Health Plan's decision to limit or deny IPA's original claims within forty-five (45) calendar days, including:

i. A specific explanation denial or payment amount or specific reason for non-payment.

ii. A statement explaining the appeal process and the provider's rights and responsibilities in appealing the Health Plan's determination by submitting a separate letter or form which:

a) Is clearly marked "appeal";

b) Contains the provider's name, date of service, date of billing, date of rejection, and reason(s) claim merits reconsideration for each appeal; and,

c) Is submitted to the Health Plan's claims manager at:
Claims Manager
Care Wisconsin
PO Box 14017
Madison, WI 53708-0017

The Health Plan will provide a representative to review the denial with the aggrieved party, and, if appropriate, will reprocess the claim for payment. In the event of any dispute arising from any claim or bill submitted by IPA, each party will have access to all reasonable and necessary documents and records that would, at the discretion of either party, tend to sustain its claim. Patient records will be released only to the extent allowable under Wisconsin and federal law. If

the IPA is not satisfied with the outcome of his or her appeal to the Health Plan or if the Health Plan has not responded in writing within forty-five (45) calendar days, the Provider may appeal the Health Plan's decision to DHS. The IPA has sixty (60) calendar days to submit a written appeal to DHS from either the date of the written notification of the Health Plan's final decision resulting from a request from reconsideration or after the Health Plan's failure to respond within forty-five (45) calendar days to the provider's request for reconsideration. The IPA agrees to abide by the terms outlined in Section O of the contract between DHS and the Health Plan, Appeals to the Health Plan and Department for Payment/Denial of Provider Claims, and as may be amended in future contracts, as outlined in the Partnership Contract and the Medicaid SSI Contract between DHS and Health Plan. Additional information can also be found in the Care Wisconsin Provider Manual at **https://www.carewisc.org/provider-manual-and-policies**.

VI. CERTIFICATION AND CREDENTIALING

6.1 Credentialing. IPA represents that IPA has established an ongoing quality assurance/assessment program which includes, but is not limited to, credentialing of participating IPA Providers. IPA shall supply to Health Plan the relevant documentation, including but not limited to, internal quality assurance/assessment protocols and credentialing policies and procedures. IPA further represents that all personnel employed by, associated or contracted with IPA and participating IPA Providers shall remain in compliance with the terms of this Agreement.

6.2 Certification. IPA Providers shall maintain WMP certification, if so required, and appropriate licenses during the term of this Agreement. IPA warrants that IPA and each health care professional employed or subcontracted by IPA to provide services under this Agreement is: licensed to provide services or practice in Wisconsin, and is qualified to provide services under the WMP.

IPA agrees to verify the credentials of all health care professionals and other staff that will provide services to Members under this Agreement, as required in Section 6.3.

6.3 Verification. Credential verification is the review of licenses, diplomas, transcripts, certificates, or other documentation of an individual's qualifications to provide services under this Agreement. For physicians and other licensed health care professionals, including members of physician groups, the process must verify current eligibility to participate in Medicaid and Medicare programs. IPA agrees to verify individual credentials of health professionals and other service workers employed or subcontracted by IPA who provide services under this Agreement. IPA agrees to comply with any requirements issued by CMS or DHS in accordance with verifying compliance of credentials. All information obtained in connection with a verification shall be treated as confidential.

6.3 Notification. IPA agrees to promptly notify Health Plan as specified in Section XXI:

6.3.1 if an IPA Provider loses his or her Medicaid or Medicare certification;
6.3.2 if IPA or any of IPA's employees or subcontractors loses organizational or individual professional licensure for any of the services provided under this Agreement;

6.3.3 of the termination or limitation of staff privileges;
6.3.4 of changes in malpractice insurance coverage;
6.3.5 of the imposition of a Statement of Deficiency issued by the Division of Quality Assurance, DHS; and
6.3.6 of the imposition of sanctions by the Medicare or the WMP against a physician, health care professional or other care giver employed or subcontracted by IPA, for those individuals providing services under this Agreement. Loss of such certification or licensure may constitute a breach subject to termination, in the sole discretion of the Health Plan, as described in Section III herein. In the sole discretion of the Health Plan, the Health Plan may request that IPA bar from participation under this Agreement any individual employee or subcontractor whose continued participation represents a threat to the health or welfare of a Member.
6.3.7 if notification received of federal disbarment.

VII. ASSIGNMENT

This Agreement cannot be assigned or delegated by either party hereto without the prior written approval of the other party hereto.

VIII. COOPERATION

8.1 Cooperation Between the Parties. Health Plan and IPA agree that to the extent compatible with the separate and independent management of each, they will at all times maintain an effective liaison and close cooperation with each other to provide maximum benefits and access to care for Members at the most reasonable cost consistent with quality standards of care.

8.2 Quality Assurance and Improvement.

8.2.1 IPA agrees to cooperate with Health Plan in its implementation of effective quality assurance and quality improvement programs, subject to state and federal laws applying to access to records. IPA agrees to:

8.2.1.1 allow Health Plan access to appropriate records in the Health Plan's conduct of oversight and review;
8.2.1.2 cooperate with CMS and DHS in their quality assurance oversight activities, including assisting CMS, DHS and/or any reviewing bodies under contract with CMS or DHS in identification of IPA and Member data required to carry out on-site medical chart review;
8.2.1.3 report Critical Incidents immediately upon discovery and cooperate with Health Plan in the investigation of critical incidents. Ensure incident is promptly addressed and notification occurs as soon as reasonably possible during the business day or next business day if weekend/holiday.

8.2.2 IPA acknowledges its access to the Care Wisconsin Provider Manual, which describes the Health Plan's and Health Plan's grievance resolution, utilization management, quality improvement, quality assurance, and provider credentialing and re-credentialing

programs. IPA shall comply with the requirements thereof, as reasonably amended from time to time by the Health Plan and communicated to the IPA. The Care Wisconsin Provider Manual is incorporated herein and made a part hereof by reference.

8.3 Restrictive Measures. The IPA agrees to work through the Interdisciplinary Team or other care management staff at Care Wisconsin to determine the appropriateness of restrictive measures, any type of restraint, isolation, seclusion, protective equipment, or medical restraint and the development of a Behavioral Support Plan, as indicated. Approval for use of such measures needs to go through the Health Plan's Restrictive Measure Workgroup. IPA will provide orientation and annual refresher training to personnel that would be involved in evaluation/training or implementation of restrictive measures.

8.5 DHS and CMS Requirements. IPA represents that IPA understands the Health Plan is subject to Medicare and WMP laws, regulations, CMS and DHS instructions, and contractual obligations with CMS and DHS, and IPA agrees to fully assist the Health Plan in complying with the terms and conditions of these laws, regulations, instructions, and Health Plan's contracts with CMS and DHS, as modified from time to time by CMS or DHS, as the case may be. Subject to its right to terminate this Agreement pursuant to Section III herein, IPA represents that IPA will also cooperate with Health Plan in complying with any amendments or additional requirements for the Health Plan's Providers. Health Plan will give IPA at least thirty (30) calendar days' prior written notice of any such amendment(s) or additional requirements, whenever Health Plan have been given sufficient time to ensure compliance with this requirement; in any other situation, Health Plan will provide such notice as soon as it is practicable to do so.

8.6 Compliance with Federal and State Laws, Continuity of Care. IPA represents and warrants that it requires its employees, subcontractors and any other individuals who may provide services under this Agreement to:

8.6.1 comply with federal and state laws; and

8.6.2 cooperate with the Health Plan to ensure continuity of care for Members.

IX. GRIEVANCES AND APPEALS

9.1 Member Appeals.

9.1.1 IPA recognizes that members have the right to file appeals or grievances and assure that such action will not adversely affect the way that the IPA treats the member.

9.1.2 The IPA agrees to cooperate and not interfere with the members' appeals, grievances and fair hearings procedures and investigations and timeframes.

9.1.3 The IPA may obtain specific information regarding member grievance, appeal and fair hearing procedures and timeframes by contacting Health Plan's Member Rights Specialist at 800-963-0035, ext. 3448. This information can also be found at **https://www.carewisc.org/provider-manual-and-policies**.

9.1.4 IPA agrees to cooperate with, and upon request, to furnish all relevant information to the Health Plan, CMS or DHS in resolving any Member's grievance or appeal related to the provision of services under this Agreement. IPA agrees to forward to the Health Plan any medical records pursuant to grievances or appeals, within fifteen (15) working days of the Health Plan's request, or promptly, if the grievance or appeal is expedited. If IPA does not meet the fifteen-(15-)day requirement, IPA will explain the reason for the delay and indicate when the medical records will be delivered. IPA agrees to comply with the Health Plan's adjudication process for any Member's grievance or appeal. This procedure allows Members to appeal any Health Plan denial or reduction of Medicare or Medicaid services or denial of payment for Medicare or Medicaid services through the Health Plan's appeals committee. A description of the Member's grievance or appeal process is found in the Member's Evidence of Coverage document. This document is available online at **https://www.carewisc.org/provider-manual-and-policies**.

9.2 Provider Appeals.

9.2.1 IPA must submit an appeal to the Health Plan in writing within sixty (60) days of the denial or notice. The Health Plan will respond in writing to the provider within forty-five (45) calendar days of receipt of the request for reconsideration.

9.2.2 If the Health Plan fails to respond within forty-five (45) days of the submitted appeal or the provider is unsatisfied with the Health Plan response, the IPA can seek a final determination from DHS. All appeals must be submitted to DHS within sixty (60) days of the date of the written notification of the Health Plan's final decision or Health Plan's failure to respond within forty-five (45) days. A description of the Provider Appeals process is available on line at **https://www.carewisc.org/provider-manual-and-policies.**

X. PROHIBITED PRACTICE AND DISPUTES

The Health Plan and the IPA agree to prohibit communication, activities or written materials that make any assertion or statement, that the Health Plan or Provider is endorsed by CMS, the Federal or State government, or any other entity.

If any dispute shall arise with regard to the interpretation of any of the terms of this Agreement, the parties hereto agree to resolve disputes by meeting or teleconference within sixty (60) calendar days of the date such dispute was brought to the attention of one party by the other party. If the parties are unable to reach a resolution of the dispute within said sixty (60) calendar days, either party may give the other party thirty (30) calendar days prior written notice of its intent to terminate this Agreement.

IPA is prohibited from influencing participants' choice of long-term care program, provider or managed care organization (Health Plan) through communications that are misleading, threatening or coercive under federal managed care regulations 42 CFR4381. DHS may impose sanctions against a provider that does so under Wisconsin Administrative Code DHS 106.08(2)€.

XI. INSURANCE AND INDEMNIFICATION

11.1 Insurance for IPA. IPA and participating IPA Providers shall secure and maintain, at their sole cost and expense throughout the term of this Agreement such policy or policies of general liability, professional liability (malpractice coverage), and workers compensation as shall be necessary to insure IPA, and participating IPA Providers its employees and subcontractors and its agents against any claims for damages arising by personal injury, death, or property damage or loss, occasioned directly or indirectly in connection with the performance of any services by IPA, IPA Providers or by said employee, subcontractor or agent. For physicians, coverage limits shall be in at least the amount specified in Chp. 655.23(4) Wis. Stats. For other provider types, the types of coverage required are set forth in the Care Wisconsin Provider Manual.

Upon entering into this Agreement, IPA will provide the Health Plan with a Certificate of Insurance in a form acceptable to same to confirm compliance with Section 11 of this Agreement. General Liability policies will be endorsed to specifically name Care Wisconsin First Inc. as an additional insured.

If General or Professional Liability coverage is written on a claims-made form rather than an occurrence form, the insurance policy's retroactive date must be noted on the Certificate of Insurance. Provider agrees to either 1) purchase claims made coverage in subsequent years with retroactive date not later than retroactive date noted on certificate or 2) purchase an Extended Reporting Period endorsement of not less than two years.

Required coverages will be provided by insurers with an A.M. Best Company general policyholder's rating of "A-" or better and a financial performance index rating of VI or better in Best's Insurance Reports or Best's Key Rating guide.

Prior to modification, expiration or cancellation of insurance coverage, IPA will secure replacement coverage and provide the Health Plan with a revised or new Certificate of insurance within ten (10) calendar days of each policy renewal.

11.2 Insurance for the Health Plan. The Health Plan, at their sole cost and expense, shall procure and maintain in full force and effect throughout the term of this Agreement, general comprehensive liability insurance in the amount of not less than one million dollars ($1,000,000). Upon request, the Health Plan will provide Provider with a Certificate of Insurance to confirm compliance with this Section XI.

11.3 Notice of Potential Complaint or Grievance. The Health Plan will promptly advise IPA in the event it has reason to believe a complaint or grievance may exist against IPA for services performed under this Agreement. Notification under this Section will be for information purposes only and will not substitute for the statutory notification and claim procedure of Section 893, Wis. Stats.

IPA will promptly identify complaints and grievances against IPA for services performed under this Agreement and will forward these complaints and grievances to the Health Plan.

11.4 Indemnification. This Agreement is not one to insure nor indemnify and each party will be responsible for its own acts or omissions and any and all claims, liabilities, injuries, suits, and demands and expenses of all kinds which may result in or arise out of any conduct, negligence or willful misconduct caused or alleged to have been caused by that party, its employees or non-physician agents, in the performance or omission of any act or responsibility of that party under this Agreement. This is in no way intended to abrogate any common law right of subrogation, contribution or indemnification a party may otherwise have available to it.

11.5 Legal Liability. The subcontract must not terminate legal liability of the Health Plan. If the Health Plan delegates selection of providers to another entity, the Health Plan retains the right to approve, suspend, or terminate any provider selected by that entity.

XII. NONDISCRIMINATION/CIVIL RIGHTS COMPLIANCE/LIMITED ENGLISH PROFICIENCY

IPA shall comply with all non-discrimination requirements and all applicable Affirmative Action and Civil Rights Compliance laws and regulations (refer to http://DHS.wisconsin.gov/civilrights/Index.HTM as a resource). At a minimum, IPA agrees to the following:

12.1 No otherwise qualified person shall be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination in any manner on the basis of age, color, disability national origin, race, religion, or sex. This policy covers eligibility for and access to service delivery, and treatment in all programs and activities. All employees of the IPA are expected to support goals and programmatic activities relating to nondiscrimination in service delivery. Further information is available in the Provider Manual at **https://www.carewisc.org/provider-manual-and-policies**.

12.2 No otherwise qualified person shall be excluded from employment, be denied the benefits of employment or otherwise be subjected to discrimination in employment in any manner or term of employment on the basis of age, ancestry, arrest record, color, conviction record, creed, disability or association with a person with a disability, genetic testing, honesty testing, marital status, membership in the national guard, state defense force or any reserve component of the military forces of the United States or this state, national origin, pregnancy or childbirth, race, religion, sex, sexual orientation, use or nonuse of lawful products off the employer's premises during nonworking hours. All employees are expected to support goals and programmatic activities relating to non-discrimination in employment.

12.3. IPA shall report to Health Plan complaints of Members or applicants related to civil rights compliance. Civil rights complaints must be investigated by IPA and the Health Plan.

XIII. RECORDS

13.1 Maintenance of Records. IPA will maintain books and records pertaining to this Agreement in a form consistent and in compliance with confidentiality provisions of applicable federal and state laws and regulations. IPA agrees to preserve the full confidentiality of medical and other Member records and protect from unauthorized disclosure all information, records, and data collected under this Agreement as required by HIPAA. The IPA will meet the requirements for maintenance and transfer of member records stipulated in Article XIII.A., Member Records, and Article XIV.F., Records Retention of the Health Plan's contract with DHS. Access to this information shall be limited to persons who, or agencies which, require the information in order to perform their duties related to the Health Plan's contract with CMS and DHS and the Health Plan's contract with DHS and are authorized to receive it. IPA will forward to the Health Plan medical records pursuant to appeals within fifteen (15) working days of the record request, or promptly, if the appeal is expedited. If IPA does not meet the fifteen (15) day requirement, IPA must explain reason(s) for the delay and indicate when IPA will deliver the required record. Further Records Retention information is available in the Provider Manual at **https://www.carewisc.org/provider-manual-and-policies**.

13.2 Members and their authorized representatives shall have access to a Member's records within ten (10) business days of the record request if records are maintained on site and sixty (60) calendar days if records maintained off site in accordance with the standards in 45 CFR 164.524 (b)(2).

13.3 Access to Records. IPA will allow duly authorized agents or representatives of the Health Plan, the state or federal government, including the Department of Health and Human Services, the Comptroller General, or their designees, upon reasonable notice and during normal business hours, access to its premises to inspect, audit, monitor, copy or otherwise evaluate the performance of IPA's contractual activities and will forthwith produce all records requested as part of such an audit or review. Such access shall be limited solely to the right to reproduce all records and material and to verify reports furnished in compliance with the provisions of the Health Plan's contract with CMS and DHS and the Health Plan's contract with DHS. In the event right of access is requested under this Section, IPA will, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate personnel conducting the audit or inspection effort. If deficiencies are found during review a corrective action plan may be required to address areas of needed performance improvement. IPA agrees to comply with any requirements issued by CMS or DHS as a result of such inspection or audit. All inspections or audits will be conducted in a manner as will not unduly interfere with the performance of IPA's activities. All information obtained during an audit or review will be treated as confidential.

13.4 Permission for Governmental Review of the Records Related to this Agreement. Upon written request by the Secretary of the Department of Health and Human Services or Comptroller General of the United States, or by any of the Secretary's or Comptroller General's duly authorized representatives, IPA will make available those contracts, books, documents or records necessary to verify the nature and extent of the costs of providing services under this Agreement. Such inspection shall be available up to ten (10) years after the rendering of such services. If IPA carries out any of the duties of this Agreement through a subcontract with a value of [redacted] with a related individual or organization, IPA agrees to include this requirement in any subcontract. This Section is included

pursuant to and is governed by the requirements of 42 CFR 422.504(e)(2), 42 CFR 422.504(e)(4), and 422.504(i)(2)(ii), as amended, 42 U.S.C. § 1395x(v)(1), and the regulations promulgated thereunder. This Section 13.4 shall be null and void if no longer required by law.

13.5 Record Copying Costs. IPA will copy and provide Member records for the Health Plan, as reasonably requested, to provide continuity of health care. IPA will not seek reimbursement from the Health Plan for copies of medical records.

XIV. SUBROGATION

State statutory subrogation rights have been extended to the Health Plan under Subch. 49.89(9), Wis. Stats. The Health Plan is obligated to collect recoverable amounts arising out of the settlement of personal injury, medical malpractice, product liability and Workers' Compensation on behalf of its Members. Recoverable amounts include monies paid by the Health Plan for the Member for all services related to the injury, not limited to health care expenses. IPA agrees to cooperate with the Health Plan on all subrogation matters, including but not limited to notifying the Health Plan within twenty-four (24) hours of an incident, and forwarding to the Health Plan copies of all documents and reports pertaining to the incident as they become available.

XV. CONFIDENTIALITY

The Health Plan and IPA agree that performance of this Agreement will result in their employees having access to confidential and/or proprietary information. Such information may include but not be limited to Member medical records, staff compensation, and certain proprietary and management information concerning both organizations. The Health Plan and IPA agree that any employees assigned to perform services or who otherwise have access to such information will be made aware of the confidential nature of such information.

IPA will comply with applicable federal and state rules and regulations, including but not limited to those promulgated from the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Title XIII of the American Recovery and Reinvestment Act of 2009 (also cited as the "HITECH Act").

IPA and Health Plan agrees that all rate negotiations, verbal or written, are confidential and not to be shared with employees or outside agencies not participating in rate negotiations. Rate negotiations are also confidential between the Health Plan and IPA and not to be shared with members, guardians, family members or member representatives.

XVI. INDEPENDENT CONTRACTOR

The relationship between IPA and the Health Plan under this Agreement will be construed and deemed to be between independent contractors and for the sole purpose of carrying out the terms of this Agreement. Nothing in this Agreement will be construed to create a partnership, joint venture, employer-employee or principal-agent relationship between the parties, nor will the parties hold themselves out as being a partnership, joint venture, and employer-employee or principal-agent relationship. As between Health Plan and IPA, each has full, complete, absolute and sole authority and

responsibility regarding its own operations; and none shall have any direction or control over the manner in which any other performs its obligations.

XVII. OSHA REQUIREMENTS

If IPA employs staff to provide services under this Agreement, IPA agrees to require its employees to comply with all applicable OSHA requirements. This provision does not apply in situations when IPA does not employ or subcontract staff to provide services under this Agreement.

XVIII. ADVERTISING

Health Plan and IPA agree to provide and obtain, in advance, the other party's written approval of all advertising and promotional materials, regardless of medium, which refer to the other party. No reference to the other party shall be made in any materials unless prior written approval is obtained. In the event of a termination under this Agreement, all advertising and promotional materials, in any medium whatsoever, shall be revised by the parties hereto as soon as possible to eliminate references to the other party.

XIX. NONEXCLUSIVITY

The parties enter into this Agreement on a nonexclusive basis.

XX. EXCLUSION FROM STATE AND FEDERAL HEALTH CARE PROGRAMS

All parties represent and warrant that, to the best of each party's knowledge, IPA and the Health Plan and their owners and employees are not excluded from participation in any federal health care programs, as defined under 42 U.S.C. § 1320a-7b (f), and to each party's knowledge, there are no pending or threatened governmental investigations that may lead to such exclusion. Each party agrees to notify the other party of the commencement of any such exclusion or investigation within seven (7) business days of first learning of it. All parties shall have the right to immediately terminate this Agreement upon learning of any such exclusion and shall be kept appraised by the other party or parties of the status of any such investigation.

XXI. NOTICE

Any notice, demand or communication required, permitted or desired to be given under this Agreement will be deemed effectively given when personally delivered or mailed by prepaid certified mail, return receipt requested, addressed as follows:

Care Wisconsin Health Plan, Inc.:

Chief Executive Officer
1617 Sherman Ave.
P.O. Box 14017
Madison, WI 53708-0017
Facsimile: 608-245-3571

Dental Professionals of Wisconsin-Management Services, LLC:
Manager
3520 W. Oklahoma Ave.
Milwaukee, WI 53215

XXII. FRAUD, WASTE AND ABUSE

22.1 IPA shall report suspected Fraud, Waste or Abuse to Health Plan within a reasonable period of time after discovery of the suspected misconduct. Health Plan has a strict policy against retaliation or retribution against any employee or subcontractor who reports suspected misconduct in good faith. IPA is afforded anti-retaliation protections under applicable state and federal laws, including 31 U.S.C. § 3730(h) for False Claims Act complaints.

22.2 IPA shall comply with the Affordable Care Act, 42 CFR 455.2 and 455.23 as relates to the suspension of payments to Provider pending investigation of a credible allegation of fraud.

22.3 IPA shall obtain Fraud, Waste and Abuse ("FWA") training and education and provide FWA training to its employees and subcontractors as appropriate. Health Plan shall make FWA training and education information available to IPA or provide it upon request.

XXIII. MISCELLANEOUS

23.1 Entire Agreement. This Agreement contains all the terms and conditions agreed upon by the parties hereto regarding the subject matter of this Agreement. Any prior agreements, promises, negotiations or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

23.2 Modifications. This Agreement constitutes the entire understanding between the parties hereto, and no changes, amendments, or alterations shall be effective unless agreed to in writing by both parties. Notice to or consent of Members shall not be required to effect any modifications to this Agreement.

23.3 Invalidity or Nonenforceability. The invalidity or non-enforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other term or provision.

23.4 Enforcement. This Agreement shall be interpreted in accordance with the laws of the state of Wisconsin. Unless waived by both parties, venue for any action to enforce or interpret the provisions of this Agreement shall be in Dane County, Wisconsin. This section is subject to Wisconsin Statute 788.02 to permit disputes to be resolved in accordance with Section X, except as otherwise specified herein.

23.5 Third Party Beneficiaries. Except as otherwise specified herein, nothing herein shall be construed as, or deemed to create, any rights or remedies to any third-party, including, but not limited to, any Members.

23.6 Health Plan will not be required to use any specific amount of IPA's services.

IN WITNESS WHEREOF, the undersigned concur with the terms, conditions and understandings as set forth in this Agreement and have executed the Agreement as of the date and year first written above:

CARE WISCONSIN HEALTH PLAN, INC.

Susan Crowley
Senior VP Government Services

10/31/16
Date

DENTAL PROFESSIONALS OF WISCONSIN-MANAGEMENT SERVICES, LLC

Paul. D. Smith, D.D.S.
Manager

11/04/2016
Date

APPENDIX A

SERVICES AND COMPENSATION INCLUDED UNDER THIS AGREEMENT

Provider agrees to arrange for the provision of services to Members. The duties and responsibilities of Provider(s) are limited to the service(s) and reimbursement as indicated below:

INITIAL FEES

The Health Plan shall reimburse IPA a total of [redacted] for any and all start up costs.

CLAIMS REIMBURSEMENT FOR PARTNERSHIP & *MEDICAID SSI* MEMBERS:

Medicaid Covered Services. Health Plan will reimburse IPA for all services at [redacted]

PRIOR AUTHORIZATION REIMBURSEMENT FOR PARTNERSHIP & *MEDICAID SSI* MEMBERS:

IPA shall submit a monthly invoice to the Health Plan detailing all prior authorizations processed in the previous month. The Health Plan shall reimburse IPA at a rate of [redacted] as outlined in Appendix C of this Agreement within 30 calendar days upon receipt of the invoice.

ADMINISTRATIVE COSTS:

IPA agrees to submit a monthly invoice to the Health Plan detailing administrative charges due to IPA for claims and/or claim files submitted to the Health Plan in the prior month. The Health Plan shall reimburse IPA a [redacted] based upon the monetary value of claims paid for the prior month within 30 calendar days upon receipt of the invoice.

All payment obligations hereunder shall survive termination of the Agreement.

APPENDIX B

MEDICAID SSI

ADDITIONAL PROVISIONS

1. IPA uses only Medicaid SSI-certified providers in accordance with this Agreement.

2. No terms on this contract are valid which terminate legal liability of the Health Plan.

3. IPA agrees to participate in and contribute required data to Health Plan Quality Assessment/Performance Improvement programs.

4. IPA agrees to abide by the terms of this Agreement for the timely provision of emergency and urgent care. Where applicable, IPA agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency room MOUs signed by the Health Plan in accordance with this Agreement.

5. IPA agrees to submit Health Plan encounter data in the format specified by the Health Plan, so that the Health Plan can meet the Department specifications required by this Agreement. The Health Plan will evaluate the credibility of data obtained from IPA vendor's external databases to ensure that any patient-reported information has been adequately verified.

6. IPA agrees comply with all record retention requirements.

7. IPA agrees to provide representatives of the Health Plan, as well as duly authorized agents or representatives of the Department and the federal Department Health and Human Services, access to its premises and its contracts, medical records, billing, including contractual rates agreed upon between the Health Plan and the IPA, and administrative records. Refusal will result in sanctions or penalties against the Health Plan for failure of its IPA to permit access to a Department or federal DHHS representative. Sanctions and penalties are outlined in Article XI of the Contract for Medicaid SSI between the Health Plan and The Wisconsin Department of Health Services. IPA agrees otherwise to preserve the full confidentiality of medical records in accordance with this Agreement.

8. IPA agrees to the requirements for maintenance and transfer of medical records stipulated in this Agreement and Article VII, Item B of the Contract for Medicaid SSI.

9. IPA agrees not to create barriers to access to care by imposing requirements on members that are inconsistent with the provision of medically necessary and covered Medicaid SSI benefits (e.g. COB recovery procedures that delay or prevent care.)

10. IPA agrees to clearly specify referral approval requirements to its providers and in any subcontracts.

11. IPA agrees not to bill Medicaid SSI members for medically necessary services covered under this Agreement and provided during the member's period of Health Plan enrollment. IPA also agrees not

to bill members for any missed appointments while the members are eligible under the Medicaid SSI Program. This provision will remain in effect even if the Health Plan becomes insolvent. However, if a member agrees in writing to pay for a non-covered service, then the Health Plan, Health Plan provider, or Health Plan subcontractor can bill.

The standard release form signed by the Member at the time of services does not relieve the Health Plan and its providers and subcontractors from the prohibition against billing a Medicaid SSI member in the absence of knowing assumption of liability for a non-covered service. The form or other type of acknowledgement relevant to Medicaid SSI member liability must specifically state the admissions, services, or procedures that are not covered by Medicaid SSI.

12. IPA agrees to the terms outlined in Section 5.5 of this Agreement regarding appeals to the Health Plan and to the Department regarding the Health Plan's nonpayment for services providers render to members.

APPENDIX C

UTILIZATION REVIEW AND CALL CENTER SERVICES

UTILIZATION REVIEW SERVICES

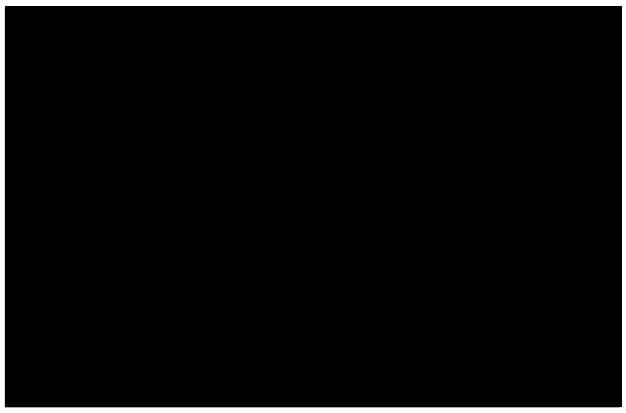
[redacted]

CALL CENTER SERVICES

1. IPA agrees to provide call center support services to Health Plan members and IPA Providers and Health Plan providers for routine calls between the hours of 8:00 A.M. through 5:00 P.M. Monday through Friday, excluding New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Day After Thanksgiving, Christmas Eve and Christmas Day.

[redacted]

4. IPA shall submit to Health Plan a monthly report documenting all member telephone and Internet activity demonstrating the following statistics:



CONFIDENTIAL

FIRST AMENDMENT TO THE AGREEMENT FOR SERVICES BETWEEN CARE WISCONSIN FIRST, INC. AND DENTAL PROFESSIONALS OF WISCONSIN-MANAGEMENT SERVICES, LLC

This First Amendment to the Agreement for Services by and between Care Wisconsin First, Inc. ("Health Plan") and Dental Professionals of Wisconsin-Management Services, LLC ("IPA"), effective as of the date of the last signature below (the "Effective Date"), and upon the following recitals and understandings:

RECITALS

WHEREAS, Health Plan and IPA entered into an Agreement for Services on November 1, 2016 (the "Original Agreement"); and

WHEREAS, Health Plan and IPA desire to amend the Original Agreement as provided for herein to, amongst other things, provide for Health Plan's designation of dental claims processing services to IPA for dental services provided to Members as provided for herein.

NOW, THEREFORE, for and in consideration of the mutual covenants and promises contained herein, and other good and valuable consideration, the receipt, adequacy and sufficiency of which is hereby acknowledged, the parties hereto agree and acknowledge as follows:

1. Recitals. Each of the foregoing prefatory paragraphs is incorporated herein as though fully set forth in full.

2. Current Contract Language. All references to claims submission and payment in the Agreement for Services between the parties is amended to include the Services described in Section 3 below.

3. Claims Processing Service Delegation. The Health Plan hereby delegates dental claims processing to the IPA for dental services provided to Members with dates of service on or after October 1, 2017 (the "Implementation Date") The parties agree that the dental claims processing services being delegated in this First Amendment include all of the following:

3.1 Plan Coverage Requirements. IPA shall be responsible for loading into its systems and maintaining all Health Plan dental coverage requirements required for all Members where dental coverage is provided by the Health Plan. IPA shall annually update its systems to reflect appropriate Member deductibles, co-payment, coinsurance and out of pocket amounts.

3.2 Claims Processing. IPA shall process and adjudicate all claims generated in connection with dental care provided to Members. IPA shall process Health Plan dental claims utilizing its check stock or drafts. IPA shall process claims in accordance with the rights of Members, terms of Provider contracts and fee schedules, and all applicable regulatory requirements. Services provided by IPA shall include:

3.2.1 Claims Adjudication. IPA will adjudicate claims and calculate the benefits payable to Providers. As a part of the claims adjudication process, IPA shall a) apply relevant Member eligibility information to the claim, such as, the Member's effective and

termination dates and benefit coverage information, b) administer any applicable out of pocket provisions, c) calculate amount payable according to the fee schedule, and d) verify that the services billed are not duplicates of any previously paid claims and/or services.

3.2.2 Appeal Rights. IPA will issue denials for non-covered prior authorized procedures and notify Members of their right to appeal such denial in accordance with the Health Plan's appeals processes, as approved by Health Plan and in accordance with regulatory requirements.

3.2.3 Claims Payments. IPA shall issue payment for approved claims at the appropriate payment amount as determined by the Member's program, fee schedule, and in accordance with applicable regulatory requirements.

3.2.4 Member and Provider Notification. IPA shall issue communication to Providers in the form of a Remittance Advice for all claims payments and distribute Explanation of Benefits to Members where Member liability on a claim exists.

3.2.5 Reconciliation Files. The IPA agrees to provide to the Health Plan daily files of all check payments with check number, check date, payee no later than five (5) business days following the payment date.

3.2.6 Member Level Payment Files. The IPA agrees to provide to the Health Plan by the fifth business day of each month a file consisting of all payments for the previous month at the Member-claim level including Member number, Member name, claim number, service code, date of service, date of payment and check number.

3.3 Check Payments. In its performance of claims payment services, IPA shall issue check payments to Providers on behalf of the Health Plan. Check payment runs shall include Explanation of Benefits and Provider Remittance Advices. The Health Plan shall be responsible for the funds required to perform claim payment services performed by the IPA on behalf of the Health Plan through accounts owned by the Health Plan

3.3.1 Check Disbursement. IPA shall have the responsibility of check printing. All claim payments shall be made from funds of or arranged by the Health Plan.

3.3.2 Authorized Signatures. The Health Plan shall designate the authorized signature for the account.

3.3.3 Sufficient Funds. The Health Plan agrees to maintain sufficient funds in a bank account(s) to cover all checks disbursed by IPA in connection with the services provided under the Agreement.

3.4 Coordination of Benefits (COB), Third-Party Liability, and Subrogation. IPA shall be responsible for identifying and maintaining COB information it receives from Health Plan eligibility files and shall process claims accordingly.

3.5 Claims Adjudication Following Agreement Termination. Following the delivery of written notice of termination of this Agreement, the Health Plan may elect to pay IPA at the current contracted rate to perform claims processing of Member claims for a period not to exceed ninety (90) calendar days for any claims incurred but not reported or paid prior to the termination date. Such election must be made within ten (10) calendar days of the Agreement termination notification date.

3.6 Encounter Data. IPA shall supply Health Plan with monthly encounter data files in the formats deemed acceptable by the State of Wisconsin, Department of Health Services no later than ten (10) business days of the following month. The IPA shall be responsible for researching and resolving any encounter rejections/errors with a corrected submission to occur no later than the following month's submission.

3.7 Invoicing. IPA shall supply Health Plan with a monthly invoice for the rates outlined in in Section 4.7 below.

3 8 Service Level Agreements. The IPA shall provide the Health Plan the following minimum service levels ("Minimum Service Levels"):

Minimum Service Level	Penalty
[redacted] will be made within 30 days of receipt of Clean Claim	[redacted] penalty pei billing cycle for timely payment rates not cured within 90 days of implementation of a corrective action plan as provided for below [redacted] penalty for timely payment rates not cured within 120 days of implementation of a corrective action plan as provided for below
Applicable to IPA errors only: [redacted] of monthly Encounter data will be accepted/priced in the first submission	[redacted] penalty per billing cycle for encounter submissions not cured within 90 days of implementation of a corrective action plan as provided for below [redacted] penalty per billing cycle for encounter submissions not cured within 120 days of implementation of a corrective action plan as provided for below
On-time daily reconciliation files and encounter submission files	[redacted] penalty per billing cycle for files not cured within 90 days of implementation of a corrective action plan as provided for below [redacted] penalty per billing cycle for files not cured within 120 days of implementation of a corrective action as provided for below

If the Minimum Service Levels are consistently not achieved solely as a result of IPA's actions or inactions, Health Plan may notify IPA in writing that IPA is to bring its levels of service to levels not less than the Minimum Service Levels within thirty (30) days of IPA's receipt of Health Plan's notice. If IPA's services do not timely conform to the Minimum Service requirements following the notice provided for in the immediately preceding sentence, the parties agree to develop a corrective action plan to bring IPA's level of service to a level not less than the Minimum Service Levels. IPA will implement any such action plan within 30 days of Health Plan's written notice to IPA of its approval of the corrective action plan. If the IPA continues to fail to timely meet the Minimum Service Levels following the implementation of a corrective action plan, the IPA shall be responsible for the penalties provided for above.

4 Obligations of Health Plan. In connection with the Services delegated in Section 3, above, the Health Plan shall be responsible for the following activities:

4.1 Provider Contracting. The Health Plan shall be responsible for negotiating, renegotiating, and executing all agreements with non-IPA network dental providers and for communicating Provider payment terms to IPA. However, the IPA shall be responsible for payment of emergency dental services as defined by the Health Plan's contract with the State of Wisconsin, Department of Health Services pursuant to Section 3.3 above.

4.2 Member Eligibility The Health Plan shall be responsible for the secured, electronic submission of Member eligibility files, which shall include accurate and complete COB information, on a frequency of no less than a monthly basis to IPA.

4.3 Benefit Determination. The Health Plan shall maintain responsibility of benefit determination for Members eligible to receive dental services through the Health Plan and in accordance with any applicable regulatory requirements

4.4 Claims Payment Funding. The Health Plan shall be responsible for the funding of all processed claims and reconciliation functions, and shall have responsibility of ensuring adequate funds are available for disbursement from the Health Plan's designated checking account(s).

4.5 Member and Provider Documentation. The Health Plan shall be responsible for reviewing and approving text accompanying claims payments, Explanation of Benefits, and Remittance Advices, or any other written material communicated to Members and Providers.

4.6 Initial Fees The Health Plan shall reimburse IPA a total of a [redacted] one-time payment for any and all set up costs associated with the Services delegated in Section 3 above.

4.7 Rates. The Health Plan shall reimburse IPA within 30 calendar days at a rate of [redacted] per processed claim upon receipt of invoice from IPA.

5. Evaluation and Rate Negotiation. Twelve months after the implementation date, the parties shall conduct an evaluation of claim volume provided in the previous twelve months and determine the opportunity for rate renegotiation for services provided herein

6. Further Amendments.

6.1 Section 9.2.2 Amendment. The first sentence in Section 9.2.2 of the Original Agreement is deleted in its entirety and replaced with the following:

> "If the Health Plan fails to respond within forty-five (45) days of the submitted appeal or the IPA is not satisfied with the Health Plan responses, the IPA can submit an appeal to DHS."

6.2 Article X Amendment. The first sentence in the third paragraph in Article X of the Original Agreement is deleted in its entirety and replaced with the following:

> "IPA is prohibited from influencing Members' choice of long-term care programs. Provider or managed care organizations (Health Plan) through communications that are misleading, threatening or coercive under federal managed care regulations 42 C.F.R. 4381"

6.3 Section 11.3 Amendment. The second sentence in Section 11.3 of the Original Agreement is deleted in its entirety and replaced with the following:

> "Notification under this Section will be for information purposes only and will not substitute for the statutory notification and claim procedure contained in Chapter 893, Wis. Stat."

6.4 Section 13.1 Amendment. The first sentence in Section 13.1 of the Original Agreement is deleted in its entirety and replaced with the following:

> "IPA will maintain books and records books and records pertaining to this Agreement in a form consistent and in compliance with applicable federal and state confidentiality laws and regulations."

7. Miscellaneous. Capitalized words not specifically defined in this First Amendment have the meaning given to them in the Original Agreement Except as amended in this First Amendment, the Original Agreement shall remain in full force and effect. In the event of any conflict between the terms, conditions and provisions of the Original Agreement and this First Amendment, the terms, conditions and provisions of this First Amendment shall prevail

IN WITNESS WHEREOF, the undersigned have executed this First Amendment as of the date, month and year set forth opposite their names below.

CARE WISCONSIN FIRST, INC.

By: Susan Crowley
Susan Crowley
Senior VP Government Services

Date: 9/19/17

DENTAL PROFESSIONALS OF WISCONSIN-MANAGEMENT SERVICES, LLC

By: _____
Signature

Printed Name: Paul D. Smith, DDS

Title: President

Date: 9/19/2017