Case 24-10164-KBO Doc 1604 Filed 09/30/25 Page 1 of 14 Docket #1604 Date Filed: 09/30/2025

IN THE UNITED STATES BANKRUPTCY COURT FOR THE DISTRICT OF DELAWARE

In re:

Chapter 11

CANO HEALTH, INC., et al., 1

Case No. 24-10164 (KBO)

Debtors.

Jointly Administered

JOINT MOTION OF PREFERRED CARE NETWORK, INC. AND PREFERRED CARE PARTNERS, INC. FOR ALLOWANCE OF ADMINSTRATIVE EXPENSE CLAIMS

Pursuant to 11 U.S.C. § 503(b), Preferred Care Network, Inc. ("<u>PCN</u>") and Preferred Care Partners, Inc. ("<u>PCP</u>" and together with PCN, "<u>Preferred Care</u>") hereby move (this "<u>Motion</u>") for the allowance of administrative expense claims in the amount of \$559,378.34 for PCN and \$4,365,325.07 for PCP against the bankruptcy estate of DGM MSO, LLC ("<u>DGM</u>").

In support of this Motion, Preferred Care relies on the Declaration of Luis Diaz de Arce (the "<u>Declaration</u>" or "<u>Decl.</u>"), which is attached hereto as <u>Exhibit B</u>, and further states as follows:

I. JURISDICTION AND VENUE

- 1. Pursuant to 28 U.S.C. § 1334, the United States District Court for the District of Delaware has jurisdiction to consider this Motion. Pursuant to 28 U.S.C. § 157 and the *Amended Standing Order of Reference* dated February 29, 2012, the Court has authority to hear and determine core proceedings. This is a core proceeding under 28 U.S.C. § 157(b)(2) and may be determined by the Court.
 - 2. Venue of this proceeding is proper in this district pursuant to 28 U.S.C. § 1409(a).

¹ The last four digits of Cano Health, Inc.'s tax identification number are 4224. A complete list of the Reorganized Debtors in the chapter 11 cases may be obtained on the website of the Reorganized Debtors' claims and noticing agent at https://www.kccllc.net/CanoHealth. The Reorganized Debtors' mailing address is 9725 NW 117th Avenue, Miami, Florida 33178.



3. The statutory basis for the relief requested herein is 11 U.S.C. § 503(b).

II. BACKGROUND

A. The Risk Agreements Between Preferred Care and DGM

- 4. Preferred Care provides health insurance benefits to members insured under certain governmental plans. (Decl. ¶ 6.) PCN and PCP have Certificates of Authority from the Florida Office of Authority from the Florida Office of Insurance Regulation and have entered into a Medicare Advantage contract (the "Medicare Advantage Contract") with the Centers for Medicare & Medicaid Services ("CMS"). (Id.) Under the Medicare Advantage Contract, PCN and PCP provide medical insurance to Medicare members enrolled in their Medicare Advantage plans ("MA Plans"). (Id.)
- 5. DGM is a management services organization and provider network that engages physicians, physician groups, and ancillary providers to provide health care services to members of health maintenance organizations, preferred provider organizations, or other managed care companies with network contracts. (Decl. Ex. 1 § 1.2, Ex. 2 § 1.2.)
- 6. PCN and DGM are parties to that certain Medicare Advantage Network Risk Agreement with an effective date of November 1, 2015 (as amended, the "PCN Risk Agreement"), 2 pursuant to which DGM arranges for or otherwise provides covered health care services to PCN members enrolled under MA Plans that are assigned to a DGM primary care provider. (*Id.* ¶ 8.) A true and accurate copy of the PCN Risk Agreement is attached as Exhibit 1 to the Declaration.

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² The original parties to the PCN Risk Agreement were Doctor's Group Management, Inc. ("<u>DGMI</u>") and Medica Healthcare Plans, Inc. ("<u>Medica</u>"). (Decl. Ex. 1.) On January 1, 2022, Medica changed its name to PCN. (Decl. ¶ 7.) In connection with DGM's acquisition of substantially all of DGMI's assets, DGMI and PCN entered into an Assignment and Assumption Agreement dated January 1, 2022, pursuant to which DGM assumed DGMI's obligation and DGMI assigned to DGM its rights under the PCN Risk Agreement. (Decl. Ex. 1.)

- 7. PCP and DGM are parties to that certain Medicare Advantage Network Risk Agreement with an effective date of November 1, 2015 (as amended, the "PCP Risk Agreement" and together with the PCN Risk Agreement, the "Risk Agreements"), pursuant to which DGM arranges for or otherwise provides covered health care services to PCP members enrolled under MA Plans that are assigned to a DGM primary care provider. (*Id.* ¶ 9.) A true and accurate copy of the PCP Risk Agreement is attached as Exhibit 2 to the Declaration.
- 8. Under the Risk Agreements, DGM agreed to, *inter alia*, provide, or arrange for the provision of, all Covered Services⁴ to all Members assigned to it or a Network Provider by Preferred Care, or who has selected a Network Provider. (Decl. Ex. 1 § 5.1, Ex. 2 § 5.1.) The compensation for DGM providing such services is set forth in Schedule B to the Risk Agreements. (Decl. Ex. 1 § 4.1, Ex. 2 § 4.1.)
- 9. Under Schedule B to the Risk Agreements, Preferred Care creates on ledger basis a Medicare Operating Fund ("MOF") and a Security Reserve Account ("SRA"). (Decl. Ex. 1 Sch. B §§ 1 & 2, Ex. 2 Sch. B §§ 2 & 7.) As full compensation for DGM's services, Preferred Care allocates to the MOF a fixed percentage of the monthly capitation payment from CMS for the provision of benefits to Members under MA Plans.⁵ (Decl. Ex. 1 Sch. B § 3, Ex. 2 Sch. B § 3.)
- 10. As set forth in Section 4 of Schedule B of the Risk Agreements, certain expenses are deducted from the MOF, including the monthly Network Capitation Payments paid to DGM for providing Primary Care Services to Members. (Decl. Ex. 1 Sch. B § 4, Ex. 2 Sch. B § 4.)

 Other expenses deducted from MOF include the following: payment for Covered Services (other

³ The original parties to the PCP Risk Agreement were DGMI and PCP. (Decl. Ex. 2.) In connection with DGM's acquisition of substantially all of DGMI's assets, DGMI and PCP entered into an Assignment and Assumption Agreement dated January 1, 2022, pursuant to which DGM assumed DGMI's obligation and DGMI assigned to DGM its rights under the PCP Risk Agreement. (*Id.*)

⁴ Capitalized terms not defined herein shall have the meaning ascribed to them in the Risk Agreements.

⁵ As set forth in Section 3 of Schedule B, there are other potential sources of funding for the MOF from proceeds of any stop loss insurance, and third-party payments, such as from other applicable insurance.

than Primary Care Services); costs for care management and disease management programs; any applicable bonus payments to Network Providers; stop loss insurance premiums; costs of medical chart reviews and hospital abstract audits of Member medical record and claims data; and a monthly deposit to the SRA. (*Id.*)

11. As set forth in Section 5 of Schedule B of the Risk Agreements, at the end of each month, Preferred Care determines the amount by which allocations to the MOF (as described above) exceeded deductions from the MOF (as described above) for the prior month (the "Target Month"). (Decl. Ex. 1 Sch. B § 5, Ex. 2 Sch. B § 5.) The amount of any initial excess is referred to as the "Initial Surplus" and such amount is retained by Preferred Care in the MOF. (Id.) At the end of the Substantial Completion Period, Preferred Care again reviews whether the allocations to the MOF exceed the deductions from the MOF for the Target Month. (Id.) Any surplus remaining at this time is referred to as the "Substantial Completion Surplus." (Id.) At this time, Preferred Care will pay to DGM the Substantial Completion Surplus reduced by the agreed upon amount of claims incurred but not yet reported for the Target Month (the "IBNR"), which remains in the MOF. (Id.) Preferred Care then performs a final reconciliation twelve months after the close of the Target Month (the "Final Completion Period"). (Id.) If there is a positive balance in the MOF at this time, this "Final Surplus" gets remitted to DGM. (Id.) However, if the claims paid after the Substantial Completion Period exceed the Target Month's IBNR creating a deficit in the MOF for the Target Month, this "Final Deficit" is deducted from the MOF for the successive Target Months until recovered in full by Preferred Care. 8 (*Id.*)

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⁶ Substantial Completion Period is defined as 120 days after the end of the Target Month. (Decl. Ex. 1 Sch. B § 5, Ex. 2 Sch. B § 5.)

⁷ The IBNR is the lesser of (i) actual claims incurred but not reported for the Target Month, or (ii) 10% of the total claims paid for the Target Month. (Decl. Ex. 1 Sch. B § 5, Ex. 2 Sch. B § 5.)

⁸ As set forth in Section 6 of Schedule B of the Risk Agreements, Preferred Care has the right to retroactively adjust MOF surplus or deficits due to, *inter alia*, audits or reviews of risk adjustment factors and to recalculate any Final

- 12. As more particularly described in Section 2 of Schedule B of the Risk Agreements, the SRA is used to "secure [DGM's] performance under the [Risk] Agreement and this Schedule B..." (Decl. Ex. 1 Sch. B § 2, Ex. 2 Sch. B § 2.) In particular, Section 5 of Schedule B of the Risk Agreements provides that "[i]f at any time the value of the [MOF] is less than \$0.00, [Preferred Care] will transfer funds from the [SRA] to the [MOF] to eliminate that deficit." (Decl. Ex. 1 Sch. B § 5, Ex. 2 Sch. B § 5.)
- 13. As noted above, the SRA is to be funded through monthly payments from the MOF on a per-Member, per-month basis, as well as by withholding a percentage of any Substantial Completion Payment and any Final Surplus payment. (Decl. Ex. 1 Sch. B § 2, Ex. 2 Sch. B § 7.) These amounts are allocated to the SRA until it has a balance of \$100 per Member. (Id.) If the SRA is not fully funded (whether due to insufficient contributions, adjustments, or transfers from the SRA to cover negative balances in the MOF), the Debtor is obligated to fund the shortfall within 30 days. (Id.) Similarly, if the SRA drops to a negative balance, Preferred Care can make demand to replenish the SRA up to the required minimum balance, which must be paid within 30 days by DGM. (Id.)

B. The Bankruptcy Filing, Rejection of Risk Agreements, and Post-Petition Deficit in MOF

14. On February 4, 2024 (the "Petition Date"), DGM and certain of its affiliates (collectively, the "Debtors") filed voluntary Chapter 11 petitions in this Court. (*E.g.*, *In re DGM MSO, LLC*, Case No. 24-10180 (Bankr. D. Del. Feb. 4, 2024), Dkt. No. 1.)

Deficit or Final Surplus based on the CMS Payment for the applicable period. (Decl. Ex. 1 Sch. B § 6, Ex. 2 Sch. B § 6.)

⁹ Preferred Care may adjust the amount reserved for in the SRA based on DGM performance and potential liability to PCN. (Decl. Ex. 1 Sch. B § 2, Ex. 2 Sch. B § 7.)

- 15. On June 28, 2024, the Court entered the *Order (I) Confirming Modified Fourth Amended Joint Chapter 11 Plan of Reorganization of Cano Health, Inc. and its Affiliated Debtors and (II) Granting Related Relief* (the "Confirmation Order"). (Dkt. No. 1148.) Subsequently, the Debtors filed a notice stating June 28, 2024, was the effective date (the "Effective Date") of the confirmed plan (the "Plan"). (Dkt. No. 1152.)¹⁰
- 16. In pertinent part, section 8.1(a) of the Plan states "[a]s of and subject to the occurrence of the Effective Date, all executory contracts and unexpired leases to which any of the Debtors are part shall be deemed assumed or assumed and assigned, as applicable, except for any executory contract or unexpired lease that . . . (v) is specifically designated as a contract or lease to be included on the Rejection Schedule". Section 8.1(b) further provides "[s]ubject to the occurrence of the Effective Date, entry of the Confirmation Order by the Bankruptcy Court shall constitute approval of the assumptions, assumptions and assignments, including assignments to another Debtor, or rejections provided for in the Plan pursuant to sections 365(a) and 1123 of the Bankruptcy Code."

17. Section 2.1 of the Plan provides, in pertinent part, as follows:

Except to the extent a holder of an Allowed Administrative Expense Claim agrees to less favorable treatment, each holder of an Allowed Administrative Expense Claim . . . shall receive, in full and final satisfaction, settlement, release, and discharge of, and in exchange for, such Claim, Cash in an amount equal to the unpaid portion of such Allowed Administrative Expense Claim on the latest of: (a) the Effective Date; (b) the first Business Day after the date that is 30 days after the date on which such Administrative Expense Claim becomes an Allowed Administrative Expense Claim; [or] (c) the date on which such Administrative Expense Claim becomes payable under any agreement with the Debtors or the applicable Reorganized Debtors relating thereto

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¹⁰ Neither the Plan nor the Confirmation Order set a deadline for claims under 11 U.S.C. § 503(b) to be filed. However, Preferred Care and DGM agreed that Preferred Care would file such a motion by October 1, 2025.

- 18. The Risk Agreements were included on the Rejection Schedule and they were therefore rejected as of June 28, 2024. (See Supplemental Notice of Proposed Rejection of Executory Contracts and Unexpired Leases Pursuant to Debtors' Proposed Chapter 11 Plan of Reorganization, Dkt. No. 1065.)
- 19. Subsequent to the Petition Date and continuing through June 28, 2024, DGM continued to render Covered Services to Preferred Care's Members and Preferred Care continued to fund the respective MOFs in accordance with the terms of the Risk Agreements. (Decl. ¶ 10.)
- 20. The Target Months of February 2024 through June 2024 have now reached their Substantial Completion Period in accordance with Schedule B of the Risk Agreements, and all adjustments arising from risk adjustment factors and any changes to the CMS Payment have been completed. (Decl. ¶ 11.) For the period from the Petition Date February 4, 2024 through the Effective Date of the rejection of the Risk Agreements on June 28, 2024, the MOFs were in a Final Deficit in the following aggregate amounts: \$559,378.34 for the MOF under the PCN Risk Agreement and \$4,365,325.07 for the MOF under the PCP Risk Agreement. (*Id* ¶ 13.) A true and accurate statement of the Final Deficits and Final Surpluses of the MOFs for each Target Month under the Risk Agreements for the calendar year of 2024 is attached as Exhibit 3 to the Declaration. A true and accurate statement of the MOFs for the post-petition Target Months of February through June 2024, including pro-rating the Final Deficit and Final Surplus for February 2024 and June 2024, is attached as Exhibit 4 to the Declaration.

III. REQUESTED RELIEF

21. Preferred Care requests the entry of an order substantially in the form of the proposed order attached as Exhibit A to this Motion granting (i) PCN an allowed administrative expense claim in the amount of \$559,378.34 under 11 U.S.C. § 503(b)(1)(A) for the amounts due

under the PCN Risk Agreement on a post-petition basis, and (ii) PCP an allowed administrative expense claim in the amount of \$4,365,325.07 under 11 U.S.C. § 503(b)(1)(A) for the amounts due under the PCP Risk Agreement on a post-petition basis. In accordance with Section 2.1 of the Plan, Preferred Care requests that such allowed administrative expense claims be paid within thirty (30) days of the entry of the order granting this Motion.¹¹

IV. ARGUMENT

- A. The Amounts Sought Represent Actual and Necessary Expenses for the Preservation of the Estate
- 22. "After notice and a hearing, there shall be allowed administrative expenses . . . including . . . the actual, necessary costs and expenses of preserving the estate." 11 U.S.C. § 503(b)(1)(A). "[T]o qualify for administrative priority, an expense 'must arise from a [post-petition] transaction with the debtor-in-possession' and the expense 'must be beneficial to the debtor-in-possession in the operation of the business." *In re Marcal Paper Mills*, 650 F.3d 311, 314–15 (3d Cir. 2011) (citing *Calpine Corp. v. O'Brien Env't Energy, Inc. (In re O'Brien Env't Energy, Inc.)*, 181 F.3d 527, 532–33 (3d Cir. 1999)) (alteration in original).
- 23. Here, both elements are met. First, the amounts sought by Preferred Care are for post-petition amounts due under the Risk Agreements. On a post-petition basis, DGM continued to provide Covered Services to Preferred Care's Members and Preferred Care continued to fund the MOF as compensation for such services. The MOFs under the Risk Agreements were in Final Deficit for the Target Months during this post-petition period, and, thus, DGM is liable to Preferred Care for the resulting Final Deficits on a post-petition basis.

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¹¹ As set forth in the Risk Agreements, this thirty day period is the same as provided for in Section 2 of Schedule B of the PCN Risk Agreement and Section 7 of Schedule B of the PCP Risk Agreement. (Decl. Ex. 1 Sch. B § 2, Ex. 2 Sch. B § 7.)

- 24. Second, Preferred Care's continued performance under the Risk Agreements on a post-petition basis was beneficial to the operation of DGM's business.
- 25. As stated in the *Declaration of Mark Kent in Support of Debtors' Chapter 11 Petitions*, the Debtors' business, including that of DGM, focuses on, among other things, "providing high-touch population health and wellness services to . . . Medicare Advantage patients" as well as those who are dual eligible for Medicare and Medicaid. (*Decl. of Mark Kent*, Dkt. No. 14, ¶ 16.) Mr. Kent further explained as follows:

A significant portion of the Debtors' revenue is capitated revenue, which, in the case of health plans, is a pre-negotiated percentage of the premium the health receives from CMS. While there are variations specific to each agreement, the Debtors generally contract with health plans, such as Humana, UnitedHealthcare, Elevance Health, CVS Health (or their respective affiliates) and others contracted by CMS, to receive recurring per-member-permonth ("PMPM") revenue. The Debtors then assume the financial responsibility for the healthcare costs of those members incurred at the Debtors' primary care locations, in addition to all third-party medical expenses (*e.g.*, hospital visits, specialist services, surgical services, and prescription drug costs).

(*Id.* ¶ 20 [emphasis in original].)

- 26. As Mr. Kent described, DGM continued to receive post-petition the benefit of the capitated revenue under the Risk Agreements, including receipt of the monthly Network Capitation Payments from the MOFs, based on having Preferred Care's Members assigned to it or one of its Network Providers. In exchange for this recurring revenue, as Mr. Kent observed, DGM assumes the financial responsibility for the healthcare costs of those Members.
- 27. "If the debtor-in-possession elects to continue to receive benefits from the other party to an executory contract pending a decision to reject or assume the contract, the debtor-in-possession is obligated to pay for the reasonable value of those services, which depending on the circumstances of a particular contract, may be what is specified in the contract." *N.L.R.B. v. Bildisco & Bildisco*, 465 U.S. 513, 531–32 (1984) (internal citations omitted); *see, e.g., In re*

Smurfit-Stone Container Corp., 425 B.R. 735, 741 (Bankr. D. Del. 2010) (observing "Courts in this District have consistently held that administrative expense priority is available to contract parties when the debtor enjoys the benefits of the contract pending assumption or rejection[;]" and collecting cases).

Because DGM chose to continue to provide Covered Services to Preferred Care's Members on a post-petition basis and receive the capitated revenue for providing such services, DGM clearly benefited from Preferred Care's performance under the Risk Agreements post-petition. Hence, DGM is obligated to pay Preferred Care the amounts due under the Risk Agreements, the Final Deficits for the post-petition Target Months, as the reasonable and necessary costs of such benefit to the estate. *Bildisco & Bildisco*, 465 U.S. at 531–32; *see Smurfit-Stone Container*, 425 B.R. at 741 (". . . this Court will apply *Bildisco*'s 'reasonable value of services' standard. Under this standard, there is a presumption that the contract rate is reasonable.")

B. Calculation of Amounts Due

29. As more particularly set forth in <u>Exhibit 3</u> to the Declaration, the Final Surpluses and Deficits for each of the Target Months of February through June 2024 are as follows:

POST-PETITION TARGET MONTHS												
		Feb-24		Mar-24		Apr-24		May-24		Jun-24 Subtotal		
PCN	\$	355,828.77	\$	24,708.58	\$	(621,808.09)	\$	(318,287.55)	\$	41,040.48	\$ (518,517.80)	
PCP	\$	(1,077,547.32)	\$	(1,374,508.15)	\$	(785,973.42)	\$	(680,283.99)	\$	(602,639.66)	\$ (4,520,952.54)	
TOTAL											\$ (5,039,470.34)	

30. As more particularly set forth in Exhibit 4 to the Declaration, once the Final Surpluses and Deficits for February and June are prorated due to DGM's petition being filed on February 4, 2024, and the rejection of the Risk Agreements being effective on June 28, 2024, upon occurrence of the Effective Date, the total aggregate Final Deficits are as follows:

POST-PETITION FINAL DEFICIT CALCULATION PRORATED												
	Feb.	. 4-28, 2024	Mar-24		Apr-24		May-24		June 1-28, 2024		Subtotal	
PCN	\$	317,704.26	\$	24,708.58	\$	(621,808.09)	\$	(318,287.55)	\$	38,304.45	\$	(559,378.34)
PCP	\$	(962,095.82)	\$	(1,374,508.15)	\$	(785,973.42)	\$	(680,283.99)	\$	(562,463.68)	\$((4,365,325.07)
TOTAL											\$ ((4,924,703.41)

31. As set forth in those calculations, DGM owes on a post-petition basis Final Deficits in the amount of \$559,378.34 under the PCN Risk Agreement and \$4,365,325.07 under the PCP Risk Agreement.

V. CONCLUSION

WHEREFORE, Preferred Care respectfully requests that this Court enter an order substantially in the form attached hereto as Exhibit A (i) granting PCN an administrative expense claim for the outstanding, post-petition amounts due under the PCN Risk Agreement in the amount of \$559,378.34, (ii) granting PCP an administrative expense claim for the outstanding, post-petition amounts due under the PCP Risk Agreement in the amount of \$4,365,325.07, (iii) ordering the Debtors to pay such amounts within thirty days of entry of such order in accordance with the terms of the Plan, and (iv) granting such other and further relief as this Court deems just and proper.

Wilmington, Delaware September 30, 2025 By: /s/ Alessandra Glorioso

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CERTIFICATE OF SERVICE

I hereby certify that on September 30, 2025, a copy of the foregoing was filed electronically and served by mail on anyone unable to accept electronic filing. Notice of this filing will be sent by e-mail to all parties by operation of the Court's electronic filing system or by First Class mail and/or by email to anyone unable to accept electronic filing as indicated on the Notice of Electronic Filing. Parties may access this filing through the Court's CM/ECF System. In addition, a copy of the foregoing was served via electronic mail on counsel listed below.

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/s/ Alessandra Glorioso

Alessandra Glorioso (DE Bar No. 5757)

EXHIBIT A

IN THE UNITED STATES BANKRUPTCY COURT FOR THE DISTRICT OF DELAWARE

In re:

CANO HEALTH, INC., et al., 1

Debtors.

Chapter 11

Case No. 24-10164 (KBO)

Jointly Administered

[PROPOSED] ORDER GRANTING JOINT MOTION OF PREFERRED CARE NETWORK, INC. AND PREFERRED CARE PARTNERS, INC. FOR ALLOWANCE OF <u>ADMINISTRATIVE EXPENSE CLAIMS</u>

Upon consideration of the joint motion (the "Motion")² of Preferred Care Network, Inc. ("PCN"), and Preferred Care Partners, Inc. ("PCP" and together with PCN, collectively, "Preferred Care") for the allowance of administrative expense claims pursuant to 11 U.S.C. § 503 in the amounts of, respectively, \$559,378.34 and \$4,365,325.07 against the bankruptcy estate of DGM MSO, LLC ("DGM") for unpaid amounts owed under, respectively, that certain Medicare Advantage Network Risk Agreement by and between PCN and DGM with an effective date of November 1, 2015 (as amended, the "PCN Risk Agreement") and that certain Medicare Advantage Network Risk Agreement by and between PCP and DGM with an effective date of November 1, 2015 (as amended, the "PCP Risk Agreement" and together with the PCN Risk Agreement, the "Risk Agreements") incurred post-petition between February 4, 2024, and June 28, 2024; this Court having jurisdiction to consider the Motion and the relief requested therein in accordance

¹ The last four digits of Cano Health, Inc.'s tax identification number are 4224. A complete list of the Reorganized Debtors in the chapter 11 cases may be obtained on the website of the Reorganized Debtors' claims and noticing agent at https://www.kccllc.net/CanoHealth. The Reorganized Debtors' mailing address is 9725 NW 117th Avenue, Miami, Florida 33178.

² Capitalized terms not defined herein shall have the meaning ascribed to them in the Motion.

with 28 U.S.C. §§ 157 and 1334 and the *Amended Standing Order of Reference* of the United States District Court for the District of Delaware dated February 29, 2012; consideration of the Motion and relief requested therein being a core proceeding pursuant to 28 U.S.C. §§ 157(b)(2)(A) and/or (B); notice of the Motion being adequate and appropriate under the circumstances; upon consideration of the record of all proceedings had before the Court; and after due deliberation and cause appearing therefor, it is hereby ORDERED:

- 1. The Motion is granted as set forth herein.
- 2. Pursuant to 11 U.S.C. § 503(b), PCN is allowed an administrative expense claim in the amount of \$559,378.34 against the bankruptcy estate of DGM for unpaid amounts owed under PCN Risk Agreement.
- 3. In accordance with Section 2.1 of the Plan, within 30 days after the entry of this Order, the Debtors shall pay PCN \$559,378.34.
- 4. Pursuant to 11 U.S.C. § 503(b), PCP is allowed an administrative expense claim in the amount of \$4,365,325.07 against the bankruptcy estate of DGM.
- 5. In accordance with Section 2.1 of the Plan, within 30 days after the entry of this Order, the Debtors shall pay PCP \$4,365,325.07.
- 6. This Court retains jurisdiction with respect to all matters arising from or related to the implementation of this Order.

EXHIBIT B

IN THE UNITED STATES BANKRUPTCY COURT FOR THE DISTRICT OF DELAWARE

Chapter 11 In re:

CANO HEALTH, INC., et al., 1 Case No. 24-10164 (KBO)

> Debtors. Jointly Administered

DECLARATION OF LUIS DIAZ DE ARCE IN SUPPORT OF JOINT MOTION OF PREFERRED CARE NETWORK, INC. AND PREFERRED CARE PARTNERS, INC. FOR ALLOWANCE OF ADMINISTRATIVE EXPENSE CLAIMS

- I, Luis Diaz de Arce, declare as follows:
- I am over the age of eighteen and believe in the obligations of an oath. 1.
- 2. I am employed by United HealthCare Services, Inc. ("UHCSI"). I am the Executive Director of Network Programs for Preferred Care Network, Inc. ("PCN"), and Preferred Care Partners, Inc. ("PCP" and together with PCN, "Preferred Care"), which are affiliates of UHCSI.
- 3. I submit this declaration in support of Preferred Care's Joint Motion of Preferred Care Network, Inc. and Preferred Care Partners, Inc. for Allowance of Administrative Expense Claims (the "Motion"), which is being filed concurrently herewith.
- 4. I make this declaration based on my personal knowledge and my personal knowledge of the books and records of Preferred Care and would competently testify thereof under oath if requested to do so.

¹ The last four digits of Cano Health, Inc.'s tax identification number are 4224. A complete list of the Reorganized Debtors in the chapter 11 cases may be obtained on the website of the Reorganized Debtors' claims and noticing agent at https://www.kccllc.net/CanoHealth. The Reorganized Debtors' mailing address is 9725 NW 117th Avenue, Miami, Florida 33178.

- 5. In my capacity as Executive Director of Network Programs, I am one of the custodians of the books, records, and files of Preferred Care that relate to the Risk Agreements (as defined below). I have personally worked on those books, records, and files, and as to the facts below, I know them to be true of my own knowledge or I have gained knowledge of them from the business records of Preferred Care, which records were made at or about the time of the events recorded, and which are maintained in the ordinary course of Preferred Care's business at or near the time of the acts, conditions, or events to which they relate. Any such document was prepared in the ordinary course of business of Preferred Care by a person who had personal knowledge of the event being recorded and had or has a business duty to record accurately such event.
- 6. Preferred Care provides health insurance benefits to members insured under certain governmental plans. PCN and PCP have Certificates of Authority from the Florida Office of Authority from the Florida Office of Insurance Regulation and have entered into a Medicare Advantage contract (the "Medicare Advantage Contract") with the Centers for Medicare & Medicaid Services ("CMS"). Under the Medicare Advantage Contract, PCN and PCP provide medical insurance to Medicare members enrolled in their Medicare Advantage plans ("MA Plans").
- 7. PCN was formerly known as Medica Healthcare Plans, Inc. ("Medica"). On January 1, 2022, Medica changed its name to PCN.
- 8. PCN and DGM MSO, LLC ("<u>DGM</u>") are parties to that certain Medicare Advantage Network Risk Agreement with an effective date of November 1, 2015 (as amended, the "<u>PCN Risk Agreement</u>"), pursuant to which DGM arranges for or otherwise provides covered health care services to PCN members enrolled under MA Plans that are assigned to a DGM primary care provider. A true and correct copy of the PCN Risk Agreement is attached as <u>Exhibit 1</u> hereto.

- 9. PCP and DGM are parties to that certain Medicare Advantage Network Risk Agreement with an effective date of November 1, 2015 (as amended, the "PCP Risk Agreement" and together with the PCN Risk Agreement, the "Risk Agreements"), pursuant to which DGM arranges for or otherwise provides covered health care services to PCP members enrolled under MA Plans that are assigned to a DGM primary care provider. A true and accurate copy of the PCP Risk Agreement is attached as Exhibit 2 hereto.
- 10. On February 4, 2024, 2024, DGM filed for bankruptcy. Subsequent to DGM's bankruptcy petition and continuing through the effective date (the "<u>Effective Date</u>") of DGM's plan of reorganization, June 28, 2024, on which date the Risk Agreements were rejected, DGM continued to render Covered Services² to Preferred Care's Members and Preferred Care continued to fund the respective Medicare Operating Funds (each, an "<u>MOF</u>") in accordance with the terms of the Risk Agreements.
- 11. Attached hereto as Exhibit 3 is a true and accurate statement of the Final Deficits and Final Surpluses of the MOFs for each Target Month under the Risk Agreements for the calendar year of 2024.
- 12. Attached hereto as Exhibit 4 is a true and accurate statement of the MOFs for the post-petition Target Months of February through June 2024, including pro-rating the Final Deficit and Final Surplus for the Target Month of February 2024 for the period of February 4 28, 2024, and for the Target Month of June 2024 for the period of June 1 28, 2024.
- 13. Taking into account the pro-rating of February and June 2024, as described above, the total aggregate Final Deficits for the post-petition Target Months of February through June

² Capitalized terms not defined herein shall have the meaning ascribed to them in the Risk Agreements.

2024 are \$559,378.34 under the PCN Risk Agreement and \$4,365,325.07 under the PCP Risk Agreement.

Pursuant to the provisions of 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct.

Executed this 24th day of September 2025.

Luis Diaz de Arce

Executive Director of Network Programs

United HealthCare Services, Inc.

Waterford Building

1000 NW 57th Court, Suite 500

Miami, FL 33126

EXHIBIT 1



MEDICARE ADVANTAGE

NETWORK RISK AGREEMENT

MEDICA HEALTHCARE PLANS, INC., a Florida corporation ("Plan") and DOCTORS GROUP MANAGEMENT LLC (the "Network") enter into this Medicare Advantage Network Risk Agreement ("Agreement") effective November 1, 2015.

1. SCOPE OF AGREEMENT

- 1.1 Plan has a Certificate of Authority from the Florida Office of Insurance Regulation, and has entered into a Medicare Advantage Contract with CMS (the "Medicare Advantage Contract"). Under Plan's Medicare Advantage Contract, Plan provides medical services to Medicare members enrolled in Plan's plans.
- 1.2 Network is a management services organization and provider network that engages physicians, physician groups, and ancillary providers to provide health care services to the members of health maintenance organizations, preferred provider organizations or other managed care companies with network contracts.
- 1.3 Plan wishes to engage to provide and arrange for the provision of Covered Services to Plan Members and Network agrees to provide and arrange Covered Services for Plan Members.
- 1.4 Plan and Network agree to enter into this Agreement under which Network will provide Covered Services to Plan Members.

2. <u>DEFINITIONS</u>

The following capitalized terms have the definitions stated this Section:

- 2.1 "Admitting Physician" means a Participating Physician who admits Members to Participating Hospital or to another hospital with approval of Plan.
 - 2.2 "AHCA" means the Florida Agency for Healthcare Administration.
- 2.3 "CMS" means the United States Centers for Medicare and Medicaid Services, an agency of the Department of Health and Human Services, with which Plan has entered into a Medicare Advantage contract to provide health care services and benefits to Medicare beneficiaries.
- 2.4 "Copayment" means the amount, if any, required to be paid by the Member to a Participating Network as additional payments for Covered Services at the time Covered Services are rendered, in accordance with Plan's schedule of benefits applicable to the particular health services plan in which a Member is enrolled. This may also be termed "cost-sharing" as further explained in the Medicare Advantage Regulatory Requirements Appendix, attached hereto.
- 2.5 "Covered Services" means the medical services Plan is required to provide to Members under Plan's agreement with CMS and under the terms of the benefit plan in which a Member has enrolled and as further explained in the Medicare Advantage Regulatory Requirements Appendix to this Agreement, including, without limitation: Primary Care, specialist medical services, hospital services, ancillary and diagnostic services, and Emergency Services.
- 2.6 "Credential" or "Credentialing" means the process for verifying that physicians and other medical professionals providing services under this Agreement are adequately trained, licensed, of good

professional reputation and capable of working with others to provide Covered Services to Members. The term includes the re-credentialing process.

- 2.7 <u>"Emergency Medical Condition"</u> means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - (a) Serious jeopardy to the health of the individual or, in the case of a pregnant women, the health of the woman or her unborn child;
 - (b) Serious impairment to bodily functions; or
 - (c) Serious dysfunction of any bodily organ or part.
- 2.8 <u>"Emergency Services"</u> means Covered Services that are (i) furnished by a provider qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an emergency medical condition.
 - 2.9 "HHS" means the United States Department of Health and Human Services.
- 2.10 "Medical Director" means a physician designated by Plan (or by Network in connection with any delegated Utilization Management functions) to monitor and review Covered Services provider to Members by a health care provider or that a health care provider requests to provide to a Member.
- 2.11 "Medically Necessary" is defined by Plan in the exercise of its sole discretion and includes due consideration of whether services are (i) consistent, specific and individualized with the symptoms or diagnosis and treatment of Member's condition, disease, ailment or injury; (ii) appropriate with regard to standards of good medical practice within the surrounding community; (iii) not solely for the convenience of the Member, Member's caretaker, a Participating Network, or other health care provider, and (iv) the most appropriate supply or level of service which can be safely provided to the Member.
- 2.12 <u>"Medicare Program"</u> means the Medicare Advantage program administered by CMS on behalf of Medicare beneficiaries covered under Title 18 of the Social Security Act.
- 2.13 "Member" (also referred to as "Customer" and "Plan enrollee") means any individual, who has been enrolled in a Medicare health services plan offered by Plan under Plan's contract with CMS and has been assigned by Plan to Network or a Network Provider or has selected a Network Provider.
- 2.14 "Network Provider" means a physician that (i) has entered into an agreement with Network to provide health care services to Members and (ii) has successfully completed Plan Credentialing.
- 2.15 "OIR" means the Florida Department of Financial Services Office of Insurance Regulation.
- 2.16 "Participating Provider" means a Physician, Primary Care Physician, ambulatory surgery center, specialty physician hospital, home health agency, pharmacy, multi-specialty group practice, nursing home, or any other health care provider that has entered into an agreement with or is otherwise engaged by Plan to provide Covered Services to Members. Participating Providers may be referred to as a Participating Physician, Participating Hospital, Participating Pharmacy, etc. All Network Providers are deemed Participating Providers under this Agreement.
- 2.17 "Physician" means, for purposes of this Agreement, an individual, or group of individuals, duly licensed under Chapter 458 or 459, Florida Statutes, to practice medicine in the State of Florida, and qualified under the Medicare Program to provide services to Medicare beneficiaries.
- 2.18 <u>"Plan Provider Manual"</u> means the Provider Manual of Plan as amended and revised from time to time by Plan in its sole discretion.
- 2.19 "Primary Care Physician" (also referred to as a "PCP") means a Physician who has contracted with Plan to provide Primary Care Services to Members, including initiating referrals to other Participating Providers for non-Primary Care Services. The Primary Care Physician will refer Members

only to Participating Networks, when Medically Necessary, and be available twenty-four hours per day in case of emergency.

- 2.20 <u>"Primary Care Services"</u> means those Covered Services customarily provided by a primary care physician in his or her office as well as services customarily provided by an attending primary care physician to institutionalized patients, as more specifically described in Schedule A to this Agreement.
- 2.21 "Quality Improvement Program" means Plan's program to measure and evaluate the quality of care provided to Members, and to implement corrective action when necessary to assure the provision of quality care and compliance with all applicable laws or regulations concerning the provision of medical and hospital services to Members.
- 2.22 <u>"Specialty Physician"</u> means a Participating Provider who: is appropriately qualified in a certain medial specialty as determined by Plan; provides Covered Services to members within the range of that specialty; elects to be designated by Plan as a Specialty Physician; and meets all other Plan requirements of a Specialty Physician.
 - 2.23 "Urgently Needed Services" is as defined in 42 CFR §422.113.
- 2.24 <u>"Utilization Management" and "Utilization Management Program"</u> mean a program of Plan to provide quality health care and outcomes that meet community standards and the standards established under the Quality Improvement Program in the most cost-effective manner. These terms include, without limitation: prior authorization; precertification of elective admissions and procedures; referral processes; concurrent review; retrospective review; discharge planning; case management; disease management protocols; and reporting of encounter data.

3. RESPONSIBILITIES OF PLAN

- 3.1 <u>Administrative Procedures.</u> Plan, through its Medical Director and other individuals designated by Plan, will establish procedures for the following:
 - (a) <u>Authorizations.</u> A system for authorizing referrals to Specialty Physicians.
 - (b) Notices, Written notice of denials of claim forms or Covered Services.
 - (c) <u>Pre-admission Certification.</u> A system of pre-admission certification for all elective hospital admissions.
 - (d) <u>Encounter Reports.</u> A Member encounter reporting process to be implemented in accordance with Plan's policies and procedures.

The Plan Provider Manual contains all procedures relating to the procedures described in this Section 3.1. Plan and Network agree that although Plan establishes these procedures, Network must provide all services and functions with respect to some of the foregoing items, such as authorizing written referrals and providing pre-admission certifications as agreed to by Plan and Network and consistent with Plan's obligations as a licensed health plan.

- 3.2 Administration of Plan. Plan will perform the appropriate administrative, regulatory, enrollment and other functions necessary for the administration of the obligations to the Members, pursuant to applicable State and Pederal law. Plan has sole responsibility and final decision making authority for: (i) payment of claims for health care services rendered to Members; (ii) credentialing of all Participating Providers, including Network Providers; (iii) eligibility for enrollment in Plan, (iv) termination of a Member's coverage under Plan; (v) all benefit determinations; and (vi) Network Provider and Member grievance systems established by Plan.
- 3.3 Advertising. Plan may utilize the name, address, telephone number, types of practice, hours of operation and such other relevant information of Network Providers in its marketing materials for dissemination to the public. Network shall not advertise or market Plan or any of their health care services and benefit plans. Network shall not utilize any trademarks, tradenames, logos or other intangible property of Plan without the Plan's prior written approval.
- 3.4 Marketing. Nothing in this Agreement shall be construed to require Plan to assign any minimum or maximum number of Members to Network. Plan does not provide any guarantee to Network

as to the number of Members who will select or be assigned to Network. Plan agrees to use commercially reasonable efforts to assign Members to Network as reasonably determined by Plan.

- 3.5 Transfer and Assignment of Members. Plan and Network acknowledge and agree that Members benefit from maintaining an ongoing relationship with their medical professionals. As such, neither Plan nor Network will encourage Members to change Networks or Network Providers absent just cause for such transfer. However, Plan may stop assigning additional Members to Network or a Network Provider and nothing in this Agreement prevents Plan from transferring Members assigned to Network to any other Network or Participating Provider if the capacity of Network or any Network Provider is overburdened to the extent that the provision of Covered Services as required by this Agreement is adversely affected, if Network or any Network Provider fails to comply with Plan's Quality Improvement Program, or if such transfer is in the best interests of the Member(s). A Network Provider may requeist in writing to Plan that a Member be assigned to another Participating Provider, however, a Network Provider may not seek to a Member transfer due to the amount of medical services required by Member or the physical condition of Member. Network acknowledges that Members have a contractual right to request a transfer to another Participating Provider.
- 3.6 <u>Enrollment.</u> Network acknowledges that Florida Law requires that the Plan must handle the enrollment of all Members. Accordingly, Network and Network Providers must not participate in any manner in the enrollment of Members. Plan and Network acknowledge and agree that in establishing the terms of this Agreement, neither party gave or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by this Agreement) for which payment may be made in whole or in part by a Federal health care program.
- 3.7 <u>Member Eligibility.</u> Plan will provide each Member with an identification card that Member will present to Network Providers so that Network Providers can verify Member eligibility. In addition, by the first day of each month, Plan will provide Network with a list of all Members ("Membership List") eligible to receive Covered Services during that month. Plan will not be responsible for medical services provided to non-eligible individuals.
- 3.8 Reports. Plan shall provide Network with information and data reasonably necessary to carry out the terms and conditions of this Agreement.
- 3.9 <u>Programs.</u> Plan shall establish and manage a Quality Improvement Program and a Utilization Management Program. Plan will consult with Network regarding Plan's medical policy, quality improvement program and medical management procedures.

4. COMPENSATION

- 4.1 <u>Payment.</u> Plan will pay Network for the continual and complete discharge of its obligations under this Agreement in accordance with Schedule B. Surcharges for any Covered Services are prohibited. Plan and Network further acknowledge and agree that:
 - (a) in establishing the terms of the Agreement, neither Plan nor Network gave or received remuneration in return for or to induce the provision or acceptance of business for which payment may be made in whole or in part by a Federal health care program (other than the healthcare services that are the subject of this Agreement); and
 - (b) neither Plan nor Network will shift the financial burden of the Agreement to the extent that increased payments are claimed from a Federal health care program.
 - (c) Network represents and agrees that Network cannot and will not claim payment in any form, directly or indirectly, from a Federal health care program for items or services covered under the Agreement, except as expressly permitted by applicable law.

5. RESPONSIBILITIES OF NETWORK

5.1 <u>Covered Services.</u> Network agrees to provide, or arrange for the provision of all Covered Services to all Members assigned to Network or a Network Provider by Plan or who select a Network Provider. Network will provide or arrange Covered Services including without limitation the services stated in Plan's Medicare Advantage health benefits filed with and approved by CMS as part of Plan's Benefit

Bids. Network will manage and administer Covered Services in accordance with the terms and conditions of this Agreement and:

- (a) the policies, procedures and Quality Improvement Programs and Utilization Management Programs of Plan;
 - (b) the professional standards of care in the medical community;
- (c) in the same manner and with the same manner of care and availability offer all other patients without regard to (i) frequency of utilization of services by Member, or (ii) physical condition or health status of Member; and
- (d) without regard to race, color, age, place of residence, economic status, health status, health care needs, benefit plan, source of payment, religion, national origin or handicap of a Member in accordance with 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.
- 5.2 Network Risk. Network assumes financial risk for the provision of all Covered Services to Members whether or not the Covered Services are provided by Network Providers. This includes financial responsibility for Covered Services provided by Participating Providers that are not Network Providers and non-participating providers to the extent permitted under a Member's benefit plan.
- 5.3 <u>Member Communication.</u> Network and all Network Providers will make appropriate provisions to communicate with Members in the primary language used by Members.
- Licensure and Credentials. The credentials of all Network Providers, including but not limited to Physicians, Radiologists, PAs and ARNPs, must be verified and approved by Plan before services are provided to Members. Network agrees that all Network Providers and all other health professionals employed, retained or in professional association with Network or any Network Provider who provide services under this Agreement must be appropriately trained, qualified and licensed by the State of Florida and all other applicable government entities to practice their profession and to perform the procedures provided under this Agreement. Plan has primary responsibility for all Credentialing functions under this Agreement, but Network will assist Plan in carrying out Plan's Credentialing program with respect to Network Providers. Network will obtain from prospective Network Providers and submit to Plan all information requested by Plan for its Credentialing determination. Network Providers must submit and at all times maintain the accuracy and completeness of credentialing data provided to Plan and its designees, Participating Hospitals, governmental authorities and any entity that has been designated to verify credentials of Physicians. Plan may rely in its credentialing process on information provided by Physician to any of the above-referenced agencies and to any hospital at which Physician is a member of the medical staff. Network agrees that if a Physician participates in more than one benefit plan sponsored by any entity under common ownership or control with Plan (a "Plan Affiliate") Plan may provide any and all credentialing information in its possession to any Plan Affiliate and that any Plan and Plan Affiliates may rely on the credentialing decisions of the Plan or any Plan Affiliate in making credentialing decisions. Network warrants that Network Providers are providers in good standing under the Medicare Program.
- 5.5 Agreements with Network Providers. Network will contract with primary care physicians and specialty physicians to arrange for the provision of Covered Services to Members. The form of these agreements ("Network Provider Agreements") is subject to review and approval by Plan in Plan's sole discretion. Network will provide Plan with a copy of each form of Network Provider Agreement and, upon request from Plan, Network will provide Plan copies of each executed Network Provider Agreement. Network may not alter the terms of a Network Provider Agreement without the prior approval of Plan in Plan's sole discretion. All Network Provider Agreements must contain a provision stating that if any term or condition of the Network Provider Agreement conflicts with any term or condition of this Agreement this Agreement will control and supercede the conflicting terms and conditions of the Network Provider Agreement. Network will use its best efforts to obtain the agreement of any provider who becomes affiliated with a Network Provider to become a Network Provider.

If Network contracts with a Network Provider that is a professional corporation, professional association or partnership, Network agrees to cause all of the terms of this Agreement to apply with equal force to the professional corporation, professional association or partnership and the individual physicians

or providers associated with that entity. Notwithstanding any interpretation of this Agreement to the contrary, Network agrees, represents and covenants that all of the provisions of this Agreement applicable to Network, unless expressly inapplicable, will apply with equal force to Network Providers. Network will represent its Network Providers in matters pertaining to the provision of Covered Services under this Agreement and Network represents that it has obtained consent to such representation from its Network Providers.

- 5.6 <u>Utilization</u>. Network and Network Providers must comply with and be monitored under the Plan's Utilization Management Program as in effect from time to time. Plan has the right to override any Utilization determination reached by Network and any such determination by Plan will bind Network. Plan may pay claims based on its utilization determinations. Without limiting the generality of the foregoing sentence, Plan may pay any claim included in a claims report provided to Network if Network does not object to payment of the claim with five business days after Network receives the report.
- 5.7 <u>Verification of Eligibility</u>. Network is responsible for verifying eligibility of Members before Network Providers render Covered Services to such individuals.
- 5.8 Referrals. Network will, and will cause Network Providers to, refer Members for the provision of Covered Services only to Participating Providers, except with the prior approval of Plan or in the case of Emergency Services, and to make referrals only when Medically Necessary. Network will, and will cause Network Providers to, make all referrals in compliance with Plan's approved Utilization Management Program. Network will, and will cause Network Providers to, furnish to health care providers to whom or to which it has referred a Member complete information on treatment procedures and all pertinent clinical services provided to Member prior to such referral. Members do not need prior authorization from Plan for the following Covered Services: (i) screening mammography and influenza vaccine; and (ii) women's routine and preventive health care services from a Participating Network that is a women's health specialist.
- 5.9 <u>Copayments.</u> If applicable under Plan's plan, Network will, and will cause Network Providers to, use reasonable efforts to collect the applicable Copayments from Members.
- 5.10 Refunds and Setoffs. Network agrees and will cause Network Providers to immediately refund to Plan all sums collected by Network or a Network Provider from Members that Network or the Network Provider was not entitled to under this Agreement. These refunds may take the form of cash payments or setoffs against amounts owed to Network by Plan. Network and Network Providers will not charge a co-payment for influenza vaccine and pneumococcal vaccine
- 5.11 Non-Covered Services. If Network or a Network Provider provides non-Covered Services to Members, Network or Network Provider must inform the Member, prior to the provision of such non-Covered Service, (i) of the service(s) to be provided, (ii) that Plan will not pay for or be liable for such non-Covered Service, and (iii) that the Member will be financially responsible for such non-Covered Service as applicable by law.
- 5.12 <u>Formulary.</u> Network will comply, and will cause Network Providers to comply, with Plan's prescription drug formulary, which may be amended from time to time, in Plan's sole discretion.
- 5.13 Hospital Admissions. Network will cause Network Providers to, admit to, and provide appropriate services at a Participating Hospital to Members. Network shall maintain clinical privileges at a Participating Hospital. Network will cause Network Providers to maintain clinical privileges at a Participating Hospital. Plan shall be responsible for the remuneration of the Admitting Physician and has the right to deduct the amount paid to the Admitting Physician from the Compensation due to Network. The Admitting Physician must sign an Acceptance Letter provided by Plan. Admission to a Participating Hospital must be certified in advance by Plan or Network in accordance with the approved Utilization Management Program. If Plan implements a plan utilizing hospitalists to provide inpatient services to Members, Network shall participate with such plan, as amended from time to time, to the extent that such participation does not violate any applicable law, rule or regulation, including F.S. §641.315, as amended.
- 5.14 Approvals. Network agrees to use and to cause Network Providers to use, only Participating Hospitals, Nursing Homes, Home Health Agencies, Ancillary Service Networks, and

Licensed Medical Professionals which have been approved in advance by Plan, and to obtain prior approval from Plan before admitting Members to such facilities, except in case of Emergency Services.

- 5.15 Coverage. Network is responsible for the provision, authorization, coordination, supervision, monitoring and overall management of all Covered Services to Members in accordance with Plan's policies and procedures. Network will ensure that Network Providers maintain adequate personnel and facilities to fulfill Network's contracted obligations under this Agreement. Network will cause Network Providers to provide or arrange for the provision of Covered Services twenty-four (24) hours per day, seven (7) days per week, including holidays, to all Members, in a manner that assures continuity of care through the coordination of overall health care and the sharing of medical records. Network will cause Network Provides to comply with the following availability schedule: urgent care within one day; routine sick care within one week; and wellcare within one month. Network will ensure that Network Providers who are Primary Care Physicians make referrals for Covered services that are not Primary Care Services when Medically Necessary. Network will cause Network Providers to maintain twenty-four (24) hours a day, seven days a week telephone answering service.
- 5.16 <u>Authorization</u>. All Covered Services for which payment is to be made must be provided in accordance with the policies and procedures of Plan. Plan reserves the right to authorize or deny, in whole or in part, any claim for payment that is the subject of a dispute between or among the Member, Network, a Network Provider or any other provider of services. Network agrees that Plan's determination will be binding and final.

5.17 Programs/Continuing Education.

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- (a) Network will cause Network Providers to receive and participate in any applicable training programs developed by Plan, including those concerning the Plan's policies and procedures, credentialing programs, quality improvement programs, utilization management programs, claims payment policies, grievances, and other similar programs established by Plan to promote appropriate standards of medical care and to control the cost and monitor the quality of medical services rendered to Members, including without limitation programs relating to the precertification of elective admissions and procedures, referral process and reporting of clinical encounter data. Network shall abide by and be bound by the respective program determination of Plan.
- (b) Network will cause Network Providers to participate in any continuing education programs established or recommended by Plan that is appropriate to the Notwork Provider's area of practice. Network will cause Network Providers to maintain the educational standards required by the Network Provider's licensure board, if applicable.
- 5.18 Arbitration and Grievances. Network agrees to participate and to cause Network Providers to participate in the arbitration of medical malpractice claims arising out of the services provided under this Agreement, in the event a Member is required to arbitrate such claims. Network further agrees to, and to cause Network Providers to, participate in, cooperate with, and be bound by the grievance procedure adopted by the Plan pursuant to State and Federal requirements. Network will notify Plan of any complaints received by Network and Network Providers. Network will, and will cause Network Providers to, use best efforts to resolve any Member complaints in a fair and equitable manner.
- 5.19 <u>Compliance with Laws and Medicare Regulations</u>. Network will comply with, and will cause all Network Providers to comply with, all applicable Federal and State Laws and regulations and CMS instructions. One or more regulatory appendix may be attached to this Agreement. These regulatory appendices are expressly incorporated into this Agreement and bind the parties to this Agreement. If any language in a regulatory appendix is inconsistent with or contrary to any other part of this Agreement, including but not limited to attachments, exhibits, appendices, and amendments, the regulatory appendix will control to the extent applicable.
- 5.20 Notice of Claims. Network must notify Plan of any claim or cause of action by or relating to a Member filed against Network within five (5) days of Network's receipt that such claim or cause of action has been filed. Network will cause each Network Provider to notify Plan of any claim or cause of action by or relating to a Member filed against Network Provider within five (5) days of Network

Provider's receipt that such claim or cause of action has been filed. Network will, and will cause Network Providers to, provide Plan with any additional information about such claims that Plan reasonably requests.

- 5.21 <u>Notification of Changes</u>. Network shall immediately notify Plan in writing upon the occurrence of any of the following:
 - (a) Any changes to the list of current Network Providers, their addresses, telephone and/or facsimile numbers on Schedules C or D;
 - (b) Any Network Provider's license to practice medicine in the State of Florida is suspended, revoked, terminated, or subject to terms of probation or other restrictions;
 - (c) Network or any Network Provider has become a defendant in any malpractice action, receives any pleadings, notices or demands of claim, or service of process relating to alleged malpractice of Network or Plan involving a Member, or is required to pay damages in any such action by way of judgment or settlement;
 - (d) Network or any Network Provider becomes the subject of any disciplinary proceeding or action before a governmental agency, including any State of Florida department, board, or agency, or a similar entity in any state;
 - (e) Any Network Provider is convicted of a felony relating directly or indirectly to the practice or conduct of Network's profession;
 - (f) Network or any Network Provider is sanctioned or is subject to sanctions by the Medicare programs;
 - (g) Any Network Provider's clinical privileges at any hospital are being terminated, restricted, canceled or suspended;
 - (h) Any Network Provider becomes incapacitated;

- (i) An act of nature or any event beyond a Network Provider's reasonable control likely to interrupt all or a portion of a Network Provider's practice for a period of sixty (60) consecutive calendar days, or which may have a material adverse effect on Network's ability to perform his/her/its obligations for this period;
 - Any change in the nature or extent of services rendered by a Network Provider;
- (k) Any material change or addition to the information and disclosures submitted by Network Provider as part of the application for a contract with Plan or Network to provide Covered Services to Members;
- Any other act, event, occurrence or the like that might materially affect a Network Provider's ability to carry out Network Provider's duties and obligations to Members;
- (m) If a Network Provider is a corporation, professional association or partnership, any of the above events with respect to a physician or other health professional who owns, is employed by, or is otherwise associated with such Network Provider; or
- (n) Any of the above events with respect to any employee, subcontractor(s) and/or independent contractor of Network who provides or will provide Covered Services to Members.
- 5.22 <u>Information Exchange.</u> Network covenants that Network will communicate with and transmit data and information to Plan's management information systems in a manner that does not disrupt Plan's business.

6. POLICIES AND PROCEDURES

Network agrees and will require Network Providers to agree to comply with and be bound by the policies, procedures and rules established by Plan that are now in effect and as adopted and amended after the date of this Agreement. Such policies, procedures and rules are incorporated in this Agreement and made a part of this Agreement including but not limited to those policies, procedures and rules set forth in the Plan's Network Manual, Plan's credentialing and re-credentialing programs, Plan's procedures to

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identify, assess, and establish a treatment plan for serious and complex conditions, Plan's quality improvement program, Plan's grievance program and any other programs established by Plan from time to time. Network acknowledges receipt of such policies, procedures and regulations, including the Plan's Network Manual. Network shall be bound by the policies, procedures and rules of Plan, and any amendments to same, upon delivery of such written policy or amendment, by hand, U.S. mail, or electronic delivery.

7. UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT

Network understands that Plan manages care to provide Medically Necessary and cost-effective Covered Services to the Members. To ensure efficiency and quality, Plan has established programs of utilization management and quality improvement that are more specifically described in the Policies and Procedures of Plan. Network agrees to support and to cause Network Providers to support the principle of managed care through participation in the Utilization Management Program of Plan and will cooperate with Plan to determine the Medical Necessity of any inpatient or outpatient service for a Member. Network further agrees to participate in and to cause Network Providers to participate in the Quality Improvement Program, which includes internal peer review, on-site external audit, independent quality review and other procedures to ensure quality services. In conjunction with any such review or program, Network will cause Network Providers to make available at no charge to Plan whatever information is requested by Plan.

8. TERM OF AGREEMENT

This Agreement commences on the Effective Date and continues for a three (3) year term. Thereafter, this Agreement automatically renews for subsequent three (3) year terms unless terminated in accordance with Section 9.

9. TERMINATION

- 9.1 <u>Termination for Cause by Plan.</u> This Agreement may be terminated by Plan for cause with regard to Network or any Network Provider by delivering to Network written notice stating; (i) the effective date of termination; (ii) reason(s) for the termination. If terminating a Network Provider, Plan must also provide (iii) information regarding the Network Provider's right to appeal the termination. The term "cause" means any of the following events:
 - (a) If Network or a Network Provider commences an action for relief as a debtor under the United States Bankruptcy Laws, or any bankruptcy, receivership, insolvency, reorganization, dissolution, liquidation or similar proceeding is instituted against Network or any of Network's physicians or principals;
 - (b) Network, Network Provider, or any of its officers, directors, employees, shareholders or Physicians, have been charged with, indicted for, or convicted of a felony;
 - (c) Failure of Network or a Network Provider to provide Covered Services in accordance with the standards of quality established by the medical community, the Plan, and all applicable state and federal laws, regulations and guidelines;
 - (d) If Network or a Network Provider is disqualified by any State or Federal regulatory agency from participation in the Medicare Program or, as a result of regulatory action, is unable to perform Network's obligation under this Agreement;
 - (e) Any action by the Board of Medicine or other governmental agency that effectively impairs Network's or a Network Provider's ability to practice Network's or Network Provider's health care profession;
 - (f) Failure of Network or a Network Provider to meet and/or maintain compliance with credentialing standards and other requirements of Plan, including but not limited to, maintaining professional liability insurance coverage as required by Plan;
 - (g) Any material breach of this Agreement by Network or a Network Provider;
 - (h) The willful breach, habitual neglect, or continued failure of Network or a Network Provider to abide by Plan's rules, regulations, procedures, policies, determinations or any other activity for which Network has received notice;

- (i) Commission of an act of fraud or theft against Plan;
- (j) Good faith determination by Plan that Network's or Network Provider's continued participation under this Agreement may adversely affect the health, safety or welfare of any Member; or
- (k) Termination or non-renewal of the Medicare Advantage Contract between CMS and the Plan.

For purposes of this Section 9.1, if a Network Provider is a corporation, professional association or partnership, the term Network shall include a physician or other health care professional who owns, is employed by or is affiliated with such Network.

- 9.2 <u>Additional for Cause Termination of Network</u>, Plan may also terminate this Agreement for cause upon written notice to Network stating any of the following grounds for termination:
 - (a) A material breach of the this Agreement by Network, including without limitation failure to maintain the Medicare Operating Fund as described in Schedule [B] that Network does not cure within thirty (30) days of receiving written notice from Plan stating the breach to be cured; provided, however, that if the breach relates to a monetary obligation of Network, Network must cure the breach within five (5) days.
 - (b) Network acts in a manner that is demonstrably injurious to the goodwill or reputation of Plan.
- 9.3 <u>Termination for Cause by Network.</u> This Agreement may be terminated by Network for cause by delivering to Plan written notice stating: (i) the effective date of termination; (ii) reason(s) for the termination. The term "cause" means any of the following events:
 - (a) Non-payment of any amount required to be paid by Plan if Plan does not cure or contest the default within thirty (30) days of receipt of demand.
 - (b) A material breach of this Agreement by Plan that Plan does not cure within thirty (30) days of receiving written notice from Network stating the breach to be cured.
 - 9.4 [SECTION OMMITTED INTENTIONALLY]
- 9.5 <u>Statutory Termination.</u> The OIR, pursuant to Florida Statute 641.234, may order the Plan to cancel this Agreement.
- 9.6 <u>Effect of Termination.</u> If this Agreement is terminated for any reason, the parties shall be relieved of all obligations under this Agreement, except that Network agrees to, and to cause Network Providers to:
 - (a) complete the course of treatment of any Member then receiving treatment until provision has been made for the reassignment of the Member to another Participating Network;
 - (b) not to seek compensation from Members for services provided prior to the termination and completion of treatment of Members then receiving treatment;
 - (c) return any and all Plan provided materials, provider manuals, or other documentation, including all copies, whether authorized or not; and
 - (d) cooperate in the transfer of Members and Members' medical records.
- 9.7 <u>Continuation of Services.</u> If this Agreement is terminated for any reason other than for cause and in addition to the obligations set forth in Section 10.4 above, Network and Plan shall allow Members for whom treatment was active to continue coverage and care when medically necessary: (i) through completion of treatment of a condition for which the Member was receiving care at the time of the termination, (ii) until the Member selects another treating provider, or (iii) during the next open enrollment period offered by the Plan, whichever is longer, but not longer than six (6) months after termination of this Agreement. Network and Plan shall allow a Member who has initiated a course of prenatal care and coverage until completion of postpartum care. This provision does not prohibit Network or a Network Provider from refusing to continue to provide care to a Member who is abusive, noncompliant, or in arrears

in payments for services provided. For care continued under this provision, Plan and Network shall continue to be bound by the terms of this then terminated Agreement.

9.8 <u>Financial Reconciliation.</u> Within one hundred eighty (180) days after the termination or expiration of this Agreement, Plan will make an accounting monies, if any, due and owing Network under this Agreement. Any payments determined to be due and owing shall be paid within thirty (30) days after Plan delivers written notice of the accounting to Network.

10. REPORTS, FORMS, MEDICAL RECORDS AND REVIEWS

- Reports, Network will cause Network Providers to submit to Plan on a monthly basis, encounter, clinical and utilization reports concerning the treatment of Members, in such form and at such times as required by Plan. Encounter information on capitated providers must be submitted to Plan within 30 days of the date of service. Network further agrees to certify that all information, data, and/or reports submitted to Plan are accurate, complete and truthful. Network will report to Plan's risk manager all Incidents involving a Member in accordance with Plan's incident report guidelines.
- 10.2 Forms. For services requiring a Referral Form, Network agrees to complete and utilize and to cause Network Providers to complete and utilize the form supplied by Plan for each referral. Network further agrees to cause Network Providers to provide services requiring a Referral Form only upon receipt of a properly completed form containing an authorization number from Plan.
- Medical Records. Network will, and will cause Network Providers to, create appropriate medical records that Network and Network Providers must maintain in accordance with the standards established by the medical community and treat as confidential. Network will cause Network Providers to participate in the record-keeping systems established by Plan, as amended. Network will cause Network Providers to make available to Plan, the Member, another Participating Network, or any other authorized individual, copies of such medical records, upon request, for a period of ten (10) years after the termination or expiration of this Agreement. Network and Network Providers will not charge Plan, a Member or a Participating Network for the provision or copying of such records.
- 10.4 Transfer of Records. In the event of (i) termination of this Agreement, (ii) the selection by a Member or assignment by Plan of Member to another Network or Participating Provider in accordance with Plan's procedures, or (iii) the approval by Plan of a Network's or a Network Provider's request to transfer a Member from such Network Provider's practice to another of Plan's Participating Providers, Network will cause Network Provider to transfer copies of Member's medical records, x-rays, and any and all other pertinent data to Plan, and to the new Participating Provider selected by Member or assigned by Plan, when requested to do so in writing by Plan or Member. This charge shall be billed to Plan at a reasonable charge, not to exceed the amount stated in Florida Statute ch. 395.3025 and shall not be billed to Members, AHCA or CMS.

11. INSURANCE AND INDEMNIFICATION

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- Insurance. During the term of this Agreement, Network must maintain at its own expense policies of general liability, professional liability, and other insurance as necessary to insure Network and Network's employees or agents against any claim for damages arising by reason of personal injury or death occasioned directly or indirectly in connection with the provision of Covered Services to Members by Networks employees or agents. Network will require Network Providers to maintain at the Network Provider's expense policies of professional liability and malpractice insurance in the minimum amount of \$250,000 per occurrence, \$750,000 per aggregate year or in such other amounts as required by applicable Federal and state laws. In lieu of the above policy requirements, providers are required to otherwise comply with provisions of Florida law relating to insolvency protection for patients. Network will and will cause Network Providers to also maintain workers compensation insurance for all of Network's employees connected with work under this Agreement, as required under Florida's Worker's Compensation law. Network shall provide Plan with evidence of such coverage upon request and require the carriers to provide Plan with notice of any policy cancellations or modifications.
- 11.2 <u>Indemnification by Plan.</u> Plan agrees to fully indemnify and hold harmless Network and Network's directors, officers, employees, servants, agents, heirs, successors and assigns from and against all and any claims, losses, damages, costs, expenses, liabilities, actions and causes of action, including

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reasonable attorneys' fees at all levels, arising out of or by reason of any damage or injury to persons or property suffered, or claimed to have been suffered, by any misconduct, omission, negligence or other wrongful conduct of Plan, its directors, officers, employees, servants and agents. This provision shall survive the termination or expiration of this Agreement for any reason.

11.3 <u>Indemnification by Network.</u> Network agrees to fully indemnify and hold harmless AHCA, OIR, CMS, and the Plan, and Plan's directors, officers, employees, servants, agents, heirs, successors and assigns from and against all and any claims, losses, damages, costs, expenses, liabilities, actions and causes of action, including reasonable attorneys' fees at all levels, arising out of or by reason of any damage or injury to persons or property suffered, or claimed to have been suffered, by any misconduct, omission, negligence or other wrongful conduct of Network, its directors, officers, employees, servants and agents. This provision shall survive the termination or expiration of this Agreement for any reason.

12. NETWORK PROVIDER FACILITIES

- 12.1 <u>Facilities.</u> Network understands that Network Providers are required to provide a functionally safe and sanitary environment for all Members. Plan reserves the right, in Plan's sole discretion to exclude from Plan any Network Provider that Plan determines does not meet this requirement.
- 12.2 <u>Physical Condition, Equipment.</u> Network will require Network Providers to use facilities that:
 - (a) are clean, safe and are designed and maintained to provide services to Members in an efficient and professional manner;
 - (b) are equipped, staffed and designed to comply with all applicable governmental regulations (including those imposed by CMS) and the reasonable requirements of Plan;
 - (c) are reasonably accommodating to handicapped individuals in accordance with The Americans with Disabilities Act and The Rehabilitation Act of 1973;
 - (d) are in compliance with applicable state and local building codes and regulations;
 - (e) are in compliance with applicable state and local fire prevention regulations;
 - (f) are inspected at least annually by the local or state fire control agency;
 - (g) contain fire equipment and illuminated signs for cases of emergency evacuation;
 - (h) offer adequate lighting and ventilation;
 - (i) can handle medical and other emergencies that may arise in connection with the provision of Covered Services to Members; and
 - (j) have all applicable federal, state and local licenses displayed as required by law.
- 12.3 Availability. Network is responsible for assuring the availability of Covered Services, and timely provision of Covered Services during appropriate business hours.
- 12.4 <u>Signage.</u> Network will cause Network Providers to prominently display signage provided by Plan that Identifies Network Provider as a part of Plan's network of Participating Providers. This signage shall be displayed in the main entrance to Network's facility as well as other locations reasonably requested by Plan.

13. COORDINATION OF BENEFITS

13.1 Other Insurance. Network will, and will cause Network Providers to, cooperate with Plan in the coordination of benefits with other health plans or insurance, or to obtain payment of any kind from a third party for any service rendered. To the extent Network has knowledge of any other insurance to which a Member may be entitled, or of any legal action under which a Member is seeking damages for medical services rendered, Network agrees to notify Plan in writing within fifteen (15) days after becoming aware of such other benefit.

13.2 Third Party Payors. Network and Network Providers may not bill third parties directly for services provided to Members covered under casualty policies which pay for medical expenses resulting from accident or injury. All such amounts will be billed and collected directly by Plan. Network and Network Providers must promptly notify Plan in the event Network receives any such monies, and any such monies received by Network shall be immediately sent to Plan. Network will, and will cause Network Providers to, assign to Plan all payments owed by third party payors and execute any documents or bill and process any forms as requested by Plan.

14. PROPRIETARY MATTERS

- 14.1 <u>Proprietary Information.</u> Network understands that Plan has developed, at a substantial investment, a going concern among its assets, the Members of Plan, the Participating Provider network, contracts, manuals, advertising and marketing materials, and other beneficial property ("Proprietary Information"). Network acknowledges the proprietary interest in the Proprietary Information and agrees that it shall keep the Proprietary Information confidential in the same manner that it would keep a trade secret. Network agrees that it will not, during the term of this Agreement and after termination or expiration of this Agreement, for any reason, use the Proprietary Information for Network's own or any other entity's benefit or gain, or disclose such Proprietary Information to any third parties except as required by process of law or regulation. Upon notice of termination or expiration of this Agreement, for any reason, Network shall return to Plan all Proprietary Information, including all copies, whether authorized or not. Plan and Network agree that this Section 14.1 will survive the termination of this Agreement.
- Non-Solicitation. Network and Network Providers must comply with all applicable state and federal law, regulation and guidance regarding communications about health plans or products to Members. During the term of the Agreement and for twelve (12) months after termination of this Agreement for any reason, Network and Network Physicians agree that they shall not solicit disenrollment of any Member or directly enter into a contract or policy of health care coverage with any Member covered under this Agreement to deliver or arrange for the delivery of health services. Furthermore, if during the term of this Agreement, Network or any Network Provider contracts to participate as a participating Provider in a "Contracted Entity", Network and Network Provider expressly agree that they shall not, directly or indirectly, market to Members covered under this Agreement for the purpose of encouraging or soliciting their enrollment under a plan or program offered by such Contracted Entity. For purposes of this Agreement, the term "Compete" means to have an ownership, membership or financial investment or interest in (whether through debt or equity), serve on the governing body of, or participate in the management or operation of, or otherwise contract with any organization or entity that is under contract with Center for Medicare and Medicaid Services ("CMS") (or any other federal government agency) to provide, arrange for the provision of, insure against, pay for or otherwise provide coverage or benefits for health care services obtained by Medicare beneficiaries (collectively, a Contracted Entity") including but not limited to the following: (1) Network Sponsored Organization ("PSO"), (2) Health Maintenance Organization ("HMO"), (3) Preferred Network Organization ("PPO"), (4) Private Fee For Service Plan ("PFFS"), (5) Religious Fraternal Benefit Plan or (6) Medical Savings Account ("MSA"). Notwithstanding any other provision of this Agreement, Network agrees that Plan has, in addition to any other remedies provided for under this Agreement, the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Network and Network Providers to enforce Plan's rights under this Section. Plan has expended considerable resources in developing its advantageous business relationships with employer, employees, Members, and other current and prospective sources of business. Network acknowledges that the provisions of this Section 14.2 are reasonable and necessary to protect the legitimate business relationships of Plan and significant damage would result from a breach.
- 14.3 <u>Injunction.</u> Plan and Network agree that any violation of this Article 14 by Network or Network Providers will result in irreparable injury to Plan. If an actual or threatened breach by Network or a Network Provider of Section 14.1 or 14.2 occurs, Plan is entitled to an injunction restraining Network or Network Provider from the prohibited conduct or, if applicable, requiring Network to take all necessary action to prevent Network Provider from engaging in the prohibited conduct. If the court should hold that the duration and/or scope of the covenants contained herein are unreasonable, then, to the extent permitted by law, it is the parties' desire and intent that the court prescribe a duration and/or scope that is reasonable, and the parties agree to accept such determination, subject to their rights of appeal. Nothing in this Agreement prohibits Plan or any third party from pursuing any other remedies available to it for such breach or threatened breach, including

recovery of damages from Network. In any action or proceeding to enforce the provisions of this Section, the prevailing party shall be reimbursed by the other party for all reasonable costs incurred in such action or proceeding, including, without limitation, all court costs and filing fees, and all attorneys' fees incurred either at the trial level or at the appellate level.

15. REPRESENTATIONS OF NETWORK

- 15.1 <u>Licenses and Authority.</u> Network represents and warrants to Plan that (i) it has and will maintain any and all applicable permits and licenses relating to its business and performance under this Agreement, and (ii) it has full power and authority to own and operate its properties and assets and to conduct and carry on the business as stated in this Agreement.
- Binding Obligation, No Conflict, Network represents and warrants to Plan that, (i) this Agreement constitutes the legal, valid and binding obligation of Network, enforceable against Network in accordance with its terms; (ii) the execution, delivery and performance of this Agreement has been duly authorized by all required action of Network and its owners, if applicable, and (ili) such execution, delivery and performance does not violate and is not restricted by any provisions of the organizational documents of Network, any agreement to which Network is a party (including any agreement with any other Network Sponsored Organization, Health Maintenance Organization or Managed Care Network), or any laws or regulations applicable to Network.

16. MISCELLANEOUS

- 16.1 <u>Professional Corporations or Partnerships.</u> All of the terms of this Agreement shall apply with equal force to the professional association, professional corporation or partnership and the individual physicians or providers associated with such entity.
- 16.2 <u>Independent Contractor Relationship.</u> None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship Among Plan, Network and Network Providers other than that of independent entities contracting with each other solely for the purposes of effecting the provisions of this Agreement. None of Plan, Network or any Network Provider, nor any of their respective associates, employees, or agents shall be construed to be the agent, the employer or the representative of the other. Network Providers are solely responsible and liable for all medical care, advice and treatments rendered or prescribed to Members.
- 16.3 Applicable Law. This Agreement, and the rights and obligations of the parties under this Agreement, must be construed, interpreted and enforced in accordance with, and governed by, the laws of the State of Florida.
- 16.4 <u>Enforceability.</u> The invalidity or unenforceability of any terms or conditions of this Agreement shall in no way affect the validity or enforceability of any other term or provision.
- Modification. This Agreement, and the attachments to this Agreement, constitute the entire understanding of the parties and may be amended or modified in writing as mutually agreed upon by the parties, unless otherwise permitted in this Agreement or any attachment to this Agreement. Plan may modify this Agreement, including the compensation terms, upon thirty (30) days advance written notice to Network. If Network does not object in writing to Plan regarding the modification, Network's silence will constitute acceptance of such modification. Notwithstanding the above, revisions to (i) Plan's and/or Network's responsibilities, (ii) Covered Services, (iii) Schedule A Description of Services, or (iv) any regulatory appendix attached to this Agreement shall not constitute modifications, amendments or alterations subject to this Section. Rather, such revision will be binding upon written notice to Network.
- 16.6 <u>Assignment.</u> This Agreement and the rights, interests and benefits under this Agreement, shall not be assigned, transferred, pledged or hypothecated in any way by Network, including by way of an asset or stock purchase of Network, and shall not be subject to execution, attachment or similar process, nor shall the duties imposed be subcontracted or delegated without the approval of Plan. This Agreement may be assigned by Plan without the consent of Network.
- 16.7 <u>Waiver</u>. No waiver of any default in the performance of any of the duties or obligations arising under this Agreement is valid unless in writing and signed by the waiving party. Waiver of any one default does not constitute and cannot be construed as creating a waiver of any other defaults. No

course of dealing between the parties will operate as a waiver or preclude the exercise of any rights or remedies under this Agreement. Failure on the part of either party to object to any act or failure to act of the other party, or to declare the other party in default, regardless of the extent of such default, will not constitute a waiver by such party of its rights under this Agreement.

- 16.8 Notices. Any notice, demand or other document required or permitted to be delivered under this Agreement shall be in writing and may be delivered personally or shall be deemed delivered when deposited in the United States Postal Service, postage prepaid, registered or certified mail, return receipt requested, addressed to the parties at their respective address listed on the signature page of this Agreement, or at such other addresses as recipient may have specified by written notice delivered in accordance with this Section 16.9.
- 16.9 <u>Authorization.</u> Each party represents that the respective officers have the requisite authority to enter into this Agreement on behalf of their respective party and to carry out the transactions and obligations contemplated in this Agreement.
- 16.10 <u>Captions.</u> Captions in this Agreement are descriptive only and do not affect the intent or interpretation of this Agreement.
- 16.11 Entire Agreement. This Agreement, including appendices, is the entire agreement between the parties and supersedes all agreements, representations, warranties, statements, promises and understandings, whether oral or written, with respect to the subject matter of this Agreement.

[SIGNATURE PAGE FOLLOWS]

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement in the State of Florida on the date first written above.

florida on the date first written above.	
	NETWORK:
	$/\mathcal{D}_{i}$
	DOCTORS GROUP MANAGEMENT LLC By:
	Name: Felix Quevedo
	Title: Press les Address: 8600 NW 17 St sufe & 1
	Donel, 61. 30126
	Plan:
	MEDICA HEALTHCARE PLANS, INC.
	By: annetto Comorati
	By: Unnetto Usuarah Annette Onorati
	Chief Operating Officer
	9100 S. Dadeland Blvd., Suite 1250 Miami, FL 33156-7838
	,
	16.7

Effective Date of Contract:

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SCHEDULE A

PRIMARY CARE SERVICES

Primary Care Services shall include, but are not limited to, all services, supplies, procedures and ancillary services either rendered or arranged by a Primary Care Physician or other health professional to provide the following: 1) Initial preventive medical examinations with comprehensive medical history, assessment, medical management of the patient, and ordering all laboratory and diagnostic tests routinely ordered and performed in connection with an age-specific initial preventive medical examination which also includes hearing and visual screening; 2) Ongoing age-specific periodic preventive health appraisal examinations including the ordering of appropriate laboratory and diagnostic procedures routinely ordered and performed in connection with age-specific preventive periodic health appraisals; 3) Those services, supplies and procedures normally provided by a Primary Care Physician when dictated by the need for a particular injury, illness, or disease which do not require the knowledge, skill or expertise of a Physician specialist; to include those services provided or arranged for in a physician's office, patient's home, hospital inpatient and/or outpatient setting, nursing home and/or in any other health care setting in which medical services, supplies and procedures may be delivered appropriately by a health care professional.

Also included are after-hours urgently needed services, hospital and skilled nursing home admissions with follow-up, stat office laboratory tests, injections, in-office radiology, EKGs, flexible sigmoidoscopy and sutures with removal.

Also, adult immunizations administered in accordance with the recommendations of the United States Public Health Service. Additionally, chiropractic and podiatric medical services shall be provided in accordance with chapters 640 and 641, respectively, of the Florida Statutes. All other medical services, at a minimum, will be provided in accordance with Agency for Health Care Administration (AHCA), Centers for Medicare and Medicaid Services (CMS) and all applicable Plan standards. Primary Care Physician agrees that the scheduling of appointments to render the above mentioned care shall meet the state mandated accessibility standards as defined by all State of Florida health care regulatory bodies.

All services performed under this Agreement shall be consistent with the standards of medicine and osteopathy in the community and such services shall, at a minimum, be performed in accordance with the customary rules of ethics and conduct promulgated by the American Medical Association, American Osteopathic Association, and the American Hospital Association and similar provider organizations, as applicable, and such other bodies, formal or informal, governmental or otherwise, from which health care providers seek advice and guidance or to which they are subject to licensing and control, as applicable.

Primary health care encompasses Medically Necessary medical care that is provided or prescribed by Member's assigned Participating Network for prevention of disease and the first level of care for diagnosis and treatment of a non-occupational illness or injury, and includes all services customarily provided in a Primary Care Physician's office as well as services customarily provided by an attending Primary Care Physician to institutionalized patients. Network agrees to provide these Covered Services offered by Plan with the exception of hospital inpatient cost and vision care services. By way of illustration and not limitation, the following services are considered Primary Care Services. These services are to be provided in accordance with Plan's policies and procedures.

General Primary Care Services:

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- ROUTINE OFFICE VISITS including biometrics evaluations, diagnosis and treatment of illness/injury.
- HOSPITAL VISITS personal attendance with the patient including skilled nursing or extended care facility.
- PERIODIC HEALTH APPRAISAL all routine tests performed in a Primary Care Physician's office (i.e. EPSDT).
- 4. TELEPHONE CONSULTATIONS with Members.
- ACUTE MINOR ILLNESS/INJURY
- CHRONIC ILLNESS/INJURY

- IMMUNIZATIONS in accord with accepted medical practices. As set forth in Schedule B, Section 3.5, Network shall receive flat rate compensation for Influenza, Pneumococcal and H1N1 vaccines dispensed to assigned Members.
- INJECTIONS -including intra-articular and trigger points in accord with accepted medical practices (excluding chemotherapy).
- ROUTINE DIAGNOSTIC LABORATORY PROCEDURES all routine procedures
 performed in a Primary Care Physician's office, including but not limited to CBC test,
 urinalyses, stool analyses for occult blood and pregnancy tests.
- 10. EYE AND EAR EXAMINATIONS for vision and hearing correction.
- 11. DIAGNOSIS AND REFERRAL OF ALCOHOLISM/DRUG ABUSE
- 12. HEALTH EDUCATION SERVICES AND REFERRAL (e.g. family planning, STDs)
- MISCELLANEOUS SUPPLIES related to treatment in a Primary Care Physician's office (e.g. gauze, tape, band aid and other routine medical supplies).
- MISCELLANEOUS SERVICES all services normally provided in a Primary Care Physician's office.
- 15. ROUTINE DIAGNOSTIC TESTS routine tests, x-rays, and electrocardiograms, including interpretation. This may include chest and bone x-rays, Pap smears and any test customarily provided in Primary Care Physician's office.
- MEDICAL RISK ASSESSMENT AND PREVENTIVE CARE SERVICES (e.g. well woman care, adult health screenings)

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SCHEDULE B

PAYMENT APPENDIX - NETWORK GLOBAL CAPITATION

- 1. <u>Initial Reimbursement.</u> Plan and Network acknowledge and agree that for the initial six month period following the effective date of this Agreement Plan will pay Network a Monthly Capitation for each Member. Plan will pay Network Providers that are not employed by Network their monthly capitation payment from the total Monthly Capitation due to Network. Plan will pay the net Monthly Capitation to Network on or before the 15th day of each month. The Monthly Capitation is \$175.00 per Member per month for each Member who resides in Miami-Dade County and \$175.00 per Member per month for each Member who resides in Broward County.
 - After the initial 6 month period Plan will compensate Network as stated in Sections 2 through 10, below of this Schedule B.
- 2. Medicare Operating Fund. Plan will establish a Medicare Operating Fund in a ledger within the financial records of Plan from which Plan will pay all medical, hospital (including but not limited to inpatient, outpatient and emergency), reinsurance, prescription, physician and health care professionals, and all other Covered Services claims, fees and expenses for individuals enrolled in Plan's Medicare Program benefit plans who are assigned to Network or a Network Provider or who have selected a Network Provider as their Primary Care Physician (each a "Member").
- 3. Security Reserve, As of the effective date of this Agreement, Plan will establish a Security Reserve Account in a ledger within the financial records of Plan to secure Network's performance under the Agreement and this Schedule B (the "Security Reserve"). The initial amount of contributions to the Security Reserve will be \$10/member/month with a minimum of \$150,000. Plan will withhold an amount equal to 25% of each Substantial Completion Payment (as defined below) and 30% of each Final Surplus until the Security Reserve is fully funded at an amount equal to \$100 (the "Per Member Reserve Amount") per member assigned to Network as of the last day of the previous calendar quarter. Plan may adjust the Per Member Reserve Amount one time each year if plan reasonably determines, in Plan's sole discretion and based on Network's performance, that the current amount is excessive or inadequate. If the Security Reserve is not fully funded at the end of each 12 month period following entry into the Agreement and this Schedule B, whether due to insufficient contributions, adjustments to the Security Reserve amount as provided below, or transfers from the Security Reserve Account to the Medicare Operating Fund due to negative balances in the Medicare Operating Fund, Network will pay to Plan within 30 days an amount equal to the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Plan and Network may, each in their sole discretion, agree to a payment plan under which Network will repay the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Failure of Network to pay to Plan the difference between the amount of the Security Reserve and the balance of the Security Reserve Account within 30 days or, if applicable, in accordance with an agreed upon payment plan will constitute a material breach of this Agreement and Plan will have the right, in Plan's sole discretion, to (a) terminate the Agreement "for Cause" as provided in the Agreement or (b) terminate payment under this Schedule B and pay Network a base capitation rate consistent with base capitation rates provided to other similar primary care providers in Plan's network for the provision of primary care services to Members.

Plan may, in Plan's sole discretion, adjust the required amount of the Security Reserve upward or downward as reasonably required based on Network performance and potential liability to Plan under the Agreement and this Schedule B. Plan may not adjust the amount of the Security Reserve more than twice in a calendar year. If Plan decreases the amount of the Security Reserve, Plan will distribute any excess in the Security Reserve Account as additional payment of equal amounts on its next 3 payments to Network. If Plan increases the amount of the Security Reserve, Plan will again withhold amounts from Substantial Completion Payments and Final Surplus payments until the Security Reserve is fully funded.

In addition, if at any time the balance of the Security Reserve Account is less than \$0.00, Plan may in its sole discretion, require Network will pay to Plan within 30 days an amount equal to the difference between the amount of the Security Reserve and the balance of the Security Reserve Account or

require Network to agree to a payment plan under which Network will repay the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Failure of Network to pay to Plan the difference between the amount of the Security Reserve and the balance of the Security Reserve Account within 30 days or, if applicable, in accordance with the payment plan will constitute a material breach of this Agreement and Plan will have the right, in Plan's sole discretion, to (a) terminate the Agreement "for Cause" as provided in the Agreement or (b) terminate payment under this Schedule B and pay Network a base capitation rate consistent with base capitation rates provided to other similar primary care providers in Plan's network for the provision of primary care services to Members.

- 4. <u>Funding.</u> As full compensation to Network for the services rendered under this Agreement, Plan will allocate to the Medicare Operating Fund the amounts stated in this Section 4, deduct from the Medicare Operating Fund the amounts stated in Section 5, and distribute to Network the amounts determined in accordance with Sections 6 and 7 of this Schedule B:
 - a. CMS Payment, An amount equal to the percentage stated in the following table of the CMS Payment

Assigned Network Members	After month 6 Compensation	After month 6 Care Management Compensation
1 to 500	83%	0.0%
501 to 1,000	83%	1.0%
1,001 or more	84%	2.0%

For purposes of this Payment Appendix, CMS Payment means the actual aggregate capitated payment for each month paid to Plan by CMS (or any other government agency representing the Medicare Program) for the provision of Medicare Program benefit plans to Members.

- b. Stop-Loss Insurance. If Network receives stop-loss protection from Plan or a Plan affiliate, Plan will credit any amounts due to Network in connection with that protection to the Medicare Operating Pund. If Network does not receive stop-loss protection from Plan or a Plan affiliate, Network will assign the proceeds or pay the amount of any recoveries under that stop-loss insurance to Plan immediately upon receipt and Plan will credit that amount to the Medicare Operating Fund.
- c. <u>Pharmacy Revenue</u>, <u>The following components of Plan's</u> Part D funding will be included in the Medicare Operating Fund: CMS National Direct Subsidy, Member Part D premiums, pharmacy manufacturer rebates, Part D reinsurance payments, and Low Income Cost Sharing Subsidies (LICS).
- d. Third Party Collections. Plan is responsible for collecting funds related to any third party liability for services provided to Members involving, but not limited to, auto insurance carriers, subrogation, Workers' Compensation, and any rights for coordination of benefits with other health insurance providers. Upon recovery by Plan, Plan will (a) account to Network for the recovered amount, and (b) contribute the recovered amount, less reasonable cost of collection paid to third parties, if any, to the Medicare Operating Fund.
- Deductions from the Medicare Operating Fund. Plan will deduct the following amounts from the Medicare Operating Fund:
 - a. Network Capitation Payment, Plan will pay Network a monthly capitation payment (the "Network Capitation Payment") of \$175.00 less the estimated cost of Primary Care Services for each Member paid by Plan(the "Estimated Plan Cost"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month. Plan will determine the Estimated Plan Cost on or before the 15th day of the first month of each calendar quarter. The Estimated Plan Cost will equal the average actual cost for Primary Care Services for each member paid by Plan during the preceding calendar quarter.

- b. Payment for Covered Services, Except as provided above, Plan will pay all claims for Covered Services, Including the actual cost of Primary Care Services for each Member paid by Plan, and deduct the amount of such payments and expenses from the Medicare Operating Fund.
- Pharmacy Costs, The amount of any recovery of pharmacy revenue previously included by Plan in the Medicare Operating Fund.
- d. Care Management and Disease Management Programs. The cost incurred by Plan to
 provide standard care management programs and disease management programs to
 Members.
- e. <u>Primary Care Provider Bonus Payments</u>, The amount of any bonus payments from Plan to Network Providers, including without limitation payments for participation in Plan's STARs Bonus Program and MLR Bonus Program.
- f. <u>Stop-Loss Protection</u>. If Network receives stop-loss protection from Plan, the cost of that stop-loss protection.
- g. <u>Chart Review and Hospital Abstracts</u>. The cost incurred by Plan to perform medical chart reviews and hospital abstract audits of Member medical records and claims data.
- 6. Calculation of Medicare Operating Fund Surpluses and Deficits. At the end of each month, Plan will determine the amount by which allocations to the Medicare Operating Fund exceeded or were less than deductions from the Medicare Operating Fund. This amount is the "Initial Surplus of Deficit". Plan will retain the Initial Surplus or Deficit for 120 days after the end of each month (the "Substantial Completion Period"). At the end of the Substantial Completion Period, Plan will again determine whether allocations to the Medicare Operating Fund exceeded or were less than deductions from the Medicare Operating Fund for that month (the "Target Month"). Claims paid as of the end of the Substantial Completion Period will be deemed to constitute 90% of all claims incurred during the Target Month for purposes of this calculation.
 - a. If there is a positive balance in the Medicare Operating Fund for the Target Month at the end of the Substantial Completion Period (the "Substantial Completion Surplus"), Plan will pay to Network a "Substantial Completion Payment" equal to 50 percent of the difference resulting from the reduction of the Substantial Completion Surplus by the lesser of (i) actual claims incurred but not reported for the Target Month or (ii) 10% of total claims paid for the Target Month (which amount will be retained in the Medicare Operating Fund as the agreed upon amount of claims incurred but not reported ("IBNR") for the Target Month).

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b. If there is a negative balance in the Medicare Operating Fund for the Target Month at the end of the Substantial Completion Period (the "Substantial Completion Deficit"), Plan will withhold from its next scheduled monthly capitation payment to Network a "Substantial Completion Recovery" equal to 50 percent of the sum resulting from adding to the Substantial Completion Deficit the lesser of (i) actual claims incurred but not reported for the Target Month or (ii) 10% of total claims paid for the Target Month (which amount will be retained in the Medicare Operating Fund as the agreed upon amount of claims incurred but not reported ("IBNR") for the Target Month). If the amount of the next scheduled monthly capitation payment to Network is not sufficient to withhold the entire Substantial Completion Recovery, Plan may recover any unrecovered amounts from the Security Reserve or any subsequent payment from Plan to Network, in Plan's sole discretion.

After paying the Substantial Completion Payment or withholding the Substantial Completion Recovery, Plan will continue to pay claims and expenses from the IBNR for the Target Month. If there is a positive balance in the Medicare Operating Fund for the Target Month at the end of the 12th month after the end of the Target Month (the "Final Completion Period"), Plan will pay to Network 50 percent of the amount of that positive balance (the "Final Surplus"). Subject to Section 4.b. of this Payment Appendix, if claims paid after the Substantial Completion Period exceed the IBNR for the Target Month, 50 percent of the amount of excess claims (the "Final Deficit") will be deducted from the Medicare Operating Fund for months after the Target Month until recovered by Plan. If at any time

the value of the Medicare Operating Fund is less than \$0.00, Plan will transfer funds from the Security Reserve Account to the Medicare Operating Fund to eliminate that deficit.

In no event will the end of a Substantial Completion Period or a Final Completion Period (i) release Network from its liability for claims incurred for Covered Services during the Target Month, or (ii) be deemed an assumption by Plan of risk for such claims regardless of when the claim is received.

Plan will pay Substantial Completion Payments and Final Surpluses for each Target Month to Network on or before the 15th day after conclusion of the Substantial Completion Period and the Final Completion Period, respectively. For example, if the first Members were assigned to Network on August 1, 2013, the Substantial Completion Period determination would be completed and the Substantial Completion Payment made on or before January 15, 2014. The Substantial Completion Period determination for September 2013 would be completed and the Substantial Completion Payment made on or before February 15, 2014. In turn, Plan would pay the Final Surplus (if any) for August 2013 to Network on or before September 15, 2014 and the Final Surplus (if any) for September 2013 on or before October 15, 2014.

If Network disagrees with Plan's calculation of any Medicare Operating Fund surplus or deficit, Network must deliver written notice of Network's proposed adjustments to the calculation to Plan within 45 days after Plan delivers Plan's calculation to Network. Plan will respond to proposed reconciliation adjustments within 120 days of receipt of Network's proposed adjustments. If Plan agrees with any proposed adjustment and the adjustments increases amounts payable to Network, Plan will include the amount of the proposed adjustment in its next distribution to Network. If Plan disagrees with the proposed adjustment, Plan and Network will then work in good faith for 30 days to agree upon a final reconciliation amount. If Plan and Network are unable to agree upon a final reconciliation amount within 30 days the dispute will be resolved in accordance with the terms of the Agreement.

7. Retroactive Adjustments to Payments. Plan has the right to make retroactive adjustments to Medicare Operating Fund Surpluses and Deficits that result from regulatory audits or reviews or Plan-initiated audits or reviews of risk adjustment factors and to recalculate the amount of any Substantial Completion Payment, Final Surplus or Final Deficit due to any resulting change in the CMS Payment applicable to that Substantial Completion Payment, Final Surplus or Final Deficit. In calculating any retroactive adjustments under this Section 7, Plan will include adjustments to the CMS Payment resulting from regulator or Plan-initiated audits or reviews of risk adjustment factor data, but Plan will not include adjustments to any other component of the CMS Payment or any other expense charged to the Medicare Operating Fund.

Plan will determine the amount of any retroactive adjustment resulting from medical chart audits or reviews initiated by Plan no later than 6 months after Network provides Plan with all information Plan needs to complete the audit or review. Plan will determine the amount of any retroactive adjustment result from (a) other risk adjustment factor audits or reviews initiated by Plan, and (b) audits or reviews of risk adjustment factors initiated by a regulator (or by a contractor to a regulator) no later than 6 months after CMS communicates the resulting change in the CMS Payment to Plan. Network must pay the amount of the retroactive adjustment to Plan no later than 90 days after receipt of written notice from Plan of the amount of the retroactive adjustment. Plan may offset the amount of the retroactive adjustment to Network if Network does not pay within 90 days.

Care Management Compensation.

- h. <u>Purpose.</u> Plan offers additional care management compensation to eligible Networks and Providers in the form of an increased allocation to the Medicare Operating Fund. The purpose of these additional care management allocations is to:
- i. Increase access to quality care for Plan enrollees.
- Ensure that Network gives adequate coverage to patients who select or are assigned by Plan to Network and Network Providers.
- Compensate Network for the additional resources required to provide quality care to larger numbers of Plan enrollees.

- Compensate Network for agreeing to arrange care for and accept the financial risk of treating larger numbers of plan enrollees on a capitated basis.
- Improve the quality of health care delivered to Plan enrollees by Plan working closely with Network to measure and improve Plan enrollee care and outcomes.
- vi. Encourage efficiencies in the delivery of medical care for Plan, Network and Network Providers as measured by costs, claim submission methods, and Plan enrollee satisfaction.
 - General Ouglity Criteria. For Network to continue to receive additional care management allocation requires Network to work with Network Providers and Plan's provider relations staff to improve Network Provider compliance with Plan's quality criteria, including:
- vii. Engagement in care coordination for Plan enrollees, as appropriate, including:
 - 1. Communication with specialists
 - 2. Cooperation with Plan's outreach efforts and health wellness and prevention programs
 - Managing Plan enrollee care during inpatient admissions, either directly or through communication with attending physician
 - 4. Supporting discharge planning and follow-up with Plan enrollees post-discharge
 - 5. Referring Plan enrollees to behavioral health providers, as appropriate
- viii. Providing initial meeting between Member and physician within 90 days of Member enrollment in Plan
- ix. Address any identified gaps in Plan enrollee care
- x. Compliance with Plan's policies and procedures, including:
 - 1. Utilization Management
 - 2. Credentialing and re-credentialing
 - Identification, assessment and establishment of treatment plans for serious and complex conditions
 - 4. Plan's grievance program

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- xi. Participation in Plan's Quality Improvement Program
 - j. Specific Quality Criteria. In addition, to assisting Plan and Network Providers efforts to fulfill the General Quality Criteria described above, Network agrees to work with Network Providers and Plan's provider relations staff to satisfy the following Specific Quality Criteria in consideration for receiving the additional care management allocation:
- xii. Participation by eligible Network Providers in Plan's STARS bonus program.
- xiii. Participation by eligible Network Providers in Plan's MLR bonus program.
- xiv. Participation by eligible Network Providers, and if appropriate Network personnel, in monthly meetings with Plan's provider relations staff during which Network Provider and Plan representatives will review Plan operations, care management for Plan enrollees, adequacy of coverage provided to Plan enrollees, gaps in care for Plan enrollees, Plan enrollee complaints (if any), Provider's compliance with Plans policies and procedures, Provider's performance under Plan's Quality Improvement Program, STARS Program, and medical management program, and Provider's compliance with the quality criteria stated in this Appendix.
- xv. Working with Network Providers and Plan's provider relations staff to address concerns identified in monthly meetings and implement initiatives developed by Plan and/or Network Providers to address these concerns with respect to all Plan enrollees who have selected or been assigned to Network Provider.
- 9. Review of Adherence to Plan's Quality of Care Programs. Plan will provide Network with reports describing Network's and Network Providers' performance on applicable quality and performance metrics to ensure that Network knows the status of Network's and Network Providers' performance. Plan's provider relations staff and medical directors will work with Network and Network Providers to assist Network and Network Providers in achieving performance goals.

- 10. Full Payment. The payments to Network under this Payment Appendix are full payment to Network for all Covered Services provided by Network to Customers. Network must not claim payment in any form, directly or indirectly, from any Federal or State health care program (except as approved by a Federal or State health care program) for items or services furnished under this Agreement. Network cannot shift any costs for items or services furnished under this Agreement to the extent that increased payments are claimed from any Federal or State health care program. Network agrees to fully and accurately report the terms of this Agreement and the amounts paid under this Agreement upon request by any Federal or State health care program.
- 11. Stop-Loss Protection. Network must maintain, at all times during which this Schedule B is in force or any payment under this Schedule B remains outstanding, stop-loss protection (the "Stop-Loss Protection") at least sufficient to satisfy the physician incentive plan regulations at 42 CFR 422,208 (the "PIP Regulations"). At Network's option, Network may obtain the Stop-Loss Protection from Plan or Network may purchase Stop-Loss Protection from a third party. If Network chooses to receive Stop-Loss Protection from Plan, Plan will deduct the full cost of providing that Stop-Loss Protection from the Medicare Operating Fund. If Network chooses to purchase the Stop-Loss Protection from a third party, Plan reserves the right to review and approve the policy and entity that provides the Stop-Loss Protection. Network will name Plan as primary payee under any third party Stop-Loss Protection and Plan will credit any payments made to the Medicare Operating Fund. Without limiting the generality of this Section, Network will ensure that Network Providers carry the correct level of reinsurance coverage for individual and institutional losses prescribed by the PIP Regulations.
- 12. <u>Referrals Prohibited.</u> Plan and Network agree that neither Plan nor Network will knowingly and willfully accept nor provide indirect or direct payment for referrals of individuals for items or services reimbursed under a federal health care program. Acceptance of the terms and conditions in this Appendix is without regard to any volume of referrals, and there are no expectations of referrals between Plan and Network based on this Appendix. The parties agree that the capitation amounts in this Agreement are based on fair market value independent of the value or volume of any referrals. Network specifically acknowledges and agrees that Network will not engage in any activities to promote or market Plan managed care products, and will make no referrals whatsoever of individuals to Plan for the provision of managed care services. Any violation of this provision will result in the immediate termination of this Appendix and Network's right to receive payments under this Appendix.
- 13. Termination of Agreement. In order to receive any payment due to Network under this Payment Appendix, this Agreement must be in force and Network must be providing Covered Services to Members on the date payment is due. Upon termination of the Agreement, no further payment will be due to Network under the Agreement or this Payment Appendix. Plan will provide a final reconciliation of all payments made before termination of the Agreement on or before the first anniversary of the termination of the Agreement. Network will have 30 days to review and object to Plan's final reconciliation. If Network does not object within 30 days, Plan will pay to Network the amount of any surplus or Network will pay to Plan the amount of any deficit in the final reconciliation on or before the 45th day following Network's receipt of the final reconciliation. If Network objects to Plan's final reconciliation, Network will deliver written notice of the basis for its objection to Plan. Plan and Network will then work in good faith for 30 days to agree upon a final reconciliation amount. If Plan and Network are unable to agree upon a final reconciliation amount within 30 days the dispute will be resolved in accordance with the terms of the Agreement. Upon resolution of any dispute and agreement upon the final reconciliation, Plan will also distribute to Network any remaining balance in the Security Reserve.

SCHEDULE C

SIGNATURES ADDENDUM

PARTICIPATING NETWORK RISK AGREEMENT

		ng Physicians agree to the terms and conditions set forth in tement. Effective this day of	
NAME	SIGNATURE	DATE	
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SCHEDULE D

PROVIDER INFORMATION AND SERVICE DELIVERY SITES

ONE PER PHYSICIAN

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Title:		
Group Name:		
Specialty:		
Federal Tax I.D. #:		
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Group NPI#:		
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Location(s) of Service:		
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Suite	0.11	
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Office Hours	Office Hours	
Age Range	Age Range	

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Address		
Suite		
Phone Number	Phone Number	
Fax Number	Fax Number	
Office Hours	Office Hours	
Age Range	Age Range	

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the network participation agreement (the "Agreement") between Plan and the physician or provider named in the Agreement ("Provider").

SECTION 1 APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; (2) as noted in Section 2 of this Appendix; or (3) as required by applicable law.

SECTION 2 DEFINITIONS

For purposes of this Appendix, the following terms have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix is in conflict with any definition in the Agreement for the same or substantially similar term, the definition for such term in the Agreement shall control. All other capitalized terms not otherwise defined in this Appendix shall be as defined in the Agreement.

- 2.1 Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer. Benefit Plan may also be referred to as benefit contract, benefit document, plan, or other similar term under the Agreement.
- 2.2 CMS Contract: A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.
- 2.3 Cost Sharing: Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments. Cost Sharing may also be referred to as patient expenses or other similar term under the Agreement.
- 2.4 Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer. A Covered Service may also be referred to as a health service or other similar term under the Agreement.
- 2.5 Customer: A person eligible and enrolled to receive coverage from a Payer for Covered Services. A Customer may also be referred to as an enrollee, member, patient, covered person, or other similar term under the Agreement.
- 2.6 Dual Eligible Customer: A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.
- 2.7 Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).
- 2.8 Medicare Advantage Customer or MA Customer; A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

- 2.9 Medicare Advantage Organization or MA Organization: For purposes of this Appendix, MA Organization is either Plan or Payor.
- 2.10 Payer: An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized by Plan to access Provider's services under the Agreement. A Payer may also be referred to as a Plan, payor, participating entity or other similar term under the Agreement.

SECTION 3 PROVIDER REQUIREMENTS

- 3.1 Data. Provider shall submit to MA Organization all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.
- 3.2 Policies. Provider shall cooperate and comply with MA Organization's policies and procedures.
- Customer Protection. Provider agrees that in no event, including but not limited to, nonpayment by MA Organization or an intermediary, insolvency of MA Organization or an intermediary, or breach by Plan of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

3.4 Dual Eligible Customers. Provider agrees that in no event, including but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by Plan of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer,

in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

- 3.5 Eligibility. Provider agrees to immediately notify MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that has been excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.
- 3.6 Laws. Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.
- 3.7 Federal Funds. Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.
- 3.8 CMS Contract. Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

3.9 Records.

- (a) Maintenance: Privacy and Confidentiality: Customer Access. Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for at least ten (10) years or such longer period as required by law. Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.
- (b) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, the Florida Agency for Health Care Administration, the Florida Office of Insurance Regulation, or their designees have the right to audit, evaluate and inspect any pertinent books, contracts, medical records, patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations. For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.
- (c) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA

Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

- 3.10 MA Organization Accountability; Delegated Activities. Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization may delegate to Provider or others. If MA Organization has delegated any of its functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:
 - (a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.
 - (b) If MA Organization has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization.
 - (c) If MA Organization has delegated to Provider the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.
 - (d) Provider acknowledges that MA Organization shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.
- 3.11 Subcontracts. If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms in this Appendix. Provider shall provide proof of such to MA Organization upon request. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by MA Organization, to meet any additional CMS requirements that may apply to the services.
- 3.12 Offshoring. Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4 OTHER

- 4.1 Payment. MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.
- 4.2 Regulatory Amendment. MA Organization may unilaterally amend this Appendix to comply with

applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(ies) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.



AMENDMENT TO NETWORK RISK AGREEMENT

THIS AMENDMENT TO THE PARTICIPATING PROVIDER AGREEMENT (the "Amendment") is made this 28TH DAY OF JULY, 2017, by and between MEDICA HEALTHCARE PLANS, INC., a Florida corporation ("PLAN") and DOCTORS GROUP MANAGEMENT ("Provider"). This amendment is effective January 1, 2016.

1. <u>Defined Terms.</u> Unless otherwise defined in this Amendment, the capitalized terms used in this Amendment have the meaning stated in the Agreement.

2. Amendments.

2.1 Attachment E – Stars Bonus Program. In an effort to improve the quality of member care as measured by STARs performance and to provide additional compensation to participating providers who successfully achieve the goals of participation in the Stars Bonus Program, Plan incorporates Attachment E - STARs Bonus Program. The STARs Bonus Program provides qualifying Network Providers with the opportunity to receive a STARS bonus payment for each Plan enrollee who selects or is assigned to Provider for Primary Care Services if Provider meets specific performance driven quality targets established in accordance with Attachment E.

3. Full Force and Effect. Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

MEDICA HEALTHCARE PLANS, INC.

9100 South Dadeland Boulevard, Suite 1250

Miaml, Florida 33156

By: Annetto Conorati

Name: Felix Quevel.

Chief Operating Officer

Title:

SCHEDULE E

STARS Bonus Program

STARS Bonus Program

The Medica Healthcare Plans STARS Bonus Program provides qualifying Network Primary Care Providers with the opportunity to receive up to \$10.00 per month ("STARS Bonus Amount") for each Plan enrollee who selects or is assigned to Provider for Primary Care Services if Provider meets quality targets established by Plan in its sole discretion.

Eligibility

All Network Primary Care Providers with 30 or more Plan enrollees are eligible to participate in the STARS Bonus Program.

Utilization and Quality Targets

Plan will determine the STARS Bonus Program quality targets in its sole discretion before the start of each plan year. Quality targets will remain in effect for the plan year. Plan will distribute quality targets for the STARS Bonus Program to Provider in writing. Plan may, in Plan's sole discretion, communicate additional terms and conditions or changes in the quality targets of the STARS Bonus Program to eligible Providers throughout the plan year. If Plan does not distribute quality targets before the start of any plan year, the quality targets for the prior plan year will continue to apply.

Payment

During the second quarter of the following plan year, Plan will determine if Provider met the quality targets for the full plan year (January 1 to December 31) and STARS Bonus Amount earned for that period, if any, will be distributed by Plan to eligible Primary Care Providers no later than third quarter of that year. Provider must be a contracted and participating Provider of Primary Care Services for Plan on the date a payment is made by Plan to be eligible to receive payment under this STARS Bonus Program. If Provider is not a contracted and participating Provider of Primary Care Services on the data Plan makes STARS Bonus Program payments, Provider will not be eligible for and will not receive any payment under this STARS Bonus Program. If Provider owes Plan monies as of the date of bonus payment, any applicable bonus payments due to provider shall first be applied to offset any balance's or deficits owed to Plan; thereafter any remaining bonus payment will be paid to Provider.

Deductions from Network's Medicare Operating Fund

If the overall STARS rating of the Members assigned to Network, determined in accordance with CMS STAR rating methodology, is 4.50 stars or greater, Plan will not deduct STARs Bonus payments to Network Providers from Network's Medicare Operating Fund. If the overall STARS rating of Members assigned to Network, determined in accordance with CMS STAR rating methodology is 4.26 stars or greater (but less than 4.50), Plan will not deduct 50% of the

amount of the STARS Bonus payments from Network's Medicare Operating Fund. If the overall STARS rating of Members assigned to Network, determined in accordance with CMS STAR rating methodology, is less than 4 stars, Plan will deduct the full amount of the STARS Bonus payments from Network's Medicare Operating Fund.

Denial of Medically Necessary Care Prohibited

Plan and Provider acknowledge and agree that:

- the compensation stated in the Agreement, including this STARS Bonus Program, does not reward Provider for limiting the provision of any medically necessary services to any patients; and
- nothing in the Agreement, including this STARS Bonus Program, will be construed in any manner as creating an obligation or inducement to limit the provision of any medically necessary services to be provided by Provider.

Provider agrees that Provider will immediately report to Plan any Provider physician whom Provider believes, or has reason to believe, may have limited or denied, or attempted to limit or deny, medically necessary or clinically appropriate care to one or more Plan enrollees. Any such limitation, denial, or attempt, as determined by Plan in its sole discretion, will be grounds for immediate termination of Provider's participation in this STARS Bonus Program and will be deemed a material breach under the Agreement for purposes of termination of the Agreement. Notwithstanding anything in this STARS Bonus Program to the contrary, no further payments will be made under this STARS Bonus Program if terminated. In its sole discretion, Plan may elect instead to exclude the individual Provider physician from the Provider group, thereby terminating that Provider physician's participation in this STARS Bonus Program. Provider acknowledges and agrees that Plan is relying upon the foregoing representations and covenants of Provider in connection with Provider's and each Provider physicians' participation in this STARS Bonus Program.

Compliance with Laws.

Plan and Provider further acknowledge and agree that:

- in establishing the terms of the Agreement, including this STARS Bonus Program, neither Plan nor Provider gave or received remuneration in return for or to induce the provision or acceptance of business for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis; and
- neither Plan nor Provider will shift the financial burden of the Agreement, including this STARS Bonus Program, to the extent that increased payments are claimed from a Federal health care program.

Provider represents and agrees that Provider cannot and will not claim payment in any form, directly or indirectly, from a Federal health care program for items or services covered under the Agreement, except as expressly permitted by applicable law.



THIS AMENDMENT TO MEDICARE ADVANTAGE NETWORK RISK AGREEMENT (this "Amendment") is dated effective as of 01/01/2016 ("Effective Date"), by and between MEDICA HEALTHCARE PLANS, INC.,, a Florida corporation ("PLAN") and DOCTOR'S GROUP MANAGEMENT ("Network").

WHEREAS, Plan and Network desire to amend the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge, the parties agree as follows:

- <u>Defined Terms.</u> Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.
- Amendments.
 - 2.1 Schedule E, Stars Bonus Program. Payment section of Schedule E, Stars Bonus Program shall be deleted in its entirety and replaced with the following:

Payment

During the second quarter of the following plan year, Plan will determine if Provider met the quality targets for the full plan year (January 1 to December 31) and STARS Bonus Amount earned for that period, if any, will be distributed by Plan to eligible Primary Care Providers no later than third quarter of that year. Provider must be a contracted and participating Provider of Primary Care Services for Plan on the date a payment is made by Plan to be eligible to receive payment under this STARS Bonus Program. If Provider is not a contracted and participating Provider of Primary Care Services on the data Plan makes STARS Bonus Program payments, Provider will not be eligible for and will not receive any payment under this STARS Bonus Program. If Provider owes Plan monies as of the date of bonus payment, any applicable bonus payments due to provider shall first be applied to offset any balance's or deficits owed to Plan; thereafter any remaining bonus payment will be paid to Provider.

3. <u>Full Force and Effect</u>. Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

MEDICA HEALTHCARE PLANS, INC.,

9100 South Dadeland Boulevard, Suite 1250

Miami, Florida 33156

Annette C. Onorati

Chief Operating Officer

DOCTOR'S GROUP MANAGEMENT

Name:

Title:

TIN:20-0534962



AMENDMENT TO MEDICARE ADVANTAGE NETWORK RISK AGREEMENT

MEDICA HEALTHCARE PLANS, INC., a Florida corporation ("Plan") and DOCTORS GROUP MANAGEMENT, LLC ("Network") enter into this amendment ("Amendment") to the Medicare Advantage Network Risk effective November 1, 2015 (the "Agreement"). This Amendment is effective [January 1, 2016] (the "Effective Date").

WHEREAS, Plan and Network desire to revise the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge, the parties agree as follows:

- 1. <u>Defined Terms.</u> Unless otherwise defined in this Amendment, the capitalized terms used in this Amendment have the meaning stated in the Agreement.
- 2. <u>Amendments</u>. As of the Effective Date, Plan and Network amend the Agreement as follows:
- 2.1 Schedule B. Payment Appendix Network Golobal Capitation. Schedule B, Payment Appendix Network Global Capitation is deleted from the Agreement and replaced with Schedule B, Payment Appendix Network Global Capitation attached to this Amendment.
- 2.2 Schedule E Stars Bonus Program. In an effort to improve the quality of member care as measured by STARs performance and to provide additional compensation to participating providers who successfully achieve the goals of participation in the Stars Bonus Program, Plan incorporates Schedule E STARs Bonus Program. The STARs Bonus Program provides qualifying Network Providers with the opportunity to receive a STARS bonus payment for each Plan enrollee who selects or is assigned to Provider for Primary Care Services if Provider meets specific performance driven quality targets established in accordance with Schedule E.
- 3. <u>Full Force and Effect</u>. Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, Plan and Network have executed this Amendment by their officers duly authorized to be effective on the date and year written above.

MEDICA HEALTHCARE PLANS, INC.

9100 South Dadeland Boulevard, Suite 1250

Miami, Florida 33156

Annette C. Onorati

Chief Operating Officer

DOCTORS GROUP MANAGEMENT

Name:

Title: Parsi

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SCHEDULE B PAYMENT APPENDIX - NETWORK GLOBAL CAPITATION

- Medicare Operating Fund. Plan will establish a Medicare Operating Fund in a ledger within
 the financial records of Plan from which Plan will pay all medical, hospital (including but not
 limited to inpatient, outpatient and emergency), reinsurance, physician and health care
 professionals, and all other Medicare Part A and Part B plan benefit claims, fees and expenses
 for Members assigned to Network.
- 2. Security Reserve. Plan will establish a Security Reserve Account in a ledger within the financial records of Plan to secure Network's performance under the Agreement and this Schedule B (the "Security Reserve"). The initial amount of contributions to the Security Reserve will be \$10/member/month with a minimum of \$150,000. Plan will withhold an amount equal to 25% of each Substantial Completion Payment (as defined below) and 30% of each Final Surplus until the Security Reserve is fully funded at an amount equal to \$100 (the "Per Member Reserve Amount") per member assigned to Network as of the last day of the previous calendar quarter. If the Security Reserve is not fully funded at the end of each 12 month period following entry into the Agreement and this Schedule B, whether due to insufficient contributions, adjustments to the Security Reserve amount as provided below, or transfers from the Security Reserve Account to the Medicare Operating Fund due to negative balances in the Medicare Operating Fund, Network will pay to Plan within 30 days an amount equal to the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Plan and Network may, each in their sole discretion, agree to a payment plan under which Network will repay the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Failure of Network to pay to Plan the difference between the amount of the Security Reserve and the balance of the Security Reserve Account within 30 days or, if applicable, in accordance with an agreed upon payment plan will constitute a material breach of this Agreement and Plan will have the right, in Plan's sole discretion, to (a) terminate the Agreement "for Cause" as provided in the Agreement or (b) terminate payment under this Schedule B and pay Network a base capitation rate consistent with base capitation rates provided to other similar primary care providers in Plan's network for the provision of primary care services to Members.

Plan may, in Plan's sole discretion, adjust the required amount of the Security Reserve upward or downward as reasonably required based on Network performance and potential liability to Plan under the Agreement and this Schedule B. Plan may not adjust the amount of the Security Reserve more than twice in a calendar year. If Plan decreases the amount of the Security Reserve, Plan will distribute any excess in the Security Reserve Account as additional payment of equal amounts on its next 3 payments to Network. If Plan increases the amount of the Security Reserve, Plan will again withhold amounts from Substantial Completion Payments and Final Surplus payments until the Security Reserve is fully funded.

In addition, if at any time the balance of the Security Reserve Account is less than \$0.00, Plan may in its sole discretion, require Network to pay to Plan within 30 days an amount equal to the difference between the amount of the Security Reserve and the balance of the Security Reserve Account or require Network to agree to a payment plan under which Network will repay the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Failure of Network to pay to Plan the difference between the amount of the Security Reserve and the balance of the Security Reserve Account within 30 days or, if applicable, in accordance with the payment plan will constitute a material breach of this Agreement and Plan will have the right, in Plan's sole discretion, to (a) terminate the Agreement "for Cause" as provided in the Agreement or (b) terminate payment under this Schedule B and pay Network a base capitation rate consistent with base capitation rates

provided to other similar primary care providers in Plan's network for the provision of primary care services to Members.

- Funding the Medicare Operation Fund. As full compensation to Network for the services rendered under this Agreement, Plan will allocate to the Medicare Operating Fund the amounts stated in this Sections 3, deduct from the Medicare Operating Fund the amounts stated in Section 4, and distribute to Network the amounts determined in accordance with Sections 5 and 6 of this Schedule B.
 - a. <u>CMS Payment</u>. An amount equal to the percentage stated in the following table of the CMS Payment.

Assigned Network Members	Percentage	Care Management Compensation
1-500	83%	0.0%
501-1,000	83%	1.0%
1,001 or more	84%	2.0%

For purposes of this Payment Appendix, CMS Payment means the actual aggregate capitated payment for each month received by Plan from CMS (or any successor government agency) for the provision of Medicare Part A and Part B benefits to Members. CMS Payment does not include payment for the provision of Part D benefits nor any other pharmacy revenue.

- b. <u>Stop-Loss Insurance</u>. If Network receives stop-loss protection from Plan or a Plan Affiliate, Plan will credit any amounts due to Network in connection with stop-loss insurance protection to the Medicare Operating Fund. If Network does not receive stop-loss protection from Plan or a Plan Affiliate, Network will assign the proceeds or pay the amount of any recoveries under Network's stop-loss protection to Plan immediately upon receipt and Plan will credit that amount to the Medicare Operating Fund.
- c. <u>Pharmacy Revenue</u>. The Medicare Operating Fund will not include any revenue received by Plan for the provision of Medicare Part D benefits or any other pharmacy-related revenue.
- d. Third Party Collections. Plan is responsible for collecting funds related to any third party liability for services provided to Members involving, but not limited to, auto insurance carriers, subrogation, Workers' Compensation, and any rights for coordination of benefits with other health insurance providers. Upon recovery by Plan, Plan will (a) account to Network for the recovered amount, and (b) contribute the recovered amount, less reasonable cost of collection paid to third parties, if any, to the Medicare Operating Fund.
- 4. <u>Deductions from the Medicare Operating Fund.</u> Plan will deduct the following amounts from the Medicare Operating Fund:
 - a. Network Capitation Payment. Plan will pay Network a monthly capitation payment for each Member (the "Network Capitation Payment") of \$175.00 less the estimated cost of Primary Care Services for each Member paid by Plan (the "Estimated Plan Cost"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month. Plan will determine the Estimated Plan Cost on or before the 15th day of the first month of each calendar quarter. The Estimated Plan Cost will equal the average actual cost for Primary Care Services for each Member paid by Plan during the preceding calendar quarter.
 - Payment for Covered Services. Except as provided above, Plan will pay all claims for Part A
 and Part B Covered Services, including the actual cost of Primary Care Services for each

- Member paid by Plan, and deduct the amount of these payments and expenses from the Medicare Operating Fund. Plan will pay all claims for Part D Covered Services but will not deduct the amount of these payments from the Medicare Operating Fund.
- c. <u>Care Management and Disease Management Programs</u>. The cost incurred by Plan to provide standard care management programs and disease management programs to Members.
- d. <u>Primary Care Provider Bonus Payments.</u> Unless stated otherwise in the terms of any bonus program attached to this Agreement, the amount of any bonus payments from Plan to Network Providers, including without limitation payments for participation in Plan's STARs Bonus Program and MLR Bonus Program.
- e. <u>Stop-Loss Protection.</u> The cost of Network's Stop-Loss Protection if provided by Plan or a Plan Affiliate.
- f. <u>Chart Review and Hospital Abstracts.</u> The cost incurred by Plan to perform medical chart reviews and hospital abstract audits of Member medical records and claims data.
- g. <u>Security Reserve Amounts:</u> the amounts corresponding with Section 2 of this Payment Appendix.
- 5. Calculation of Medicare Operating Fund Surpluses and Deficits. At the end of each month, Plan will determine the amount by which allocations to the Medicare Operating Fund exceeded or were less than deductions from the Medicare Operating Fund. This amount is the "Initial Surplus" or "Initial Deficit". Plan will retain the Initial Surplus for 120 days after the end of each month (the "Substantial Completion Period"). At the end of the Substantial Completion Period, Plan will again determine whether allocations to the Medicare Operating Fund exceeded deductions from the Medicare Operating Fund for that month (the "Target Month"). Claims paid as of the end of the Substantial Completion Period will be deemed to constitute 90% of all claims incurred during the Target Month for purposes of this calculation.
 - a. If there is a positive balance in the Medicare Operating Fund for the Target Month at the end of the Substantial Completion Period (a "Substantial Completion Surplus"), Plan will pay to Network a "Substantial Completion Payment" equal to 50 percent of difference resulting from the reduction of the Substantial Completion Surplus by the lesser of (i) actual claims incurred but not reported for the Target Month or (ii) 10% of total claims paid for the Target Month (which amount will be retained in the Medicare Operating Fund as the agreed upon amount of claims incurred but not reported ("IBNR") for the Target Month).
 - b. If there is a negative balance in the Medicare Operating Fund for the Target Month at the end of the Substantial Completion Period (a "Substantial Completion Deficit"), Plan will withhold from its next scheduled monthly capitation payment to Network a "Substantial Completion Recovery" equal to 50% of the sum resulting from adding to the Substantial Completion Deficit the lesser of (i) actual claims incurred but not reported fro the Target Month or (ii) 10% of total claims paid for the Target Month (which amount will be retained in the Medicare Operating Fund as the agreed upon amount IBNR for the Target Month). If the amount of the next scheduled monthly capitation payment to Network is not sufficient to withhold the entire Substantial Completion Recovery, Plam may recover any unrecovered amounts from the Security Reserve or any subsequent payment from Plan to Network, in Plan's sole discretion.

After paying of the Substantial Completion Payment or withholding the Substantial Completion Recovery, Plan will continue to pay claims and expenses from the IBNR for the Target Month. If there is a positive balance in the Medicare Operating Fund for the Target

Month at the end of the 12th month after the end of the Target Month (the "Final Completion Period"), Plan will pay to Network 50% of the amount of that positive balance (the "Final Surplus"). Subject to Section 3.b. of this Payment Appendix, if claims paid after the Substantial Completion Period exceed the IBNR for the Target Month, the amount of excess claims (the "Final Deficit") will be deducted from the Medicare Operating Fund for months after the Target Month until recovered by Plan. If at any time the value of the Medicare Operating Fund is less than \$0.00, Plan will transfer funds from the Security Reserve Account to the Medicare Operating Fund to eliminate that deficit.

In no event will the end of a Substantial Completion Period or a Final Completion Period (i) release Network from its liability for claims incurred for Covered Services during the Target Month, or (ii) be deemed an assumption by Plan of risk for such claims regardless of when the claim is received.

Plan will pay Substantial Completion Payments and Final Surpluses for each Target Month to Network on or before the 15th day after conclusion of the Substantial Completion Period and the Final Completion Period, respectively. For example, if the first Members were assigned to Network on August 1, 2013, the Substantial Completion Period determination would be completed and the Substantial Completion Payment made on or before January 15, 2014. The Substantial Completion Period determination for September 2013 would be completed and the Substantial Completion Payment made on or before February 15, 2014. In turn, Plan would pay the Final Surplus (if any) for August 2013 to Network on or before September 15, 2014 and the Final Surplus (if any) for September 2013 on or before October 15, 2014.

If Network disagrees with Plan's calculation of any Medicare Operating Fund surplus or deficit, Network must deliver written notice of Network's proposed adjustments to the calculation to Plan within 45 days after Plan delivers Plan's calculation to Network. Plan will respond to proposed reconciliation adjustments within 120 days of receipt of Network's proposed adjustments. If Plan agrees with any proposed adjustment and the adjustments increases amounts payable to Network, Plan will include the amount of the proposed adjustment in its next distribution to Network. If Plan disagrees with the proposed adjustment, Plan and Network will then work in good faith for 30 days to agree upon a final reconciliation amount. If Plan and Network are unable to agree upon a final reconciliation amount within 30 days, the dispute will be resolved in accordance with the terms of the Agreement.

6. Retroactive Adjustments to Payments. Plan has the right to make retroactive adjustments to Medicare Operating Fund Surpluses and Deficits that result from regulatory audits or reviews or Plan-initiated audits or reviews of risk adjustment factors and to recalculate the amount of any Substantial Completion Payment, Final Surplus or Final Deficit due to any resulting change in the CMS Payment applicable to that Substantial Completion Payment, Final Surplus or Final Deficit. In calculating any retroactive adjustments under this Section 6, Plan will include adjustments to the CMS Payment resulting from regulator or Plan-initiated audits or reviews of risk adjustment factor data, but Plan will not include adjustments to any other component of the CMS Payment or any other expense charged to the Medicare Operating Fund.

Plan will determine the amount of any retroactive adjustment resulting from medical chart audits or reviews initiated by Plan no later than 6 months after Network provides Plan with all information Plan needs to complete the audit or review. Plan will determine the amount of any retroactive adjustment result from (a) other risk adjustment factor audits or reviews initiated by Plan, and (b) audits or reviews of risk adjustment factors initiated by a regulator (or by a contractor to a regulator) no later than 6 months after CMS communicates the resulting change in the CMS Payment to Plan. Network must pay the amount of the retroactive adjustment to Plan no later than 90 days after receipt of written notice from Plan

of the amount of the retroactive adjustment. Plan may offset the amount of the retroactive adjustment against future payments to Network if Network does not pay within 90 days.

7. Care Management Compensation.

- a. <u>Purpose.</u> Plan offers additional care management compensation to eligible Networks and Providers in the form of an increased allocation to the Medicare Operating Fund. The purpose of these additional care management allocations is to:
 - 1. Increase access to quality care for Plan enrollees.
 - 2. Ensure that Network gives adequate coverage to patients who select or are assigned by Plan to Network and Network Providers.
 - 3. Compensate Network for the additional resources required to provide quality care to larger numbers of Plan enrollees.
 - 4. Compensate Network for agreeing to arrange care for and accept the financial risk of treating larger numbers of plan enrollees on a capitated basis.
 - 5. Improve the quality of health care delivered to Plan enrollees by Plan working closely with Network to measure and improve Plan enrollee care and outcomes.
 - 6. Encourage efficiencies in the delivery of medical care for Plan, Network and Network Providers as measured by costs, claim submission methods, and Plan enrollee satisfaction.
- b. <u>General Quality Criteria.</u> For Network to continue to receive additional care management allocation requires Network to work with Network Providers and Plan's provider relations staff to improve Network Provider compliance with Plan's quality criteria, including:
 - 1. Engagement in care coordination for Plan enrollees, as appropriate, including:
 - (i)Communication with specialists
 - (ii)Cooperation with Plan's outreach efforts and health wellness and prevention programs
 - (iii)Managing Plan enrollee care during inpatient admissions, either directly or through communication with attending physician
 - (iv)Supporting discharge planning and follow-up with Plan enrollees post-discharge
 - (v)Referring Plan enrollees to behavioral health providers, as appropriate
 - (vi)Providing initial meeting between Member and physician within 90 days of Member enrollment in Plan

(vii)Address any identified gaps in Plan enrollee care

- 2. Compliance with Plan's policies and procedures, including:
 - (i) Utilization Management
- (ii) Credentialing and re-credentialing
- (iii) Identification, assessment and establishment of treatment plans for serious and complex conditions
- (iv) Plan's grievance program
- (v) Participation in Plan's Quality Improvement Program
- c. <u>Specific Quality Criteria.</u> In addition, to assisting Plan and Network Providers efforts to fulfill the General Quality Criteria described above, Network agrees to work with Network

Providers and Plan's provider relations staff to satisfy the following Specific Quality Criteria in consideration for receiving the additional care management allocation:

- 1. Participation by eligible Network Providers in Plan's STARS bonus program.
- 2. Participation by eligible Network Providers in Plan's MLR bonus program.
- 3. Participation by eligible Network Providers, and if appropriate Network personnel, in monthly meetings with Plan's provider relations staff during which Network Provider and Plan representatives will review Plan operations, care management for Plan enrollees, adequacy of coverage provided to Plan enrollees, gaps in care for Plan enrollees, Plan enrollee complaints (if any), Provider's compliance with Plans policies and procedures, Provider's performance under Plan's Quality Improvement Program, STARS Program, and medical management program, and Provider's compliance with the quality criteria stated in this Appendix.
- 4. Working with Network Providers and Plan's provider relations staff to address concerns identified in monthly meetings and implement initiatives developed by Plan and/or Network Providers to address these concerns with respect to all Plan enrollees who have selected or been assigned to Network Provider.
- 8. Review of Adherence to Plan's Quality of Care Programs. Plan will provide Network with reports describing Network's and Network Providers' performance on applicable quality and performance metrics to ensure that Network knows the status of Network's and Network Providers' performance. Plan's provider relations staff and medical directors will work with Network and Network Providers to assist Network and Network Providers in achieving performance goals.
- 9. <u>Full Payment.</u> The payments to Network under this Payment Appendix are full payment to Network for all Covered Services provided by Network to Customers. Network must not claim payment in any form, directly or indirectly, from any Federal or State health care program (except as approved by a Federal or State health care program) for items or services furnished under this Agreement. Network cannot shift any costs for items or services furnished under this Agreement to the extent that increased payments are claimed from any Federal or State health care program. Network agrees to fully and accurately report the terms of this Agreement and the amounts paid under this Agreement upon request by any Federal or State health care program.
- 10. Stop-Loss Protection. Network must maintain, at all times during which this Schedule B is in force or any payment under this Schedule B remains outstanding, stop-loss protection (the "Stop-Loss Protection")at least sufficient to satisfy the physician incentive plan regulations at 42 CFR 422.208 (the "PIP Regulations"). At Network's option, Network may obtain the Stop-Loss Protection from Plan or Network may purchase Stop-Loss Protection from a third party. If Network chooses to receive Stop-Loss Protection from Plan, Plan will deduct the full cost of providing that Stop-Loss Protection from the Medicare Operating Fund. If Network chooses to purchase the Stop-Loss Protection from a third party, Plan reserves the right to review and approve the policy and entity that provides the Stop-Loss Protection. Network will name Plan as primary payee under any third party Stop-Loss Protection and Plan will credit any payments made to the Medicare Operating Fund. Without limiting the generality of this Section, Network will ensure that Network Providers carry the correct level of reinsurance coverage for individual and institutional losses prescribed by the PIP Regulations.
- 11. <u>Referrals Prohibited.</u> Plan and Network agree that neither Plan nor Network will knowingly and willfully accept nor provide indirect or direct payment for referrals of individuals for items or services reimbursed under a federal health care program. Acceptance of the terms and conditions in this Appendix is without regard to any volume of referrals, and there are no

- expectations of referrals between Plan and Network based on this Appendix. The parties agree that the capitation amounts in this Agreement are based on fair market value independent of the value or volume of any referrals. Network specifically acknowledges and agrees that Network will not engage in any activities to promote or market Plan managed care products, and will make no referrals whatsoever of individuals to Plan for the provision of managed care services. Any violation of this provision will result in the immediate termination of this Appendix and Network's right to receive payments under this Appendix.
- 12. Termination of Agreement. In order to receive any payment due to Network under this Payment Appendix, this Agreement must be in force and Network must be providing Covered Services to Members on the date payment is due. Upon termination of the Agreement, no further payment will be due to Network under the Agreement or this Payment Appendix. Plan will provide a final reconciliation of all payments made before termination of the Agreement on or before the first anniversary of the termination of the Agreement. Network will have 30 days to review and object to Plan's final reconciliation. If Network does not object within 30 days, Plan will pay to Network the amount of any surplus or Network will pay to Plan the amount of any deficit in the final reconciliation on or before the 45th day following Network's receipt of the final reconciliation. If Network objects to Plan's final reconciliation, Network will deliver written notice of the basis for its objection to Plan. Plan and Network will then work in good faith for 30 days to agree upon a final reconciliation amount. If Plan and Network are unable to agree upon a final reconciliation amount within 30 days the dispute will be resolved in accordance with the terms of the Agreement. Upon resolution of any dispute and agreement upon the final reconciliation, Plan will also distribute to Network any remaining balance in the Security Reserve.

SCHEDULE E

STARS Bonus Program

STARS Bonus Program

The MEDICA HEALTHCARE PLANS, INC STARS Bonus Program provides qualifying Network Primary Care Providers with the opportunity to receive up to \$10.00 per month ("STARS Bonus Amount") for each Plan enrollee who selects or is assigned to Provider for Primary Care Services if Provider meets quality targets established by Plan in its sole discretion.

Eligibility

All Network Primary Care Providers with 30 or more Plan enrollees are eligible to participate in the STARS Bonus Program.

Utilization and Quality Targets

Plan will determine the STARS Bonus Program quality targets in its sole discretion before the start of each plan year. Quality targets will remain in effect for the plan year. Plan will distribute quality targets for the STARS Bonus Program to Provider in writing. Plan may, in Plan's sole discretion, communicate additional terms and conditions or changes in the quality targets of the STARS Bonus Program to eligible Providers throughout the plan year. If Plan does not distribute quality targets before the start of any plan year, the quality targets for the prior plan year will continue to apply.

Payment

Plan will determine STARS Bonus Amounts to eligible Primary Care Providers two times per year. For the first two quarters of each plan year (January 1 to June 30), Plan will determine if Provider has met the quality targets for that period and pay any STARS Bonus Amount earned during that period during the third quarter of the year (the "1st Payment"). During the second quarter of the next year, Plan will determine if Provider met the quality targets for the full plan year (January 1 to December 31) and any STARS Bonus Amount earned for that period. If the STARS Bonus Amount for the full plan year exceeds the amount of the 1st Payment, Plan will pay the excess amount to Provider during the second quarter of the next year (the "2" Payment"). If the STARS Bonus Amount for the full plan year equals the amount of the 1st Payment, no additional payment will be due to Provider. If the STARS Bonus Amount for the full year is less than the amount of the 1st Payment, Plan will recover the difference from Provider through offsets against future payments from Plan. Provider must be a contracted and participating Provider of Primary Care Services for Plan on the date a payment is made by Plan to be eligible to receive payment under this STARS Bonus Program. If Provider is not a contracted and participating Provider of Primary Care Services on the data Plan makes STARS Bonus Program payments, Provider will not be eligible for and will not receive any payment under this STARS Bonus Program. Plan will distribute STARS Bonus Amounts as follows:

1. If the Provider is employed by Network, Plan will distribute, and if applicable recover, the 1st Payment and the 2nd Payment from Network.

- 2. If the Provider provides services to Members under a contract with Network, Plan will distribute, and if applicable, recover the 1st payment and the 2nd Payment from Network. Network will distribute and recover STARS Bonus Amounts to Provider in accordance with the terms of Network's agreement with Provider. If Network's agreement with Provider does not address STARS Bonus payments, Network will pay the STARS Bonus Amount to Provider in full.
- If the Provider provides services to Members under a contract directly with Plan, Plan will distribute, and if applicable recover, the 1st Payment and the 2nd Payment directly from Provider.

Deductions from Network's Medicare Operating Fund

If the overall STARS rating of the Members assigned to Network, determined in accordance with CMS STAR rating methodology, is 4.50 stars or greater, Plan will not deduct STARs Bonus payments to Network Providers from Network's Medicare Operating Fund. If the overall STARS rating of Members assigned to Network, determined in accordance with CMS STAR rating methodology is 4.26 stars or greater (but less than 4.50), Plan will not deduct 50% of the amount of the STARS Bonus payments from Network's Medicare Operating Fund. If the overall STARS rating of Members assigned to Network, determined in accordance with CMS STAR rating methodology, is less than 4 stars, Plan will deduct the full amount of the STARS Bonus payments from Network's Medicare Operating Fund.

Denial of Medically Necessary Care Prohibited

Plan and Provider acknowledge and agree that:

- the compensation stated in the Agreement, including this STARS Bonus Program, does not reward Provider for limiting the provision of any medically necessary services to any patients; and
- nothing in the Agreement, including this STARS Bonus Program, will be construed in any manner as creating an obligation or inducement to limit the provision of any medically necessary services to be provided by Provider.

Provider agrees that Provider will immediately report to Plan any Provider physician whom Provider believes, or has reason to believe, may have limited or denied, or attempted to limit or deny, medically necessary or clinically appropriate care to one or more Plan enrollees. Any such limitation, denial, or attempt, as determined by Plan in its sole discretion, will be grounds for immediate termination of Provider's participation in this STARS Bonus Program and will be deemed a material breach under the Agreement for purposes of termination of the Agreement. Notwithstanding anything in this STARS Bonus Program to the contrary, no further payments will be made under this STARS Bonus Program if terminated. In its sole discretion, Plan may elect instead to exclude the individual Provider physician from the Provider group, thereby terminating that Provider physician's participation in this STARS Bonus Program. Provider acknowledges and agrees that Plan is relying upon the foregoing representations and covenants of Provider in connection with Provider's and each Provider physicians' participation in this STARS Bonus Program.

Compliance with Laws.

Plan and Provider further acknowledge and agree that:

- in establishing the terms of the Agreement, including this STARS Bonus Program, neither Plan nor Provider gave or received remuneration in return for or to induce the provision or acceptance of business for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis; and
- 2) neither Plan nor Provider will shift the financial burden of the Agreement, including this STARS Bonus Program, to the extent that increased payments are claimed from a Federal health care program.

Provider represents and agrees that Provider cannot and will not claim payment in any form, directly or indirectly, from a Federal health care program for items or services covered under the Agreement, except as expressly permitted by applicable law.



AMENDMENT TO MEDICARE ADVANTAGE PARTICIPATING PROVIDER AGREEMENT - NETWORK RISK AGREEMENT

THIS AMENDMENT TO MEDICARE ADVANTAGE NETWORK RISK AGREEMENT (this "Amendment") is dated effective as of 01/01/2016 ("Effective Date"), by and between MEDICA HEALTHCARE PLANS, INC.,, a Florida corporation ("PLAN") and DOCTORS GROUP MANAGEMENT ("Network").

WHEREAS, Plan and Provider entered into a Medicare Advantage Network Risk Agreement dated effective as of 11/01/2015 (the "Agreement"), and the parties desire to amend the Agreement as set forth herein.

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

- 1. <u>Defined Terms.</u> Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.
- 2. Amendments.
 - **2.1 Section 8. Term of Agreement.** Section 8 shall be deleted in its entirety and replaced with the following:
 - 8. TERM OF AGREEMENT

This Agreement commences on the Effective Date and continues for a four (4) year term. Thereafter, this Agreement automatically renews for subsequent three (3) year terms unless terminated in accordance with Section 9.

- **2.1 Schedule B. Payment Appendix.** Section 5. shall be deleted in its entirety and replaced with the following:
- 5. Calculation of Medicare Operating Fund Surpluses and Deficits.

At the end of each month, Plan will determine the amount by which allocations to the Medicare Operating Fund exceeded deductions from the Medicare Operating Fund. The amount of this excess is the Initial Surplus. Plan will retain the Initial Surplus for 120 days after the end of each month (the "Substantial Completion Period"). At the end of the Substantial Completion Period, Plan will again determine whether allocations to the Medicare Operating Fund exceeded deductions from the Medicare Operating Fund for that month (the "Target Month"). Claims paid as of the end of the Substantial Completion Period will be deemed to constitute 90% of all claims incurred during the Target Month. If there is a positive balance in the Medicare Operating Fund for the Target Month at the end of the Substantial Completion Period (the "Substantial Completion Surplus"), Plan will pay to Network a "Substantial Completion Payment" equal to:

- a. For Target Months January 2016 through December 2017, 50% percent of the amount of the Substantial Completion Surplus reduced by the lesser of (i) actual claims incurred but not reported for the Target Month or (ii) 10% of total claims paid for the Target Month (which amount will be retained in the Medicare Operating Fund as the agreed upon amount of claims incurred but not reported ("IBNR") for the Target Month); and
- b. For Target Months January 2018 and after, 100% the amount of the Substantial Completion Surplus reduced by the lesser of (i) actual claims incurred but not reported for the Target Month or (ii) 10% of total claims paid for the Target Month (which amount will be retained in the Medicare Operating Fund as the agreed upon amount of claims incurred but not reported ("IBNR") for the Target Month).

After payment of the Substantial Completion Payment (if any), Plan will continue to pay claims and expenses from the IBNR for the Target Month. If there is a positive balance in the Medicare Operating Fund for the Target Month at the end of the 12th month after the end of the Target Month (the "Final Completion Period"), Plan will pay to Network the amount of that positive balance (the "Final Surplus"). Subject to Section 4.b. of this Payment Appendix, if claims paid after the Substantial Completion Period exceed the IBNR for:

- a. Target Months January 2016 through December 2017, no deduction will be made from the Medicare Operating Fund; and
- b. Target Months January 2018 and after, the amount of excess claims (the "Final Deficit") will be deducted from the Medicare Operating Fund for months after the Target Month until recovered by Plan.

If at any time the value of the Medicare Operating Fund is less than \$0.00, Plan will transfer funds from the Security Reserve Account to the Medicare Operating Fund to eliminate that deficit. In no event will the end of a Substantial Completion Period or a Final Completion Period (i) release Network from its liability for claims incurred for Covered Services during the Target Month, or (ii) be deemed an assumption by Plan of risk for such claims regardless of when the claim is received.

Plan will pay Substantial Completion Payments and Final Surpluses for each Target Month to Network on or before the 15th day after conclusion of the Substantial Completion Period and the Final Completion Period, respectively. For example, if the first Members were assigned to Network on August 1, 2013, the Substantial Completion Period determination would be completed and the Substantial Completion Payment made on or before January 15, 2014. The Substantial Completion Period determination for September 2013 would be completed and the Substantial Completion Payment made on or before February 15, 2014. In turn, Plan would pay the Final Surplus (if any) for August 2013 to Network on or before September 15, 2014 and the Final Surplus (if any) for September 2013 on or before October 15, 2014.

If Network disagrees with Plan's calculation of any Medicare Operating Fund surplus or deficit, Network must deliver written notice of Network's proposed adjustments to the calculation to Plan within 45 days after Plan delivers Plan's calculation to Network. Plan will respond to proposed reconciliation adjustments within 120 days of receipt of Network's proposed adjustments. If Plan agrees with any proposed adjustment and the adjustments increases amounts payable to Network, Plan will include the amount of the proposed adjustment in its next distribution to Network. If Plan disagrees with the proposed adjustment, Plan and Network will then work in good faith for 30 days to agree upon a final reconciliation amount. If Plan and Network are unable to agree upon a final reconciliation amount within 30 days the dispute will be resolved in accordance with the terms of the Agreement.

3. <u>Full Force and Effect.</u> Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

MEDICA HEALTHCARE PLANS, INC.,

9100 South Dadeland Boulevard, Suite 1250 Miami, Florida 33156

Annette C. Onorati

Chief Operating Officer

DOCTORS GROUP MANAGEMENT

Ву: __

Name: ___

Title: MSI deas

Date: /2-23-20/6

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AMENDMENT TO MEDICARE ADVANTAGE PARTICIPATING PROVIDER AGREEMENT - NETWORK RISK

	PARTICIPATING PROVIDER AGRE	LIVERY - NETWORK RISK
11/10/2	re Advantage Network Risk Agreement" or "A	E PARTICIPATING PROVIDER AGREEMENT (the Agreement"), originally dated effective as of TWORK, INC., a Florida corpration ("PLAN") and
1.	<u>Description of Services</u> . Schedule A of the Parti force and effect.	cipating Provider Agreement, shall remain in full
2.	<u>Compensation</u> . Schedule B of the Participating Reffect.	Provider Agreement shall remain in full force and
3.	Name & Tax Identification: Changed to: DGM M	SO, LLC., TIN 82-3464109
4.	Effective Date. The Effective Date of this Amend	ment is JANUARY 1, 2022.
5.	<u>Provisions of Participating Provider Agreemer</u> Agreement, not amended herein, shall remain in	nt. All provisions of the Participating Provider full force and effect.
	ESS WHEREOF, the parties hereto have executed t written above.	this Amendment in the State of Florida on the
PROVIDI	ER: IS GROUP MANAGEMENT, INC.	PLAN: PREFERRED CARE NETWORK, INC.
Ву:	Dr. Marlow Hernandez	By:
Name: _		Name: Roger Rodriguez
Title:	CEO	Title: CEO
		î



AMENDMENT TO MEDICARE ADVANTAGE PARTICIPATING PROVIDER AGREEMENT - NETWORK RISK

This Amendment effective JANUARY 1, 2022 is made between PREFERRED CARE NETWORK, INC., ("PLAN or "PCN") and DGM MSO, LLC. ("Provider") or other applicable term used in the Provider Agreement for the purpose of amending the terms and conditions of the Network Risk Services Agreement ("the Agreement").

- 1. Description of Services. Schedule A of the Network Risk Agreement, shall remain in full force and effect.
- 2. Compensation. Schedule B Section 3(a) of the Network Risk Agreement shall be amended as follows:

3. Funding. As full compensation to Network for the services rendered under this Agreement, Plan will allocate to the Medicare Operating Fund the amounts stated in this Sections 3, deduct from the Medicare Operating Fund the amounts stated in Section 4, and distribute to Network the amounts determined in accordance with Sections 5 and 6 of this Schedule B:

CMS Payment. An amount equal to the percentage stated in the following table of the CMS Payment

Assigned Network Members	Percentage	Care Management Compensation
1-999	83%	0.0%
1,000-1,999	84%	0.0%
2,000+	85.8%	0.0%

For purposes of this Payment Appendix, CMS Payment means the actual aggregate capitated payment for each month paid to Plan by CMS (or any other government agency representing the Medicare Program) for the provision of Medicare Program benefit plans to Members.

- 3. Effective Date. The Effective Date of this Amendment is: JANUARY 1, 2022
- Provisions of Network Risk Agreement. All provisions of the Network Risk Agreement shall remain in full 4. force and effect.

PREFERRED CARE NETWORK, INC. 9100 South Dadeland Boulevard, Suite 1250	DGM MSO, LLC.
Miami, Florida 32156	
Ву:	By: 4/4/
Name: Roger Rodriguez	Name: Marlow Hernander
Title: CEO	Title: CEO
Date:	Date: 12/23/2/

Assignment and Assumption Agreement

This Assignment and Assumption Agreement (this "Agreement") is made and entered into this January 1, 2022, by and among, PREFERRED CARE NETWORK, INC. ("Plan"), DOCTORS GROUP MANAGEMENT ("Network") and DGM MSO, LLC. ("Purchaser").

Recitals

WHEREAS, Plan and Network entered into a Medicare Advantage Network Risk Agreement effective November 1, 2015 (the "Participation Agreement");

WHEREAS, Network has entered into a transaction pursuant to which Network will sell substantially all of its assets to Purchaser (the "Transaction");

WHEREAS, Network desires to assign Participation Agreement and Purchaser desires to assume Network's rights and obligations under the Participation Agreement; and

WHEREAS, Network may not assign the Participation Agreement without Plan's approval.

- Date of Service. For purposes of this Agreement, rights and obligations relating to: (i) payment of a claim, (ii) additional payment of an underpayment on a claim, or (iii) refund of an overpayment on a claim, will be deemed to arise on the date of service. The date of service of an entire inpatient admission is the first day of the admission, regardless of the length of stay.
- Assumption. Purchaser shall assume all rights and obligations under the Participation Agreement which may arise on or after January 1, 2022 or the date of completion of the Transaction, whichever occurs later.
- Assignment. Network assigns all rights and obligations under the Participation Agreement which may arise on or after January 1, 2022 or the date of completion of the Transaction, whichever occurs later.
- Consent. As described herein, Plan consents to the assignment of the Participation Agreement by Network to Purchaser and the assumption of the Participation Agreement by Purchaser.
- 5. <u>Non-completion of the Transaction</u>. In the event that Purchaser and Network do not complete the Transaction, this Agreement is null and void.
- 6. <u>Effect on the Participation Agreement</u>. Except as may be provided herein, the terms and conditions of the Participation Agreement remain in full force and effect.

Signatures appear on the following page.

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first written above.

	PREFERRED CARE NETWORK, INC.By: Marlumum Name: Marren Marrell Title: CE 0
DOCTORS GROUP MANAGEMENT	DGM MSO, LLC.
By:	By: Dr. Marlow Hernandez Name: CEO Title:



AMENDMENT TO NETWORK RISK AGREEMENT

THIS AMENDMENT TO MEDICARE ADVANTAGE NETWORK RISK AGREEMENT (this "Amendment") is dated effective as of $\frac{11/1/2023}{}$ ("Effective Date"), by and between PREFERRED CARE PARTNERS INC., a Florida corporation ("PLAN") and DGM MSO, LLC. ("Network").

WHEREAS, Plan and Network desire to amend the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge the parties agree as follows:

- 1. <u>Defined Terms.</u> Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.
- 2. Amendments.
- **2.1 Schedule B, Payment Appendix.** Schedule B Section 1 and Section 4(i), Payment Appendix shall be amended with the attached effective ___11/1/2023 __.
- **3.** <u>Full Force and Effect.</u> Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

PREFERRED CARE PARTNERS, INC.

9100 South Dadeland Boulevard, Suite 1250

Miami, Florida 33156

Warren Murrell

Chief Executive Officer

DGM MSO, LLC.

Name:

Mark D. Ken

Title:

10/22/23

SCHEDULE B

- Initial Reimbursement. Plan and Network acknowledge and agree that, until such time as Network and Network Providers have been selected by or assigned a sufficient number of Members (as defined below) for Network to be capable of impacting and managing the health, quality of care and related medical costs of those Members, Plan will pay Network a Monthly Capitation for each Member. Plan will pay Network Providers that are not employed by Network their monthly capitation payment from the total Monthly Capitation due to Network. Plan will pay the net Monthly Capitation to Network on or before the 15th day of each month. The Monthly Capitation is \$175.00 per Member per month for each Member who resides in Broward County, and \$175.00 per Member per month for each Member who resides in Palm Beach County.
- 4. <u>Deductions from the Medicare Operating Fund.</u> Plan will deduct the following amounts from the Medicare Operating Fund:
 - (i) Network Capitation Payment. Plan will pay Network a monthly capitation payment of \$175.00 for each Member (the "Network Capitation Payment"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month.



AMENDMENT TO NETWORK RISK AGREEMENT

THIS AMENDMENT TO MEDICARE ADVANTAGE NETWORK RISK AGREEMENT (this "Amendment") is dated effective as of __11/1/2023__("Effective Date"), by and between PREFERRED CARE NETWORK, INC., a Florida corporation ("PLAN") and DGM MSO, LLC. ("Network").

WHEREAS, Plan and Network desire to amend the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge, the parties agree as follows:

- 1. <u>Defined Terms.</u> Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.
- 2. Amendments.
- **2.1 Schedule B, Payment Appendix**. Schedule B Section 1 and Section 4(i), Payment Appendix shall be amended with the attached effective ____11/1/2023 __.
- **3.** <u>Full Force and Effect.</u> Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

PREFERRED CARE NETWORK, INC.	D
9100 South Dadeland Boulevard, Suite 1250	
Miami, Florida 33156	
By: Camelinus	D.

Warren Murrell

Chief Executive Officer

DGM MSO, LLC.

Name: Mark D. Kent
Title: CEO

SCHEDULE B

- Initial Reimbursement. Plan and Network acknowledge and agree that, until such time as Network and Network Providers have been selected by or assigned a sufficient number of Members (as defined below) for Network to be capable of impacting and managing the health, quality of care and related medical costs of those Members, Plan will pay Network a Monthly Capitation for each Member. Plan will pay Network Providers that are not employed by Network their monthly capitation payment from the total Monthly Capitation due to Network. Plan will pay the net Monthly Capitation to Network on or before the 15th day of each month. The Monthly Capitation is \$150.00 per Member per month for each Member who resides in Miami-Dade County and \$150.00 per Member per month for each Member who resides in Broward County.
- 4. <u>Deductions from the Medicare Operating Fund.</u> Plan will deduct the following amounts from the Medicare Operating Fund:
 - (i) Network Capitation Payment. Plan will pay Network a monthly capitation payment of \$150.00 for each Member (the "Network Capitation Payment"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month.

EXHIBIT 2



MEDICARE ADVANTAGE

NETWORK RISK AGREEMENT

PREFERRED CARE PARTNERS, INC., a Florida corporation ("Plan") and DOCTORS GROUP MANAGEMENT (the "Network") enter into this Medicare Advantage Network Risk Agreement ("Agreement") effective November 1st, 2015.

1. SCOPE OF AGREEMENT

- 1.1 Plan has a Certificate of Authority from the Florida Office of Insurance Regulation, and has entered into a Medicare Advantage Contract with CMS (the "Medicare Advantage Contract"). Under Plan's Medicare Advantage Contract, Plan provides medical services to Medicare members enrolled in Plan's plans.
- 1.2 Network is a management services organization and provider network that engages physicians, physician groups, and ancillary providers to provide health care services to the members of health maintenance organizations, preferred provider organizations or other managed care companies with network contracts.
- 1.3 Plan wishes to engage to provide and arrange for the provision of Covered Services to Plan Members and Network agrees to provide and arrange Covered Services for Plan Members.
- 1.4 Plan and Network agree to enter into this Agreement under which Network will provide Covered Services to Plan Members.

2. **DEFINITIONS**

The following capitalized terms have the definitions stated this Section:

- 2.1 <u>"Admitting Physician"</u> means a Participating Physician who admits Members to Participating Hospital or to another hospital with approval of Plan.
 - 2.2 "AHCA" means the Florida Agency for Healthcare Administration.
- 2.3 "CMS" means the United States Centers for Medicare and Medicaid Services, an agency of the Department of Health and Human Services, with which Plan has entered into a Medicare Advantage contract to provide health care services and benefits to Medicare beneficiaries.
- 2.4 "Copayment" means the amount, if any, required to be paid by the Member to a Participating Network as additional payments for Covered Services at the time Covered Services are rendered, in accordance with Plan's schedule of benefits applicable to the particular health services plan in which a Member is enrolled. This may also be termed "cost-sharing" as further explained in the Medicare Advantage Regulatory Requirements Appendix, attached hereto.
- 2.5 "Covered Services" means the medical services Plan is required to provide to Members under Plan's agreement with CMS and under the terms of the benefit plan in which a Member has enrolled and as further explained in the Medicare Advantage Regulatory Requirements Appendix to this Agreement, including, without limitation: Primary Care, specialist medical services, hospital services, ancillary and diagnostic services, and Emergency Services.
- 2.6 <u>"Credential" or "Credentialing"</u> means the process for verifying that physicians and other medical professionals providing services under this Agreement are adequately trained, licensed, of good professional reputation and capable of working with others to provide Covered Services to Members. The term includes the re-oredentialing process.

- 2.7 <u>"Emergency Medical Condition"</u> means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:
 - (a) Serious jeopardy to the health of the individual or, in the case of a pregnant women, the health of the woman or her unborn child;
 - (b) Serious impairment to bodily functions; or
 - (c) · Serious dysfunction of any bodily organ or part.
- 2.8 "Emergency Services" means Covered Services that are (i) furnished by a provider qualified to furnish emergency services; and (ii) needed to evaluate or stabilize an emergency medical condition.
 - 2.9 "HHS" means the United States Department of Health and Human Services.
- 2.10 <u>"Medical Director"</u> means a physician designated by Plan (or by Network in connection with any delegated Utilization Management functions) to monitor and review Covered Services provider to Members by a health care provider or that a health care provider requests to provide to a Member.
- 2.11 "Medically Necessary" is defined by Plan in the exercise of its sole discretion and includes due consideration of whether services are (i) consistent, specific and individualized with the symptoms or diagnosis and treatment of Member's condition, disease, ailment or injury; (ii) appropriate with regard to standards of good medical practice within the surrounding community; (iii) not solely for the convenience of the Member, Member's caretaker, a Participating Network, or other health care provider, and (iv) the most appropriate supply or level of service which can be safely provided to the Member.
- 2.12 <u>"Medicare Program"</u> means the Medicare Advantage program administered by CMS on behalf of Medicare beneficiaries covered under Title 18 of the Social Security Act.
- 2.13 "Member" (also referred to as "Customer" and "Plan enrollee") means any individual, who has been enrolled in a Medicare health services plan offered by Plan under Plan's contract with CMS and has been assigned by Plan to Network or a Network Provider or has selected a Network Provider.
- 2.14 "Network Provider" means a physician that (i) has entered into an agreement with Network to provide health care services to Members and (ii) has successfully completed Plan Credentialing.
- 2.15 "OIR" means the Florida Department of Financial Services Office of Insurance Regulation.
- 2.16 "Participating Provider" means a Physician, Primary Care Physician, ambulatory surgery center, specialty physician hospital, home health agency, pharmacy, multi-specialty group practice, nursing home, or any other health care provider that has entered into an agreement with or is otherwise engaged by Plan to provide Covered Services to Members. Participating Providers may be referred to as a Participating Physician, Participating Hospital, Participating Pharmacy, etc. All Network Providers are deemed Participating Providers under this Agreement.
- 2.17 "Physician" means, for purposes of this Agreement, an individual, or group of individuals, duly licensed under Chapter 458 or 459, Florida Statutes, to practice medicine in the State of Florida, and qualified under the Medicare Program to provide services to Medicare beneficiaries.
- 2.18 <u>"Plan Provider Manual"</u> means the Provider Manual of Plan as amended and revised from time to time by Plan in its sole discretion.
- 2.19 <u>"Primary Care Physician"</u> (also referred to as a "PCP") means a Physician who has contracted with Plan to provide Primary Care Services to Members, including initiating referrals to other Participating Providers for non-Primary Care Services. The Primary Care Physician will refer Members only to Participating Networks, when Medically Necessary, and be available twenty-four hours per day in case of emergency.

- 2.20 <u>"Primary Care Services"</u> means those Covered Services customarily provided by a primary care physician in his or her office as well as services customarily provided by an attending primary care physician to institutionalized patients, as more specifically described in Schedule A to this Agreement.
- 2.21 "Quality Improvement Program" means Plan's program to measure and evaluate the quality of care provided to Members, and to implement corrective action when necessary to assure the provision of quality care and compliance with all applicable laws or regulations concerning the provision of medical and hospital services to Members.
- 2.22 "Specialty Physician" means a Participating Provider who: is appropriately qualified in a certain medial specialty as determined by Plan; provides Covered Services to members within the range of that specialty; elects to be designated by Plan as a Specialty Physician; and meets all other Plan requirements of a Specialty Physician.
 - 2.23 "Urgently Needed Services" is as defined in 42 CFR §422.113.
- 2.24 "Utilization Management" and "Utilization Management Program" mean a program of Plan to provide quality health care and outcomes that meet community standards and the standards established under the Quality Improvement Program in the most cost-effective manner. These terms include, without limitation: prior authorization; precertification of elective admissions and procedures; referral processes; concurrent review; retrospective review; discharge planning; case management; disease management protocols; and reporting of encounter data.

3. RESPONSIBILITIES OF PLAN

- 3.1 <u>Administrative Procedures.</u> Plan, through its Medical Director and other individuals designated by Plan, will establish procedures for the following:
 - (a) Authorizations. A system for authorizing referrals to Specialty Physicians.
 - (b) Notices. Written notice of denials of claim forms or Covered Services.
 - (c) <u>Pre-admission Certification.</u> A system of pre-admission certification for all elective hospital admissions.
 - (d) <u>Encounter Reports.</u> A Member encounter reporting process to be implemented in accordance with Plan's policies and procedures.

The Plan Provider Manual contains all procedures relating to the procedures described in this Section 3.1. Plan and Network agree that although Plan establishes these procedures, Network must provide all services and functions with respect to some of the foregoing items, such as authorizing written referrals and providing pre-admission certifications as agreed to by Plan and Network and consistent with Plan's obligations as a licensed health plan.

- 3.2 Administration of Plan. Plan will perform the appropriate administrative, regulatory, enrollment and other functions necessary for the administration of the obligations to the Members, pursuant to applicable State and Federal law. Plan has sole responsibility and final decision making authority for: (1) payment of claims for health care services rendered to Members; (ii) credentialing of all Participating Providers, including Network Providers; (iii) eligibility for enrollment in Plan, (iv) termination of a Member's coverage under Plan; (v) all benefit determinations; and (vi) Network Provider and Member grievance systems established by Plan.
- 3.3 Advertising. Plan may utilize the name, address, telephone number, types of practice, hours of operation and such other relevant information of Network Providers in its marketing materials for dissemination to the public. Network shall not advertise or market Plan or any of their health care services and benefit plans. Network shall not utilize any trademarks, tradenames, logos or other intangible property of Plan without the Plan's prior written approval.
- 3.4 <u>Marketing.</u> Nothing in this Agreement shall be construed to require Plan to assign any minimum or maximum number of Members to Network. Plan does not provide any guarantee to Network as to the number of Members who will select or be assigned to Network. Plan agrees to use commercially reasonable efforts to assign Members to Network as reasonably determined by Plan.

- 3.5 Transfer and Assignment of Members. Plan and Network acknowledge and agree that Members benefit from maintaining an ongoing relationship with their medical professionals. As such, neither Plan nor Network will encourage Members to change Networks or Network Providers absent just cause for such transfer. However, Plan may stop assigning additional Members to Network or a Network Provider and nothing in this Agreement prevents Plan from transferring Members assigned to Network to any other Network or Participating Provider if the capacity of Network or any Network Provider is overburdened to the extent that the provision of Covered Services as required by this Agreement is adversely affected, if Network or any Network Provider fails to comply with Plan's Quality Improvement Program, or if such transfer is in the best interests of the Member(s). A Network Provider may requeist in writing to Plan that a Member be assigned to another Participating Provider, however, a Network Provider may not seek to a Member transfer due to the amount of medical services required by Member or the physical condition of Member. Network acknowledges that Members have a contractual right to request a transfer to another Participating Provider.
- 3.6 <u>Enrollment.</u> Network acknowledges that Florida Law requires that the Plan must handle the enrollment of all Members. Accordingly, Network and Network Providers must not participate in any manner in the enrollment of Members. Plan and Network acknowledge and agree that in establishing the terms of this Agreement, neither party gave or received remuneration in return for or to induce the provision or acceptance of business (other than business covered by this Agreement) for which payment may be made in whole or in part by a Federal health care program.
- 3.7 <u>Member Eligibility</u>. Plan will provide each Member with an identification card that Member will present to Network Providers so that Network Providers can verify Member eligibility. In addition, by the first day of each month, Plan will provide Network with a list of all Members ("Membership List") eligible to receive Covered Services during that month. Plan will not be responsible for medical services provided to non-eligible individuals.
- 3.8 Reports, Plan shall provide Network with information and data reasonably necessary to carry out the terms and conditions of this Agreement.
- 3.9 <u>Programs</u>. Plan shall establish and manage a Quality Improvement Program and a Utilization Management Program. Plan will consult with Network regarding Plan's medical policy, quality improvement program and medical management procedures.

4. COMPENSATION

1:01

- 4.1 <u>Payment.</u> Plan will pay Network for the continual and complete discharge of its obligations under this Agreement in accordance with Schedule B. Surcharges for any Covered Services are prohibited. Plan and Network further acknowledge and agree that:
 - (a) in establishing the terms of the Agreement, neither Plan nor Network gave or received remuneration in return for or to induce the provision or acceptance of business for which payment may be made in whole or in part by a Pederal health care program (other than the healthcare services that are the subject of this Agreement); and
 - (b) neither Plan nor Network will shift the financial burden of the Agreement to the extent that increased payments are claimed from a Federal health care program.
 - (c) Network represents and agrees that Network cannot and will not claim payment in any form, directly or indirectly, from a Federal health care program for items or services covered under the Agreement, except as expressly permitted by applicable law.

5. RESPONSIBILITIES OF NETWORK

5.1 <u>Covered Services.</u> Network agrees to provide, or arrange for the provision of all Covered Services to all Members assigned to Network or a Network Provider by Plan or who select a Network Provider. Network will provide or arrange Covered Services including without limitation the services stated in Plan's Medicare Advantage health benefits filed with and approved by CMS as part of Plan's Benefit Bids. Network will manage and administer Covered Services in accordance with the terms and conditions of this Agreement and:

- (a) the policies, procedures and Quality Improvement Programs and Utilization Management Programs of Plan;
 - (b) the professional standards of care in the medical community;
- (c) in the same manner and with the same manner of care and availability offer all other patients without regard to (i) frequency of utilization of services by Member, or (ii) physical condition or health status of Member; and
- (d) without regard to race, color, age, place of residence, economic status, health status, health care needs, benefit plan, source of payment, religion, national origin or handicap of a Member in accordance with 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.
- 5.2 Network Risk. Network assumes financial risk for the provision of all Covered Services to Members whether or not the Covered Services are provided by Network Providers. This includes financial responsibility for Covered Services provided by Participating Providers that are not Network Providers and non-participating providers to the extent permitted under a Member's benefit plan.
- 5.3 <u>Member Communication.</u> Network and all Network Providers will make appropriate provisions to communicate with Members in the primary language used by Members.
- Licensure and Credentials. The credentials of all Network Providers, including but not limited to Physicians, Radiologists, PAs and ARNPs, must be verified and approved by Plan before services are provided to Members. Network agrees that all Network Providers and all other health professionals employed, retained or in professional association with Network or any Network Provider who provide services under this Agreement must be appropriately trained, qualified and licensed by the State of Florida and all other applicable government entities to practice their profession and to perform the procedures provided under this Agreement. Plan has primary responsibility for all Credentialing functions under this Agreement, but Network will assist Plan in carrying out Plan's Credentialing program with respect to Network Providers. Network will obtain from prospective Network Providers and submit to Plan all information requested by Plan for its Credentialing determination. Network Providers must submit and at all times maintain the accuracy and completeness of credentialing data provided to Plan and its designees, Participating Hospitals, governmental authorities and any entity that has been designated to verify credentials of Physicians. Plan may rely in its credentialing process on information provided by Physician to any of the above-referenced agencies and to any hospital at which Physician is a member of the medical staff. Network agrees that if a Physician participates in more than one benefit plan sponsored by any entity under common ownership or control with Plan (a "Plan Affiliate") Plan may provide any and all credentialing information in its possession to any Plan Affiliate and that any Plan and Plan Affiliates may rely on the credentialing decisions of the Plan or any Plan Affiliate in making credentialing decisions. Network warrants that Network Providers are providers in good standing under the Medicare Program.
- 5.5 Agreements with Network Providers. Network will contract with primary care physicians and specialty physicians to arrange for the provision of Covered Services to Members. The form of these agreements ("Network Provider Agreements") is subject to review and approval by Plan in Plan's sole discretion. Network will provide Plan with a copy of each form of Network Provider Agreement and, upon request from Plan, Network will provide Plan copies of each executed Network Provider Agreement. Network may not alter the terms of a Network Provider Agreement without the prior approval of Plan in Plan's sole discretion. All Network Provider Agreements must contain a provision stating that if any term or condition of the Network Provider Agreement conflicts with any term or condition of this Agreement this Agreement will control and supercede the conflicting terms and conditions of the Network Provider Agreement. Network will use its best efforts to obtain the agreement of any provider who becomes affiliated with a Network Provider to become a Network Provider.

If Network contracts with a Network Provider that is a professional corporation, professional association or partnership, Network agrees to cause all of the terms of this Agreement to apply with equal force to the professional corporation, professional association or partnership and the individual physicians or providers associated with that entity. Notwithstanding any interpretation of this Agreement to the contrary, Network agrees, represents and covenants that all of the provisions of this Agreement applicable to Network, unless expressly inapplicable, will apply with equal force to Network Providers. Network will

represent its Network Providers in matters pertaining to the provision of Covered Services under this Agreement and Network represents that it has obtained consent to such representation from its Network Providers.

- 5.6 <u>Utilization</u>. Network and Network Providers must comply with and be monitored under the Plan's Utilization Management Program as in effect from time to time. Plan has the right to override any Utilization determination reached by Network and any such determination by Plan will bind Network. Plan may pay claims based on its utilization determinations. Without limiting the generality of the foregoing sentence, Plan may pay any claim included in a claims report provided to Network does not object to payment of the claim with five business days after Network receives the report.
- 5.7 <u>Verification of Eligibility</u>. Network is responsible for verifying eligibility of Members before Network Providers render Covered Services to such individuals.
- 5.8 Referrals. Network will, and will cause Network Providers to, refer Members for the provision of Covered Services only to Participating Providers, except with the prior approval of Plan or in the case of Emergency Services, and to make referrals only when Medically Necessary. Network will, and will cause Network Providers to, make all referrals in compliance with Plan's approved Utilization Management Program. Network will, and will cause Network Providers to, furnish to health care providers to whom or to which it has referred a Member complete information on treatment procedures and all pertinent clinical services provided to Member prior to such referral. Members do not need prior authorization from Plan for the following Covered Services: (i) screening mammography and influenza vaccine; and (ii) women's routine and preventive health care services from a Participating Network that is a women's health specialist.
- 5.9 <u>Copayments.</u> If applicable under Plan's plan, Network will, and will cause Network Providers to, use reasonable efforts to collect the applicable Copayments from Members.
- 5.10 Refunds and Setoffs. Network agrees and will cause Network Providers to immediately refund to Plan all sums collected by Network or a Network Provider from Members that Network or the Network Provider was not entitled to under this Agreement. These refunds may take the form of cash payments or setoffs against amounts owed to Network by Plan. Network and Network Providers will not charge a co-payment for influenza vaccine and pneumococcal vaccine
- 5.11 Non-Covered Services. If Network or a Network Provider provides non-Covered Services to Members, Network or Network Provider must inform the Member, prior to the provision of such non-Covered Service, (i) of the service(s) to be provided, (ii) that Plan will not pay for or be liable for such non-Covered Service, and (iii) that the Member will be financially responsible for such non-Covered Service as applicable by law.
- 5.12 <u>Formulary</u>, Network will comply, and will cause Network Providers to comply, with Plan's prescription drug formulary, which may be amended from time to time, in Plan's sole discretion.
- 5.13 Hospital Admissions. Network will cause Network Providers to, admit to, and provide appropriate services at a Participating Hospital to Members. Network shall maintain clinical privileges at a Participating Hospital. Network will cause Network Providers to maintain clinical privileges at a Participating Hospital. Plan shall be responsible for the remuneration of the Admitting Physician and has the right to deduct the amount paid to the Admitting Physician from the Compensation due to Network. The Admitting Physician must sign an Acceptance Letter provided by Plan. Admission to a Participating Hospital must be certified in advance by Plan or Network in accordance with the approved Utilization Management Program. If Plan implements a plan utilizing hospitalists to provide inpatient services to Members, Network shall participate with such plan, as amended from time to time, to the extent that such participation does not violate any applicable law, rule or regulation, including F.S. §641.315, as amended.
- 5.14 Approvals. Network agrees to use and to cause Network Providers to use, only Participating Hospitals, Nursing Homes, Home Health Agencies, Ancillary Service Networks, and Licensed Medical Professionals which have been approved in advance by Plan, and to obtain prior approval from Plan before admitting Members to such facilities, except in case of Emergency Services.
- 5.15 <u>Coverage</u>. Network is responsible for the provision, authorization, coordination, supervision, monitoring and overall management of all Covered Services to Members in accordance with

Plan's policies and procedures. Network will ensure that Network Providers maintain adequate personnel and facilities to fulfill Network's contracted obligations under this Agreement. Network will cause Network Providers to provide or arrange for the provision of Covered Services twenty-four (24) hours per day, seven (7) days per week, including holidays, to all Members, in a manner that assures continuity of care through the coordination of overall health care and the sharing of medical records. Network will cause Network Provides to comply with the following availability schedule: urgent care - within one day; routine sick care - within one week; and wellcare - within one month. Network will ensure that Network Providers who are Primary Care Physicians make referrals for Covered services that are not Primary Care Services when Medically Necessary. Network will cause Network Providers to maintain twenty-four (24) hours a day, seven days a week telephone answering service.

5.16 <u>Authorization</u>. All Covered Services for which payment is to be made must be provided in accordance with the policies and procedures of Plan. Plan reserves the right to authorize or deny, in whole or in part, any claim for payment that is the subject of a dispute between or among the Member, Network, a Network Provider or any other provider of services. Network agrees that Plan's determination will be binding and final.

5.17 Programs/Continuing Education.

- (a) Network will cause Network Providers to receive and participate in any applicable training programs developed by Plan, including those concerning the Plan's policies and procedures, credentialing programs, quality improvement programs, utilization management programs, claims payment policies, grievances, and other similar programs established by Plan to promote appropriate standards of medical care and to control the cost and monitor the quality of medical services rendered to Members, including without limitation programs relating to the precertification of elective admissions and procedures, referral process and reporting of clinical encounter data. Network shall abide by and be bound by the respective program determination of Plan.
- (b) Network will cause Network Providers to participate in any continuing education programs established or recommended by Plan that is appropriate to the Network Provider's area of practice. Network will cause Network Providers to maintain the educational standards required by the Network Provider's licensure board, if applicable.
- 5.18 Arbitration and Grievances. Network agrees to participate and to cause Network Providers to participate in the arbitration of medical malpractice claims arising out of the services provided under this Agreement, in the event a Member is required to arbitrate such claims. Network further agrees to, and to cause Network Providers to, participate in, cooperate with, and be bound by the grievance procedure adopted by the Plan pursuant to State and Federal requirements. Network will notify Plan of any complaints received by Network and Network Providers. Network will, and will cause Network Providers to, use best efforts to resolve any Member complaints in a fair and equitable manner.
- 5.19 Compliance with Laws and Medicare Regulations. Network will comply with, and will cause all Network Providers to comply with, all applicable Federal and State Laws and regulations and CMS instructions. One or more regulatory appendix may be attached to this Agreement. These regulatory appendices are expressly incorporated into this Agreement and bind the parties to this Agreement. If any language in a regulatory appendix is inconsistent with or contrary to any other part of this Agreement, including but not limited to attachments, exhibits, appendices, and amendments, the regulatory appendix will control to the extent applicable.
- 5.20 Notice of Claims. Network must notify Plan of any claim or cause of action by or relating to a Member filed against Network within five (5) days of Network's receipt that such claim or cause of action has been filed. Network will cause each Network Provider to notify Plan of any claim or cause of action by or relating to a Member filed against Network Provider within five (5) days of Network Provider's receipt that such claim or cause of action has been filed. Network will, and will cause Network Providers to, provide Plan with any additional information about such claims that Plan reasonably requests.
- 5.21 <u>Notification of Changes</u>. Network shall immediately notify Plan in writing upon the occurrence of any of the following:

- (a) Any changes to the list of current Network Providers, their addresses, telephone
 and/or facsimile numbers. Attachment D is a complet list of Network Providers;
- (b) Any Network Provider's license to practice medicine in the State of Florida is suspended, revoked, terminated, or subject to terms of probation or other restrictions;
- (c) Network or any Network Provider has become a defendant in any malpractice action, receives any pleadings, notices or demands of claim, or service of process relating to alleged malpractice of Network or Plan involving a Member, or is required to pay damages in any such action by way of judgment or settlement;
- (d) Network or any Network Provider becomes the subject of any disciplinary proceeding or action before a governmental agency, including any State of Florida department, board, or agency, or a similar entity in any state;
- (e) Any Network Provider is convicted of a felony relating directly or indirectly to the practice or conduct of Network's profession;
- (f) Network or any Network Provider is sanctioned or is subject to sanctions by the Medicare programs;
- (g) Any Network Provider's clinical privileges at any hospital are being terminated, restricted, canceled or suspended;
 - (h) Any Network Provider becomes incapacitated;
- (i) An act of nature or any event beyond a Network Provider's reasonable control likely to interrupt all or a portion of a Network Provider's practice for a period of sixty (60) consecutive calendar days, or which may have a material adverse effect on Network's ability to perform his/her/its obligations for this period;
 - (j) Any change in the nature or extent of services rendered by a Network Provider;
- (k) Any material change or addition to the information and disclosures submitted by Network Provider as part of the application for a contract with Plan or Network to provide Covered Services to Members;
- (I) Any other act, event, occurrence or the like that might materially affect a Network Provider's ability to carry out Network Provider's duties and obligations to Members;
- (m) If a Network Provider is a corporation, professional association or partnership, any of the above events with respect to a physician or other health professional who owns, is employed by, or is otherwise associated with such Network Provider; or
- (n) Any of the above events with respect to any employee, subcontractor(s) and/or independent contractor of Network who provides or will provide Covered Services to Members.
- 5.22 <u>Information Exchange</u>, Network covenants that Network will communicate with and transmit data and information to Plan's management information systems in a manner that does not disrupt Plan's business.

6. POLICIES AND PROCEDURES

Network agrees and will require Network Providers to agree to comply with and be bound by the policies, procedures and rules established by Plan that are now in effect and as adopted and amended after the date of this Agreement. Such policies, procedures and rules are incorporated in this Agreement and made a part of this Agreement including but not limited to those policies, procedures and rules set forth in the Plan's Network Manual, Plan's credentialing and re-credentialing programs, Plan's procedures to identify, assess, and establish a treatment plan for serious and complex conditions, Plan's quality improvement program, Plan's grievance program and any other programs established by Plan from time to time. Network acknowledges receipt of such policies, procedures and regulations, including the Plan's Network Manual. Network shall be bound by the policies, procedures and rules of Plan, and any amendments to same, upon delivery of such written policy or amendment, by hand, U.S. mail, or electronic delivery.

7. UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT

Network understands that Plan manages care to provide Medically Necessary and cost-effective Covered Services to the Members. To ensure efficiency and quality, Plan has established programs of utilization management and quality improvement that are more specifically described in the Policies and Procedures of Plan. Network agrees to support and to cause Network Providers to support the principle of managed care through participation in the Utilization Management Program of Plan and will cooperate with Plan to determine the Medical Necessity of any inpatient or outpatient service for a Member. Network further agrees to participate in and to cause Network Providers to participate in the Quality Improvement Program, which includes internal peer review, on-site external audit, independent quality review and other procedures to ensure quality services. In conjunction with any such review or program, Network will cause Network Providers to make available at no charge to Plan whatever information is requested by Plan.

8. TERM OF AGREEMENT

This Agreement commences on the Effective Date and continues for a three (3) year term. Thereafter, this Agreement automatically renews for subsequent three (3) year terms unless terminated in accordance with Section 9.

9. TERMINATION

- 9.1 Termination for Cause by Plan. This Agreement may be terminated by Plan for cause with regard to Network or any Network Provider by delivering to Network written notice stating: (i) the effective date of termination; (ii) reason(s) for the termination. If terminating a Network Provider, Plan must also provide (iii) information regarding the Network Provider's right to appeal the termination. The term "cause" means any of the following events:
 - (a) If Network or a Network Provider commences an action for relief as a debtor under the United States Bankruptcy Laws, or any bankruptcy, receivership, insolvency, reorganization, dissolution, liquidation or similar proceeding is instituted against Network or any of Network's physicians or principals;
 - (b) Network, Network Provider, or any of its officers, directors, employees, shareholders or Physicians, have been charged with, indicted for, or convicted of a felony;
 - (c) Failure of Network or a Network Provider to provide Covered Services in accordance with the standards of quality established by the medical community, the Plan, and all applicable state and federal laws, regulations and guidelines;
 - (d) If Network or a Network Provider is disqualified by any State or Federal regulatory agency from participation in the Medicare Program or, as a result of regulatory action, is unable to perform Network's obligation under this Agreement;
 - (e) Any action by the Board of Medicine or other governmental agency that effectively impairs Network's or a Network Provider's ability to practice Network's or Network Provider's health care profession;
 - (f) Failure of Network or a Network Provider to meet and/or maintain compliance with credentialing standards and other requirements of Plan, including but not limited to, maintaining professional liability insurance coverage as required by Plan;
 - (g) Any material breach of this Agreement by Network or a Network Provider;
 - (h) The willful breach, habitual neglect, or continued failure of Network or a Network Provider to abide by Plan's rules, regulations, procedures, policies, determinations or any other activity for which Network has received notice;
 - (i) Commission of an act of fraud or theft against Plan;
 - (j) Good faith determination by Plan that Network's or Network Provider's continued participation under this Agreement may adversely affect the health, safety or welfare of any Member; or

(k) Termination or non-renewal of the Medicare Advantage Contract between CMS and the Plan.

For purposes of this Section 9.1, if a Network Provider is a corporation, professional association or partnership, the term Network shall include a physician or other health care professional who owns, is employed by or is affiliated with such Network.

- 9.2 <u>Additional for Cause Termination of Network</u>, Plan may also terminate this Agreement for cause upon written notice to Network stating any of the following grounds for termination:
 - (a) A material breach of the this Agreement by Network, including without limitation failure to maintain the Medicare Operating Fund as described in Attachment [B] that Network does not cure within thirty (30) days of receiving written notice from Plan stating the breach to be cured; provided, however, that if the breach relates to a monetary obligation of Network, Network must cure the breach within five (5) days.
 - (b) Network acts in a manner that is demonstrably injurious to the goodwill or reputation of Plan.
- 9.3 <u>Termination for Cause by Network.</u> This Agreement may be terminated by Network for cause by delivering to Plan written notice stating: (i) the effective date of termination; (ii) reason(s) for the termination. The term "cause" means any of the following events:
 - (a) Non-payment of any amount required to be paid by Plan if Plan does not oure or contest the default within thirty (30) days of receipt of demand.
 - (b) A material breach of this Agreement by Plan that Plan does not cure within thirty (30) days of receiving written notice from Network stating the breach to be cured.
 - 9.4 [SECTION OMMITTED INTENTIONALLY]
- 9.5 <u>Statutory Termination.</u> The OIR, pursuant to Florida Statute 641.234, may order the Plan to cancel this Agreement.
- 9.6 <u>Effect of Termination.</u> If this Agreement is terminated for any reason, the parties shall be relieved of all obligations under this Agreement, except that Network agrees to, and to cause Network Providers to:
 - (a) complete the course of treatment of any Member then receiving treatment until provision has been made for the reassignment of the Member to another Participating Network;
 - (b) not to seek compensation from Members for services provided prior to the termination and completion of treatment of Members then receiving treatment;
 - (c) return any and all Plan provided materials, provider manuals, or other documentation, including all copies, whether authorized or not; and
 - (d) cooperate in the transfer of Members and Members' medical records.
- 9.7 <u>Continuation of Services</u>. If this Agreement is terminated for any reason other than for cause and in addition to the obligations set forth in Section 10.4 above, Network and Plan shall allow Members for whom treatment was active to continue coverage and care when medically necessary: (i) through completion of treatment of a condition for which the Member was receiving care at the time of the termination, (ii) until the Member selects another treating provider, or (iii) during the next open enrollment period offered by the Plan, whichever is longer, but not longer than six (6) months after termination of this Agreement. Network and Plan shall allow a Member who has initiated a course of prenatal care and coverage until completion of postpartum care. This provision does not prohibit Network or a Network Provider from refusing to continue to provide care to a Member who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this provision, Plan and Network shall continue to be bound by the terms of this then terminated Agreement.
- 9.8 <u>Financial Reconciliation.</u> Within one hundred eighty (180) days after the termination or expiration of this Agreement, Plan will make an accounting monies, if any, due and owing Network under

this Agreement. Any payments determined to be due and owing shall be paid within thirty (30) days after Plan delivers written notice of the accounting to Network.

10. REPORTS, FORMS, MEDICAL RECORDS AND REVIEWS

- 10.1 Reports, Network will cause Network Providers to submit to Plan on a monthly basis, encounter, clinical and utilization reports concerning the treatment of Members, in such form and at such times as required by Plan. Encounter information on capitated providers must be submitted to Plan within 30 days of the date of service. Network further agrees to certify that all information, data, and/or reports submitted to Plan are accurate, complete and truthful. Network will report to Plan's risk manager all Incidents involving a Member in accordance with Plan's incident report guidelines.
- 10.2 Forms. For services requiring a Referral Form, Network agrees to complete and utilize and to cause Network Providers to complete and utilize the form supplied by Plan for each referral. Network further agrees to cause Network Providers to provide services requiring a Referral Form only upon receipt of a properly completed form containing an authorization number from Plan.
- 10.3 Medical Records. Network will, and will cause Network Providers to, create appropriate medical records that Network and Network Providers must maintain in accordance with the standards established by the medical community and treat as confidential. Network will cause Network Providers to participate in the record-keeping systems established by Plan, as amended. Network will cause Network Providers to make available to Plan, the Member, another Participating Network, or any other authorized individual, copies of such medical records, upon request, for a period of ten (10) years after the termination or expiration of this Agreement. Network and Network Providers will not charge Plan, a Member or a Participating Network for the provision or copying of such records.
- 10.4 Transfer of Records. In the event of (i) termination of this Agreement, (ii) the selection by a Member or assignment by Plan of Member to another Network or Participating Provider in accordance with Plan's procedures, or (iii) the approval by Plan of a Network's or a Network Provider's request to transfer a Member from such Network Provider's practice to another of Plan's Participating Providers, Network will cause Network Provider to transfer copies of Member's medical records, x-rays, and any and all other pertinent data to Plan, and to the new Participating Provider selected by Member or assigned by Plan, when requested to do so in writing by Plan or Member. This charge shall be billed to Plan at a reasonable charge, not to exceed the amount stated in Florida Statute ch. 395.3025 and shall not be billed to Members, AHCA or CMS.

11. INSURANCE AND INDEMNIFICATION

- Insurance. During the term of this Agreement, Network must maintain at its own expense policies of general liability, professional liability, and other insurance as necessary to insure Network and Network's employees or agents against any claim for damages arising by reason of personal injury or death occasioned directly or indirectly in connection with the provision of Covered Services to Members by Networks employees or agents. Network will require Network Providers to maintain at the Network Provider's expense policies of professional liability and malpractice insurance in the minimum amount of \$250,000 per occurrence, \$750,000 per aggregate year or in such other amounts as required by applicable Federal and state laws. In lieu of the above policy requirements, providers are required to otherwise comply with provisions of Florida law relating to insolvency protection for patients. Network will and will cause Network Providers to also maintain workers compensation insurance for all of Network's employees connected with work under this Agreement, as required under Florida's Worker's Compensation law. Network shall provide Plan with evidence of such coverage upon request and require the carriers to provide Plan with notice of any policy cancellations or modifications.
- 11.2 <u>Indemnification by Plan.</u> Plan agrees to fully indemnify and hold harmless Network and Network's directors, officers, employees, servants, agents, heirs, successors and assigns from and against all and any claims, losses, damages, costs, expenses, liabilities, actions and causes of action, including reasonable attorneys' fees at all levels, arising out of or by reason of any damage or injury to persons or property suffered, or claimed to have been suffered, by any misconduct, omission, negligence or other wrongful conduct of Plan, its directors, officers, employees, servants and agents. This provision shall survive the termination or expiration of this Agreement for any reason.

11.3 <u>Indemnification by Network.</u> Network agrees to fully indemnify and hold harmless AHCA, OIR, CMS, and the Plan, and Plan's directors, officers, employees, servants, agents, heirs, successors and assigns from and against all and any claims, losses, damages, costs, expenses, liabilities, actions and causes of action, including reasonable attorneys' fees at all levels, arising out of or by reason of any damage or injury to persons or property suffered, or claimed to have been suffered, by any misconduct, omission, negligence or other wrongful conduct of Network, its directors, officers, employees, servants and agents. This provision shall survive the termination or expiration of this Agreement for any reason.

12. NETWORK PROVIDER FACILITIES

- 12.1 <u>Facilities.</u> Network understands that Network Providers are required to provide a functionally safe and sanitary environment for all Members. Plan reserves the right, in Plan's sole discretion to exclude from Plan any Network Provider that Plan determines does not meet this requirement.
- 12.2 <u>Physical Condition, Equipment.</u> Network will require Network Providers to use facilities that:
 - (a) are clean, safe and are designed and maintained to provide services to Members in an efficient and professional manner;
 - (b) are equipped, staffed and designed to comply with all applicable governmental regulations (including those imposed by CMS) and the reasonable requirements of Plan;
 - (c) are reasonably accommodating to handicapped individuals in accordance with The Americans with Disabilities Act and The Rehabilitation Act of 1973;
 - (d) are in compliance with applicable state and local building codes and regulations;
 - (e) are in compliance with applicable state and local fire prevention regulations;
 - (f) are inspected at least annually by the local or state fire control agency;
 - (g) contain fire equipment and illuminated signs for cases of emergency evacuation;
 - (h) offer adequate lighting and ventilation;
 - (i) Can handle medical and other emergencies that may arise in connection with the provision of Covered Services to Members; and
 - (j) have all applicable federal, state and local licenses displayed as required by law.
- 12.3 <u>Availability</u>. Network is responsible for assuring the availability of Covered Services, and timely provision of Covered Services during appropriate business hours.
- 12.4 <u>Signage.</u> Network will cause Network Providers to prominently display signage provided by Plan that identifies Network Provider as a part of Plan's network of Participating Providers. This signage shall be displayed in the main entrance to Network's facility as well as other locations reasonably requested by Plan.

13. COORDINATION OF BENEFITS

- 13.1 Other Insurance. Network will, and will cause Network Providers to, cooperate with Plan in the coordination of benefits with other health plans or insurance, or to obtain payment of any kind from a third party for any service rendered. To the extent Network has knowledge of any other insurance to which a Member may be entitled, or of any legal action under which a Member is seeking damages for medical services rendered, Network agrees to notify Plan in writing within fifteen (15) days after becoming aware of such other benefit.
- 13.2 Third Party Payors, Network and Network Providers may not bill third parties directly for services provided to Members covered under casualty policies which pay for medical expenses resulting from accident or injury. All such amounts will be billed and collected directly by Plan. Network and Network Providers must promptly notify Plan in the event Network receives any such monies, and any such monies received by Network shall be immediately sent to Plan. Network will, and will cause Network

Providers to, assign to Plan all payments owed by third party payors and execute any documents or bill and process any forms as requested by Plan.

14. PROPRIETARY MATTERS

- 14.1 <u>Proprietary Information.</u> Network understands that Plan has developed, at a substantial investment, a going concern among its assets, the Members of Plan, the Participating Provider network, contracts, manuals, advertising and marketing materials, and other beneficial property ("Proprietary Information"). Network acknowledges the proprietary interest in the Proprietary Information and agrees that it shall keep the Proprietary Information confidential in the same manner that it would keep a trade secret. Network agrees that it will not, during the term of this Agreement and after termination or expiration of this Agreement, for any reason, use the Proprietary Information for Network's own or any other entity's benefit or gain, or disclose such Proprietary Information to any third parties except as required by process of law or regulation. Upon notice of termination or expiration of this Agreement, for any reason, Network shall return to Plan all Proprietary Information, including all copies, whether authorized or not. Plan and Network agree that this Section 14.1 will survive the termination of this Agreement.
- Non-Solicitation. Network and Network Providers must comply with all applicable state and federal law, regulation and guidance regarding communications about health plans or products to Members. During the term of the Agreement and for twelve (12) months after termination of this Agreement for any reason, Network and Network Physicians agree that they shall not solicit disenrollment of any Member or directly enter into a contract or policy of health care coverage with any Member covered under this Agreement to deliver or arrange for the delivery of health services. Furthermore, if during the term of this Agreement, Network or any Network Provider contracts to participate as a participating Provider in a "Contracted Entity", Network and Network Provider expressly agree that they shall not, directly or indirectly, market to Members covered under this Agreement for the purpose of encouraging or soliciting their enrollment under a plan or program offered by such Contracted Entity. For purposes of this Agreement, the term "Compete" means to have an ownership, membership or financial investment or interest in (whether through debt or equity), serve on the governing body of, or participate in the management or operation of, or otherwise contract with any organization or entity that is under contract with Center for Medicare and Medicaid Services ("CMS") (or any other federal government agency) to provide, arrange for the provision of, insure against, pay for or otherwise provide coverage or benefits for health care services obtained by Medicare beneficiaries (collectively, a Contracted Entity") including but not limited to the following: (1) Network Sponsored Organization ("PSO"), (2) Health Maintenance Organization ("HMO"), (3) Preferred Network Organization ("PPO"), (4) Private Fee For Service Plan ("PFFS"), (5) Religious Fraternal Benefit Plan or (6) Medical Savings Account ("MSA"). Notwithstanding any other provision of this Agreement, Network agrees that Plan has, in addition to any other remedies provided for under this Agreement, the right to seek a judicial temporary restraining order, preliminary injunction, or other equitable relief against Network and Network Providers to enforce Plan's rights under this Section. Plan has expended considerable resources in developing its advantageous business relationships with employer, employees, Members, and other current and prospective sources of business. Network acknowledges that the provisions of this Section 14.2 are reasonable and necessary to protect the legitimate business relationships of Plan and significant damage would result from a breach.
 - 14.3 <u>Injunction.</u> Plan and Network agree that any violation of this Article 14 by Network or Network Providers will result in irreparable injury to Plan. If an actual or threatened breach by Network or a Network Provider of Section 14.1 or 14.2 occurs, Plan is entitled to an injunction restraining Network or Network Provider from the prohibited conduct or, if applicable, requiring Network to take all necessary action to prevent Network Provider from engaging in the prohibited conduct. If the court should hold that the duration and/or scope of the covenants contained herein are unreasonable, then, to the extent permitted by law, it is the parties' desire and intent that the court prescribe a duration and/or scope that is reasonable, and the parties agree to accept such determination, subject to their rights of appeal. Nothing in this Agreement prohibits Plan or any third party from pursuing any other remedies available to it for such breach or threatened breach, including recovery of damages from Network. In any action or proceeding to enforce the provisions of this Section, the prevailing party shall be reimbursed by the other party for all reasonable costs incurred in such action or proceeding, including, without limitation, all court costs and filing fees, and all attorneys' fees incurred either at the trial level or at the appellate level.

15. REPRESENTATIONS OF NETWORK

- 15.1 <u>Licenses and Authority.</u> Network represents and warrants to Plan that (i) it has and will maintain any and all applicable permits and licenses relating to its business and performance under this Agreement, and (ii) it has full power and authority to own and operate its properties and assets and to conduct and carry on the business as stated in this Agreement.
- Binding Obligation, No Conflict. Network represents and warrants to Plan that, (i) this Agreement constitutes the legal, valid and binding obligation of Network, enforceable against Network in accordance with its terms; (ii) the execution, delivery and performance of this Agreement has been duly authorized by all required action of Network and its owners, if applicable, and (ili) such execution, delivery and performance does not violate and is not restricted by any provisions of the organizational documents of Network, any agreement to which Network is a party (including any agreement with any other Network Sponsored Organization, Health Maintenance Organization or Managed Care Network), or any laws or regulations applicable to Network.

16. MISCELLANEOUS

- 16.1 <u>Professional Corporations or Partnerships.</u> All of the terms of this Agreement shall apply with equal force to the professional association, professional corporation or partnership and the individual physicians or providers associated with such entity.
- 16.2 <u>Independent Contractor Relationship.</u> None of the provisions of this Agreement are intended to create nor shall be deemed or construed to create any relationship Among Plan, Network and Network Providers other than that of independent entities contracting with each other solely for the purposes of effecting the provisions of this Agreement. None of Plan, Network or any Network Provider, nor any of their respective associates, employees, or agents shall be construed to be the agent, the employer or the representative of the other. Network Providers are solely responsible and liable for all medical care, advice and treatments rendered or prescribed to Members.
- 16.3 <u>Applicable Law.</u> This Agreement, and the rights and obligations of the parties under this Agreement, must be construed, interpreted and enforced in accordance with, and governed by, the laws of the State of Florida.
- 16.4 <u>Enforceability.</u> The invalidity or unenforceability of any terms or conditions of this Agreement shall in no way affect the validity or enforceability of any other term or provision.
- Modification. This Agreement, and the attachments to this Agreement, constitute the entire understanding of the parties and may be amended or modified in writing as mutually agreed upon by the parties, unless otherwise permitted in this Agreement or any attachment to this Agreement. Plan may modify this Agreement, including the compensation terms, upon thirty (30) days advance written notice to Network. If Network does not object in writing to Plan regarding the modification, Network's silence will constitute acceptance of such modification. Notwithstanding the above, revisions to (i) Plan's and/or Network's responsibilities, (ii) Covered Services, (iii) Schedule A Description of Services, or (iv) any regulatory appendix attached to this Agreement shall not constitute modifications, amendments or alterations subject to this Section. Rather, such revision will be binding upon written notice to Network.
- 16.6 <u>Assignment.</u> This Agreement and the rights, interests and benefits under this Agreement, shall not be assigned, transferred, pledged or hypothecated in any way by Network, including by way of an asset or stock purchase of Network, and shall not be subject to execution, attachment or similar process, nor shall the duties imposed be subcontracted or delegated without the approval of Plan. This Agreement may be assigned by Plan without the consent of Network.
- Maiver. No waiver of any default in the performance of any of the duties or obligations arising under this Agreement is valid unless in writing and signed by the waiving party. Waiver of any one default does not constitute and cannot be construed as creating a waiver of any other default or defaults. No course of dealing between the parties will operate as a waiver or preclude the exercise of any rights or remedies under this Agreement. Failure on the part of either party to object to any act or failure to act of the other party, or to declare the other party in default, regardless of the extent of such default, will not constitute a waiver by such party of its rights under this Agreement.

- 16.8 Notices. Any notice, demand or other document required or permitted to be delivered under this Agreement shall be in writing and may be delivered personally or shall be deemed delivered when deposited in the United States Postal Service, postage prepaid, registered or certified mail, return receipt requested, addressed to the parties at their respective address listed on the signature page of this Agreement, or at such other addresses as recipient may have specified by written notice delivered in accordance with this Section 16.9.
- 16.9 <u>Authorization.</u> Each party represents that the respective officers have the requisite authority to enter into this Agreement on behalf of their respective party and to carry out the transactions and obligations contemplated in this Agreement.
- 16.10 <u>Captions.</u> Captions in this Agreement are descriptive only and do not affect the intent or interpretation of this Agreement.
- 16.11 Entire Agreement. This Agreement, including appendices, is the entire agreement between the parties and supersedes all agreements, representations, warranties, statements, promises and understandings, whether oral or written, with respect to the subject matter of this Agreement.

[SIGNATURE PAGE FOLLOWS]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement in the State of Florida on the date first written above.

nereto have executed this Agreement in the State of	
By: Name: filip Quevel Title: Parti let Address: \$600 pl w 17 st sete	/3°
Plan:	
PREFERRED CARE PARTNERS, INC.	
By: Ornatte Constant Annette Onorati Chief Operating Officer 9100 S. Dadeland Blvd., Suite 1250 Miami, FL 33156-7838	
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TO BE COMPLETED BY Plan:		
Effective Date of Contract:	uto-Fire and	

SCHEDULE A

PRIMARY CARE SERVICES

Primary Care Services shall include, but are not limited to, all services, supplies, procedures and ancillary services either rendered or arranged by a Primary Care Physician or other health professional to provide the following: 1) Initial preventive medical examinations with comprehensive medical history, assessment, medical management of the patient, and ordering all laboratory and diagnostic tests routinely ordered and performed in connection with an age-specific initial preventive medical examination which also includes hearing and visual screening; 2) Ongoing age-specific periodic preventive health appraisal examinations including the ordering of appropriate laboratory and diagnostic procedures routinely ordered and performed in connection with age-specific preventive periodic health appraisals; 3) Those services, supplies and procedures normally provided by a Primary Care Physician when dictated by the need for a particular injury, illness, or disease which do not require the knowledge, skill or expertise of a Physician specialist; to include those services provided or arranged for in a physician's office, patient's home, hospital inpatient and/or outpatient setting, nursing home and/or in any other health care setting in which medical services, supplies and procedures may be delivered appropriately by a health care professional.

Also included are after-hours urgently needed services, hospital and skilled nursing home admissions with follow-up, stat office laboratory tests, injections, in-office radiology, EKGs, flexible sigmoidoscopy and sutures with removal.

Also, adult immunizations administered in accordance with the recommendations of the United States Public Health Service. Additionally, chiropractic and podiatric medical services shall be provided in accordance with chapters 640 and 641, respectively, of the Florida Statutes. All other medical services, at a minimum, will be provided in accordance with Agency for Health Care Administration (AHCA), Centers for Medicare and Medicaid Services (CMS) and all applicable Plan standards. Primary Care Physician agrees that the scheduling of appointments to render the above mentioned care shall meet the state mandated accessibility standards as defined by all State of Florida health care regulatory bodies.

All services performed under this Agreement shall be consistent with the standards of medicine and osteopathy in the community and such services shall, at a minimum, be performed in accordance with the customary rules of ethics and conduct promulgated by the American Medical Association, American Osteopathic Association, and the American Hospital Association and similar provider organizations, as applicable, and such other bodies, formal or informal, governmental or otherwise, from which health care providers seek advice and guidance or to which they are subject to licensing and control, as applicable.

Primary health care encompasses Medically Necessary medical care that is provided or prescribed by Member's assigned Participating Network for prevention of disease and the first level of care for diagnosis and treatment of a non-occupational illness or injury, and includes all services customarily provided in a Primary Care Physician's office as well as services customarily provided by an attending Primary Care Physician to institutionalized patients. Network agrees to provide these Covered Services offered by Plan with the exception of hospital inpatient cost and vision care services. By way of illustration and not limitation, the following services are considered Primary Care Services. These services are to be provided in accordance with Plan's policies and procedures.

General Primary Care Services:

- ROUTINE OFFICE VISITS including biometrics evaluations, diagnosis and treatment of illness/injury.
- HOSPITAL VISITS personal attendance with the patient including skilled nursing or extended care facility.
- PERIODIC HEALTH APPRAISAL all routine tests performed in a Primary Care Physician's office (i.e. EPSDT).
- TELEPHONE CONSULTATIONS with Members.
- ACUTE MINOR ILLNESS/INJURY
- CHRONIC ILLNESS/INJURY

- IMMUNIZATIONS in accord with accepted medical practices. As set forth in Schedule B, Section 3.5, Network shall receive flat rate compensation for Influenza, Pneumococcal and H1N1 vaccines dispensed to assigned Members.
- INJECTIONS --including intra-articular and trigger points in accord with accepted medical practices (excluding chemotherapy).
- ROUTINE DIAGNOSTIC LABORATORY PROCEDURES all routine procedures
 performed in a Primary Care Physician's office, including but not limited to CBC test,
 urinalyses, stool analyses for occult blood and pregnancy tests.
- 10. EYE AND EAR EXAMINATIONS for vision and hearing correction.
- 11. DIAGNOSIS AND REFERRAL OF ALCOHOLISM/DRUG ABUSE
- 12. HEALTH EDUCATION SERVICES AND REFERRAL (e.g. family planning, STDs)
- MISCELLANEOUS SUPPLIES related to treatment in a Primary Care Physician's office (e.g. gauze, tape, band aid and other routine medical supplies).
- MISCELLANEOUS SERVICES all services normally provided in a Primary Care Physician's office.
- 15. ROUTINE DIAGNOSTIC TESTS routine tests, x-rays, and electrocardiograms, including interpretation. This may include chest and bone x-rays, Pap smears and any test customarily provided in Primary Care Physician's office.
- MEDICAL RISK ASSESSMENT AND PREVENTIVE CARE SERVICES (e.g. well woman care, adult health screenings)

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SCHEDULE B

PAYMENT APPENDIX - NETWORK GLOBAL CAPITATION

1. <u>Initial Reimbursement.</u> Plan and Network acknowledge and agree that, until such time as Network and Network Providers have been selected by or assigned a sufficient number of Members (as defined below) for Network to be capable of impacting and managing the health, quality of care and related medical costs of those Members, Plan will pay Network a Monthly Capitation for each Member. Plan will pay Network Providers that are not employed by Network their monthly capitation payment from the total Monthly Capitation due to Network. Plan will pay the net Monthly Capitation to Network on or before the 15th day of each month. The Monthly Capitation is \$175.00 per Member per month for each Member who resides in Miami-Dade County, \$175.00 per Member per month for each Member who resides in Broward County and \$175.00 per Member per month for each Member who resides in Palm Beach County

Plan and Network acknowledge and agree that Network will receive Monthly Capitation until such time as Network and Network Providers have been selected by or assigned 1 or more Members. If Network and Network Providers have been selected by or assigned 1 or more Members, Plan will compensate Network as stated in Sections 4 through 10, below of this Schedule B.

- 2. Medicare Operating Fund, Plan will establish a Medicare Operating Fund in a ledger within the financial records of Plan from which Plan will pay all medical, hospital (including but not limited to inpatient, outpatient and emergency), reinsurance, prescription, physician and health care professionals, and all other Covered Services claims, fees and expenses for individuals enrolled in Plan's Medicare Program benefit plans who are assigned to Network or a Network Provider or who have selected a Network Provider as their Primary Care Physician (each a "Member").
- 3. <u>Funding.</u> As full compensation to Network for the services rendered under this Agreement, Plan will allocate to the Medicare Operating Fund the amounts stated in this Sections 3, deduct from the Medicare Operating Fund the amounts stated in Section 4, and distribute to Network the amounts determined in accordance with Sections 5 and 6 of this Schedule B:
 - a. CMS Payment. An amount equal to the percentage stated in the following table of the CMS Payment

Assigned Network Members	Percentage	Care Management Compensation
1-999	83%	0.0%
1,000 - 1,999	83%	1.0%
2,000 or more	84%	2,0%

For purposes of this Payment Appendix, CMS Payment means the actual aggregate capitated payment for each month paid to Plan by CMS (or any other government agency representing the Medicare Program) for the provision of Medicare Program benefit plans to Members.

- b. <u>Stop-Loss Insurance</u>, Plan will credit any amounts due to Network in connection with that protection to the Medicare Operating Fund. If Network does not receive stop-loss protection from Plan or a Plan affiliate, Network will assign the proceeds or pay the amount of any recoveries under that stop-loss insurance to Plan immediately upon receipt and Plan will credit that amount to the Medicare Operating Fund.
- c. <u>Pharmacy Revenue</u>. The following components of Plan's Part D funding will be included in the Medicare Operating Fund: CMS National Direct Subsidy, Member Part D premiums, pharmacy manufacturer rebates, Part D reinsurance payments, and Low Income Cost Sharing Subsidies (LICS).
- d. Third Party Collections. Plan is responsible for collecting funds related to any third party liability for services provided to Members involving, but not limited to, auto insurance carriers, subrogation, Workers' Compensation, and any rights for coordination of benefits with other health insurance providers. Upon recovery by Plan, Plan will (a) account to Network for the recovered

- amount, and (b) contribute the recovered amount, less reasonable cost of collection paid to third parties, if any, to the Medicare Operating Fund.
- Deductions from the Medicare Operating Fund. Plan will deduct the following amounts from the Medicare Operating Fund:
 - a. <u>Network Capitation Payment</u>. Plan will pay Network a monthly capitation payment of \$175.00 for each Member (the "Network Capitation Payment"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month.
 - Payment for Covered Services. Except as provided above, Plan will pay all claims for Covered Services and deduct the amount of such payments and expenses from the Medicare Operating Fund.
 - Pharmacy Costs. The amount of any recovery of pharmacy revenue previously included by Plan in the Medicare Operating Fund.
 - d. Care Management and Disease Management Programs. The cost incurred by Plan to provide standard care management programs and disease management programs to Members.
 - e. <u>Primary Care Provider Bonus Payments</u>. The amount of any bonus payments from Plan to Network Providers, including without limitation payments for participation in Plan's STARs Bonus Program and MLR Bonus Program.
 - f. Stop-Loss Protection.. The cost of that stop-loss protection.
 - g. <u>Chart Review and Hospital Abstracts</u>. The cost incurred by Plan to perform medical chart reviews and hospital abstract audits of Member medical records and claims data.
 - Security Reserve Amounts: the amounts corresponding with Section 7 of this Payment Attachment.
- 5. Calculation of Medicare Operating Fund Surpluses and Deficits. At the end of each month, Plan will determine the amount by which allocations to the Medicare Operating Fund exceeded "deductions from the Medicare Operating Fund. The amount of this excess is the Initial Surplus. Plan will retain the Initial Surplus for 120 days after the end of each month (the "Substantial Completion Period"). At the end of the Substantial Completion Period, Plan will again determine whether allocations to the Medicare Operating Fund exceeded deductions from the Medicare Operating Fund for that month (the "Target Month"). Claims paid as of the end of the Substantial Completion Period will be deemed to constitute 90% of all claims incurred during the Target Month. If there is a positive balance in the Medicare Operating Fund for the Target Month at the end of the Substantial Completion Period (the "Substantial Completion Surplus"), Plan will pay to Network a "Substantial Completion Payment" equal to the amount of the Substantial Completion Surplus reduced by the lesser of (i) actual claims incurred but not reported for the Target Month or (ii) 10% of total claims paid for the Target Month (which amount will be retained in the Medicare Operating Fund as the agreed upon amount of claims incurred but not reported ("IBNR") for the Target Month).

After payment of the Substantial Completion Payment, Plan will continue to pay claims and expenses from the IBNR for the Target Month. If there is a positive balance in the Medicare Operating Fund for the Target Month at the end of the 12th month after the end of the Target Month (the "Final Completion Period"), Plan will pay to Network the amount of that positive balance (the "Final Surplus"). Subject to Section 4.b. of this Payment Appendix, if claims paid after the Substantial Completion Period exceed the IBNR for the Target Month, the amount of excess claims (the "Final Deficit") will be deducted from the Medicare Operating Fund for months after the Target Month until recovered by Plan. If at any time the value of the Medicare Operating Fund is less than \$0.00, Plan will transfer funds from the Security Reserve Account to the Medicare Operating Fund to eliminate that deficit.

In no event will the end of a Substantial Completion Period or a Final Completion Period (i) release Network from its liability for claims incurred for Covered Services during the Target Month, or (ii) be deemed an assumption by Plan of risk for such claims regardless of when the claim is received.

Plan will pay Substantial Completion Payments and Final Surpluses for each Target Month to Network on or before the 15th day after conclusion of the Substantial Completion Period and the Final Completion Period, respectively. For example, if the first Members were assigned to Network on August 1, 2013, the Substantial Completion Period determination would be completed and the Substantial Completion Payment made on or before January 15, 2014. The Substantial Completion Period determination for September 2013 would be completed and the Substantial Completion Payment made on or before February 15, 2014. In turn, Plan would pay the Final Surplus (if any) for August 2013 to Network on or before September 15, 2014 and the Final Surplus (if any) for September 2013 on or before October 15, 2014.

If Network disagrees with Plan's calculation of any Medicare Operating Fund surplus or deficit, Network must deliver written notice of Network's proposed adjustments to the calculation to Plan within 45 days after Plan delivers Plan's calculation to Network. Plan will respond to proposed reconciliation adjustments within 120 days of receipt of Network's proposed adjustments. If Plan agrees with any proposed adjustment and the adjustments increases amounts payable to Network, Plan will include the amount of the proposed adjustment in its next distribution to Network. If Plan disagrees with the proposed adjustment, Plan and Network will then work in good faith for 30 days to agree upon a final reconciliation amount. If Plan and Network are unable to agree upon a final reconciliation amount within 30 days the dispute will be resolved in accordance with the terms of the Agreement.

6. Retroactive Adjustments to Payments. Plan has the right to make retroactive adjustments to Medicare Operating Fund Surpluses and Deficits that result from regulatory audits or reviews or Plan-initiated audits or reviews of risk adjustment factors and to recalculate the amount of any Substantial Completion Payment, Final Surplus or Final Deficit due to any resulting change in the CMS Payment applicable to that Substantial Completion Payment, Final Surplus or Final Deficit. In calculating any retroactive adjustments under this Section 6, Plan will include adjustments to the CMS Payment resulting from regulator or Plan-initiated audits or reviews of risk adjustment factor data, but Plan will not include adjustments to any other component of the CMS Payment or any other expense charged to the Medicare Operating Fund.

Plan will determine the amount of any retroactive adjustment resulting from medical chart audits or reviews initiated by Plan no later than 6 months after Network provides Plan with all information Plan needs to complete the audit or review. Plan will determine the amount of any retroactive adjustment result from (a) other risk adjustment factor audits or reviews initiated by Plan, and (b) audits or reviews of risk adjustment factors initiated by a regulator (or by a contractor to a regulator) no later than 6 months after CMS communicates the resulting change in the CMS Payment to Plan. Network must pay the amount of the retroactive adjustment to Plan no later than 90 days after receipt of written notice from Plan of the amount of the retroactive adjustment. Plan may offset the amount of the retroactive adjustment against future payments to Network if Network does not pay within 90 days.

7. Security Reserve. As of the effective date of the agreement, Plan will establish a Security Reserve Account in a ledger within the financial records of Plan to secure Network's performance under the Agreement and this Schedule B (the "Security Reserve"). The initial amount of contributions to the Security Reserve will be \$10/member/month with a minimum of \$150,000. Plan will withhold an amount equal to 25% of each Substantial Completion Payment (as defined below) and 30% of each Final Surplus until the Security Reserve is fully funded at an amount equal to \$100 (the "Per Member Reserve Amount") per member assigned to Network as of the last day of the previous calendar quarter. If the Security Reserve is not fully funded at the end of each 12 month period following entry into the Agreement and this Schedule B, whether due to insufficient contributions, adjustments to the Security Reserve amount as provided below, or transfers from the Security Reserve Account to the Medicare Operating Fund due to negative balances in the

Medicare Operating Fund, Network will pay to Plan within 30 days an amount equal to the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Plan and Network may, each in their sole discretion, agree to a payment plan under which Network will repay the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Failure of Network to pay to Plan the difference between the amount of the Security Reserve and the balance of the Security Reserve Account within 30 days or, if applicable, in accordance with an agreed upon payment plan will constitute a material breach of this Agreement and Plan will have the right, in Plan's sole discretion, to (a) terminate the Agreement "for Cause" as provided in the Agreement or (b) terminate payment under this Schedule B and pay Network a base capitation rate consistent with base capitation rates provided to other similar primary care providers in Plan's network for the provision of primary care services to Members.

Plan may, in Plan's sole discretion, adjust the required amount of the Security Reserve upward or downward as reasonably required based on Network performance and potential liability to Plan under the Agreement and this Schedule B. Plan may not adjust the amount of the Security Reserve more than twice in a calendar year. If Plan decreases the amount of the Security Reserve, Plan will distribute any excess in the Security Reserve Account as additional payment of equal amounts on its next 3 payments to Network. If Plan increases the amount of the Security Reserve, Plan will again withhold amounts from Substantial Completion Payments and Final Surplus payments until the Security Reserve is fully funded.

In addition, if at any time the balance of the Security Reserve Account is less than \$0.00, Plan may in its sole discretion, require Network will pay to Plan within 30 days an amount equal to the difference between the amount of the Security Reserve and the balance of the Security Reserve Account or require Network to agree to a payment plan under which Network will repay the difference between the amount of the Security Reserve and the balance of the Security Reserve Account. Failure of Network to pay to Plan the difference between the amount of the Security Reserve and the balance of the Security Reserve Account within 30 days or, if applicable, in accordance with the payment plan will constitute a material breach of this Agreement and Plan will have the right, in Plan's sole discretion, to (a) terminate the Agreement "for Cause" as provided in the Agreement or (b) terminate payment under this Schedule B and pay Network a base capitation rate consistent with base capitation rates provided to other similar primary care providers in Plan's network for the provision of primary care services to Members.

8. Care Management Compensation.

- a. <u>Purpose</u>. Plan offers additional care management compensation to eligible Networks and Providers in the form of an increased allocation to the Medicare Operating Fund. The purpose of these additional care management allocations is to:
 - 1. Increase access to quality care for Plan enrollees.
 - Ensure that Network gives adequate coverage to patients who select or are assigned by Plan to Network and Network Providers.
 - Compensate Network for the additional resources required to provide quality care to larger numbers of Plan enrollees.
 - Compensate Network for agreeing to arrange care for and accept the financial risk of treating larger numbers of plan enrollees on a capitated basis.
 - Improve the quality of health care delivered to Plan enrollees by Plan working closely with Network to measure and improve Plan enrollee care and outcomes.
 - Encourage efficiencies in the delivery of medical care for Plan, Network and Network Providers as measured by costs, claim submission methods, and Plan enrollee satisfaction.
- b. <u>General Quality Criteria</u>. For Network to continue to receive additional care management allocation requires Network to work with Network Providers and Plan's provider

relations staff to improve Network Provider compliance with Plan's quality criteria, including:

- i. Engagement in care coordination for Plan enrollees, as appropriate, including:
- ii. Communication with specialists
- iii. Cooperation with Plan's outreach efforts and health wellness and prevention programs
- Managing Plan enrollee care during inpatient admissions, either directly or through communication with attending physician
- v. Supporting discharge planning and follow-up with Plan enrollees post-discharge
- vi. Referring Plan enrollees to behavioral health providers, as appropriate
- Providing initial meeting between Member and physician within 90 days of Member enrollment in Plan
- viii. Address any identified gaps in Plan enrollee care
- ix. Compliance with Plan's policies and procedures, including:
 - 1. Utilization Management
 - 2. Credentialing and re-credentialing
 - Identification, assessment and establishment of treatment plans for serious and complex conditions
 - 4. Plan's grievance program

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- 5. Participation in Plan's Quality Improvement Program
- c. Specific Quality Criteria. In addition, to assisting Plan and Network Providers efforts to fulfill the General Quality Criteria described above, Network agrees to work with Network Providers and Plan's provider relations staff to satisfy the following Specific Quality Criteria in consideration for receiving the additional care management allocation:
 - Participation by eligible Network Providers in Plan's STARS bonus program.
 - ii. Participation by eligible Network Providers in Plan's MLR bonus program.
 - ii. Participation by eligible Network Providers, and if appropriate Network personnel, in monthly meetings with Plan's provider relations staff during which Network Provider and Plan representatives will review Plan operations, care management for Plan enrollees, adequacy of coverage provided to Plan enrollees, gaps in care for Plan enrollees, Plan enrollee complaints (if any), Provider's compliance with Plans policies and procedures, Provider's performance under Plan's Quality Improvement Program, STARS Program, and medical management program, and Provider's compliance with the quality criteria stated in this Appendix.
 - iv. Working with Network Providers and Plan's provider relations staff to address concerns identified in monthly meetings and implement initiatives developed by Plan and/or Network Providers to address these concerns with respect to all Plan enrollees who have selected or been assigned to Network Provider.
- 9. Review of Adherence to Plan's Quality of Care Programs. Plan will provide Network with reports describing Network's and Network Providers' performance on applicable quality and performance metrics to ensure that Network knows the status of Network's and Network Providers' performance. Plan's provider relations staff and medical directors will work with Network and Network Providers to assist Network and Network Providers in achieving performance goals.
- 10. Full Payment. The payments to Network under this Payment Appendix are full payment to Network for all Covered Services provided by Network to Customers. Network must not claim payment in any form, directly or indirectly, from any Federal or State health care program (except as approved by a Federal or State health care program) for items or services furnished under this Agreement. Network cannot shift any costs for items or services furnished under this Agreement

- to the extent that increased payments are claimed from any Federal or State health care program. Network agrees to fully and accurately report the terms of this Agreement and the amounts paid under this Agreement upon request by any Federal or State health care program.
- 11. Stop-Loss Protection. Network must maintain, at all times during which this Schedule B is in force or any payment under this Schedule B remains outstanding, stop-loss protection (the "Stop-Loss Protection") at least sufficient to satisfy the physican incentive plan regulations at 42 CFR 422.208 (the "PIP Regulations"). At Network's option, Network may obtain the Stop-Loss Protection from Plan or Network may purchase Stop-Loss Protection from a third party. If Network chooses to receives Stop-Loss Protection from Plan, Plan will deduct the full cost of providing that Stop-Loss Protection from the Medicare Operating Fund. If Network chooses to purchase the Stop-Loss Protection from a third party, Plan reserves the right to review and approve the policy and entity that provides the Stop-Loss Protection. Network will name Plan as primary payee under any third party Stop-Loss Protection and Plan will credit any payments made to the Medicare Operating Fund. Without limiting the generality of this Section, Network will ensure that Network Providers carry the correct level of reinsurance coverage for individual and institutional losses prescribed by the PIP Regulations.
- 12. <u>Referrals Prohibited</u>, Plan and Network agree that neither Plan nor Network will knowingly and willfully accept nor provide indirect or direct payment for referrals of individuals for items or services reimbursed under a federal health care program. Acceptance of the terms and conditions in this Appendix is without regard to any volume of referrals, and there are no expectations of referrals between Plan and Network based on this Appendix. The parties agree that the capitation amounts in this Agreement are based on fair market value independent of the value or volume of any referrals. Network specifically acknowledges and agrees that Network will not engage in any activities to promote or market Plan managed care products, and will make no referrals whatsoever of individuals to Plan for the provision of managed care services. Any violation of this provision will result in the immediate termination of this Appendix and Network's right to receive payments under this Appendix.
- Appendix, this Agreement must be in force and Network must be providing Covered Services to Members on the date payment is due. Upon termination of the Agreement, no further payment will be due to Network under the Agreement or this Payment Appendix. Plan will provide a final reconciliation of all payments made before termination of the Agreement on or before the first anniversary of the termination of the Agreement. Network will have 30 days to review and object to Plan's final reconciliation. If Network does not object within 30 days, Plan will pay to Network the amount of any surplus or Network will pay to Plan the amount of any deficit in the final reconciliation on or before the 45th day following Network's receipt of the final reconciliation. If Network objects to Plan's final reconciliation, Network will deliver written notice of the basis for its objection to Plan. Plan and Network will then work in good faith for 30 days to agree upon a final reconciliation amount. If Plan and Network are unable to agree upon a final reconciliation amount within 30 days the dispute will be resolved in accordance with the terms of the Agreement. Upon resolution of any dispute and agreement upon the final reconciliation, Plan will also distribute to Network any remaining balance in the Security Reserve.

SCHEDULE C

SIGNATURES ADDENDUM PARTICIPATING NETWORK RISK AGREEMENT

By signing below, the Participating Physicians agree to the terms and conditions set forth in the attached Participating Network Risk Agreement. Effective this day of,		
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SCHEDULE D

PROVIDER INFORMATION AND SERVICE DELIVERY SITES

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Suite	Suite
Phone Number	Phone Number
Fax Number	Fax Number
Office Hours	Office Hours
Age Range	Age Range

MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX

THIS MEDICARE ADVANTAGE REGULATORY REQUIREMENTS APPENDIX (this "Appendix") supplements and is made part of the network participation agreement (the "Agreement") between Plan and the physician or provider named in the Agreement ("Provider").

SECTION 1 APPLICABILITY

This Appendix applies to the Covered Services Provider provides to Medicare Advantage Customers. In the event of a conflict between this Appendix and other appendices or any provision of the Agreement, the provisions of this Appendix shall control except: (1) with regard to Benefit Plans outside the scope of this Appendix; (2) as noted in Section 2 of this Appendix; or (3) as required by applicable law.

SECTION 2 DEFINITIONS

For purposes of this Appendix, the following terms have the meanings set forth below; provided, however, in the event any definition set forth in this Appendix is in conflict with any definition in the Agreement for the same or substantially similar term, the definition for such term in the Agreement shall control. All other capitalized terms not otherwise defined in this Appendix shall be as defined in the Agreement.

- 2.1 Benefit Plan: A certificate of coverage, summary plan description, or other document or agreement, whether delivered in paper, electronic, or other format, under which a Payer is obligated to provide coverage of Covered Services for a Customer. Benefit Plan may also be referred to as benefit contract, benefit document, plan, or other similar term under the Agreement.
- 2.2 CMS Contract: A contract between the Centers for Medicare & Medicaid Services ("CMS") and a Medicare Advantage Organization for the provision of Medicare benefits pursuant to the Medicare Advantage Program under Title XVIII, Part C of the Social Security Act.
- 2.3 Cost Sharing: Those costs, if any, under a Benefit Plan that are the responsibility of the Customer, including deductibles, coinsurance, and copayments. Cost Sharing may also be referred to as patient expenses or other similar term under the Agreement.
- 2.4 Covered Service: A health care service or product for which a Customer is entitled to receive coverage from a Payer, pursuant to the terms of the Customer's Benefit Plan with that Payer. A Covered Service may also be referred to as a health service or other similar term under the Agreement.
- 2.5 Customer: A person eligible and enrolled to receive coverage from a Payer for Covered Services. A Customer may also be referred to as an enrollee, member, patient, covered person, or other similar term under the Agreement.
- 2.6 Dual Eligible Customer: A Medicare Advantage Customer who is: (a) eligible for Medicaid; and (b) for whom the state is responsible for paying Medicare Part A and B Cost Sharing.
- 2.7 Medicare Advantage Benefit Plans: Benefit Plans sponsored, issued or administered by a Medicare Advantage Organization as part of the Medicare Advantage program or as part of the Medicare Advantage program together with the Prescription Drug program under Title XVIII, Part C and Part D, respectively, of the Social Security Act (as those program names may change from time to time).
- 2.8 Medicare Advantage Customer or MA Customer: A Customer eligible for and enrolled in a Medicare Advantage Benefit Plan in which Provider participates pursuant to the Agreement.

- 2.9 Medicare Advantage Organization or MA Organization: For purposes of this Appendix, MA Organization is either Plan or Payor.
- 2.10 Payer: An entity obligated to a Customer to provide reimbursement for Covered Services under the Customer's Benefit Plan and authorized by Plan to access Provider's services under the Agreement. A Payer may also be referred to as a Plan, payor, participating entity or other similar term under the Agreement.

SECTION 3 PROVIDER REQUIREMENTS

- 3.1 Data. Provider shall submit to MA Organization all risk adjustment data as defined in 42 CFR 422.310(a), and other Medicare Advantage program-related information as may be requested by MA Organization, within the timeframes specified and in a form that meets Medicare Advantage program requirements. By submitting data to MA Organization, Provider represents to MA Organization, and upon MA Organization's request Provider shall certify in writing, that the data is accurate, complete, and truthful, based on Provider's best knowledge, information and belief.
- 3.2 Policies. Provider shall cooperate and comply with MA Organization's policies and procedures.
- Customer Protection. Provider agrees that in no event, including but not limited to, nonpayment by MA Organization or an intermediary, insolvency of MA Organization or an intermediary, or breach by United of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any MA Customer or person (other than MA Organization or an intermediary) acting on behalf of the MA Customer for Covered Services provided pursuant to the Agreement or for any other fees that are the legal obligation of MA Organization under the CMS Contract. This provision does not prohibit Provider from collecting from MA Customers allowable Cost Sharing. This provision also does not prohibit Provider and an MA Customer from agreeing to the provision of services solely at the expense of the MA Customer, as long as Provider has clearly informed the MA Customer, in accordance with applicable law, that the MA Customer's Benefit Plan may not cover or continue to cover a specific service or services.

In the event of MA Organization's or an intermediary's insolvency or other cessation of operations or termination of MA Organization's contract with CMS, Provider shall continue to provide Covered Services to an MA Customer through the later of the period for which premium has been paid to MA Organization on behalf of the MA Customer, or, in the case of MA Customers who are hospitalized as of such period or date, the MA Customer's discharge.

This provision shall be construed in favor of the MA Customer, shall survive the termination of the Agreement regardless of the reason for termination, including MA Organization's insolvency, and shall supersede any contrary agreement, oral or written, between Provider and an MA Customer or the representative of an MA Customer if the contrary agreement is inconsistent with this provision.

For the purpose of this provision, an "intermediary" is a person or entity authorized to negotiate and execute the Agreement on behalf of Provider or on behalf of a network through which Provider elects to participate.

3.4 Dual Eligible Customers. Provider agrees that in no event, including but not limited to, non-payment by a state Medicaid agency or other applicable regulatory authority, other state source, or breach by Plan of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Dual Eligible Customer, person acting on behalf of the Dual Eligible Customer, or MA Organization (unless notified otherwise) for Medicare Part A and B Cost Sharing. Instead, Provider will either: (a) accept payment made by or on behalf of MA Organization as payment in full; or (b) bill the appropriate state source for such Cost Sharing amount. If Provider imposes an excess charge on a Dual Eligible Customer, Provider is subject to any lawful sanction that may be imposed under Medicare or Medicaid. This provision does not prohibit Provider and a Dual Eligible Customer from agreeing to the provision of services solely at the expense of the Dual Eligible Customer, as long as Provider has clearly informed the Dual Eligible Customer,

in accordance with applicable law, that the Dual Eligible Customer's Benefit Plan may not cover or continue to cover a specific service or services.

- 3.5 Eligibility. Provider agrees to immediately notify MA Organization in the event Provider is or becomes excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act. Provider also shall not employ or contract for the provision of health care services, utilization review, medical social work or administrative services, with or without compensation, with any individual or entity that has been excluded from participation in any federal or state health care program under Section 1128 or 1128A of the Social Security Act.
- 3.6 Laws. Provider shall comply with all applicable federal and Medicare laws, regulations, and CMS instructions, including but not limited to: (a) federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including but not limited to, applicable provisions of federal criminal law, the False Claims Act (31 U.S.C. §3729 et seq.), and the anti-kickback statute (§1128B of the Social Security Act); and (b) HIPAA administrative simplification rules at 45 CFR Parts 160, 162, and 164.
- 3.7 Federal Funds. Provider acknowledges and agrees that MA Organization receives federal payments under the CMS Contract and that payments Provider receives from or on behalf of MA Organization are, in whole or in part, from federal funds. Provider is therefore subject to certain laws that are applicable to individuals and entities receiving federal funds.
- 3.8 CMS Contract. Provider shall perform the services set forth in the Agreement in a manner consistent with and in compliance with MA Organization's contractual obligations under the CMS Contract.

3.9 Records.

- (a) Maintenance: Privacy and Confidentiality; Customer Access. Provider shall maintain records and information related to the services provided under the Agreement, including but not limited to MA Customer medical records and other health and enrollment information, in an accurate and timely manner. Provider shall maintain such records for at least ten (10) years or such longer period as required by law. Provider shall safeguard MA Customer privacy and confidentiality, including but not limited to the privacy and confidentiality of any information that identifies a particular MA Customer, and shall comply with all federal and state laws regarding confidentiality and disclosure of medical records or other health and enrollment information. Provider shall ensure that MA Customers have timely access to medical records and information that pertain to them, in accordance with applicable law.
- (b) Government Access to Records. Provider acknowledges and agrees that the Secretary of Health and Human Services, the Comptroller General, the Florida Agency for Health Care Administration, the Florida Office of Insurance Regulation, or their designees have the right to audit, evaluate and inspect any pertinent books, contracts, medical records, patient care documentation and other records and information belonging to Provider that involve transactions related to the CMS Contract. This right shall extend through ten (10) years from the later of the final date of the CMS Contract period in effect at the time the records were created or the date of completion of any audit, or longer in certain instances described in the applicable Medicare Advantage regulations. For the purpose of conducting the above activities, Provider shall make available its premises, physical facilities and equipment, records relating to MA Customers, and any additional relevant information CMS may require.
- (c) MA Organization Access to Records. Provider shall grant MA Organization or its designees such audit, evaluation, and inspection rights identified in subsection 3.9(b) as are necessary for MA Organization to comply with its obligations under the CMS Contract. Whenever possible, MA Organization will give Provider reasonable notice of the need for such audit, evaluation or inspection, and will conduct such audit, evaluation or inspection at a reasonable time and place. Provider shall submit medical records of MA

Customers to the MA Organization as may be requested, within the timeframes specified, for the purpose of (i) CMS audits of risk adjustment data and (ii) for other purposes medical records from providers are used by MA Organization, as specified by CMS. Provision of medical records must be in the manner consistent with HIPAA privacy statute and regulations.

- 3.10 MA Organization Accountability; Delegated Activities. Provider acknowledges and agrees that MA Organization oversees and is accountable to CMS for any functions and responsibilities described in the CMS Contract and applicable Medicare Advantage regulations, including those that MA Organization may delegate to Provider or others. If MA Organization has delegated any of its functions and responsibilities under the CMS Contract to Provider pursuant to the Agreement, the following shall apply in addition to the other provisions of this Appendix:
 - (a) Provider shall perform those delegated activities specified in the Agreement, if any, and shall comply with any reporting responsibilities as set forth in the Agreement.
 - (b) If MA Organization has delegated to Provider any activities related to the credentialing of health care providers, Provider must comply with all applicable CMS requirements for credentialing, including but not limited to the requirement that the credentials of medical professionals must either be reviewed by MA Organization, or the credentialing process must be reviewed, pre-approved and audited on an ongoing basis by MA Organization.
 - (c) If MA Organization has delegated to Provider the selection of health care providers to be participating providers in MA Organization's Medicare Advantage network, MA Organization retains the right to approve, suspend or terminate the participation status of such health care providers.
 - (d) Provider acknowledges that MA Organization shall monitor Provider's performance of any delegated activities on an ongoing basis. If MA Organization or CMS determines that Provider has not performed satisfactorily, MA Organization may revoke any or all delegated activities and reporting requirements. Provider shall cooperate with MA Organization regarding the transition of any delegated activities or reporting requirements that have been revoked by MA Organization.
- 3.11 Subcontracts. If Provider has any arrangements, in accordance with the terms of the Agreement, with affiliates, subsidiaries, or any other subcontractors, directly or through another person or entity, to perform any of the services Provider is obligated to perform under the Agreement that are the subject of this Appendix, Provider shall ensure that all such arrangements are in writing, duly executed, and include all the terms in this Appendix. Provider shall provide proof of such to MA Organization upon request. Provider further agrees to promptly amend its agreements with such subcontractors, in the manner requested by MA Organization, to meet any additional CMS requirements that may apply to the services.
- 3.12 Offshoring. Unless previously authorized by MA Organization in writing, all services provided pursuant to the Agreement that are subject to this Appendix must be performed within the United States, the District of Columbia, or the United States territories.

SECTION 4 OTHER

- 4.1 Payment. MA Organization or its designee shall promptly process and pay or deny Provider's claim no later than sixty (60) days after MA Organization or its designee receives all appropriate information as described in MA Organization's administrative procedures. If Provider is responsible for making payment to subcontracted providers for services provided to MA Customers, Provider shall pay them no later than sixty (60) days after Provider receives request for payment for those services from subcontracted providers.
- 4.2 Regulatory Amendment. MA Organization may unifaterally amend this Appendix to comply with

applicable laws and regulations and the requirements of applicable regulatory authorities, including but not limited to CMS. MA Organization shall provide written or electronic notice to Provider of such amendment and its effective date. Unless such laws, regulations or regulatory authority(les) direct otherwise, the signature of Provider will not be required in order for the amendment to take effect.



AMENDMENT TO NETWORK RISK AGREEMENT

PREFERRED CARE PARTNERS INC., a Florida corporation ("PLAN") and DOCTOR'S GROUP MANAGEMENT, a Florida Corporation ("Network") enter into this AMENDMENT ("Amendment") to the NETWORK RISK AGREEMENT by and between Plan and Network effective 01/01/2016 (the "Effective Date")

WHEREAS, Plan and Network desire to amend the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge, the parties agree as follows:

 <u>Defined Terms</u>, Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.

2. Amendments.

2.1 Schedule E, Stars Bonus Program. Payment section of Schedule E, Stars Bonus Program shall be deleted in its entirety and replaced with the following:

Payment

During the second quarter of the following plan year, Plan will determine if Provider met the quality targets for the full plan year (January 1 to December 31) and STARS Bonus Amount earned for that period, if any, will be distributed by Plan to eligible Primary Care Providers no later than third quarter of that year. Provider must be a contracted and participating Provider of Primary Care Services for Plan on the date a payment is made by Plan to be eligible to receive payment under this STARS Bonus Program. If Provider is not a contracted and participating Provider of Primary Care Services on the data Plan makes STARS Bonus Program payments, Provider will not be eligible for and will not receive any payment under this STARS Bonus Program. If Provider owes Plan monies as of the date of bonus payment, any applicable bonus payments due to provider shall first be applied to offset any balances or deficits owed to Plan; thereafter any remaining bonus payment will be paid to Provider.

 <u>Full Force and Effect.</u> Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

PREFFERD CARE PARNTERS, INC. 9100 South Dadeland Boulevard, Suite 1250 Miami, Florida 33156

Annette C. Onorati

Chief Operating Officer

DOCTOR'S GROUP MANAGEMEN

Name:

Title: PRSI Devi

TIN:20-0534962



AMENDMENT TO NETWORK RISK AGREEMENT

THIS AMENDMENT TO THE PARTICIPATING PROVIDER AGREEMENT (the "Amendment") is made this 28TH DAY OF JULY, 2017, by and between PREFERRED CARE PARTNERS, INC., a Florida corporation ("PLAN") and DOCTORS GROUP MANAGEMENT ("Provider"). This amendment is effective January 1, 2016.

<u>Defined Terms.</u> Unless otherwise defined in this Amendment, the capitalized terms used in this Amendment have the meaning stated in the Agreement.

2. Amendments.

DEFECTED CARE DARNITEDS INC

2.1 Attachment E — Stars Bonus Program. In an effort to improve the quality of member care as measured by STARs performance and to provide additional compensation to participating providers who successfully achieve the goals of participation in the Stars Bonus Program, Plan incorporates Attachment E - STARs Bonus Program. The STARs Bonus Program provides qualifying Network Providers with the opportunity to receive a STARS bonus payment for each Plan enrollee who selects or is assigned to Provider for Primary Care Services if Provider meets specific performance driven quality targets established in accordance with Attachment E.

3. <u>Full Force and Effect</u>. Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

9100 South Dadeland Boulevard, Suite 1250 Miami, Florida 33156	DOCTORS GROUP WAINAGEWENT
By: annetto C Onorate	Ву:
Annette C. Onorati	Name: relix Guevedo
Chief Operating Officer	Title: PN SI BOUT

SCHEDULE E

STARS Bonus Program

STARS Bonus Program

The Preferred Care Partners STARS Bonus Program provides qualifying Network Primary Care Providers with the opportunity to receive up to \$10.00 per month ("STARS Bonus Amount") for each Plan enrollee who selects or is assigned to Provider for Primary Care Services if Provider meets quality targets established by Plan in its sole discretion.

Eligibility

All Network Primary Care Providers with 30 or more Plan enrollees are eligible to participate in the STARS Bonus Program.

Utilization and Quality Targets

Plan will determine the STARS Bonus Program quality targets in its sole discretion before the start of each plan year. Quality targets will remain in effect for the plan year. Plan will distribute quality targets for the STARS Bonus Program to Provider in writing. Plan may, in Plan's sole discretion, communicate additional terms and conditions or changes in the quality targets of the STARS Bonus Program to eligible Providers throughout the plan year. If Plan does not distribute quality targets before the start of any plan year, the quality targets for the prior plan year will continue to apply.

Payment

During the second quarter of the following plan year, Plan will determine if Provider met the quality targets for the full plan year (January 1 to December 31) and STARS Bonus Amount earned for that period, if any, will be distributed by Plan to eligible Primary Care Providers no later than third quarter of that year. Provider must be a contracted and participating Provider of Primary Care Services for Plan on the date a payment is made by Plan to be eligible to receive payment under this STARS Bonus Program. If Provider is not a contracted and participating Provider of Primary Care Services on the data Plan makes STARS Bonus Program payments, Provider will not be eligible for and will not receive any payment under this STARS Bonus Program. If Provider owes Plan monies as of the date of bonus payment, any applicable bonus payments due to provider shall first be applied to offset any balance's or deficits owed to Plan; thereafter any remaining bonus payment will be paid to Provider.

Deductions from Network's Medicare Operating Fund

If the overall STARS rating of the Members assigned to Network, determined in accordance with CMS STAR rating methodology, is 4.50 stars or greater, Plan will not deduct STARs Bonus payments to Network Providers from Network's Medicare Operating Fund. If the overall STARS rating of Members assigned to Network, determined in accordance with CMS STAR rating methodology is 4.26 stars or greater (but less than 4.50), Plan will not deduct 50% of the

amount of the STARS Bonus payments from Network's Medicare Operating Fund. If the overall STARS rating of Members assigned to Network, determined in accordance with CMS STAR rating methodology, is less than 4 stars, Plan will deduct the full amount of the STARS Bonus payments from Network's Medicare Operating Fund.

Denial of Medically Necessary Care Prohibited

Plan and Provider acknowledge and agree that:

- the compensation stated in the Agreement, including this STARS Bonus Program, does not reward Provider for limiting the provision of any medically necessary services to any patients; and
- nothing in the Agreement, including this STARS Bonus Program, will be construed in any manner as creating an obligation or inducement to limit the provision of any medically necessary services to be provided by Provider.

Provider agrees that Provider will immediately report to Plan any Provider physician whom Provider believes, or has reason to believe, may have limited or denied, or attempted to limit or deny, medically necessary or clinically appropriate care to one or more Plan enrollees. Any such limitation, denial, or attempt, as determined by Plan in its sole discretion, will be grounds for immediate termination of Provider's participation in this STARS Bonus Program and will be deemed a material breach under the Agreement for purposes of termination of the Agreement. Notwithstanding anything in this STARS Bonus Program to the contrary, no further payments will be made under this STARS Bonus Program if terminated. In its sole discretion, Plan may elect instead to exclude the individual Provider physician from the Provider group, thereby terminating that Provider physician's participation in this STARS Bonus Program. Provider acknowledges and agrees that Plan is relying upon the foregoing representations and covenants of Provider in connection with Provider's and each Provider physicians' participation in this STARS Bonus Program.

Compliance with Laws.

Plan and Provider further acknowledge and agree that:

- In establishing the terms of the Agreement, including this STARS Bonus Program, neither Plan nor Provider gave or received remuneration in return for or to induce the provision or acceptance of business for which payment may be made in whole or in part by a Federal health care program on a fee-for-service or cost basis; and
- neither Plan nor Provider will shift the financial burden of the Agreement, including this STARS Bonus Program, to the extent that increased payments are claimed from a Federal health care program.

Provider represents and agrees that Provider cannot and will not claim payment in any form, directly or indirectly, from a Federal health care program for items or services covered under the Agreement, except as expressly permitted by applicable law.



AMENDMENT TO MEDICARE ADVANTAGE PARTICIPATING PROVIDER AGREEMENT - NETWORK RISK

THIS AMENDMENT TO THE PARTICIPATING PROVIDER AGREEMENT (the "Amendment") is made, by and between **PREFERRED CARE PARTNERS, INC.**, a Florida corporation ("PLAN") and **DOCTORS GROUP MANAGEMENT, INC.** ("Provider").

- Description of Services. Schedule A of the Participating Provider Agreement, shall remain in full force and effect.
- Compensation. Schedule B of the Participating Provider Agreement shall remain in full force and effect.
- 3. Name & Tax Identification: Changed to: DGM MSO, LLC., TIN 82-3464109
- 4. Effective Date. The Effective Date of this Amendment is JANUARY 1, 2022.
- Provisions of Participating Provider Agreement. All provisions of the Participating Provider Agreement, not amended herein, shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment in the State of Florida on the date first written above.

PROVIDER:

DOCTORS GROUP MANAGEMENT, INC.

PLAN:

PREFERRED CARE PARTNERS, INC.

Roger Rodriguez

Chief Executive Officer



AMENDMENT TO MEDICARE ADVANTAGE PARTICIPATING PROVIDER AGREEMENT – NETWORK RISK

This Amendment effective <u>JANUARY 1, 2022</u> is made between <u>PREFERRED CARE PARTNERS</u>, INC., ("PLAN or "PCP") and **DGM MSO, LLC**. ("Provider") or other applicable term used in the Provider Agreement for the purpose of amending the terms and conditions of the Network Risk Services Agreement ("the Agreement").

- 1. Description of Services. Schedule A of the Network Risk Agreement, shall remain in full force and effect.
- 2. <u>Compensation</u>. Schedule B Section 3(a) of the Network Risk Agreement shall be amended as follows:

3. Funding. As full compensation to Network for the services rendered under this Agreement, Plan will allocate to the Medicare Operating Fund the amounts stated in this Sections 3, deduct from the Medicare Operating Fund the amounts stated in Section 4, and distribute to Network the amounts determined in accordance with Sections 5 and 6 of this Schedule B:

a. CMS Payment. An amount equal to the percentage stated in the following table of the CMS Payment

Assigned Network Members	Percentage	Care Management Compensation
1-999	83%	0.0%
1,000-1,999	84%	0.0%
2,000+	85.8%	0.0%

For purposes of this Payment Appendix, CMS Payment means the actual aggregate capitated payment for each month paid to Plan by CMS (or any other government agency representing the Medicare Program) for the provision of Medicare Program benefit plans to Members.

- 3. Effective Date. The Effective Date of this Amendment is: JANUARY 1, 2022
- Provisions of Network Risk Agreement. All provisions of the Network Risk Agreement shall remain in full force and effect.

PREFERRED CARE PARTNERS, INC. 2100 South Dadeland Boulevard, Suite 1250 Miami, Florida 32156	DGM MSO, LLC.	
Ву:	By:	
Name: Roger Rodriguez	Dr. Marlow Hernandez	
Title: CEO	CEO Title:	
Date:	12/21/2021 Date:	

Assignment and Assumption Agreement

This Assignment and Assumption Agreement (this "Agreement") is made and entered into this January 1, 2022, by and among, PREFERRED CARE PARTNERS, INC. ("Plan"), DOCTORS GROUP MANAGEMENT ("Network") and DGM MSO, LLC. ("Purchaser").

Recitals

WHEREAS, Plan and Network entered into a Medicare Advantage Network Risk Agreement effective November 1, 2015 (the "Participation Agreement");

WHEREAS, Network has entered into a transaction pursuant to which Network will sell substantially all of its assets to Purchaser (the "Transaction");

WHEREAS, Network desires to assign Participation Agreement and Purchaser desires to assume Network's rights and obligations under the Participation Agreement; and

WHEREAS, Network may not assign the Participation Agreement without Plan's approval.

- <u>Date of Service</u>. For purposes of this Agreement, rights and obligations relating to: (i) payment of a claim, (ii) additional payment of an underpayment on a claim, or (iii) refund of an overpayment on a claim, will be deemed to arise on the date of service. The date of service of an entire inpatient admission is the first day of the admission, regardless of the length of stay.
- 2. <u>Assumption</u>. Purchaser shall assume all rights and obligations under the Participation Agreement which may arise on or after January 1, 2022 or the date of completion of the Transaction, whichever occurs later.
- 3. <u>Assignment</u>. Network assigns all rights and obligations under the Participation Agreement which may arise on or after January 1, 2022 or the date of completion of the Transaction, whichever occurs later.
- 4. <u>Consent.</u> As described herein, Plan consents to the assignment of the Participation Agreement by Network to Purchaser and the assumption of the Participation Agreement by Purchaser.
- 5. Non-completion of the Transaction. In the event that Purchaser and Network do not complete the Transaction, this Agreement is null and void.
- 6. <u>Effect on the Participation Agreement</u>. Except as may be provided herein, the terms and conditions of the Participation Agreement remain in full force and effect.

Signatures appear on the following page.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first written above.

	PREFERRED CARE PARTNERS, INC.By: Murrell Name: Marrell Title: CFO
DOCTORS GROUP MANAGEMENT	DGM MSO, LLC.
By:	By: Dr. Marlow Hernandez Name:
Title: President	Title:



AMENDMENT TO NETWORK RISK AGREEMENT

THIS AMENDMENT TO MEDICARE ADVANTAGE NETWORK RISK AGREEMENT (this "Amendment") is dated effective as of JANUARY 1, 2023 ("Effective Date"), by and between PREFERRED CARE PARTNERS INC., a Florida corporation ("PLAN") and DGM MSO, LLC. ("Network").

WHEREAS, Plan and Network desire to amend the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge the parties agree as follows:

- 1. Defined Terms. Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.
- 2. Amendments.
- 2.1 Schedule B, Payment Appendix. Schedule B Section 1 and Section 4(i), Payment Appendix shall be amended with the attached effective JANUARY 1, 2023.
- Full Force and Effect. Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

PREFERRED CARE PARTNERS, INC. 9100 South Dadeland Boulevard, Suite 1250 Miami, Florida 33156

Chief Executive Officer

DGM MSO, LLC.

Marlow Hernandez Name:

Title:

CEO

SCHEDULE B

- Initial Reimbursement. Plan and Network acknowledge and agree that, until such time as Network and Network Providers have been selected by or assigned a sufficient number of Members (as defined below) for Network to be capable of impacting and managing the health, quality of care and related medical costs of those Members, Plan will pay Network a Monthly Capitation for each Member. Plan will pay Network Providers that are not employed by Network their monthly capitation payment from the total Monthly Capitation due to Network. Plan will pay the net Monthly Capitation to Network on or before the 15th day of each month. The Monthly Capitation is \$275 per Member per month for each Member who resides in Miami-Dade County, \$275 per Member per month for each Member who resides in Broward County, and \$275 per Member per month for each Member who resides in Palm Beach County.
- 4. <u>Deductions from the Medicare Operating Fund.</u> Plan will deduct the following amounts from the Medicare Operating Fund:
 - (i) Network Capitation Payment. Plan will pay Network a monthly capitation payment of \$275 for each Member (the "Network Capitation Payment"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month.



AMENDMENT TO NETWORK RISK AGREEMENT

"Amendment") is dated effective as of ___11/1/2023 ____ ("Effective Date"), by and between PREFERRED CARE PARTNERS INC., a Florida corporation ("PLAN") and DGM MSO, LLC. ("Network").

WHEREAS, Plan and Network desire to amend the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge the parties agree as follows:

- **1.** <u>Defined Terms.</u> Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.
- 2. Amendments.
- **2.1 Schedule B, Payment Appendix.** Schedule B Section 1 and Section 4(i), Payment Appendix shall be amended with the attached effective 11/1/2023.
- **3.** <u>Full Force and Effect.</u> Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

PREFERRED CARE PARTNERS, INC.

9100 South Dadeland Boulevard, Suite 1250

Miami, Florida 33156

Warren Murrell

Chief Executive Officer

DGM MSO, LLC.

Title:

10/22/23

SCHEDULE B

- Initial Reimbursement. Plan and Network acknowledge and agree that, until such time as Network and Network Providers have been selected by or assigned a sufficient number of Members (as defined below) for Network to be capable of impacting and managing the health, quality of care and related medical costs of those Members, Plan will pay Network a Monthly Capitation for each Member. Plan will pay Network Providers that are not employed by Network their monthly capitation payment from the total Monthly Capitation due to Network. Plan will pay the net Monthly Capitation to Network on or before the 15th day of each month. The Monthly Capitation is \$175.00 per Member per month for each Member who resides in Broward County, and \$175.00 per Member per month for each Member who resides in Palm Beach County.
- 4. <u>Deductions from the Medicare Operating Fund.</u> Plan will deduct the following amounts from the Medicare Operating Fund:
 - (i) Network Capitation Payment. Plan will pay Network a monthly capitation payment of \$175.00 for each Member (the "Network Capitation Payment"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month.



AMENDMENT TO NETWORK RISK AGREEMENT

THIS AMENDMENT TO MEDICARE ADVANTAGE NETWORK RISK AGREEMENT (this "Amendment") is dated effective as of 11/1/2023 ("Effective Date"), by and between PREFERRED CARE PARTNERS INC., a Florida corporation ("PLAN") and DGM MSO, LLC. ("Network").

WHEREAS, Plan and Network desire to amend the Agreement as stated in this Amendment.

THEREFORE, in consideration of the mutual covenants and agreements in this Amendment, and for other good and valuable consideration, the receipt and sufficiency of which the parties acknowledge the parties agree as follows:

- 1. <u>Defined Terms.</u> Unless otherwise defined herein, the capitalized terms used herein shall have the same meaning set forth in the Agreement.
- 2. Amendments.
- 2.1 Schedule B, Payment Appendix. Schedule B Section 1 and Section 4(i), Payment Appendix shall be amended with the attached effective 11/1/2023.
- 3. <u>Full Force and Effect.</u> Except as amended by this Amendment, all of the terms and provisions of the Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, the parties hereto have executed this Amendment by their officers duly authorized to be effective on the date and year first written above.

PREFERRED CARE PARTNERS, INC.

9100 South Dadeland Boulevard, Suite 1250

Miami, Florida 33156

Warren Murrell

Chief Executive Officer

DGM MSO, LLC.

Title:

Mark D. Kent

SCHEDULE B

- Initial Reimbursement. Plan and Network acknowledge and agree that, until such time as Network and Network Providers have been selected by or assigned a sufficient number of Members (as defined below) for Network to be capable of impacting and managing the health, quality of care and related medical costs of those Members, Plan will pay Network a Monthly Capitation for each Member. Plan will pay Network Providers that are not employed by Network their monthly capitation payment from the total Monthly Capitation due to Network. Plan will pay the net Monthly Capitation to Network on or before the 15th day of each month. The Monthly Capitation is \$175.00 per Member per month for each Member who resides in Broward County, and \$175.00 per Member per month for each Member who resides in Palm Beach County.
- 4. <u>Deductions from the Medicare Operating Fund.</u> Plan will deduct the following amounts from the Medicare Operating Fund:
 - (i) Network Capitation Payment. Plan will pay Network a monthly capitation payment of \$175.00 for each Member (the "Network Capitation Payment"). Network is responsible for paying Network's Primary Care Physicians for provision of Primary Care Services to Members from this monthly capitation payment. Plan will pay the Network Capitation Payment on or before the 15th day of each month.

EXHIBIT 3

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SUMMARY - Contracted Deficits
FundPool August 2025 FP

Reconciling Month April

Entity	Brand		Ending 2023	2024													
			Running Balance - Prior														
			Years	January	February	March	April	May	June	July	August	September	October	November	December	Total 2024	
DGM	PCN	Members	2,248	2,184	2,191	2,118	2,047	1,995	1,096				-	-	-		
		SurPlus/Deficit Contracted	\$ (6,488,114)	\$ (384 009) \$	355 829	\$ 24 709	\$ (621 808)	\$ (318 288)	\$ 41 040	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ (902,5	526)
		Reserves		\$ - \$	-	\$ -	-	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -		
		Running Balance/Month Contracted		\$ (6,872,123)	(6,516,294)	\$ (6,491,586)	(7,113,394)	\$ (7,431,681)	\$ (7,390,641)	\$ (7,390,641)	\$ (7,390,641)	(7,390,641)	\$ (7,390,641)	\$ (7,390,641)	\$ (7,390,641))	
	PCP	Members	5,660	5,703	5,719	5,229	5,169	4,949	2,927								
		SurPlus/Deficit Contracted	\$ (7,987,684)	\$ (195 492) \$	(1 077 547)	\$ (1 374 508)	\$ (785 973)	\$ (680 284)	\$ (602 640)	\$ -	\$ -	-	\$ -	\$ -	\$ -	\$ (4,716,4	445)
		Reserves		\$ - \$	-	\$ -	-	\$ -	\$ -	\$ -	\$ -	-	\$ -	\$ -	\$ -		
		Running Balance/Month Contracted		\$ (8.183.177) \$	(9.260,724)	\$ (10,635,232)	\$ (11,421,205)	\$ (12,101,489)	\$ (12,704,129)	\$ (12,704,129)	\$ (12,704,129)	(12,704,129)	\$ (12,704,129)	\$ (12,704,129)	\$ (12,704,129)		

EXHIBIT 4

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POST-PETITION FINAL DEFICIT CALCULATION PRORATED

	Feb. 4-28, 2024		Feb. 4-28, 2024		Mar-24	Apr-24	May-24	Jun	e 1-28, 2024	Su	btotal
PCN	\$	317,704.26	\$ 24,708.58	\$ (621,808.09)	\$ (318,287.55)	\$	38,304.45	\$	(559,378.34)		
PCP	\$	(962,095.82)	\$ (1,374,508.15)	\$ (785,973.42)	\$ (680,283.99)	\$	(562,463.68)	\$	(4,365,325.07)		
TOTAL								\$	(4,924,703.41)		