

**PROVIDER AGREEMENT
EXECUTION PAGE**

This Provider Agreement ("Agreement"), by and between Guardian Life Insurance Company of America ("GLIC"), for itself and on behalf of its Affiliated Companies (defined below), which include but are not limited to **Avēsis Third Party Administrators, Inc., Avēsis Incorporated, Avēsis Insurance Incorporated.** (collectively "Avēsis") and City of New Orleans dba Health Care for the Homeless for itself and, if applicable, on behalf of its employed or contracted providers (collectively "Provider"), shall be effective this ___ day of _____, 20__ (the "Effective Date"). For purposes of this Agreement, unless otherwise specified, GLIC, Avēsis, and Affiliated Companies shall be referred to collectively as "Guardian". By execution of this Agreement and checking below, Provider agrees to participate in those products and networks operated or administered by GLIC, Avēsis, or one or more Affiliated Companies. Full descriptions of products are set forth in Exhibit C attached hereto.

☒	Commercial	☒	Network Access (dental only)
☒	Medicaid	☒	CHIP
☒	Medicare Advantage	☒	Medicare/Medicaid Duals

This Agreement, together with its Exhibits, constitutes the entire understanding of the Parties with respect to the subject matter expressed herein and supersedes any prior agreements between the Parties. In consideration of the mutual covenants and promises stated herein, and for good and valuable consideration, the Parties hereby agree:

PROVIDER EXECUTION SECTION:

City of New Orleans dba Health Care for the Homeless
Practice Name (Entity name as it appears on W9 and tax returns)

By: [Signature]
Authorized Signature

1043427693

NPI-2*



Tax ID Number

Latoya Cantrell, Mayor
Printed Name and Title

11/12/21
Date

Address for Notice: 2222 Simon Bolivar ave 2nd floor New Orleans LA 70113

*FQHCs, certain health plans and/or regulatory agencies require the inclusion of the NPI-2 (organizational NPI) for claims to be paid. Please provide the NPI-2, if available.

GUARDIAN EXECUTION SECTION:

THE GUARDIAN LIFE INSURANCE COMPANY OF AMERICA*
10 Hudson Yards
New York, NY 10001
Attn: Legal Department

By: _____
Authorized Signature

Printed Name and Title

Date

*Guardian executes this Agreement on behalf of, and binds, those Affiliated Companies listed in Exhibit D

PROVIDER AGREEMENT

RECITALS

WHEREAS, GLIC, Avēsis, or Affiliated Companies are appropriately licensed by the Department of Insurance (or other state agency or division with jurisdiction over such companies) to insure or otherwise arrange and provide coverage for dental and vision care services in the State of Louisiana;

WHEREAS, Provider is licensed under applicable State law to provide those dental services described below; and

WHEREAS, Guardian and Provider mutually desire for Provider to participate in Guardian's networks of Participating Providers to render Covered Benefits to Members, as those terms are defined below.

NOW THEREFORE, in consideration of the promises and mutual covenants contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually agreed by and between the Parties as follows.

TERMS AND CONDITIONS

A. DEFINITIONS.

1. Affiliated Companies – those companies that are owned by or affiliated with GLIC and are listed on Exhibit D attached hereto and incorporated by reference to this Agreement.
2. CMS - the Centers for Medicare and Medicaid Services.
3. Covered Benefits - those dental services within Provider's license and scope of practice that are covered and payable under the applicable Sponsor Plan and offered to Members. Covered Benefits are listed in Exhibit A and may vary by Sponsor/Sponsor Plan.
4. Claim - a request for payment submitted by Provider, in a format acceptable to Guardian as identified in the Provider Manual for the processing of payment for Covered Benefits.
5. Clean Claim – unless otherwise defined by applicable law, a complete and accurate Claim that is free of errors and/or omissions for services personally provided by Provider.
6. Federally Qualified Health Center ("FQHC") - a provider that receives a federal grant pursuant to Section 330 of the Public Health Service Act, 42 U.S.C. 254b, ("**Section 330**") administered by the Health Resources and Services Administration ("**HRSA**") within the United States Department of Health and Human Services, to provide community-based comprehensive primary and preventive health care and related enabling services to medically underserved populations regardless of the individual's or family's ability to pay for such services.
7. Fee Schedule - A listing of fees paid by Guardian to Provider for Covered Benefits rendered.
8. HIPAA – The Health Insurance Portability and Accountability Act of 1996 including all pertinent regulations (45 CFR Parts 160 and 164) issued by the U.S. Department of Health and Human Services as amended from time to time.

9. Indian - Any individual defined at 25 USC 1603(13), 1603(28), or 1679(a), or who has been determined eligible as an Indian, under 42 CFR 136.12. This means the individual is a member of a federally recognized Indian tribe or resides in an urban center and meets one or more of the following criteria: (a) Is a member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such member; (b) Is an Eskimo or Aleut or other Alaska Native; (c) Is considered by the Secretary of the Interior to be an Indian for any purpose; (d) Is determined to be an Indian under regulations issued by the Secretary. The term "Indian" also includes an individual who is considered by the Secretary of the Interior to be an Indian for any purpose or is considered by the Secretary of Health and Human Services to be an Indian for purposes of eligibility for Indian health care services, including as a California Indian, Eskimo, Aleut, or other Alaska Native.
10. Indian Health Care Provider ("IHCP") – a health care program operated by the Indian Health Service ("IHS") or by an Indian Tribe, Tribal Organization, or Urban Indian Organization ("I/T/U") as those terms are defined in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603). IHCPs are subject to those specific terms and conditions necessitated by federal law and regulations that govern IHCP's provision of health care services to Members who are Indians and included in this Agreement in **Exhibit F-2**.
11. Member - an individual, spouse or dependent who is eligible to receive Covered Benefits under a Sponsor Plan. Member shall also refer to those individuals who are covered by an insurance or health benefit product offered or administered by a Network Access Payor (defined below).
12. Network Access Arrangement – *applicable to dental only* - a direct or indirect contractual arrangement by which Guardian is obligated to make a network of Participating Providers available to a third-party insurer, self-funded group, employer, union trust or health benefit plan (each a "**Network Access Payor**").
13. Participating Provider(s) – a health care provider, including but not limited to a dentist, denturist, physician, hospital, laboratory, or other professional, facility, or supplier, that has entered into a direct or indirect written agreement with Guardian to provide Covered Benefits to Members.
14. Sponsor - an insurer, self-funded group, employer, union trust, Medicaid managed care plan, Medicare Advantage plan, MA Special Needs Plan, Medicare/Medicaid Duals Plan, CHIP plan, or Medicare Advantage managed care organization, State Medicaid agency, or other entity that has directly or indirectly entered into an agreement with GLIC, Avēsis, or an Affiliated Company, through which GLIC, Avēsis, or an Affiliated Company must arrange for provision of Covered Benefits to Members enrolled in such Sponsor's health benefit plan products ("**Sponsor Plans**"). For purposes of this Agreement, the term Sponsor shall also refer to Network Access Payors (defined above).
15. Provider Manual – Guardian's policies and procedures applicable to Participating Providers, including Provider, including but not limited to the administrative policies and procedures established by Guardian for the provision of Covered Benefits to Members. The Provider Manual is expressly incorporated by reference into this Agreement.
16. Rural Health Clinic ("RHC") - a federally qualified health clinic situated in rural areas and certified to receive special Medicare and Medicaid reimbursement. RHCs must demonstrate that they have met the conditions set forth in Section 330 of the Public Health Service Act.

B. RESPONSIBILITIES OF GUARDIAN.

1. Sponsor Contracts.

- a. GLIC, Avēsis, or one or more Affiliated Companies may, from time to time, enter into agreements with Sponsors whereby GLIC, Avēsis, or such Affiliated Companies will arrange for the provision of Covered Benefits for Members through one or more networks of Participating Providers. GLIC, Avēsis, and each Affiliated Company are party to this Agreement only insofar as such entity contracts with Provider hereunder for Provider's participation in a network related to Sponsor Plan for which GLIC, Avēsis or an Affiliated Company is contracted to provide services. By executing this Agreement, Provider agrees to participate in the networks that Guardian makes available to Sponsors.
 - b. **Exhibit C**, attached hereto and incorporated by reference, lists the following: (i) all Sponsors offering Medicare Advantage or Medicaid plans (including Medicaid managed care, Medicare Advantage, MA Special Needs Plans, CHIP plans, and Medicare/Medicaid Duals plans) that are under contract with GLIC, Avēsis, or an Affiliated Company as of the Effective Date; and (ii) general descriptions of the Commercial Sponsor Plans as of the Effective Date.
 - c. From time to time, GLIC, Avēsis, or an Affiliated Company may update the list of Sponsors within a line of business (i.e., Medicaid or Medicare Advantage or commercial) by commercially reasonable means including fax-blasts, e-mail, web portal updates, etc., provided that such notice is **not** subject to the methods described Section I below and does not require signature or amendment of this Agreement unless otherwise required by applicable law. Provider shall have thirty (30) days to accept or reject participation in new Sponsors' Plans. If Provider does not respond within such thirty (30) day timeframe, participation is deemed accepted.
 - d. In the event GLIC, Avēsis, or an Affiliated Company is adding a new line of business to this Agreement the Parties shall agree to the terms and conditions for such line of business in writing. For example, if Provider only agrees to participate in commercial Sponsor Plans as of the Effective Date, in the event GLIC, Avēsis, or an Affiliated Company or Provider seeks to include Provider in Medicaid or Medicare Advantage Sponsor Plans at a later date, such modification would require a mutually executed and agreed upon amendment to this Agreement.
 - e. Those specific terms and conditions required to be included in this Agreement pursuant to state or federal law applicable to a Sponsor Plan are attached hereto and incorporated by reference as **Exhibit E (Medicare Advantage Required Terms)**, **Exhibit E-1 (Medicare/Medicaid Duals Required Terms)**, **Exhibit F (Medicaid Required Terms)**, **Exhibit F-1 (CHIP Required Terms)**, and **Exhibit G (Commercial Required Terms)** (collectively, the "**Product Addendum**"). In addition, **Exhibit F-2** is specific to Indian Members receiving Covered Services from Indian Health Care Providers. To the extent any provision of **Exhibit F-2** is inconsistent with any provision of this Agreement as it relates to Indian Members, **Exhibit F-2** shall control and supersede all such other provisions.
 - f. Where part of a Sponsor Plan, Members may present an identification card that denotes coverage by or enrollment in GLIC, Avēsis, or an Affiliated Company or such Sponsor Plan.
 - g. Provider understands and agrees that Provider's participation in any current or future Sponsor Plan does not mean that Provider shall be permitted to participate in each and every Sponsor Plan.
 - h. Affiliated Companies shall be bound to this Agreement in the event, and to the extent, Provider participates in a network or Sponsor Plan administered by an Affiliated Company.
2. **Payment for Covered Benefits**. GLIC, Avēsis or the relevant Affiliated Company shall compensate Provider for Covered Benefits in accordance with this Agreement and **Exhibit A** attached hereto. Payment is made to Provider based upon information submitted by Provider to GLIC, Avēsis or the relevant Affiliated Company.

3. Provider Directory. Guardian shall make available to Members, through Guardian's and/or the Sponsor's website or through a toll-free telephone number, the names, addresses, phone numbers and specialties of all providers who agree to participate under each Sponsor's program. Provider shall not be listed for any Sponsor Plan in which they do not participate.
4. Provider Manual. Guardian shall make available to Provider a Provider Manual which supplements and is made a part of and incorporated into this Agreement. Guardian may amend the Provider Manual from time to time upon notice to Provider by posting to Guardian's provider website, email or other means of notice. Unless otherwise required by law, changes to the Provider Manual are not required to follow the Notice and Amendment provisions of this Agreement (Sections I and J.8, respectively). Changes to the Provider Manual shall become effective thirty (30) days after posting or notice, or as of another time period required for Guardian to comply with federal or state laws, Sponsor program requirements or accreditation standards. Provider shall have and maintain systems necessary for access to Guardian's provider website, and check for revisions to the Provider Manual from time to time.
5. Payment Processing. In consideration of Provider's agreement to provide Covered Benefits in accordance with this Agreement, GLIC, Avēsis or the relevant Affiliated Company shall pay Provider in accordance with any specific and applicable terms and conditions in Exhibit A. GLIC, Avēsis or the relevant Affiliated Company shall pay Clean Claims within thirty (30) days or as otherwise required in a Product Addendum or applicable state law. If GLIC, Avēsis or the relevant Affiliated Company fails to pay Provider in accordance with this Section, GLIC, Avēsis or the relevant Affiliated Company shall pay interest in addition to any reimbursement due for Covered Benefits at such interest rate then in effect pursuant to applicable law, from the date payment was due until payment is made.
6. Non-Guardian Payors. In the event GLIC, Avēsis, or an Affiliated Company is not the ultimate payor of Claims, such as in the case of self-funded or self-insured Sponsors or Network Access arrangements, such Sponsor shall have the ultimate obligation and liability to Provider with respect to any Claim or fee for Covered Benefits relating to, or arising under, this Agreement. Provider agrees that it shall not file suit against GLIC, Avēsis, or an Affiliated Company as a result of such Sponsor's nonpayment. Guardian cannot guarantee payment by an ultimate payor, such as a self-funded or self-insured Sponsor or Network Access Payors, other than GLIC, Avēsis, or an Affiliated Company.
7. Administration of Duties. From time to time, during the term of the Agreement, GLIC, Avēsis, or an Affiliated Company, as applicable, may delegate or subcontract certain of its claims payment, utilization review, or other operations to another Affiliated Company, in which case the Affiliated Company shall comply with the terms of this Agreement.

C. RESPONSIBILITIES OF PROVIDER.

1. Professional Services. Provider agrees to be a Participating Provider in one or more networks offered by Guardian and provide Covered Benefits to Sponsors and their Members. Provider shall be properly licensed in the jurisdiction where services are provided and shall ensure all Covered Benefits rendered are consistent with professionally recognized standards of practice. Provider shall furnish Covered Benefits to Members as required by the Sponsor, Exhibit A and Product Addendum. Provider agrees to provide services to Members in a timely manner and on the same basis as other patients. Provider reserves the right to limit or reduce the number of members accepted by Provider in the event that Provider reaches its capacity to provide comprehensive care to its existing patients and in order to meet its legal obligations to provide services to all other patients residing in the service area regardless of ability to pay. Provider shall make

every reasonable effort to satisfy the needs of Members. All services rendered by Provider under this Agreement shall be furnished in accordance with the Provider's best professional judgment and in compliance with applicable laws, rules and regulations of the licensing or other governmental bodies having jurisdiction as well as the guidelines as set forth by the appropriate national association(s).

2. Identification Cards. Provider shall verify the identity of the Member by requiring the Member to produce his/her identification card and another form of identification with a photo whenever possible or by confirming eligibility and benefits through the IVR line, customer service, or using the provider web portal. If Member is a minor, a parent's identification will be acceptable if the Member's eligibility is verified with Sponsor as otherwise set forth in this Section. If eligibility has not been confirmed and authorization is not obtained (when required), Guardian reserves the right to deny all or part of payment for the Claims.
3. Appointments. Unless otherwise required by a Product Addendum, Covered Benefits shall be provided to Members in a timely manner and in accordance with Provider's routine practice pattern. Provider shall provide services as quickly as possible but no more than thirty (30) days after an appointment is first sought. In the case of emergencies, Provider shall make every reasonable effort to see the Member immediately. Guardian reserves the right to require Provider to submit quarterly reports stating average wait times for Members or, alternatively, Guardian may randomly and anonymously telephone Provider offices to ascertain this information.
4. Claims and Payment.
 - a. Claims Processing.
 - i. Provider shall submit Clean Claims for reimbursement, and any encounter data or forms as required in the Provider Manual or a Product Addendum. Provider shall bill and code claims in accordance with generally accepted industry standards. Guardian reserves the right to require appropriate documentation and coding to support payment for Covered Benefits.
 - ii. Clean Claims shall be submitted to GLIC, Avēsis, or Affiliated Company within the time frame specified in the Product Addendum. If no time frame is specified, Clean Claims shall be submitted within ninety (90) days of the date of service unless otherwise required by law.
 - iii. Provider understands and agrees that failure to submit Clean Claims or requested documentation within the specified time period may result in denial, reduction, rejection, or loss of reimbursement for services provided.
 - iv. By submitting claims, Provider certifies and represents that all claims and related data are accurate complete and truthful based on best knowledge, information and belief.
 - v. In accordance with applicable state law, Guardian shall have the right to recover claims payments, or retain portions of future claims payments, in the event that Guardian determines that a Member was not eligible for coverage at the time of services, or in the event of duplicate payment, overpayment, payment for non-Covered Benefits, or fraud.
 - b. Member Payment and Hold Harmless. Provider agrees to accept as payment in full those amounts listed or referenced in Exhibit A. Unless otherwise permitted by applicable law, Provider agrees and warrants that in no event, including but not limited to nonpayment by Guardian, Guardian insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from or have any recourse against any Member or persons acting on behalf of any Member for providing Covered Benefits. This provision does not prohibit Provider from

seeking to collect co-insurance, copayments or deductibles from Members or fees for non-Covered Benefits delivered on a fee for service basis to Members as well as services received by ineligible persons in accordance with the terms of the Covered Benefits and Fee Schedule, if allowed by applicable state law or as stated in a Product Addendum attached hereto. Provider agrees that the Member shall be held harmless and Provider shall not bill the Member for non-Covered Benefits if the non-Covered Benefits are not covered as a result of any error or omission by Provider. This hold harmless provision shall supersede any oral or written agreement entered into between Provider, Guardian, Sponsor and Members or designees and shall survive the termination of the Agreement regardless of the cause giving rise to the termination.

- c. Non-Covered Benefits. Provider shall enter into a written agreement with Member to pay for non-Covered Benefits if the Member knowingly elects to receive non-Covered Benefits and the fees charged do not exceed the usual fees to Provider.
 - d. Coordination of Benefits. Provider will notify Guardian when it is determined that a Member may be entitled to coverage under any other benefit plan. If Guardian is the primary carrier, Provider agrees that Guardian's obligation to Provider will not exceed the compensation described or referenced in Exhibit A. If Guardian is the secondary carrier, Provider agrees that Guardian's obligation to Provider will not exceed the compensation described or referenced in Exhibit A and Provider will refund the aggregate compensation that Provider received from other Sponsor for services or goods in question. If Member is covered by one or more Sponsor Plans, Guardian shall coordinate benefits between the Sponsor Plans and, unless otherwise required by law or the applicable Sponsor Plans, pay according to the lowest applicable fee schedule.
5. Code of Ethics. Provider shall adhere to the code of ethics of the state or national board to which the Provider belongs.
 6. Program Coverage. For Covered Benefits requiring prior authorization as required by a Sponsor Plan, Provider agrees to submit the prior authorization request prior to providing the Covered Benefits requested. Provider acknowledges that possession of a Guardian or Sponsor's identification card does not guarantee that an individual is still a Member on the date services are rendered, or that a Member is necessarily covered for any or all services or materials to be provided. Provider is strongly encouraged to verify eligibility prior to rendering services to a Member.
 7. Provider Identifiers.
 - a. NPI Number/Taxonomy Codes. Provider shall only submit claims for Covered Benefits using the NPI numbers assigned by CMS to Provider. Provider shall only submit claims under the NPI number of the individual who personally rendered the services. Provider may also submit claims under the NPI Type 2 (group) for the group practice with which he/she is attached. Provider shall not loan or otherwise allow any person or entity to bill claims under his/her individual NPI number. Provider may be required to submit a valid taxonomy number that corresponds with the taxonomy Provider has on file with a federal or state governing body.
 - b. Use of Provider Number(s). Provider identification numbers (PIN), required to establish the login for the Guardian web portal shall not be provided until the credentialing process has been successfully completed.
 8. Personnel and Office.

- a. Rosters. Provider shall provide Guardian with a complete list (roster) of all employed, contracted, Locum Tenens or other health care provider that will see Members at each location concurrent with the execution of this Agreement using the forms attached hereto as Exhibit B and Exhibit B-1. Rosters must include the status of each listed provider (owner, employee, independent contractor, Locum Tenens). Provider shall provide updated rosters to Guardian at least every ninety (90) days and within ten (10) business days of an addition or termination of listed providers. Listed providers must be credentialed prior to rendering services to Members. Those who are independent contractors working at the Provider's location must be credentialed and contracted with Guardian. Updated rosters and other updates to Provider demographic information shall be emailed as directed by Guardian.
- b. Prohibitions. Provider represents and warrants that neither it or any of its employees, principals, providers, subcontractors, or persons with an ownership or controlling interest in Provider, or an agent or managing employee of Provider is currently, or has been: (a) excluded from participation in federal health care programs under either Section 1128 or Section 1128A of the Social Security Act or state health care programs; or (b) 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; or an affiliate, as defined in the Federal Acquisition Regulation, of such a person. In no event shall Provider employ, or subcontract any responsibilities hereunder to, any individual excluded, debarred, or suspended from participation as specified in this Section.
- c. Locum Tenens. Provider may use the services of a Locum Tenens provider subject to the following:
- i. Provider is unavailable to provide the Covered Benefits;
 - ii. the Member has arranged or seeks to receive Covered Benefits from Provider;
 - iii. the Provider pays the Locum Tenens for his/her services on a per diem basis or similar fee for time basis;
 - iv. the Locum Tenens provider does not provide the Covered Benefits to Members for a period of time not to exceed sixty (60) continuous days within a twelve (12) month period;
 - v. the Locum Tenens provider has a valid NPI number;
 - vi. the Locum Tenens provider has a valid State Medicaid number, if providing services to Medicaid Members; and
 - vii. Provider notifies Guardian in writing of any Locum Tenens arrangement prior to submitting claims for services rendered by the Locum Tenens provider.

Should the above conditions be met, Provider shall submit a claim to Guardian in compliance with the claims submissions requirements of this Agreement and the Provider Manual. The claim shall be submitted with the Provider as the billing provider and the Locum Tenens as the servicing/rendering provider, as applicable.

- d. Provider Additional Affiliations. If Provider provides services to Members at a location or practice not affiliated with Provider, Provider must execute a separate Provider Agreement for that location or practice. Provider shall not bill for services rendered by Provider at a location not specifically defined in this Agreement.
- e. Closing of Practice. If the Provider desires to no longer see Members, Provider must notify Guardian in writing and comply with the applicable Sponsor's continuity of care requirements. Should Sponsor not have a continuity of care policy, Provider may close the practice to the specified Members effective the first of the following month provided Provider gave Guardian written notice at least five (5)

business days before the end of the month; otherwise, the policy will become effective the first of the following month.

9. Records. Provider shall complete and maintain, in a timely manner, confidential, complete, adequate, legible and proper Member records, claims and correspondence in accordance with applicable State or Federal law, this Agreement and Product Addendum, and industry standards, with respect to all services rendered to Members of Guardian. Notwithstanding the termination of this Agreement, the Provider shall maintain Member records for a period of not less than ten (10) years or other period required by applicable law. Records shall be maintained in accordance with applicable industry standards and the requirements of applicable state or federal law. Records shall be provided to any subsequent designated Provider according to state and federal law or Sponsor requirements.
 - a. Confidentiality of Records. Confidentiality of Member records and personal information shall be maintained in accordance with all applicable federal and state law. Provider shall not use any information received in the course of providing services to Members except as necessary for the proper discharge of his/her obligations under this Agreement. Provider agrees to comply with all of the applicable federal requirements for privacy and security of health information as set forth in HIPAA and the American Recovery and Reinvestment Act of 2009.
 - b. Records Access. Member and billing records, and any other records maintained as part of, or relevant to this Agreement, shall be subject to inspection, audit or copying by Guardian, the Sponsor, state Medicaid agency, the U.S. Department of Health and Human Services, CMS, and any other duly authorized representative of the state or federal government during normal business hours at the Provider's place of business, and at no charge. Notwithstanding termination of this Agreement, this right of access to Member records shall continue for a period of seven (7) years after termination of this Agreement or as set forth in a Product Addendum. Provider further agrees to make copies of the records available, at no charge, to Guardian, the Sponsor, state Medicaid agency, the U.S. Department of Health and Human Services, CMS, and any other duly authorized representative of the state or federal government.
10. Compliance with Law, Policies and Procedures and Provider Manual. Provider shall at all times:
 - a. conduct his professional practice and supervise all personnel in a manner that complies with:
 - i. all applicable laws and regulations;
 - ii. this Agreement and its Exhibits;
 - iii. policies and procedures of Guardian;
 - iv. the Provider Manual, as amended from time to time;
 - v. Sponsor(s)'s policies and procedures, as applicable; and
 - vi. accreditation standards, as applicable;
 - b. maintain in good standing and keep current all permits, certificates and licenses required by all applicable federal and state laws and regulations to provide services under this Agreement; and
 - c. comply with all applicable federal and state laws, including but not limited to those relating to advance directives and those relating to non-discrimination and equal opportunity.
11. Required Notices. In addition to any other notices required under this Agreement, Provider shall give notice to Guardian within two (2) business days of the occurrence of any of the following events, or any event that could reasonably be expected to impair the ability of Provider to comply with the obligations of this Agreement:
 - a. Relocation or closure of Provider's office, change in Provider's office telephone number;

- b. an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of Provider to be inaccurate;
 - c. Provider fails to maintain insurance as required by this Agreement;
 - d. Provider's license, certification, DEA certificate, or accreditation expires or is suspended, revoked, conditioned, or otherwise restricted;
 - e. Provider has a confirmed medical disability that limits Provider's ability to practice medicine;
 - f. Provider is excluded, suspended, disbarred from, or sanctioned under a federal or state health care program;
 - g. a disciplinary action is initiated by a governmental authority against Provider;
 - h. where applicable, Provider's hospital privileges are suspended, limited, revoked or terminated;
 - i. a grievance or legal action is filed by a Member concerning Provider;
 - j. Provider no longer participates in the Medicare Program and, if applicable, the state Medicaid program in which Provider practices;
 - k. Provider is under investigation for fraud or a felony; or
 - l. Provider enters into a settlement related to any of the items listed above.
12. Non-discrimination. Unless otherwise specified in a Product Addendum, Provider, its employees and contractors shall not discriminate in the treatment or quality of services provided to Members on the basis of age, race, religion, gender identity, color, national origin, or creed. Provider agrees to comply, and ensure that all employees and contractors comply with all applicable federal and state laws relating to non-discrimination and equal opportunity. As may be applicable, in compliance with Section 1557 of the Affordable Care Act, Provider shall post non-discrimination notices in its office and on its website to provide meaningful access to effective communications for patients with limited English proficiency and/or disabilities.
13. Credentialing Program. Provider shall meet and maintain NCQA and/or established industry standards for credentialing adopted by the Guardian Credentialing Program as well as any other requirements that may be imposed by the Sponsor, from time to time. These include, but are not limited to: a) current licensure; b) current certifications, as appropriate; c) professional liability insurance coverage; d) compliance with continuing education requirements; and e) other requirements and qualifications as may be required by Guardian, Sponsor or any federal or state agency. Specific Sponsor or state requirements will be described in the applicable Sponsor Addendum. Failure to cooperate with the credentialing or recredentialing requirements may result in payment for services rendered being withheld or denied until all recredentialing materials have been received by Guardian. Provider shall notify Guardian of subsequent changes in status of any information relating to Provider's ownership or professional credentials.
14. Insurance. While this Agreement is in effect, Provider shall keep in force all professional liability insurance coverage required by state and/or federal law. If the state does not require specific limits, Provider agrees to maintain professional liability insurance of One Million Dollars (\$1,000,000) per claim and THREE MILLION DOLLARS (\$3,000,000) annual aggregate, or such other amounts as may be recommended by the State licensing board. Insurance shall cover, at a minimum, each location where Provider provides services under this Agreement. Provider also agrees to maintain comprehensive general liability insurance and/or such other available insurance as shall be necessary to insure Provider and his employees against and from any and all damages arising from its duties and obligations under this Agreement. Proof of such insurance shall be made available to Guardian within two (2) business days of its request. The costs of securing said insurance coverages shall be borne by the Provider. Insurance carried by Provider will not relieve Provider from the indemnity obligations in this Agreement. Provider shall notify Guardian or Sponsor at least thirty (30) days prior to the cancellation of any such policy. Provider shall notify Guardian immediately upon the termination of any such policy. Where applicable, the Federal Tort Claims Act or state-specific Tort Claims Act shall either replace or supplement the Provider's professional liability insurance to meet the requirements stated in this paragraph.

15. Licensure. Provider and employees or agents rendering services to Members shall be appropriately licensed to render such services as required by state or federal law or any regulatory agency. Such licenses shall be maintained in good standing. Provider shall provide Guardian a copy of said license(s) at the time of credentialing, upon renewal and/or at recredentialing.
16. Professional Training and Education. Provider and all employees or agents rendering services to Members shall possess and maintain the training and ability and other qualifications necessary to provide quality care to Members. Guardian will review the status of the Provider following notification of any action by the state licensing agency. Provider comply with all continuing education standards as required by federal or state law or regulation or by the applicable state licensing board.
17. Professional Standards. Provider and all employees or agents rendering services to Members shall provide care that meets or exceeds the standards of care for like providers in the region as determined by the applicable state board and shall comply with all standards for like providers as established by federal or state law or regulation.
18. Member Grievances and Appeals. Provider agrees to cooperate with Guardian as reasonably necessary to resolve Member grievances and appeals, including providing Guardian or Sponsor with requested relevant information within specified timeframes.
19. Quality Improvement. Provider agrees to respond and / or comply with Guardian's Quality Improvement Program as it relates to quality assurance, independent quality review, utilization review and Member grievance program as explained in the Provider Manual or required by applicable law. Provider shall cooperate with all Guardian or Sponsor Quality Improvement activities, including independent quality review/improvement activities.
20. Utilization Management. When applicable, Provider shall comply with Guardian and Sponsor's Utilization Management programs including pre- and post-payment review of certain Covered Benefits. Covered Benefits requiring Pre-Treatment/Prior Authorization estimates are defined in Sponsor Addendums, the Provider Manual and on the Guardian provider website.
 - a. Provider shall follow the Pre-Treatment/Prior Authorization referral guidelines defined in the Guardian Provider Manual except for emergencies.
 - b. Provider shall provide requested documentation to the Guardian claims and utilization management departments upon request. Failure to provide the requested documentation will result in the denial of a pending claim or the recoupment of a paid claim.
 - c. Failure of Provider to participate in the utilization management program shall be deemed a breach of this Agreement and may result in termination by Guardian.
21. Applicability of Guardian Programs. None of Guardian's or Sponsor's utilization management, quality management, credentials verification or provider sanction programs shall either: a) override the professional or ethical responsibility of Provider; or b) interfere with Provider's ability to provide information or assistance to Members.
22. Physician Incentive Plans. Provider agrees to comply with the Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR § 422.208, and 42 CFR § 422.210. No specific payment will be made directly or indirectly to a physician or physician group as an inducement to reduce or limit medically

necessary services furnished to an enrollee.

23. **Fraud and Abuse.** Provider agrees to comply with applicable laws and regulations designed to prevent, detect, and correct fraud, waste, and abuse. Provider shall institute, operate, and maintain, an effective compliance program to detect, correct, and prevent the incidence of non-compliance with applicable state and federal law. Such compliance program shall be appropriate to Provider's organization and operations and shall require participation by all officers, directors, employees, contractors, and agents of Provider. In the event Provider treats Medicare Members, the compliance program shall meet all applicable CMS requirements.
24. **Reporting.** Provider shall comply and cooperate with any applicable statutory, regulatory, Guardian or Sponsor-required reporting requirements, including but not limited to those related to encounter data. All reporting must be true, complete, and accurate.

D. RELATIONSHIP OF PARTIES.

1. **Professional Judgment.** Provider has the sole right and responsibility for determining treatment and administering care. Nothing in this Agreement shall be construed to interfere with the Provider/Member relationship or limit Provider from discussing treatment or non-treatment options with Member that may not be covered in whole or part by Sponsor. Nothing in this Agreement shall be construed to limit Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's health status, medical care or non-treatment options, including any alternative treatments that may be self-administered by the Member. Nothing in this Agreement shall limit or prohibit Provider from advocating on behalf of the Member in any grievance system, utilization review process or individual authorization process to obtain necessary health care or Covered Benefits.
2. **Independent Contractor.** Provider is an independent contractor(s), and nothing herein shall be construed to create an agency, employment, partnership, joint venture or fiduciary relationship between Guardian, Provider and Sponsor.
3. **Non-Exclusive Relationship.** Each Party's rights hereunder are non-exclusive. Provider may provide services to non-Guardian patients, and Provider may enter into agreements with other networks and organizations for such purposes. Guardian may contract with other providers to render Covered Benefits to Members.
4. **Rights Reserved by Guardian.** Guardian retains all ownership rights in the Guardian networks and system, the sole and exclusive right to operate offices or license other providers to participate in the Guardian system, and exclusive rights in and to the names and marks of GLIC and its Affiliated Companies, together with any and all other trademarks and service marks that may hereafter be adopted or used by Guardian. Provider shall not advertise or use any names, symbols, trademarks or service marks of Guardian in any advertising or public communication without the prior written authorization of Guardian.

E. INDEMNIFICATION.

Neither Guardian nor any Sponsor, their officers, shareholders, directors, employees, agents, successors nor assigns ("**Indemnified Party**") shall be responsible for, or guarantee the quality of, any services or materials furnished by Provider. Provider agrees to indemnify and hold Guardian and all Sponsors, their officers, directors, employees and agents from and against any claim, damage, loss (including any amounts paid in compromise or settlement of disputed claims), expenses, liability, obligation, action or cause of action, including reasonable attorneys' fees and all costs of investigation (collectively the "**Indemnified Claims**"), which the Indemnified Party may sustain pay, suffer incur by reason of any service provided by Provider to any Member. Attorneys'

fees shall include not only those fees incurred in connection with investigating and defending the Indemnified Claims but also all attorneys' fees incurred by Guardian in prosecuting, enforcing and collecting this indemnity. The Indemnified Party is not responsible for nor does the Indemnified Party guarantee the quality of any services or materials furnished by Provider. Provider shall indemnify Guardian and all Sponsors from all claims, liabilities and damages incurred in connection with, or arising out of Provider's material breach of this Agreement or any services furnished, or to be furnished, by Provider to Members. The obligations of indemnification shall survive the termination of the Agreement.

F. REPRESENTATIONS, WARRANTIES AND COVENANTS OF PROVIDER.

Except as otherwise disclosed to Guardian in writing prior to execution of this Agreement, Provider hereby warrants that the representations, warranties and covenants set forth below in this are true and accurate as of the date of this Agreement, and that they shall remain true and accurate at all times throughout the Term of this Agreement. Provider acknowledges that the accuracy and fulfillment of these representations, warranties and covenants are a condition of initial and continued survival of this Agreement:

1. Authorization. The individual executing this Agreement on behalf of Provider is duly authorized to do so; and upon its execution, this Agreement shall constitute the legal, valid and binding obligation of Provider. Further, Provider is authorized to enter into this Agreement for itself and, if Provider is a group practice or group of Participating Providers, Provider's execution of this Agreement binds all employees, contractors, partners, etc., that operate as part of Provider's practice, and all such individuals agree to be so bound.
2. No Inducements. Except as otherwise specifically set forth herein, no promises or guarantees of specific payment or volume or value of referrals have been made to Provider as an inducement to reduce, delay or limit specific, medically necessary services covered by the Sponsor Plans or by any person representing either party to induce Provider to execute this Agreement. Provider agrees that they shall not profit from provision of Covered Benefits that are not medically necessary or appropriate.
3. Review. Provider and any employees, contractors, partners or shareholders, if applicable, have read the entire Agreement and represent that each of them is capable of complying and will comply with it.
4. Licensure and Standards for Practice. Provider shall at all times render services to Members of Guardian in a competent, professional, and ethical manner, in accordance with prevailing standards of professional care and practice, and all applicable statutes, regulations, rules, orders, and directives of any and all applicable governmental and regulatory bodies having competent jurisdiction. Provider is duly licensed, registered and in good standing, and shall maintain such licensure throughout the Term, to practice in the states where s/he provides services under this Agreement and such license and registration is not restricted, conditioned or limited in any way. Provider has no obligation to others that is inconsistent with Provider's obligations under this Agreement and the undertaking of this Agreement by Provider will not constitute a breach of any other agreement to which Provider is a party or any obligation to which Provider is bound. Provider is currently not, and has not in the past been, the subject of any investigation for suspected healthcare fraud or abuse or violation of any other state or federal law, nor has Provider's Medicare or Medicaid provider status been limited, conditioned, revoked, or suspended for any reason. Provider represents and warrants that he is not now under any obligation to any person or entity nor does he have any other interest which is inconsistent with or in conflict with this Agreement or in conflict with any other agreement which would prevent, limit or impair, in any way, his performance of any of the covenants or duties herein. If Provider is a group practice, Provider represents and warrants that the foregoing also is true and accurate as it relates to the employed or contracted providers and staff that operate as part of Provider's practice under this Agreement.
 - a. Provider's license to practice in any state has never been suspended, limited, conditioned, revoked or voluntarily relinquished under the threat of disciplinary action;

- b. Provider has never been reprimanded, sanctioned or disciplined by a licensing board or state or local professional society or specialty board;
- c. There has never been entered against Provider a claim, final judgment or agreed settlement in a malpractice action;

G. TERM AND TERMINATION.

1. **Term.** The term of this Agreement shall be for a period of one (1) year beginning on the Effective Date (“Initial Term”). Upon expiration of the Initial Term, this Agreement will automatically renew for successive one-year periods (each one-year period a “Renewal Term” and the Initial Term and all Renewal Terms, if any, referred to collectively as the “Term”), unless otherwise terminated by either party in accordance with the terms of this Agreement.
2. **Termination without Cause.** This Agreement may be terminated, in whole or in part, without cause by either Party providing written notice to the other at least ninety (90) calendar days prior to the end of the then-current Initial or Renewal Term. It is understood that during the ninety (90) day period, the terms and conditions of this Agreement shall remain in force and effect. Terminations without cause may not be appealed, except where a state or local law exists requiring such terminations to be appealable.
3. **Termination for Cause.**
 - a. **Breach.** Either Party may terminate this Agreement for breach of a material term, condition, or provision of this Agreement, after thirty (30) days prior written notice to the other Party specifying the nature of such breach. The breaching Party shall have such thirty (30) day period, or longer if mutually agreed upon by the Parties, to cure or correct such material breach. If the breaching Party fails or refuses to cure the material breach within such time, then the non-breaching Party may elect to terminate the Agreement effective the last day of the month following the end of the thirty (30) day notice period. The remedy herein shall not be exclusive of, but shall be in addition to, any remedy available at law or in equity to the non-breaching Party. In the event a Party contests the claim of breach; the Agreement shall remain in effect until the dispute is resolved in accordance with Section J.5 below.
 - b. **Immediate Termination by Guardian.** Guardian may terminate this Agreement immediately, in whole or in part, by providing written notice to Provider, of any of the following:
 - i. Provider poses an imminent danger to Guardian Members or the public health, safety and welfare;
 - ii. Provider is charged or convicted with, or files a plea of no contest to, a felony or a crime of moral turpitude;
 - iii. Provider is charged with or convicted of, or files a plea of no contest to, an offense related to health care delivery, Medicaid, or Medicare;
 - iv. Provider has been excluded, debarred, or suspended from Medicare or Medicaid;
 - v. Provider fails to satisfy the credentialing or recredentialing program requirements;
 - vi. Provider ceases participating in Guardian network(s) through non-renewal of credentialing application or denial of approval for participation;
 - vii. Provider’s license, certification, or accreditation has been terminated, revoked, suspended, or otherwise limited;
 - viii. Provider’s insurance has been terminated or significantly limited, or Provider is deemed uninsurable;

- ix. Provider fails to obtain or maintain hospital privileges, if applicable;
- x. Provider's death;
- xi. Provider files bankruptcy, voluntarily or involuntarily, declares insolvency, or has a receiver or conservator of assets appointed; or
- xii. Sponsor has a good faith reason to require Guardian to terminate the Agreement.

4. Effect of Termination. Termination of this Agreement does not nullify Provider's responsibility for the adequacy of service provided to Members. Under no circumstances will reimbursement be made by Guardian for any services rendered after the termination date of this Agreement unless required by the applicable state law provisions regarding continued coverage of services for Members. Any due process or appeal rights of Provider shall be governed by the provisions defined in the Provider Manual, incorporated herein by reference, unless superseded by conflicting and governing state law. Upon termination of this Agreement, Provider shall immediately and forever cease and desist from using Guardian advertising and promotional materials, and all trade secrets and confidential material delivered to Provider pursuant to this Agreement. Provider shall also refrain from doing anything which would indicate that Provider is participating in Guardian's network.

5. Suspension. Guardian may, in its sole and absolute discretion, suspend rather than terminate Provider's participation in the network if any of the following were to occur.

- a. Upon claims or utilization review by Guardian, billing or claims submission issues occur with such frequency that Guardian, in its sole and absolute discretion, determines that Provider should be suspended pending further investigation by Guardian and such billing and claims issues are resolved.
- b. Provider has been determined by Sponsor, CMS, or a State Medicaid Agency to be subject to an order of suspension due to a credible allegation of fraud.
- c. Breach of this Agreement by Provider for which Guardian elects, in its sole and absolute discretion, to suspend Provider until such problem or problems that caused the breach of this Agreement have been cured.

6. Non-Solicitation. So long as this Agreement is in effect, and for a period of one (1) year after its termination, Provider agrees that it will not solicit, advise, or counsel any Sponsor or Member to terminate its relationship or contract with Guardian, or otherwise interfere with Guardian's relationship. Guardian or Sponsor shall be solely responsible for notifying Members that Provider is no longer a Participating Provider. Nothing in this Section shall be construed as Guardian's violation of Section D.1 above. In the event either Party violates this Section, the other Party may seek injunctive relief. This Section shall survive termination of this Agreement.

7. Termination of Individual Participating Providers. Where Provider is a group practice, Guardian may require that one or more Participating Providers who are employed by, or contracted with, Provider to provide Covered Benefits to Members are terminated or suspended from participation under this Agreement under those circumstances listed in Sections G.3(a), G.3(b), or G.5 above.

H. SPECIAL REMEDIES.

Provider acknowledges that if Provider breaches any of the provisions of this Agreement, Guardian may have incomplete and inadequate remedies at law. Therefore, Provider agrees that Guardian may, in addition to any

other available remedies, obtain an injunction and/or temporary restraining order to terminate or prevent the continuation of any such violation.

I. NOTICES.

All notices provided for in this Agreement shall be in writing and sent to the address below. Notices shall be deemed to have been duly given upon (a) actual delivery; (b) five (5) days after deposit for mailing by registered or certified mail, postage prepaid, return receipt requested, addressed to the other party at the address shown at the end of this Agreement; or (c) one business day after delivery to a commercial overnight delivery service addressed as provided above for delivery the next business day. Either party may change its address by written notice to the other party. Any notices required to be given pursuant to the terms and provisions hereof shall be sent by mail to:

IF TO GUARDIAN:

The Guardian Life Insurance Company of America
Dental Network Administration
605 E Holland Ave., Suite 300
Spokane, WA 99218

IF TO PROVIDER:

At address on execution page

With copies to:

The Guardian Life Insurance Company of America
Attn: General Counsel
10 Hudson Yards
New York, NY 10001

J. GENERAL PROVISIONS.

1. **Headings.** Headings are for convenience and shall not affect interpretation. Words in this Agreement shall be deemed to refer to whatever number or gender the context requires. This Agreement shall be binding upon and inure to the benefit of the parties hereto and their permitted successors and assigns. No right or remedy shall be exclusive of any other right or remedy herein or provided by law, but such rights and remedies shall be cumulative and enforceable simultaneously or sequentially.
2. **Severability.** If any provision of this Agreement shall be declared invalid or unenforceable, that provision shall be deemed modified to the extent necessary to make it valid and enforceable. If it cannot be so modified, then the provision shall be severed, and the modified or remaining provisions shall remain in full force and effect.
3. **Assignment.** Neither this Agreement nor any of the rights or obligations hereunder shall be assigned, transferred or delegated by Provider, by operation of law or otherwise, without the prior written consent of Guardian. Any change of ownership interest in Provider shall be deemed an assignment of the Agreement, and would require the prior written consent of Guardian. Guardian may assign its rights and obligations hereunder.
4. **Choice of Law.** This Agreement and all questions relating to its validity, interpretation, performance and enforcement, shall be governed by and construed, interpreted and enforced in accordance with the laws in the state where Provider is located without regard to such state's choice of law provisions.

5. **Disputes.** In the event the Parties cannot resolve a dispute by good faith negotiation among their executives, except as may otherwise be provided for herein, and, where permissible by law, any and all disputes arising out of or relating to this Agreement and the transactions contemplated herein, shall be solely and finally settled by binding arbitration and administered by the American Arbitration Association in accordance with its Commercial Arbitration Rules (the “Rules”), by a single arbitrator selected in accordance with the Rules (the “Arbitrator”). The Arbitrator shall not have been employed by or affiliated with any of the parties or their affiliates. Except as set forth below, the parties hereby renounce all recourse to litigation as to matters subject to arbitration hereunder, and the parties agree that the award of the Arbitrator shall be final and subject to no judicial review, except as expressly provided by applicable law. The Arbitrator shall decide the issues submitted to him in accordance with: (a) the provisions and purposes of this Agreement; and (b) the laws in the state where Provider is located, and shall issue a written award setting forth the reasons for his decision. Judgment on the award of the Arbitrator may be entered in any court having jurisdiction thereof. Notwithstanding the foregoing, each party shall have the right to seek injunctive or other equitable relief in any court of competent jurisdiction to enforce the provisions of this Agreement without first seeking or obtaining any decision of the Arbitrator with respect to the subject matter of this Agreement, even if a similar or related matter has already been referred to arbitration in accordance with the terms of this paragraph.
6. **Attorneys' Fees.** Should Guardian incur attorneys' fees in order to enforce the terms and conditions of this Agreement, including post-term covenants, whether or not a legal action is instituted, Guardian shall be entitled to reimbursement of such attorneys' fees and costs, in addition to any other remedies Guardian may have at law or in equity.
7. **Confidentiality.** This Agreement shall be regarded as confidential and its terms and contents shall not be disclosed to any other party unless agreed to in writing by the Parties. In addition, each Party shall maintain the confidentiality of the other Party's proprietary information that is not otherwise public information, provided that Guardian may disclose reimbursement terms to a Sponsor if necessary. Both Parties may disclose the terms and contents to their legal representation or government agents without the consent of the other Party.
8. **Amendment.** Except as otherwise required by applicable law or as stated in Section B.1.c above, this Agreement may be amended in writing by Guardian at any time upon thirty (30) days prior written notice to Provider. If an amendment is not acceptable to Provider, he/she must reject such amendment by providing written notice to Guardian at the addresses set forth in Section I of this Agreement within such thirty (30) day period. In the absence of such notice of rejection by Provider to Guardian, Provider will be deemed to have accepted such amendment as of its stated effective date. If Provider rejects the amendment, Guardian shall have the right to continue the terms of this Agreement without giving effect to the proposed amendment. Guardian reserves the right to immediately amend this Agreement upon notice to Provider with respect to an amendment which it reasonably believes is required by applicable law or regulation.
9. **Waiver of Breach.** The waiver by either party of a breach or violation of the Agreement shall not operate as or be construed to be a waiver of any subsequent breach hereof.
10. **Entire Agreement.** This Agreement, including the Execution Page, the Recitals and Terms and Conditions, together with the Provider Manual and any Exhibits or Addendums referred to herein, constitute the entire Agreement between Provider and Guardian. This Agreement supersedes all prior and contemporaneous agreements, understandings and conditions, express or implied, oral or written, of any nature whatsoever with respect to the subject matter hereof.

- 11. Exhibits.** Any Exhibits attached hereto are incorporated by reference into this Agreement and made a part hereof.
- 12. Responsibility for Actions.** Each party shall be responsible for any and all claims, liabilities, damages, or judgments that may arise as a result of its own negligence or intentional wrong doing.
- 13. Form.** All words used herein in the singular number shall extend to and include the plural. All words used in the plural number shall extend and include the singular. All words used herein apply to all genders.
- 14. Errors.** Guardian shall make every effort to maintain accurate information however, Guardian shall not be held liable for any damages directly or indirectly due to typographical errors. Provider agrees to notify Guardian of any errors found in remittance statements.

LIST OF EXHIBITS

<u>Exhibit A:</u>	Covered Benefits and Fee Schedules
<u>Exhibit B:</u>	Provider Roster
<u>Exhibit B-1:</u>	Multiple Location/TIN Set Up Form
<u>Exhibit C:</u>	Sponsors and Sponsor Plans
<u>Exhibit D:</u>	List of Guardian Affiliated Companies
<u>Exhibit E:</u>	Medicare Advantage Product Addendum (if relevant to Provider)
<u>Exhibit E-1:</u>	Medicare/Medicaid Duals Product Addendum (if relevant to Provider)
<u>Exhibit F:</u>	Medicaid Product Addendum (if relevant to Provider)
<u>Exhibit F-1:</u>	CHIP Product Addendum (if relevant to Provider)
<u>Exhibit F-2:</u>	Medicaid/CHIP Managed Care Addendum for Indian Health Care Providers
<u>Exhibit G:</u>	Commercial Product Addendum (if relevant to Provider)

EXHIBIT A

COVERED BENEFITS AND FEE SCHEDULES

Unless otherwise stated in a Product Addendum, Covered Benefits shall be paid at the lesser of Provider's billed charges or the applicable fee schedules for the applicable Sponsor. Fee Schedules are attached to this Agreement in this Exhibit A. A full listing of Sponsor Plan designs and Covered Benefits can be found by logging into your Provider Web Portal at www.Avesis.com for Medicaid or Medicare Advantage products (as applicable) or www.GuardianAnytime.com for Commercial and Network Access products.

REFER TO EXHIBIT A FEE SCHEDULE ATTACHMENTS

EXHIBIT B

The following is a list of individuals either contracted with or employed by Provider, who are a party to this Agreement. Please complete one (1) roster per location participating under this Provider (Tax ID Number). This list may be modified, as needed. Please put an "X" or "✓" in the appropriate box of the Network Participation Section below to indicate which products listed in Exhibit C each provider wants to participate in. Larger group practices can attach an excel file containing the same data elements or use multiple copies of this page.

Service Office Location Street Address	City, State, Zip	Effective Date

[illegible]

**EXHIBIT B-1
MULTIPLE LOCATION/TIN SET UP FORM**

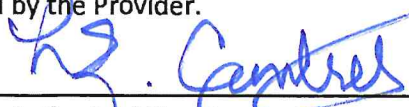
Please Note: This form is only required for Providers with 2 or more locations and/or TINs.

This form is designed to help Guardian understand all the Tax Entities covered under the terms of your Provider Agreement and to assist Provider with multiple locations or Tax ID Numbers (TIN) with the proper set up of their web portal access. Please list all locations, addresses and associated TINs that will be covered under the terms of your Provider Agreement. Please include a completed W9 form for each TIN listed below.

Provider Name: Alise Steward NPI: 1003958216

Location Name	Street Address	TIN#
Edna Pilsbury	2222 Simon Bolivar Ave New Orleans LA 70113	

☒ I attest that all Locations and Tax Identification Numbers listed above are bound under the terms of the agreement signed by the Provider.

By:  11/12/21
Authorized Signature Date

FORM AND LEGALITY APPROVED:

EXHIBIT C
LOUISIANA SPONSORS AND SPONSOR PLANS

MEDICARE ADVANTAGE AND MEDICARE/MEDICAID DUALS SPONSORS

- AmeriHealth LA

MEDICAID AND CHIP SPONSORS

- AmeriHealth LA

COMMERCIAL SPONSORS

- Various PPO and self-funded ASO accounts, which may be as evidenced by Member Identification card or other evidence of insurance/coverage presented to Provider at time of service. For information regarding Commercial plan designs and Commercial Sponsors, please reference the website listed on the Member's identification card or the Guardian provider website.

NETWORK ACCESS ARRANGEMENTS

- In addition to the above, Provider agrees to participate in those networks maintained by Guardian for use by Network Access Payors. In such cases: (a) the Network Access Payor shall have the sole responsibility to pay Clean Claims pursuant to the Agreement, less any applicable coinsurance or deductible or any other payment for which the Member is personally responsible as specified in the Member's plan documents and (b) the Network Access Payor shall include Provider discounts/negotiated fees on any Member explanation of benefits and preauthorization statements by identifying the discounts applied based on Provider's participation under this Agreement. Provider may bill the Member or the Network Access Payor, as applicable, at such Provider's usual fees for services rendered to the extent permitted by applicable state or federal law when (i) such services are not covered by a Negotiated Rate or (ii) when such services are not covered by the Group Policy. In addition, Provider may bill Members for payments, if any, due directly from the Member under the Group Policy, including, but not limited to deductibles, co-payments, coinsurance or other payments due directly from the Members under the Group Policy's schedule of benefits. Network Access Payor agrees that Network Access Payor shall be liable for any fines, penalties, costs, or interest charges imposed by applicable law resulting from Provider not receiving timely payment for Covered Benefits rendered to Members. For purposes of this Network Access section, the following definitions shall apply:

Group Policy – those policies issued by Network Access Payors providing certain benefits to Members who are eligible to participate in such benefits.

Negotiated Rate – the amount listed on the Fee Schedule that Providers agree to accept pursuant to the terms of this Agreement for Covered Benefits rendered to Members under Network Access Arrangements.

EXHIBIT D
LIST OF GUARDIAN AFFILIATED COMPANIES

Avesis Incorporated
Avesis Insurance Incorporated
Avesis Third Party Administrators, Inc.
Premier Access Insurance Company

EXHIBIT E
MEDICARE ADVANTAGE PRODUCT ADDENDUM (if relevant to Provider)

THIS MEDICARE ADVANTAGE ADDENDUM (this “**MA Addendum**”) to the Provider Agreement (“**Agreement**”) is made as of the Effective Date of the Agreement. GLIC, Avësis, or Affiliated Companies (for purposes of this **Exhibit E**, “**Affiliated Company**”) are under one of more contracts with a Sponsor that is an MA Organization (defined below) and listed on **Exhibit C** to the Agreement. Provider agrees to provide Covered Benefits to Members enrolled in one or more Sponsor’s Medicare plans listed on **Exhibit C** (“**Sponsor Plans**”). The Centers for Medicare and Medicaid Services (“**CMS**”) requires that specific terms and conditions be incorporated into provider agreements in order to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108- 173, 117 Stat. 2066 (“**MMA**”). Affiliated Company is a First Tier Entity to one or more Sponsors. Except as provided herein, all other provisions of the Agreement not inconsistent with the terms and conditions stated below shall remain in full force and effect. This MA Addendum shall supersede and replace any inconsistent provisions to such Agreement to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

Definitions:

Completion Of An Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity.

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

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

Medical Necessity: For purposes of determinations of Medical Necessity of services provided to Members in Sponsor’s Medicare Products, Affiliated Company and Sponsor will utilize the following definition in accordance with CMS regulations:

Medical Necessity or Medically Necessary means medical or hospital services that are determined by Affiliated Company or Sponsor to be: (1) Rendered for the treatment or diagnosis of an injury or illness; and (2) Appropriate for the symptoms, consistent with diagnosis, and otherwise in accordance with sufficient scientific evidence and professionally recognized standards; and (3) Not furnished primarily for the convenience of the Member, the attending physician or other provider of service. Whether there is “sufficient scientific evidence” shall be determined by Affiliated Company or Sponsor based on the following: peer reviewed medical literature; publications; reports; evaluations and regulations issued by State and federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Affiliated Company or Sponsor.

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.

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.

Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

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.

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. **Record Retention.** Provider shall give the U.S. Department of Health and Human Services (HHS), the Comptroller General, and their authorized designees, the right to collect, audit, evaluate and inspect any pertinent information for any particular contract period, including but not limited to, books, contracts, computer or other electronic systems (including medical records), and other records of Provider relating to its participation in Sponsor's Medicare Advantage product(s) and to services furnished to Medicare Advantage Members, and any other relevant information that the Centers for Medicare and Medicaid Service (CMS) may require during the term of this Agreement and for a period of ten (10) years following the final date of the final contract period of the contract entered into between CMS and Sponsor, or from the date of Completion Of An Audit, whichever is later, unless such time frame is extended pursuant to 42 C.F.R. § 422.504(e)(4) (such as in the event of fraud). This provision shall survive termination of the Agreement. Provider shall require that any of its Related Entities or Downstream Entities acknowledge and agree that HHS, the Comptroller General, and their authorized designees also have the right to audit, evaluate, collect, and inspect any records described in this Section.
2. **Privacy/Confidentiality.** Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them.
3. **Hold Harmless.** Provider shall not, at any time including insolvency of Sponsor, hold Members liable for payment of any fees that are the legal obligation of the MA Organization. Provider shall not hold Members who are eligible for both Medicare and Medicaid liable for Medicare Part A and B cost-sharing when the applicable State program is responsible for paying such amounts. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under Title XIX if the individual were not enrolled in such a plan. Provider will (a) accept the MA plan payment as payment in full, or (b) bill the

appropriate state source. This provision shall survive termination of the Agreement.

4. **Prompt Payment.** Affiliated Company and Provider agree to follow prompt pay regulations regarding clean claims payment within thirty (30) days according to arrangements set forth in the Agreement and Affiliated Company policy as outlined in the Provider Manual.
5. **Delegation.** If Provider is delegated any activities or responsibilities that fall under Sponsor's MA contract, Affiliated Company and Provider shall specify delegated activities and reporting responsibilities in a written document. The written document shall also identify revocation of delegation activities and reporting requirements or specify other such remedies in instances where CMS, Sponsor, or Affiliated Company determines that Provider has not performed satisfactorily. Sponsor or Affiliated Company shall monitor the performance of Provider. If the credentialing process is delegated, Affiliated Company or Sponsor shall audit the credentialing process on an ongoing basis. Sponsor retains the right to approve, suspend, or terminate any individual Provider selected or credentialed by Provider.
6. **Compliance with Medicare Advantage Program Laws, Policies and Procedures.** Provider, and any Related Entity, contractor, or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions, and all services or other activity performed under the Agreement shall be consistent and comply with Sponsor's contractual obligations. In addition, Affiliated Company agrees to comply with such other terms and conditions as CMS may find necessary and appropriate in order to implement MA requirements. [42 C.F.R. § 422.504(j)]
7. **Federal Funds.** Payments made to Provider for the treatment of a Member enrolled in an MA Organization are made, in whole or in part, from Federal funds, and subject Provider to all laws applicable to the individuals or entities who receive Federal funds, including the False Claims Act (32 USC 3729, et. seq.), the Anti-Kickback Statute (section 1128B(b) of the Social Security Act), Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and the Rehabilitation Act of 1973. Provider shall comply with such laws.
8. **Medicare Number.** In accordance with CMS guidelines, if Provider writes prescriptions for Members, Provider must either apply for a Medicare ID number or a Referring Provider Medicare ID number prior to implementation of CMS's requirement which is scheduled to be fully implemented on January 1, 2019.
9. **Accountability.** In accordance with 42 CFR 422.504(i)(3)(ii)(A), Affiliated Company is accountable for monitoring Provider on an ongoing basis and is accountable to Sponsor (and Sponsor is accountable to CMS) for any functions or responsibilities that are described in applicable regulations.
10. **Medicare Participation.** Provider shall participate in the Medicare Program. Provider shall notify Affiliated Company of any change in participation status in accordance with the Agreement.
11. **Continuation of Care.** Provider and its related entities, contractors, subcontractor or transferees, shall continue to provide Covered Benefits to Members through the period for which CMS payments have been made for said Members. Such continuation of care shall be in accordance with the terms and conditions of the Agreement, including, but not limited to the reimbursement rates. This paragraph shall survive the termination of this Agreement.
12. **Missed Appointments.** Under no circumstances shall Affiliated Company bill or charge Members for missed appointments.

EXHIBIT F
MEDICAID and CHIP ADDENDUM

Louisiana Medicaid Program Regulatory Requirements

This State of Louisiana Medicaid Program (the “**Medicaid Program**”) Addendum to the Provider Agreement (“**Agreement**”) is effective as of the date of the Agreement between Provider and Guardian. Guardian, or one of its Affiliated Companies (as defined under the Agreement), anticipates entering into one or both of the following:

- (1) A direct agreement with the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing (“**DHH**”) to administer one or more vision or dental benefit plans for the Medicaid Program; or
- (2) An agreement with one or more Sponsors (as listed on **Exhibit C**) whereby Guardian or one of its Affiliated Companies will provide vision or dental benefit plans for the benefit of such Sponsors members who are enrollees of the Louisiana Medicaid Program.

In both instances, for purposes of this Exhibit, the underlying agreement that DHH enters into with Guardian or its Affiliated Company (as described in (1) above) or the agreement that DHH enters into with the Sponsor (as described in (2) above) shall be referred to as the “**Agency Contract**”.

For purposes of the terms below, use of “Guardian” shall refer to Guardian or the Affiliated Company that enters into an Agency Contract or into a contract with a Sponsor that enters into an Agency Contract. Provider agrees to provide Covered Benefits to Members enrolled in the Medicaid Program pursuant to the terms and conditions of the Louisiana State Plan, the Agency Contract, and this **Exhibit E**. All other terms and conditions of the Agreement apply hereto unless in conflict, in which case the terms and conditions of this Louisiana Addendum shall apply as to the Medicaid Program. For purposes of the Medicaid program, Members shall include a Medicaid or CHIP eligible individual who enrolls in the program.

1. **Prohibited Relationships.** Provider represents and warrants that neither it nor its officers, directors, agents, or managing employees have been, nor are currently: (a) debarred, suspended or otherwise lawfully prohibited from participating in any public procurement activity or from participating in non-procurement activities under regulations issued under Executive Order 12549 or under guidelines implementing Executive Order 12549; (b) excluded from participation in Federal health care programs under either Section 1128, Section 1128A, or §1156 of the Social Security Act or state funded health care programs, or (c) otherwise barred from participation in the Medicaid and/or Medicare program. In the event of any of the foregoing, Guardian may immediately terminate this Agreement.
2. **Cost-Sharing.** Provider may not charge Members fees of any kind or collect copayments or cost sharing from Members unless permitted by the Medicaid State Plan. Furthermore, Provider may not deny services to a Member who is eligible for services because of the Member’s inability to pay the cost sharing.
3. **Provider Training.** Guardian shall provide training to Provider and its staff regarding the requirements of the Agency Contract, including but not limited to limitations on provider

marketing, and identification of special needs of Members. Guardian shall conduct initial training within thirty (30) days of Provider becoming available to Members in Guardian's network. Guardian shall also conduct ongoing training, as deemed necessary by Guardian or DHH, in order to ensure compliance with program standards, the Agreement, and the Agency Contract.

4. **Cultural Competency.** Provider shall deliver services in a culturally competent manner to all Members, including those with limited English proficiency and diverse cultural and ethnic backgrounds and provide for interpreters in accordance with 42 CFR §438.206(c)(2).
5. **Access to Services.** Provider shall comply with, and Guardian is responsible for monitoring and assuring that Provider complies with, the following access and appointment standards, and provision of appropriate after-hour coverage:
 - a. Emergency Dental visits immediately upon presentation at the service delivery site;
 - b. Urgent Care within twenty-four (24) hours;
 - c. Non-urgent sick care within 72 hours or sooner if medical condition(s) deteriorates into an urgent or Emergency Dental Condition;
 - d. Routine, non-urgent, or preventative care visits within 6 weeks;
 - e. Specialty care consultation within 1 month of referral or as clinically indicated;
 - f. If applicable to Provider's services, Lab and X-ray services (usual and customary) not to exceed three (3) weeks for regular appointments and 48 hours for urgent care or as clinically indicated;
 - g. In office waiting time for scheduled appointments should not routinely exceed 45 minutes, including time in the waiting room and examining room;
 - h. If Provider is delayed, Members shall be notified immediately. If the wait is anticipated to be more than 90 minutes, Provider shall offer Member a new appointment.
 - i. Walk-in patients with non-urgent needs should be seen if possible or scheduled for an appointment consistent with written scheduling procedures.
 - j. Direct contact with a qualified clinical staff person must be available through a toll-free telephone number at all times.
6. **Provision of Services to Members.** Provider shall make all Covered Benefits that it is licensed and trained to provide, and that are covered under the Agreement and the Agency Contract, accessible to Members in comparable timeliness, amount, duration and scope as those available to other insured individuals in the same service area. In addition:
 - a. Provider shall comply with American with Disabilities Act (ADA) requirements and provide physical access for Members with disabilities.
 - b. Provider shall accept members for treatment shall not intentionally segregate members in any way from other persons receiving services.
 - c. Provider shall provide Covered Benefits to Members without regard to race, color, creed, sex, religion, age, national origin ancestry, marital status, sexual preference, health status, income status, program membership, or physical or behavioral disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:
 - i. Denying or not providing to a Member any Covered Benefit or availability of a facility.

- ii. Providing to a Member any Covered Benefit which is different, or is provided in a different manner, or at a different time from that provided to other Members, other public or private patients, or the public at large.
- iii. Discriminatory practices with regard to Members such as separate waiting rooms, separate appointment days, separate physical locations, or preference to private pay or Medicaid fee-for-service patients.

Guardian reserves the right to, and Provider shall comply with Guardian regarding, monitor the adequacy, accessibility and availability of its provider network to meet the needs of Members, including the provision of care to members with limited proficiency in English.

7. **Exclusivity Prohibited.** Nothing in the Agreement shall be construed as limiting, and Guardian shall not otherwise limit, Provider from having contractual arrangements with other MCOs and Guardian shall not agree to only contract with Provider to the exclusion of other Providers. Neither Party shall advertise or otherwise hold itself out as having an exclusive relationship with the other Party.
8. **DHH Approval of Agreement.** The Parties acknowledge and agree that DHH has the right to review and approve or disapprove this Agreement, or any amendments hereto, or request that edits are made.
9. **Provider Preventable Conditions.** Guardian shall specifically deny payments to Provider for Provider Preventable Conditions.
10. **Member Communications.** Subject to the limitations described in 42 CFR §438.102(a)(2), Guardian shall not prohibit or otherwise restrict Provider, acting within the lawful scope of practice, from advising or advocating on behalf of a Member, who is a patient of Provider, regardless of whether benefits for such care or treatment are provided under the Agency Contract, for the following:
 - a. The Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered;
 - b. Any information the Member needs in order to decide among relevant treatment options;
 - c. The risks, benefits and consequences of treatment or non-treatment; and
 - d. The Member's right to participate in decisions regarding their health care, including, the right to refuse treatment, and to express preferences about future treatment decisions.
11. **Claims.**
 - a. As an alternative to the filing of paper-based Claims, Provider is encouraged to submit and receive Claims information through electronic data interchange (EDI).
 - b. Guardian shall process all Claims in adherence to information exchange and data management requirements of the Agency Contract and applicable state and federal law.
 - c. Guardian shall not pay any Claim submitted by Provider if Provider is excluded or suspended from the Medicare, Medicaid or SCHIP programs for fraud, abuse or waste, or otherwise included on DHH or the U.S. Department of Health and Human Services Office of Inspector General exclusions list, or if Provider employs someone on those lists. Guardian shall not pay any Claim submitted by Provider if Provider is on payment hold under the authority of DHH or its authorized agent(s).

- d. Guardian shall notify Providers ninety (90) calendar days before implementing changes to Claims coding and processing guidelines.
- e. Guardian shall ensure that all Claims are processed according to the following timeframes:
 - i. Within five (5) business days of receipt of a Claim, Guardian shall perform an initial screening, and either reject the Claim, or assign a unique control number and enter it into the system for processing and adjudication.
 - ii. Process and pay or deny, as appropriate, at least Ninety percent (90%) of all Clean Claims for each Claim type, within fifteen (15) business days of the receipt.
 - iii. Process and pay or deny, as appropriate, at least Ninety-nine percent (99%) of all Clean Claims for each Claim type, within thirty (30) calendar days of the date of receipt.
 - iv. Fully adjudicate (pay or deny) all pending Claims within sixty (60) calendar days of the date of receipt.
- f. Guardian may reject Claims because of missing or incomplete information. The original Claim must be returned to Provider accompanied by a reject letter. A rejected Claim should not appear on the Remittance Advice (RA) because it will not have entered the Claims processing system. The rejection letter shall indicate why the Claim is being returned, including all defects or reasons known at the time the determination is made.
- g. If a Clean Claim is received, but additional information is required for adjudication, Guardian may pend the Claim and request in writing (notification via e-mail, Web site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all necessary information such that the Claim can be adjudicated within established timeframes.
- h. Provider shall submit Medicaid-only Claims within one hundred eighty (180) days of the date of service. Guardian must deny any Claim not initially submitted to Guardian by the one hundred and eightieth (180) calendar day from the date of service, unless DHH, Guardian or its sub-contractors created the error. If a provider files erroneously with another Guardian or with DHHs FI, but produces documentation verifying that the initial filing of the Claim occurred timely, within the one hundred and eighty (180) calendar day period, Guardian shall process Provider's Claim and not deny for failure to meet timely filing guidelines. Guardian shall not deny Claims solely for failure to meet timely filing guidelines due to error by DHH or its subcontractors. For purposes of Guardian reporting on payment to providers, an adjustment to a paid Claim shall not be counted as a Claim and electronic Claims shall be treated as identical to paper based Claims.
- i. Guardian shall not deny Provider's Claims on the basis of untimely filing in situations regarding coordination of services or subrogation, in which case Provider is pursuing payment from a third party. In situations of third party benefits, the timeframes for filing a Claim shall begin on the date that the third party completes resolution of the Claim.
- j. Guardian shall pay Provider interest at twelve percent (12%) per annum, calculated daily for the full period in which a payable Clean Claim remains unpaid beyond the thirty (30) day Claims processing deadline. Interest owed to Provider must be paid the same date that the Claim is adjudicated.
- k. Guardian shall adjudicate all disputed Claims to a paid or denied status within thirty (30) business days of receipt of the dispute Claim. Guardian shall adjudicate all Claims, including disputed Claims, within twenty-four (24) months from the date of service.

12. **Claims Dispute Process.** Guardian shall develop an internal Claims dispute process for those Claims or group of Claims that have been denied or underpaid. The Claims Dispute process shall allow Provider the option to request binding arbitration for Claims that have denied or underpaid Claims or a group of Claims bundled, by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If Guardian and Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Section shall be binding on all parties. The arbitrator shall conduct a hearing and issue a final ruling within ninety (90) days of being selected, unless Guardian and Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.
13. **Physician Incentive Plans.** In accordance with 42 CFR §422.208 and §422.210, Guardian may operate a Physician Incentive Plan, but specific payment cannot be made directly or indirectly under a Physician Incentive Plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual. Any incentive plan under this Agreement shall be in compliance with 42 CFR §438.6(h), §422.208 and §422.210. Any sub-capitation arrangement with Provider is considered a provider incentive plan and subject to all applicable requirements of federal law and the Agency Contract.
14. **Marketing Requirements.** Provider is obligated to comply with the Marketing and Member Education guidelines that are set forth in greater detail in the Agency Contract, including, but not limited to, the following:
- a. Provider may not solicit enrollment or disenrollment in Guardian or another Medicaid managed care organization (each an "MCO"), or distribute Guardian or other MCO-specific materials at a marketing activity.
 - b. In the event Provider wishes to let their patients know of their affiliations with MCOs, Provider must list each MCO with which Provider has a contract;
 - c. Provider may display and/or distribute health education materials for all contracted MCOs or they may choose not to display and/or distribute for any contracted MCOs. Health education materials must adhere to the following guidance:
 - i. Health education posters cannot be larger than 16" X 24";
 - ii. Children's books, donated by MCOs, must be in common areas;
 - iii. Materials may include the MCOs name, logo, phone number and Web site; and
 - iv. Provider is not required to distribute and/or display all health education materials provided by each MCO with whom it contracts. Provider can choose which items to display as long as it distributes items from each contracted MCO and that the distribution and quantity of items displayed are equitable.

- d. Provider may display marketing materials for MCOs, provided that appropriate notice is conspicuously and equitably posted, in both size of material and type set, for all MCOs with whom Provider has a contract.
 - e. Provider may display MCO participation stickers, but Provider must display stickers by all contracted MCOs or choose to not display stickers for any contracted MCOs. MCO stickers indicating Provider participates with a particular MCO cannot be larger than 5" x 7" and not indicate anything more than "the MCO or MCO is accepted or welcomed here."
 - f. Provider may inform their patients of the benefits, services and specialty care services offered through the MCOs in which they participate. However, Provider may not recommend one MCO over another MCO, offer patients incentives for selecting one MCO over another, or assist the patient in deciding to select a specific MCO in any way, including but not limited to faxing, using the office phone, or a computer in the office.
 - g. Upon actual termination of a contract with Guardian, if Provider has contracts with other MCOs, Provider may notify their patients of the change in status and the impact of such a change on the patient included the date of the contract termination. Providers must continue to see current patients enrolled in Guardian until the contract is terminated according to all terms and conditions specified in the contract between Provider and Guardian.
15. **Disclosures.** Provider shall comply with all federal requirements (42 CFR Part 455) on disclosure reporting. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Agreement and the Agency Contract shall submit routine disclosures in accordance with timeframes specified in 42 CFR Part 455, Subpart B and Louisiana Medicaid policies and procedures, including at the time of initial contracting, contract renewal, within thirty-five (35) days of any change to any of the information on the disclosure form, at least once annually, and at any time upon request. Provider shall comply with all federal requirements (42 C.F.R. §1002) on exclusion and debarment screening. All tax-reporting provider entities that bill and/or receive Louisiana Medicaid funds as the result of this Agreement and the Agency Contract shall screen their owners and employees against the federal exclusion databases (such as LEIE and System for Award Management). Any unallowable funds made to excluded individuals as full or partial wages and/or benefits shall be refunded to and/or obtained by the State and/or Guardian dependent upon the entity that identifies the payment of unallowable funds to excluded individuals.
16. **Withhold of Funds.** Guardian is prohibited from taking any actions to recoup or withhold improperly paid funds already paid or potentially due to Provider when the issues, services or Claims upon which the recoupment or withhold are based meet one or more of the following criteria:
- a. The improperly paid funds have already been recovered by the State of Louisiana, either by Louisiana Medicaid directly or as part of a resolution of a state or federal investigation and/or lawsuit, including but not limited to false claims act cases; or
 - b. The improperly paid funds have already been recovered by the States Recovery Audit Contractor (RAC) contractor; or

c. When the issues, services or Claims that are the basis of the recoupment or withhold are currently being investigated by the State of Louisiana, are the subject of pending Federal or State litigation or investigation, or are being audited by the Louisiana RAC. This prohibition shall be limited to Provider, for specific dates, and for specific issues, services or Claims. Guardian shall confer with DHH before initiating any recoupment or withhold of any program integrity related funds to ensure that the recovery recoupment or withhold is permissible. In the event that Guardian obtains funds in cases where recovery recoupment or withhold is prohibited under this Section, Guardian will return the funds to DHH.

17. **Records Made Available to State/Federal Authorities.** Provider shall, upon request and as required by this Agreement and the Agency Contract or state and/or federal law, make available to the MFCU any and all administrative, financial and Medical Records relating to the delivery of items or services for which Louisiana Medicaid monies are expended. Such records will be made available at no cost to the requesting agency. In addition, the MFCU shall, as required by the Agency Contract or state and/or federal law, be allowed access to the place of business and to all Medicaid records of Provider during normal business hours, except under special circumstances when after hour admission shall be allowed. Special circumstances shall be determined by the MFCU.

18. **Fraud and Abuse.**

- a. As a condition of receiving any amount of Medicaid payment, Provider shall comply with the fraud, waste, and abuse provisions of the Agency Contract.
- b. Provider acknowledges and agrees that Guardian is responsible for investigating possible acts of fraud, abuse, and waste for all services under the Agency Contract. Guardian has the exclusive right of review and recovery for twelve (12) months from the original date of service of a Claim to initiate a "complex" review of such Claim to determine a potential overpayment and/or underpayment, by delivering notice to Provider in writing of initiation of such a review. No such notice shall be required in instances resulting from suspected fraud, which Guardian has identified and referred to DHH, the Medicaid Fraud Control Unit, or other appropriate law enforcement agency. A "complex" review is one for which a review of medical, financial and/or other records is necessary to determine the existence of a mispayment. Guardian shall complete its review and notify Provider of the results of such review within sixty (60) days of the date of receipt of documentation from Provider, not to exceed one hundred and twenty (120) days of the date of the notice to Provider. Guardian shall notify DHH, on at least a quarterly basis, the results of reviews as well as instances of suspected fraud.
- c. Guardian shall not retain the exclusive right of review and/or recovery beyond twelve (12) months from the original date of service of a Claim for a "complex" review, but Guardian may conduct audits of Provider's Claims for a five (5) year period from the date of service of a Claim.
- d. If Guardian does not initiate action with respect to a "complex" Claim review within the twelve (12) month-period from the date of service of the Claim, DHH or its agent may recover from Provider any overpayments which they identify and said recovered funds will be returned to the State.
- e. Guardian shall not retain the exclusive right of review and/or recovery from the initial date of service of a Claim for which DHH or its agent identifies mispayments as a result of "automated" Claims reviews. An "automated" review is one for which an analysis of

the paid Claims is sufficient to determine the existence of a mispayment. No additional documentation is required to be submitted from Provider to determine the existence of an overpayment.

- f. DHH may recover from Provider any overpayments which they identify through an "automated" review and said recovered funds will be returned to the State.
- g. Guardian shall not correct the Claims nor initiate an audit on the Claims upon notification by DHH or its agent.
- h. In the event Provider does not refund overpayments identified by DHH or its agent to the State, or arrange for an acceptable payment plan with the State, within thirty (30) calendar days of notification to Provider of the overpayment, DHH or its agent will notify Guardian and Guardian shall initiate a payment withhold on Provider in the amount due to DHH. Guardian shall collect and refund the overpayment to DHH.

19. **Services Within the United States.** Provider shall provide all services to be provided under the Agreement and the Agency Contract entirely within the boundaries of the United States. In addition, Provider will not hire any individual to perform any services under the Agency Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement. Provider shall indemnify and hold Guardian (and Sponsors, if applicable) harmless from any violation of the foregoing requirements, including any costs, fees, damages, Claims, or expenses imposed by DHH.

20. **Records.**

- a. Provider shall maintain an individual Medical Record for each Member it provides services to. The Medical Record shall:
 - i. Be accurate and legible;
 - ii. Be safeguarded against loss, destruction, or unauthorized use and maintained in an organized fashion for all Members evaluated or treated;
 - iii. Be accessible for review and audit;
 - iv. Be readily available for review, and provides medical and other clinical data required for quality and UM review; and
 - v. Include the following, minimally:
 - 1. Member identifying information, including name, identification number, date of birth, sex and legal guardianship (if applicable);
 - 2. Primary language spoken by the member and any translation needs of the member;
 - 3. Services provided through the MCO, date of service, service site, and name of service provider;
 - 4. Medical history, diagnoses, treatment prescribed, therapy prescribed and drugs administered or dispensed, beginning with, at a minimum, the first member visit with or by the MCO;
 - 5. Referrals including follow-up and outcome of referrals;
 - 6. Documentation of Emergency and/or after-hours encounters and follow-up;
 - 7. Signed and dated consent forms (as applicable); Documentation of immunization status; Documentation of advance directives, as appropriate;
 - 8. Documentation of each visit must include

- a. Date and begin and end times of service;
 - b. Chief complaint or purpose of the visit;
 - c. Diagnoses or medical impression;
 - d. Objective findings;
 - e. Patient assessment findings;
 - f. Studies ordered and results of those studies (*e.g.* laboratory, x-ray, EKG);
 - g. Medications prescribed;
 - h. Health education provided;
 - i. Name and credentials of the provider rendering services (*e.g.* MD, DO, OD) and the signature or initials of the provider; and
 - j. Initials of providers must be identified with correlating signatures.
9. Documentation of EPDST requirements including, but not limited to:
- a. Comprehensive health history;
 - b. Developmental history;
 - c. Unclothed physical exam;
 - d. Vision, hearing and dental screening;
 - e. Appropriate immunizations;
 - f. Appropriate lab testing including mandatory lead screening; and
 - g. Health education and anticipatory guidance.
- b. All documentation and/or records maintained by Provider shall be maintained for at least six (6) years after the last good, service, or supply has been provided to a Member or an authorized agent of the state or federal government, or any of its authorized agents, unless those records are subject to review, audit, investigations, or subject to an administrative or judicial action brought by or on behalf of the state or federal government.
- c. Provider shall comply and cooperate with Guardian's (and Sponsors', if applicable) efforts to verify that services were provided to Members for which reimbursement was made.

21. **Definitions.** The following definitions shall apply to this Exhibit:

- a. **Claim** – means (1) a bill for services, (2) a line item of service, or (3) all services for one recipient within a bill.
- b. **Clean Claim** means a Claim that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a Claim with errors originating in a state's claims system. It does not include a Claim from a provider who is under investigation for fraud or abuse, or a Claim under review for Medical Necessity.
- c. **Emergency Dental Condition**: A dental or oral condition that requires immediate services for relief of symptoms and stabilization of the condition; such conditions to include severe pain, hemorrhage, acute infection, traumatic injury to the teeth and surrounding tissue, or unusual swelling of the face or gums.
- d. **Medical Necessity**: Those health care services that are in accordance with generally accepted, evidence-based medical standards, or that are considered by most physicians (or other independent licensed practitioners) within the community of their respective

professional organizations to be the standard of care. In order to be considered medically necessary, services must be: 1) deemed reasonably necessary to diagnose, correct, cure, alleviate or prevent the worsening of a condition or conditions that endanger life, cause suffering or pain or have resulted or will result in a handicap, physical deformity or malfunction; and 2) those for which no equally effective, more conservative and less costly course of treatment is available or suitable for the recipient. Any such services must be individualized, specific and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and neither more nor less than what the recipient requires at that specific point in time. Services that are experimental, non-FDA approved, investigational, or cosmetic are specifically excluded from Medicaid coverage and will be deemed "not medically necessary." The Medicaid Director, in consultation with the Medicaid Dental Director, may consider authorizing services at his discretion on a case-by-case basis.

- e. Medical Record. A single complete record kept at the site of the Member's treatment(s), which documents medical or allied goods and services, including, but not limited to, outpatient and emergency medical or dental health care services. The records may be electronic, paper, magnetic material, film or other media. In order to qualify as a basis for reimbursement, the records must be dated, legible and signed or otherwise attested to, as appropriate to the media, and meet the requirements of 42 CFR §456.111 and §456.211.
- f. Provider Preventable Conditions: Preventable healthcare-acquired or other provider-preventable conditions and events, also known as never events, identified by DHH for nonpayment, such as but not limited to, bed pressure ulcers or decubitus ulcers; or events such as surgical or invasive procedures performed on the wrong body part or wrong patient; wrong surgical procedure performed on a patient.

EXHIBIT G
LOUISIANA COMMERCIAL PRODUCT ADDENDUM

This State of Louisiana Commercial Product Addendum ("**Commercial Addendum**") to the Provider Agreement ("**Agreement**") is effective as of the date of the Provider Agreement. Provider agrees to provide Covered Benefits to Members enrolled in one or more commercial dental plans listed on Exhibit C in the State of Louisiana that are underwritten or administered by GLIC, as an Affiliated Company under the Agreement. All other terms and conditions of the Agreement apply hereto unless in conflict, in which case the terms and conditions of this Commercial Addendum apply.

1. Nothing in this Agreement shall include, or be construed to include, an incentive or specific payment made directly, in any form, to Provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific insured or groups of insureds with similar medical conditions; provided, however, that this Section shall not be construed to prohibit an incentive plan that involves general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving specific insured or groups of insureds with similar medical conditions. The Parties agree that payments rendered or to be rendered by GLIC to Provider under these arrangements shall be deemed confidential information.
2. GLIC shall not interfere with Provider's ability to communicate with a Member regarding his or her health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements. Notwithstanding the foregoing, Provider shall not solicit for alternative coverage arrangements for the primary purpose of securing financial gain.
3. GLIC shall not refuse to contract, renew, cancel, restrict, or otherwise terminate the Agreement solely on the basis of a medical communication. GLIC shall not refuse to refer Members to or allow others to refer Members to Provider, refuse to compensate Provider for Covered Benefits, or take other retaliatory action against Provider. As used in this Subsection "medical communication" shall mean information regarding the mental or physical health care needs or the treatment of a patient. No communication regarding treatment options shall be represented or construed to expand or revise the scope of benefits or Covered Benefits.
4. GLIC shall not, through the Agreement, written policy, or written procedure, prohibit or restrict Provider from:
 - a. filing a complaint, making a report, or commenting to an appropriate governmental body regarding GLIC's policies or practices which may negatively impact upon the quality of, or access to, patient care; or
 - b. advocating to GLIC on behalf of a Member for approval or coverage of a particular course of treatment or for the provision of health care services.
5. Nothing in the Agreement shall contain, or shall be construed as containing, any clause purporting to transfer to Provider by indemnification or otherwise any liability relating to GLIC's activities, actions, or omissions.

6. GLIC shall reimburse Provider in accordance with the applicable fee schedule in cases where GLIC requests or requires substitution of a medication for a Member and Provider has executed the requested or required substitution. This Section shall not apply to generic substitution or step therapy programs utilized by GLIC or its delegated entity that promote generic drugs as a first-line therapy.
7. GLIC shall not require Provider, as a condition of participation or continuation in the provider network of one or more Sponsor Plans or GLIC benefit plans, to serve in the provider network of all or Sponsor Plans or GLIC benefit plans. GLIC shall not terminate the Agreement based on Provider's refusal to serve in its network for such additional plans.
8. GLIC shall pay claims within thirty (30) days of receipt from Provider unless just and reasonable grounds, such as would put a reasonable and prudent businessman on his guard, exist. Failure to comply with the provisions of this Section shall subject the insurer to a penalty applicable under state law.
9. In the event GLIC determines that additional information is needed for payment, GLIC shall notify Provider and Member in writing regarding the information needed and identify the party responsible for furnishing such information. In the event that the Member is the party responsible for providing such additional information and the Member does not provide the requested information to GLIC within forty-five (45) days from the date of such notification, Provider may bill the Member for services at the contracted reimbursement rate under the Agreement. If a Member approves in advance and in writing the charges for which the Member will be responsible, nothing in this Section shall be construed to prevent a Member/dental patient from choosing any type, form, or quality of dental procedure that is a non-Covered Benefit.
10. If GLIC's payment of benefits under the Member's plan is based upon the usual and customary fee charged by Provider, the following shall apply:
 - a. The frequency of the determination of the usual and customary fee.
 - b. A specific and detailed description of the methodology used to determine the usual and customary fee.
 - c. The percentile that determines the maximum benefit that GLIC will pay for each dental procedure, if the usual and customary fee is determined by taking a sample of fees submitted on actual claims from licensed dentists and then determining the benefit by selecting a percentile of those fees.
11. As used in Section 10 above, the following definitions shall apply:
 - a. "Usual fee" is the fee which an individual dentist most frequently charges for a specific dental procedure.
 - b. "Customary fee" is the fee level determined by the administrator of the dental benefit plan from actual submitted fees for a specific dental procedure to establish the maximum benefit payable under a given plan for that specific procedure.
12. GLIC may not require that Provider provide dental health care services to a Member at a particular fee unless such services are Covered Benefits for which benefits are paid under the Agreement.

13. GLIC may offer Provider optional agreements for participation in a dental plan in which Provider may choose to participate either with or without a provision to provide discounts to covered persons for non-Covered Benefits provided that all of the following apply:
- a. GLIC may not restrict in any manner the choice of Provider to Covered Benefits except that the option for Provider choosing to participate in the plan under such an optional agreement to cease providing such discounts under said optional agreement but still continue participating in the plan may be limited to each time said optional agreement is up for renewal.
 - b. The provision for discounts on non-covered services shall be the only material difference between agreements entered into with a dentist who accepts such an optional agreement and those with a dentist who accepts a contract without said optional agreement.