23	**AGENDA ITEM** **ST. JOHNS COUNTY BOARD OF COUNTY COMMISSIONERS**
	Deadline for Submission - Wednesday 9 a.m. – Thirteen Days Prior to BCC Meeting

12/19/2023

BCC MEETING DATE

TO: **Joy Andrews, County Administrator** **DATE:** **October 30, 2023**

FROM: **Shawna Novak, Health and Human Services Director** **PHONE:** **904 209-6089**

SUBJECT OR TITLE: **Sunshine State Health Plan, Inc.**

AGENDA TYPE: **Consent Agenda, Contract, Resolution**

BACKGROUND INFORMATION:

Community Based Care (CBC) is requesting the Board's approval on a Services Agreement between St. Johns County and Sunshine State Health Plan, Inc. for the coordination of the delivery of Medicaid services to children in child welfare. Sunshine shall compensate the County $8,000 per month for services rendered in accordance with this Agreement. It is requested that the BCC approve the terms, conditions, and requirements of the Agreement, recognize and appropriate the unanticipated revenue and authorize the County Administrator to execute the Agreement on behalf of the County.

1. IS FUNDING REQUIRED? Yes **2. IF YES, INDICATE IF BUDGETED.** Yes

IF FUNDING IS REQUIRED, MANDATORY OMB REVIEW IS REQUIRED:

INDICATE FUNDING SOURCE: Recognizing additional grant funding for Community Based Care Fund-Human SVCS Grants Other (1400-33760) in the amount of $8,000 per month and appropriating associated projects in Community Based Care/Sunshine State Health Plan (1401).

SUGGESTED MOTION/RECOMMENDATION/ACTION:

Motion to adopt Resolution 2023-_____, approving the terms, conditions, and requirements of the Services Agreement between St. Johns County, Florida and Sunshine State Health Plan, Inc., recognize and appropriate the unanticipated revenue and authorizing the County Administrator, or designee, to execute the Agreement on behalf of the County.

For Administration Use Only:
Legal: Kealey West 11/30/2023 **OMB: JN 12/5/2023** **Admin: Brad Bradley 12/6/2023**

RESOLUTION NO. 2023-_____

A RESOLUTION BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, APPROVING THE TERMS, PROVISIONS, CONDITIONS, AND REQUIREMENTS OF A SERVICES AGREEMENT BETWEEN ST. JOHNS COUNTY, FLORIDA, AND SUNSHINE STATE HEALTH PLAN, INC., RECOGNIZING AND APPROPRIATING UNANTICIPATED REVENUE AND AUTHORIZING THE COUNTY ADMINISTRATOR, OR DESIGNEE TO EXECUTE THE AGREEMENT ON BEHALF OF THE COUNTY

WHEREAS, Sunshine State Health Plan, Inc. represents seventeen child welfare lead agencies and works with theses lead agencies to coordinate the delivery of Medicaid services in child welfare; and

WHEREAS, the County is a child welfare lead agency; and

WHEREAS, Sunshine State Health Plan, Inc. wishes to enter into a Services Agreement with the County for the purpose of coordinating the provision of Medicaid services to children in child welfare who are eligible Medicaid enrollees; and

WHEREAS, Sunshine State Health Plan, Inc. shall compensate the County eight thousand dollars per month for services rendered in accordance with this Agreement; and

WHEREAS, the County has reviewed the terms, provisions, conditions, and requirements of the Agreement; and

WHEREAS, the County has determined that accepting the terms of the Agreement, and entering into said Agreement will serve the interests of the County.

NOW, THEREFORE, BE IT RESOLVED BY THE BOARD OF COUNTY COMMISSIONERS OF ST. JOHNS COUNTY, FLORIDA, AS FOLLOWS:

Section 1. The above Recitals are hereby incorporated into the body of this Resolution, and are adopted as Findings of Fact.

Section 2. The Board of County Commissioners hereby approves the terms, provisions, conditions, and requirements of the amendment of the Agreement between the St. Johns County, Florida, and Sunshine State Health Plan, Inc. recognizing and appropriating unanticipated revenue and authorizing the County Administrator, or designee to execute the Agreement on behalf of the County.

Section 3. To the extent that there are typographical and/or administrative errors and/or omissions that do not change the tone, tenor, or context of this Resolution, then this Resolution may be revised, without subsequent approval of the Board of County Commissioners.

PASSED AND ADOPTED by the Board of County Commissioners of St. Johns County, Florida, this _____ day of _____, 2024.

BOARD OF COUNTY COMMISSIONERS OF
ST. JOHNS COUNTY, FLORIDA

Attest: Brandon J. Patty, Clerk of the Circuit Court & Comptroller

By:

_____
Sarah Arnold, Chair

_____

VENDOR SERVICES MASTER AGREEMENT

THIS VENDOR SERVICES MASTER AGREEMENT (the "***Agreement***") is made and entered into this April 1 day of 2024 ("***Effective Date***")**,** by and between Sunshine State Health Plan, Inc. a Florida health maintenance organization with the principal places of business located at P.O. Box 459089, Fort Lauderdale, FL 33345 ("***Health Plan***"), and St. Johns County Board of County Commissioners with its principal place of business located at 500 San Sebastian View, St Augustine, FL 32084 ("***Vendor***"). Health Plan and Vendor shall each be referred to herein as a "***Party,***" and collectively as the "***Parties***").

1. **DEFINITIONS**. The following terms shall have the meanings set forth below.

1.1. ***Affiliate*** means a person or entity controlling, controlled by, or under common control with an identified party

1.2. ***Attachment*** means any document, including an addendum, schedule or exhibit, attached to this Agreement (or other Attachment hereto) as of the Effective Date or that becomes attached pursuant the terms of this Agreement, each of which is hereby incorporated in this Agreement and may be amended from time to time as provided in this Agreement.

1.3. ***CBC*** means a Community Based Care Lead Agency that is one of the child welfare lead agencies (hereinafter referred to as "CBC Subcontract") in accordance with the terms of this agreement.

1.4. ***CBC Staff*** means Nurse Care Coordinators and Behavioral Health Care Coordinators hired or contracted by the CBC to coordinate all activities at the CBC.

1.5. ***Company*** means (collectively or individually, as appropriate in the context) Health Plan and its Affiliates, which include but are not limited to WellCare of Florida, Inc.; WellCare Health Insurance of Arizona, Inc.; Sunshine Health Plan Community Solutions, Inc.; and Celtic Insurance Company, and do not include those Affiliates specifically excluded by Health Plan.

1.6. ***Coverage Agreement*** means any agreement, program or certificate entered into, issued or agreed to by Company or Payor, under which Company or Payor furnishes administrative services or other services in support of a health care program for an individual or group of individuals, and which may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan.

1.7. ***Covered Person*** means any individual entitled to receive Covered Services pursuant to the terms of a Coverage Agreement.

1.8. ***Covered Services*** means those services and items for which benefits are available and payable under the applicable Coverage Agreement and which are determined, if applicable, to be medically necessary under the applicable Coverage Agreement.

1.9. ***Participating Provider*** means, with respect to a particular Product, any physician, hospital, ancillary, or other health care provider that has contracted, directly or indirectly, with Company to provide Covered Services to Covered Persons, that has been approved for participation by Company, and that is designated by Company as a "participating provider" in such Product.

1.10. ***Payor*** means the entity (including Company where applicable) that bears direct financial responsibility for paying from its own funds, without reimbursement from another entity, the cost of Covered Services rendered to Covered Persons under a Coverage Agreement and, if such entity is not Company, such entity contracts, directly or indirectly, with Company for the provision of certain administrative or other services with respect to such Coverage Agreement.

1.11. ***Payor Contract*** means the contract with a Payor, pursuant to which Company furnishes administrative services or other services in support of the Coverage Agreements entered into, issued or agreed to by a Payor, which services may include access to one or more of Company's provider networks or vendor arrangements, except those excluded by Health Plan. The term "Payor Contract" includes Company's or other Payor's contract with a governmental authority (also referred to herein as a "***Governmental Contract***") under which Company or Payor arranges for the provision of Covered Services to Covered Persons.

1.12. ***Product*** means, with respect to Company, any program or health benefit arrangement designated as a "product" by Health Plan (e.g., MCO Product, Medicaid Product, PPO Product, Payor-specific Product, etc.) that is now or hereafter offered by or available from or through Company (and includes the Coverage Agreements that access, or are issued or entered into in connection with such product, except those excluded by Health Plan).

1.13. ***Product Attachment*** means an Attachment setting forth requirements, terms and conditions specific or applicable to one or more Products, including certain provisions that must be included in a vendor or provider agreement under the Regulatory Requirements, which may be alternatives to, or in addition to, the requirements, terms and conditions set forth in this Agreement or the Provider Manual.

1.14. ***Provider Manual*** means the "provider manual" and any billing manuals adopted by Company or Payor which include, without limitation, requirements relating to utilization management, quality management, grievances and appeals, and Product-specific, Payor-specific and State-specific requirements, as may be amended from time to time by Company or Payor.

1.15. ***Regulatory Requirements*** means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of Governmental Contracts and standards and requirements of any accrediting or certifying organization, including, but not limited to, the requirements set forth in a Product Attachment.

1.16. ***State*** is defined as the state identified in the applicable Attachment.

1.17 ***Adverse Incident*** means an injury of an enrollee occurring during delivery of Health Plan Covered Services that; (i) is associated in whole or in part with service provision rather than the condition for which such service provision occurred; and, (ii) is not consistent with or expected to be a consequence of service provision; or, (iii) occurs as a result of service provision to which the patient has not given informed consent; or (iv) occurs as a result of any other action or lack therof on the part of the staff of the provider.

1.18 ***Sentinel Event*** means an event that is not an Adverse Incident but is categorized as "Death", "media Event", or "Human Trafficking" that occurred related to an enrolled member.

1.19 ***Business Day*** means business days during a calendar year which exclude specified dates of closure for recognized holidays or unforeseen emergency closures.

1. SERVICES.

2.1 Description of Services. Vendor shall perform the services and provide all items to be delivered to Company or Payor, as applicable, if any ("***Deliverables***"), described in the Agreement with respect to those Products referenced in the Product Attachments attached at Exhibit D hereto. If there is a conflict or inconsistency between the terms of this Master Services Agreement and any Product Attachment, the terms of the Product Attachment will prevail.

2.2 Delegation of Administrative Services. As applicable, Health Plan hereby delegates to Vendor the responsibility to perform certain administrative services in connection with the provision of Services hereunder, subject to the continuing oversight of Company. The terms of this delegation, including a description of those Services

that constitute delegated administrative services to be provided by Vendor, are set forth in the Delegated Services Agreement attached to this Agreement as Exhibit E and incorporated herein by this reference. Company will retain all other functions not specified in this Vendor Agreement or Delegated Services Agreement.

2.3 Non-Exclusivity. Company retains the right at all times to negotiate terms and enter contracts with any other person or entity for services that are the same or similar to the Services without notice to Vendor and without incurring any liability by virtue thereof.

2.4 Place of Performance. Vendor shall not perform the Services or any portion thereof outside the United States, nor send or make available outside the United States any Confidential Information (defined below) of Company or any individually identifiable information.

2.5 Compliance with Policies. Vendor shall comply with all Company policies, procedures, and rules and regulations, as applicable, including but not limited to applicable Provider Manuals. Vendor shall be notified in writing of any changes in such Company policies, procedures and rules and regulations within a reasonable time frame but not less than at least thirty (30) days prior to the effective date of the change, or as soon as reasonably practicable in the event more expedient compliance is required by an applicable state or federal government agency. Company shall make the Provider Manual available to Vendor via one or more designated websites or alternative means. Upon Vendor's reasonable request, Health Plan shall provide Vendor with a copy of the Provider Manual. In the event of a material change to the Provider Manual, Company will use reasonable efforts to notify Vendor in advance of such change. Such notice may be given by Company through a periodic provider newsletter, an update to the on-line Provider Manual, or any other written method (electronic or paper).

2.6 New Products, Payors. Vendor acknowledges that at any time during the term of this Agreement, upon notice to Vendor: (i) Health Plan may add a Product Attachment; and (ii) Health Plan may add a new Payor for the purpose of accessing a Product Attachment.

2.7 Program Integrity Required Disclosures. Vendor agrees to furnish to Health Plan complete and accurate information necessary to permit it to comply with the collection of disclosures requirements specified in 42 C.F.R. Part 455 Subpart B or any other applicable State or federal requirements, within such time period as is necessary to permit Health Plan to comply with such requirements, which in no event shall be less than the response time defined by applicable regulations. Such requirements include but are not limited to: (i) 42 C.F.R. §455.105, relating to (a) the ownership of any subcontractor with whom Vendor has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request and (b) any significant business transaction between Vendor and any wholly owned supplier or subcontractor during the five (5) year period ending on the date of the request; (ii) 42 C.F.R. §455.104, relating to individuals or entities with an ownership or controlling interest in Vendor; and (iii) 42 C.F.R. §455.106, relating to individuals with an ownership or controlling interest in Vendor, or who are managing employees of Vendor, who have been convicted of a crime.

3. PAYMENT.

3.1. Fees. In full consideration for Vendor's performance of the Services in the Agreement, Payor shall pay the fees set forth in the Compensation section of this Agreement. Vendor is not entitled to any compensation or remuneration other than the Fees. Expenses incurred by Vendor in the provision of Services hereunder shall be the sole responsibility of Vendor and shall not be reimbursed hereunder.

3.1.1. Payment. In the event Company or Payor disputes the payment amounts in good faith, Company or Payor shall notify Vendor of the reasons therefor, and Vendor shall negotiate with Company or Payor in good faith to resolve such dispute as soon as practicable. If the dispute is not resolved within ninety (90) days after such notice of dispute, either Party may initiate Dispute Resolution, as set forth in Section 10 of this Agreement. Payor may withhold

from the payment any credits or other amounts Vendor is not entitled to or owes Payor in connection with this Agreement or any other agreement between Vendor and Payor or their respective Affiliates.

3.2. Taxes. Each Party will be responsible for its own income taxes, employment taxes, and property taxes. Vendor agrees to pay and hold Company or Payor harmless against any tax, penalty, interest or other charges that may be levied or assessed as a result of Vendor's performance of this Agreement.

3.3. Penalties. To the extent described in the Agreement, Company or Payor, as applicable, shall be entitled to payment of penalties and/or credits against Fees as a result of Vendor's failure to meet performance standards set forth in the Agreement, it's Attachments, and/or in the Delegated Services Agreement. If, due to noncompliance by Vendor or its contractor or Subcontractor with applicable Regulatory Requirements or this Agreement, sanctions or penalties are imposed on Company or Payor, Company or Payor may, in its sole discretion, offset such amounts against any amounts due Vendor or require Vendor to reimburse Company or Payor for such amounts. Company or Payor, as applicable, shall preserve any and all legal and contractual right to object to or protest the assessment of the sanctions or penalties, or the amount thereof, and shall make reasonable attempt to cooperate with Vendor to make such objections or protests on Vendor's behalf, or allow Vendor to proceed directly to make such objection or protests if permitted by the contract with the governmental entity.

3.4. Withhold or Off-Set. If Vendor is not in substantial compliance with any section of this Agreement, Company or Payor may withhold any amounts due to Vendor hereunder, or may off-set such amounts against any payment obligations due to Vendor hereunder, provided that: (i) Company first gives Vendor thirty (30) days written notice stating the basis for the proposed off-set and Vendor fails to cure the non-compliance or payment obligation defined within an action plan, and (2) Company or Payor shall repay all amounts withheld (less any actual damages incurred by Company or Payor as a result of any failure of performance by Vendor) promptly following any cure of non-compliance by Vendor.

3.5. Covered Person Hold Harmless. Vendor agrees that in no event, including but not limited to nonpayment by Payor, or Company's or Payor's insolvency or breach of this Agreement, shall Vendor bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Covered Person, or any person other than Company or Payor acting on such Covered Person's behalf, for Services provided under this Agreement. Vendor further agrees that: (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Covered Person, subscriber and enrollee; and (b) this provision supersedes any oral or written contrary agreement now existing or hereinafter entered into between Vendor and any Covered Person or any person acting on such Covered Person's behalf.

3.6. Recoupment Rights. Except as may otherwise be specifically provided in this Agreement or as may be separately agreed between parties, Payor or its delegate shall have the right to immediately recoup any and all amounts owed by Vendor to Payor due to overpayments, underpayments, or payments made in error. Vendor agrees that all recoupment and any offset rights pursuant to this Agreement shall be deemed to be and to constitute rights of recoupment authorized in State or federal law or in equity to the maximum extent possible under law, and that such rights shall not be subject to any requirement of prior or other approval from any court or other government authority that may now have or hereafter have jurisdiction over Vendor.

4. RECORDS AND AUDIT.

4.1. Records and Audit. Except as otherwise expressly provided in this Agreement, until the expiration of ten (10) years after the furnishing of Services hereunder, Vendor shall maintain complete and accurate records to validate and document Vendor's (i) compliance with this Agreement, (ii) performance of the Services, and (iii) Fees for Services and/or the Deliverables, all in accordance with generally accepted accounting principles consistently applied. Vendor will, upon written request, make available to Company and any governmental or regulatory authority and any of their duly authorized representatives, this Agreement and portions of all books, documents and records of

Vendor that are related to the provision of Services and necessary to verify the foregoing. Vendor shall provide reasonable assistance to Company or its designated agent to conduct such audits. Any such audit will be conducted upon reasonable notice and during regular business hours, and shall be at Company's expense, unless such audit reveals an overcharge of more than five percent (5%) for the audited Services and/or Fees, in which event Vendor shall reimburse Company the reasonable cost of that portion of the audit that revealed the overcharge. All overcharges revealed by any audit hereunder shall be promptly returned to Company. Notwithstanding anything herein to the contrary, any audit shall be subject to the following limitations: (i) use of any third party auditor that is a competitor of Vendor shall be subject to Vendor's prior written approval, such approval not to be unreasonably withheld or delayed; and (ii) Company or any auditor conducting any such audit shall at all times comply with any and all reasonable security and confidentiality guidelines and other policies of Vendor with respect to the audit.

4.2. Access. Vendor shall, upon requests which comply with procedural prerequisites, provide the Comptroller General of the United States, the Secretary of the United States Department of Health and Human Services, the State, the Centers for Medicare and Medicaid Services, the DOI, and their designees or duly authorized agents, access to this Agreement, and those books, documents, subcontracts, and records as are deemed necessary by Health Plan or government agents to verify the nature and extent of the costs of Medicaid or Medicare services, as applicable, provided to Covered Persons. Vendor shall notify Health Plan of any requests for access to information relating to Covered Persons, pursuant to a Medicaid or Medicare audit by any government agency, within twenty-four (24) hours of any government request and shall make available upon written request by Health Plan any and all relevant books, documents, subcontracts, and records relating to such Medicaid/Medicare information regarding Covered Persons for inspection and use by Health Plan. Vendor agrees to indemnify and hold harmless Health Plan and Payors against any and all liability, loss, damages, or expenses including, but not limited to, Medicaid or Medicare reimbursement losses, legal expenses, or costs for contracting with other service providers (in excess of the original contract) which Health Plan incurs as a result of Vendor's refusal to grant access to its books, documents, subcontracts, and records in accordance with the provisions of this Agreement. Vendor's refusal to grant access to any government agent's request for books, documents, subcontracts, or records shall constitute a material breach of this Agreement and may result in the immediate termination of this Agreement at Health Plan's discretion. In the event of such termination for cause, neither Vendor nor Vendor Provider will be entitled to any consequential, general, or specific costs, expenses, or damages of any kind.

4.3. On-Site Inspections. Vendor and Vendor Providers agree that their offices shall be maintained in accordance with the provisions of the Vendor provider manual and all applicable federal and State regulatory requirements. Upon reasonable notice and in accordance with Vendor's policies and procedures, Vendor and Vendor Providers shall cooperate in on-site inspections of their facilities, offices and records by Health Plan pursuant to Health Plan requirements or by authorized government officials, including, but not limited to, the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, the DOI, and applicable State or federal agency(ies) (and any of their external review agencies or evaluators) with jurisdiction over Health Plan and/or responsibility for the administration of a government-sponsored program, during normal business hours (defined as 8:00 am through 5:00 p.m., Monday through Friday, except State designated holidays). Vendor further agrees that, in such documents data or other information as required to evidence its compliance with this agreement or as otherwise required by the applicable regulatory body. Medical and other records, or copies thereof, shall be provided to Health Plan or applicable state or federal agencies, as requested, and in the formal requested, by Health Plan, for transfer for review by such agency and at the Vendor's expense.

5. PROJECT MANAGEMENT.

5.1. Vendor Project Personnel. Vendor shall staff each Project with sufficient qualified personnel to complete its obligations hereunder. The Agreement may describe additional qualifications and background screening requirements applicable to the Vendor personnel providing the Services within the Agreement. Vendor shall promptly replace any such individual upon Company's reasonable request and a stated lawful reason. Vendor shall not otherwise remove, replace or reassign any individuals identified in the Agreement as "Key Vendor Personnel" without prior notice to Company.

5.2. Anticipated Performance Deficiencies, Delays. If Vendor has failed or is likely to fail to provide the Services (including with respect to implementation Services) on time and in the manner required hereunder, Vendor shall, at Vendor's expense, take all commercially reasonable steps, which may include the provision of additional Vendor personnel, to meet the performance requirements herein, including applicable timelines. Vendor will inform Company as early as possible of any anticipated delays in the Services and of the actions being taken to ensure completion of the Services in accordance with this Agreement. At any time during the term of this Agreement, Vendor shall, upon request, provide Company with a status report regarding Vendor's progress toward meeting required timelines set forth in the Agreement.

5.3. Information Systems. Vendor shall maintain information data systems that meet the applicable requirements of any Payor Contract(s) and that interface with Company's information systems. This includes, if and as applicable, HIPAA transaction code set requirements for electronic health information data exchange, National Provider Identification requirements and Privacy and Security Rule Standards. Vendor shall notify Company immediately of any significant disruption in information and data systems immediately but in no event later than three (3) hours of Vendor's outage. "***Significant disruption***" is one that adversely affects Company's obligations to the State, and may include but is not limited to partial or total loss of electric power, telephonic functionality, or environmental controls in the building in which the information data systems are located. Vendor shall be responsible for the costs and expenses it incurs in relation to the establishment and maintenance of such interface.

6. WARRANTIES; COMPLIANCE WITH LAW.

6.1. Service and Performance Warranty. Vendor represents and warrants that it shall perform the Services in a timely, competent, workmanlike manner and in conformance with the requirements of this Agreement, and that all Deliverables will conform in all material respects to their documentation, functional specifications and requirements for the period of time commencing on the date the applicable Deliverable is first included in Company's production environment, and continuing through ninety (90) days following the date such Deliverable is first executed in Company's production environment, provided that in no event shall the warranty continue for a period of more than one (1) year (the "***Warranty Period***"). In the event the Services or Deliverables do not conform to this warranty, Vendor will, at no cost or expense to Company, promptly correct, re-perform and, as applicable, re-deliver the Services and Deliverables. Vendor represents and warrants that neither the Services nor any Deliverable will infringe a third party's patent or copyright, nor result from the misappropriation of a trade secret.

6.2. Mutual Warranties. Each Party represents and warrants to the other that: (i) it is validly existing under the laws of the state of its formation and has the full right, authority, capacity and ability to enter into this Agreement and to carry out its obligations hereunder; (ii) this Agreement is a legal and valid obligation binding upon it and enforceable according to its terms; and (iii) its execution, delivery and performance of this Agreement does not conflict with any agreement, instrument or understanding, oral or written, to which it is bound.

6.3. Compliance with Law. Vendor shall comply, and shall provide the Services in compliance with, all applicable Regulatory Requirements, including, if applicable and without limitation, HIPAA, the Foreign Corrupt Practices Act, and their related regulations. Vendor agrees to report any violation of Regulatory Requirements committed by Vendor, its employees or Subcontractors in the performance of the Services to Health Plan's Ethics Hotline at (888) 866-1366 or Health Plan's Ethics Officer at Health Plan's address for notices. Vendor shall comply with the terms of the Business Associate Agreement set forth at Exhibit to this Agreement. Vendor acknowledges and agrees that Vendor, its employees and Subcontractors are subject to, and shall comply with, the provisions set forth in any Product Attachment to this Agreement.

6.4. Program Exclusion. Vendor represents that Vendor and its affiliates (including, without limitation, any person controlling or under common control with Vendor or in which Vendor has a 5% or more ownership interest), and their respective employees, officers, directors, representatives, and Subcontractors providing Services

to Company under this Agreement have not been debarred, suspended or otherwise excluded from participating in: (i) procurement activities under the Federal Acquisition Regulation, or (ii) non-procurement activities under regulations or guidelines implementing or issued under Executive Order No. 12549. Vendor also represents that neither Vendor nor its affiliates, nor any of their respective employees, officers, directors representatives and Subcontractors providing Services to Company under this Agreement: (i) has been or is excluded from Medicare, Medicaid or another federal health care program participation under Sections 1128 or 1128A of the Social Security Act for, among other things, the provision of health care, utilization review, medical social work, or administrative services or who could be excluded under Section 1128(b)(8) of the Social Security Act as being controlled by a sanctioned individual, (ii) has been or is excluded, disqualified, debarred, suspended or proposed for debarment by the General Services Administration, the Department of Health and Human Services Office of the Inspector General, or other or successor federal or state agency from participation in federal or state health care programs or government procurement or non-procurement activities or programs, (iii) has been or is discharged or suspended from doing business with any state; (iv) has been convicted of certain crimes described in Section 1128(b)(8) of the Social Security Act or has a contractual relationship (direct or indirect) with an individual or entity that has been convicted of such crimes. Vendor shall notify Health Plan in writing immediately upon it having knowledge of any investigation, proposal, or action that may result in such an exclusion, disqualification, debarment or suspension of it or any of its affiliates or their respective employees, officers, directors, representatives, including any Subcontractors providing Services under this Agreement, and shall immediately cease using any such person in connection with this Agreement. Upon receipt of such notice or within a reasonable time thereafter, Health Plan may terminate this Agreement by giving written notice thereof to Vendor if Health Plan determines that such termination is necessary or appropriate in order to comply with applicable federal or state law.

7. INTELLECTUAL PROPERTY AND CONFIDENTIALITY.

7.1. Intellectual Property. Each Party shall retain exclusive ownership of all patents, patent applications, inventions, copyrights, trademarks, developments, data, processes, trade secrets, ideas, improvements and other intellectual property rights (hereinafter called "***Intellectual Property***") which were its property as of or prior to the date of this Agreement. Vendor agrees that all Deliverables, including all intermediate versions and all derivatives thereof, shall be owned exclusively by Company in any and all manner or media now known or hereafter devised in perpetuity. Such ownership shall inure to the benefit of Company from the date of creation, or fixation in a tangible medium of expression, as applicable. All Deliverables shall be considered a "work-made-for-hire" in favor of Company within the meaning of the Copyright Act of 1976, as amended. If and to the extent the Deliverables, or any part thereof, are found by a court of competent jurisdiction not to be a "work-made-for-hire" within the meaning of the Copyright Act of 1976, as amended, Vendor hereby expressly assigns to Company all exclusive right, title and interest in and to the copyright, patent, trademark, trade secret and all other proprietary rights in and to the Deliverables without further consideration, free from any claim, lien for balance due, or rights of retention thereto on the part of Vendor. Vendor agrees to execute all documents that Company reasonably requires to perfect such assignment, and, in the event that Vendor fails to execute such documents for any reason, Vendor hereby appoints Company as its attorney-in-fact for the sole purpose of executing such documents. Vendor shall require its employees and Subcontractors to execute all documents necessary (including without limitation documents similar to those required of Vendor in this paragraph) to enable Vendor to fulfill its obligations in this paragraph.

7.2. Electronic Data. Company exclusively owns all rights, title and interest in and/or to any and all electronic data and information submitted by or for Company to Vendor pursuant to this Agreement ("Electronic Data"). Electronic Data is deemed Confidential Information under the Agreement. Nothing in this Agreement provides Vendor with any rights or license to use such Electronic Data in any manner other than as specifically provided for in this Agreement.

7.3. Confidentiality.

7.3.1. Definition of Confidential Information. For the purposes of this Agreement, "***Confidential Information***" means any software, data, business, financial, pricing operational, customer, source code, methodologies, tools vendor or other information that is disclosed by Company or Vendor (the "Disclosing Party") to

the other (the "Receiving Party") and that is not generally known by or disclosed to the public. Confidential Information shall include any and all Personal Information, defined as any information that is or includes personally identifiable information, including but not limited to, name, address and any unique personal identification number. Notwithstanding anything herein to the contrary, Confidential Information shall not include information that is: (a) already known to or otherwise in the possession of a Receiving Party at the time of receipt from the Disclosing Party, provided such knowledge or possession was not the result of a violation of any obligation of confidentiality; (b) publicly available or otherwise in the public domain prior to disclosure by Disclosing Party or subsequently becomes publicly available through no fault of the Receiving Party; (c) rightfully obtained by a Receiving Party from any third party having a right to disclose such information without breach of any confidentiality obligation by such third party; or (d) developed by a Receiving Party independent of any disclosure hereunder.

7.3.2. Confidentiality Obligations. A Receiving Party shall maintain all of the Disclosing Party's Confidential Information in strict confidence and will protect such information with the same degree of care that the Receiving Party exercises with its own Confidential Information, but in no event less than a reasonable degree of care. If a Receiving Party suffers any unauthorized disclosure, loss of, or inability to account for the Confidential Information of the Disclosing Party, then the Receiving Party to whom such Confidential Information was disclosed shall promptly notify and reasonably cooperate with the Disclosing Party and take such actions as may be necessary or reasonably requested by the Disclosing Party to minimize the damage that may result therefrom. Except as provided in this Agreement, a Receiving Party shall not use or disclose (or allow the use or disclosure of) any Confidential Information of the Disclosing Party without the prior written consent of the Disclosing Party. If a Receiving Party is legally required to disclose the Confidential Information of the Disclosing Party, the Receiving Party required to disclose will, as soon as reasonably practicable, provide the Disclosing Party with written notice of the applicable order or subpoena creating the obligation to disclose so that the Disclosing Party may seek a protective order or other appropriate remedy. In any event, the Receiving Party subject to such disclosure obligation will only disclose that Confidential Information which the Receiving Party is advised by counsel as legally required to be disclosed. In addition, the Receiving Party will exercise reasonable efforts to obtain assurance that confidential treatment will be accorded to such Confidential Information. Access to and use of any Confidential Information shall be restricted to those employees and persons within a Receiving Party's organization who have a need to use the information to perform the Receiving Party's obligations or exercise the Receiving Party's rights under this Agreement and are subject to a contractual or other obligation to keep such information confidential. A Receiving Party's consultants and Subcontractors are included within the meaning of "persons within a Party's organization," provided such consultants and Subcontractors have executed confidentiality agreements with provisions no less stringent than those contained in this section. Such signed agreements shall be available to the Disclosing Party upon request. Additionally, a Receiving Party may, in response to a request, disclose Confidential Information to a regulator or other governmental entity with oversight authority over the Receiving Party or its affiliate, provided the Receiving Party (i) first informs the Disclosing Party of the request, and (ii) requests the recipient to keep such information confidential. In the event that the Receiving Party has reason to believe that the Confidential Information of the Disclosing Party that was disclosed to the Receiving Party has been used or disclosed in violation of this Agreement, the Receiving Party shall immediately notify the Disclosing Party.

7.3.3. Return of Confidential Information. All of a Disclosing Party's Confidential Information disclosed to the Receiving Party, and all copies thereof, are and shall remain the property of the Disclosing Party. All such Confidential Information and any and all copies and reproductions thereof shall, upon request of the Disclosing Party or the expiration or termination of this Agreement, be promptly returned to the Disclosing Party or destroyed (and removed from the Receiving Party's computer systems and electronic media) at the Disclosing Party's direction, except that to the extent any Confidential Information is contained in the Receiving Party's backup media, databases and email systems, then the Receiving Party shall continue to maintain the confidentiality of such information and shall destroy it as soon as practicable and, in any event, no later than required by the Receiving Party's record retention policy. In the event of any destruction hereunder, the Receiving Party who destroyed such Confidential Information shall, upon written request, provide to the Disclosing Party written certification of compliance therewith within fifteen (15) days after such request.

7.4. Security. Vendor shall take adequate physical, technical and administrative measures to safeguard Electronic Data (as defined in Section 7.2 herein) against unauthorized use, disclosure, access, acquisition, transfer or destruction. Vendor shall notify Company in accordance with the applicable notification requirements in the Business Associate Agreement regarding any accidental or unauthorized use, disclosure, access, acquisition, transfer or destruction of Electronic Data.

8. TERM AND TERMINATION.

8.1. Term. This Agreement shall commence on the Effective Date and continue until the anniversary of the Effective Date (the "***Initial Term***"). Thereafter, this Agreement will automatically renew for one (1) year periods (each, a "***Renewal Term***") unless either Party gives written notice of its intent not to renew this Agreement by providing at least one hundred twenty (120) days prior written notice to the other Party, or unless sooner terminated in accordance with this Section 8. The word "***Term***" shall mean any and all extensions and renewals of this Agreement.

8.2. Termination.

8.2.1. Without Cause. Either Party may terminate this Agreement after delivering written notice to the other Party at least one hundred and twenty (120) days prior to the effective date of any intended termination.

8.2.2. Termination by Health Plan. Health Plan may terminate this Agreement, or any Product Attachment for convenience without cost or penalty at any time upon one hundred and twenty (120) days advance written notice to Vendor. Health Plan may also terminate this Agreement if Vendor fails to cure a material breach of this Agreement within 30 days after receipt of written notice of such breach. In the event Health Plan terminates this Agreement for an uncured breach and it is later adjudicated that no breach occurred, Health Plan's notice of material breach shall be deemed to be a notice of termination for convenience.

8.2.3. Termination by Vendor. If Company or Payor fails to comply with the terms of this Agreement, within sixty (60) days after receipt of written notice of such breach, then Vendor may terminate this Agreement by sending written notice to Health Plan, in which event the Agreement shall terminate as of the date specified in the notice of termination.

8.3. Immediate Termination. Notwithstanding any other provision of this Agreement, Health Plan may terminate this Agreement or any Product Attachment immediately upon written notice to Vendor if: i) Vendor's provision of Services is reasonably determined by Company to violate any law or regulation; ii) Vendor or any of its agents or managing employees is convicted of a criminal offense related to that person's involvement in any program under Titles XVIII, XIX, XX, or XXI of the Social Security Act or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any program under Titles XVIII, XIX, XX or XXI of the Social Security Act; iii) an applicable governmental contract between Company and a governmental agency is terminated; iv) termination of Vendor is necessary for Company to maintain full compliance with Regulatory Requirements, an applicable governmental contract, or to maintain full compliance with all requirements communicated by a governmental agency with respect to the applicable governmental contract. Health Plan may in addition terminate this Agreement immediately if Company or an applicable governmental agency determines that the continued participation of Vendor under this Agreement poses an immediate threat or potential harm to Covered Persons (as such term is hereinafter defined)

8.4. Effect of Termination. Upon the termination or expiration of this Agreement, Vendor shall: (a) deliver to Company all Deliverables in whatever form or media they may then exist; (b) document the status of the Services that have been terminated and deliver such documentation to Company; (c) deliver to Company all fees paid by Company or Payor for Services and Deliverables that remain unperformed or undelivered as of the date of termination; (d) delivery to Company all Company property and materials that are in the possession of Vendor, its employees, Subcontractors and

agents; and (e) provide any transition assistance requested by Company in accordance with Section 8.5 (Transition Assistance). The termination or expiration of this Agreement for any reason shall not affect Company's or Vendor's rights or obligations for any Services or Deliverables completed and delivered to Company through the date of termination, and Company or Payor shall promptly pay all amounts (not otherwise disputed in good faith) owed to Vendor for such Services and Deliverables provided through the effective date of termination.

8.5. Transition Assistance. Upon Company's request during the Term (defined below) and at any time during the first six (6) months following the expiration or termination of this Agreement ("***Transition Period***"), Vendor shall make available to Company all Services and reasonable assistance necessary for an orderly transition of the Services (or any portion thereof) to Company or a replacement vendor designated by Company, including providing at no cost or expense all Company files in HTML format (or such other mutually agreed format) and all data and other property of Company that are in the possession of Vendor, its employees, agents and Subcontractors. Vendor shall use commercially reasonable efforts to provide transition assistance utilizing Vendor personnel then being regularly used to perform the components of the Services being transitioned. Vendor shall continue to perform all Services that are not transitioned in accordance with this Agreement.

8.6. Remedies. Notwithstanding anything in this Agreement to the contrary, where a breach of certain provisions of this Agreement may cause either Party irreparable injury or may be inadequately compensable in monetary damages, either Party may seek such equitable relief in addition to any other remedies which may be available. The rights and remedies of the Parties are not exclusive and are in addition to any other rights and remedies available at law or in equity.

8.7. Force Majeure. Neither Party will be liable for any default or delay in the performance of its obligations under this Agreement if and to the extent such default or delay is caused by an event (including fire, flood, terrorism, pestilence, earthquake, elements of nature or acts of God, riots, or civil disorders) beyond the reasonable control of such Party, provided (i) the non-performing Party is without fault in causing such default or delay, (ii) such default or delay could not have been prevented by reasonable precautions (including the implementation of, and adherence to, a prudent disaster recovery and business continuity plan), and (iii) such default or delay could not reasonably be circumvented by the non-performing Party through the use of alternate sources, workaround plans or other means.

9. INDEMNIFICATION.

9.1. Relating to Infringement.

9.1.1. Vendor agrees to defend, indemnify and hold harmless Company, Payor, and their respective affiliates, subsidiaries, officers, directors and employees (collectively, "***Health Plan Indemnitees***") from and against all damages, reasonable expenses, and liabilities, including, without limitation, reasonable attorneys' fees, arising out of any claim by a third party that the Deliverables or Services or any portion thereof, infringe or misappropriate any third party trade secret, patent, copyright, trademark or other proprietary or personal right of any person or entity. Health Plan (or its delegate) agrees to notify Vendor promptly in writing of any such claim and to cooperate with Vendor, at Vendor's expense, by providing such assistance as is reasonably necessary for the defense of a claim against the Health Plan Indemnitees. Vendor's obligation to defend, indemnify and hold the Health Plan Indemnitees harmless may be mitigated to the extent Vendor has been prejudiced by a failure of Health Plan to provide prompt notice and reasonable cooperation in the defense and settlement of such claims. Vendor's settlement of any claim shall require Health Plan's prior written approval, which shall not be unreasonably withheld.

9.1.2. If the use of any Deliverable or the Services is enjoined or threatened to be enjoined due to an alleged infringement or misappropriation, Vendor shall, at its discretion and expense, (i) procure the right for Company to continue using such Deliverable or Services, (ii) modify or replace the affected items with functionally equivalent or better items, or (iii) refund the amount paid by Company or Payor in connection with the affected Deliverables or Services.

9.1.3. Vendor shall have no obligations under this Section 9.1 or other liability for any infringement or misappropriation to the extent such infringement or misappropriation results from: (i) modifications made by Company or Payor, (ii) use of the Deliverables in a manner inconsistent with the terms of this Agreement.

9.2. Generally. Vendor shall indemnify and hold harmless (and at Health Plan's request defend) Company and Payor and all of their respective officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees) judgments or obligations arising from or relating to any negligence, wrongful act or omission, or breach of this Agreement by Vendor or any of its officers, directors, agents or employees. Health Plan agrees to indemnify and hold harmless (and at Vendor's request defend) Vendor and its officers, directors, agents and employees from and against any and all third party claims for any loss, damages, liability, costs, or expenses (including reasonable attorney's fees), judgments, or obligations arising from or relating to any negligence, wrongful act or omission or breach of this Agreement by Company or its directors, officers, agents or employees.

10. INSURANCE. Vendor shall maintain insurance coverage and satisfy the requirements in the Insurance Addendum attached hereto. If Vendor ceases operations or for any other reason terminates such insurance coverage, Vendor shall obtain coverage for an extended claims reporting period for claims made coverage for no less than two (2) years after the expiration or termination of this Agreement.

11. DISPUTE RESOLUTION. In the event of any Dispute between the parties relating to the provision of Services by Vendor arising out of, or relating to, this Agreement and/or any Attachment, the parties shall attempt to resolve the Dispute through good faith negotiations between designated representatives of the parties that have authority to settle the Dispute. If the matter has not been resolved within sixty (60) days of the request to commence good faith negotiations, either party wishing to pursue the dispute shall submit it to binding arbitration conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association ("***AAA***"). Notwithstanding the foregoing, in no event may any arbitration be initiated more than one (1) year following the sending of written notice of the dispute. Any arbitration proceeding under this Agreement shall be conducted in a location within the State that is agreed to by the Parties. The arbitrators shall have no right to award any punitive or exemplary damages or to vary or ignore the terms of this Agreement and shall be bound by controlling law. Each party shall bear its own costs related to the arbitration except that the costs imposed by the AAA shall be shared equally. The existence of a dispute or arbitration proceeding shall not in and of itself constitute cause for termination of this Agreement. Notwithstanding any dispute arising under this Agreement, each party hereto shall continue to perform its obligations hereunder pending the decision of the arbitrator. This provision shall survive any termination of this Agreement. The parties hereby consent to the jurisdiction of the courts in the applicable State and of the United States District Courts in the applicable State for injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding. Judgment on the award rendered may be entered in any court having jurisdiction thereof.

12. MISCELLANEOUS.

12.1. Use of Name; Publicity. Vendor agrees that Health Plan may use Vendor's and any Vendor Provider's name in Health Plan marketing, advertisement, and Covered Person information materials, including provider and related directories. Except for its internal business use, as required by Law or to comply with the request of a governmental entity, neither Party shall use the other Party's name, trademarks, service marks, logos or other identifiers (collectively, "***Trademarks***"), or make any reference to the other Party or its Trademarks in any manner including, without limitation, client lists and press releases, without the prior written approval of such other Party.

12.2. Notices. Unless otherwise provided herein, any notice, consent, request, or other communication to be given under this Agreement will be deemed to have been given by either Party to the other Party upon the date of receipt, if hand delivered, or two (2) business days after deposit in the U.S. mail if mailed to the other Party by registered or certified mail, properly addressed, postage prepaid, return receipt requested, or one (1) business day after deposit with a

national overnight courier for next business day delivery, or upon the date of electronic confirmation of receipt of a facsimile transmission if followed by the original copy mailed to the applicable Party at its address set below, or upon the date of transmission of electronic notice to an authorized email address with written confirmation of receipt. Either Party may change its address for notices effective three (3) business days after providing written notice to the other Party.

To Health Plan:	**To Vendor:**
Plan President	Shawna Novak
Sunshine State Health Plan, Inc.	Health and Human Services Director
_____	St. Johns County Board of County Commissioners
_____	200 San Sebastian View, Suite 2300
_____	St. Augustine, FL 32084
	snovak@sjcfl.us

12.3. Assignment. The duties and obligations of Vendor hereunder may not be delegated or assigned (in whole or in part) by Vendor without Health Plan's prior written consent. Any assignment or delegation made by Vendor without Health Plan's written consent is void. Health Plan shall have the right, exercisable in its sole discretion, to assign or transfer all or any portion of its rights or to delegate all or any portion of its interests under this Agreement or any Attachment to an Affiliate, successor of Health Plan, or purchaser of the assets or stock of Health Plan, or the line of business or business unit primarily responsible for carrying out Health Plan's obligations under this Agreement. The provisions of this Agreement are binding upon and inure to the benefit of the Parties and their respective permitted successors and assigns.

12.4. Amendments and Modifications. Except as otherwise provided in this Agreement, this Agreement may be amended only by written agreement of duly authorized representatives of the Parties. Health Plan may amend this Agreement by giving Vendor written notice of the amendment to the extent such amendment is deemed necessary or appropriate by Health Plan to comply with any Regulatory Requirements. Any such amendment will be deemed accepted by Vendor upon the giving of such notice. Health Plan may amend this Agreement by giving Vendor written notice (electronic or paper) of the proposed amendment. Unless Vendor notifies Health Plan in writing of its objection to such amendment during the thirty (30) day period following the giving of such notice by Health Plan, Vendor shall be deemed to have accepted the amendment. If Vendor objects to any proposed amendment to either the base agreement or any Attachment, Health Plan may exclude one or more of the Contracted Providers from being Participating Providers in the applicable Product (or any component program of, or Coverage Agreement in connection with, such Product). No terms or conditions related to the Services or Deliverables available via click-through or similar mechanism, in shrink-wrap or other Deliverable packaging, or described on Vendor's or a third party's website will be binding on Health Plan. The Parties agree that Company is authorized to submit copies of this Agreement and any and all amendments thereto to any regulatory agency for the purpose of obtaining necessary regulatory approvals or conducting other business of a regulatory nature.

12.5. Independent Contractor. Vendor is acting as an independent contractor in performing the Services hereunder. Nothing contained herein or done in pursuance of this Agreement shall constitute a joint venture or partnership and neither Party shall have the right to make any warranty or representation to such effect or to otherwise bind the other Party.

12.6. Subcontractors. Vendor may engage third parties to perform services under this Agreement ("***Subcontractors***") so long as Company approves such Subcontractor in writing in advance. Vendor will be responsible for the performance of any of Vendor's Subcontractors, all of whom shall comply with the applicable terms of this Agreement. Vendor will be responsible for the direction and coordination of the activities of any

Subcontractor in connection with this Agreement and will remain ultimately responsible for any Subcontractor's performance under this Agreement. Vendor will be solely responsible for the payment of its Subcontractors. Vendor shall ensure that any and all Subcontractors have insurance in the types and amounts set forth in the Insurance Addendum hereto. Any third parties or Subcontractors shall be required, pursuant to the Business Associate Agreement, to execute a business associate agreement or agent agreement binding the third party/Subcontractor to materially the same provisions as apply to Vendor under the Business Associate Agreement. Upon request, Vendor shall make available to Health Plan and to any applicable regulatory authority a copy of each of its Vendor Provider Subcontracts with Vendor Providers.

12.7. Nondiscrimination. Vendor acknowledges that this Agreement is subject to the affirmative action and nondiscrimination requirements of Executive Order 11246 as amended, Section 503 of the Rehabilitation Act of 1973, and Section 402 of the Vietnam Era Veterans' Readjustment Assistance Act of 1974, and with all rules, regulations, pertaining thereto, which are incorporated herein by specific reference.

12.8. Headings. Section headings are used for convenience only and shall in no way affect the construction or interpretation of this Agreement.

12.9. Counterparts; Time is of the Essence. This Agreement, and any Amendments thereto may be executed in counterparts and by facsimile or emailed PDF signature, all of which taken together constitute a single agreement between the Parties. Each signed counterpart, including a signed counterpart reproduced by reliable means (such as facsimile and emailed PDF), will be considered as legally effective as an original signature. The Parties acknowledge and agree that time is of the essence in this Agreement.

12.10. Survival. The following sections shall survive the expiration or termination of this Agreement: [Section 7.4 (Transition Services), Section 2 (Payment), Section 3.4 (Service Credits), Section 6.1 (Services and Performance Warranty) and Sections 7 to 11.]

12.11. Waiver and Severability. An individual waiver of a breach of any provision of this Agreement requires the consent of the Party whose rights are being waived and such waiver will not constitute a subsequent waiver of any other breach. If a court of competent jurisdiction declares any provision of this Agreement invalid or unenforceable, such judgment shall not invalidate or render unenforceable the remainder of the Agreement, provided the basic purposes of this Agreement are achieved through the provisions remaining herein.

12.12. Governing Law. This Agreement will be governed by and construed in accordance with the laws of the state of Company's incorporation, without regard to any conflict of law principles. Any suit or proceeding relating to this Agreement shall be brought only in the state or federal courts located in the State of Florida, and each Party hereby submits to the personal jurisdiction and venue of such courts.

12.13. Equal Opportunity. Vendor and its Subcontractors shall abide by the requirements of 41 CFR 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals on the basis of protected veteran status or disability, and require affirmative action by covered prime contractors and Subcontractors to employ and advance in employment qualified protected veterans and individuals with disabilities.

12.14. Conflicts of Interest. Vendor shall report to Health Plan any (i) transactions that Vendor engages in with any entity in which Vendor has a financial interest and that relates to Vendor's obligations under this Agreement, and (ii) any transactions that any contractor or Subcontractor of Vendor, or any immediate family member thereof, has with any entity in which such contractor or Subcontractor or immediate family member has a financial interest and that relates to such contractor's or Subcontractor's director indirect obligations under this Agreement.

12.15. Litigation Assistance. Vendor shall use commercially reasonable efforts to make itself and any Subcontractors, employees or agents assisting in the performance of its obligations under this Agreement, available to Company to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being

commenced against Company, its directors, officers or employees based upon claimed violation of contract or laws, each as related to this Agreement.

12.16. Entire Agreement. This Agreement, and all exhibits and addenda thereto are incorporated herein and constitute the entire agreement of the Parties. This Agreement supersedes all prior and contemporaneous negotiations, representations, promises, and agreements concerning the subject matter herein whether written or oral.

12.17. Rights and Obligations of Company. Vendor acknowledges that the rights and obligations of "Company" under this Agreement are references to the rights and obligations of each Company individually and not collectively. A Company is only responsible for performing its respective obligations hereunder with respect to a particular Product, Coverage Agreement, Payor Contract, Covered Service or Covered Person. A breach of default by an individual Company shall not constitute a breach or default by any other Company, including but not limited to Health Plan, and the exercise of any right under this Agreement by or as relating to a Company (including Health Plan) does not by operation of this Agreement constitute the exercise of such right by or relating to any other Company or other entity.

12.18. Disparagement Prohibition. Vendor and Company shall each not disparage the other during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Nothing in this Agreement should be construed as limiting the ability of either Company, Payor, or Vendor to inform Covered Persons that this Agreement has been terminated or otherwise expired or, with respect to Vendor, to promote Vendor to the general public or to post information regarding other health plans consistent with Vendor's usual procedures, provided that no such promotion or advertisement is specifically directed at one or more Covered Persons. In addition, nothing in this provision should be construed as limiting Company's ability to use and disclose information and data obtained from or about Vendor and/or its contractors and Subcontractors, including this Agreement, to the extent determined reasonably necessary or appropriate by Company in connection with its efforts to comply with Regulatory Requirements and to communicate with regulatory authorities.

12.19. Non-Solicitation. During the term of this Agreement, or any renewal thereof, and for a period of six (6) months from the date of termination, Vendor shall not, and shall ensure that its contractors and Subcontractors do not, advise, counsel or solicit any Covered Persons to end enrollment with Company, and will not solicit any Covered Persons to become enrolled with any other health maintenance organization, or other hospitalization or medical payment plan or insurance policy, for any reason. Vendor shall not, and shall ensure that its contractors and Subcontractors do not, interfere in any manner with Company's direct or indirect contractual relationships, including but not limited to those with Covered Persons or other vendors or Participating Providers. During the term of this Agreement and for a period of twelve (12) months following the expiration or termination hereof, regardless of the reasons for termination, neither Company (or its Affiliates) nor Vendor (or its affiliates) shall solicit for employment or hire for employment any employee of the other party (or its Affiliates) that has been involved directly in the implementation, operation, or administration of this Agreement. This provision shall not be construed to limit the Vendor from advising those Covered Persons for who they have guardianship responsibility as they deem appropriate in good faith in the best interest of the Covered Person. Vendor shall ensure such advisement is not based on financial or any other interests of Vendor.

12.20. Third Party Beneficiary. This Agreement is entered into by the Parties signing it for their benefit, as well as, in the case of Health Plan, the benefit of Company. Except as specifically provided in Section 3.4 hereof, no Covered Person or third party, other than Company, will be considered a third party beneficiary of this Agreement.

List of Attachments as of the Effective Date:

Insurance Addendum
Exhibit A – Compensation Schedule
Exhibit B – Reports

Exhibit C – Performance Standards
Exhibit D – Product Attachment
Exhibit E – Delegated Services Agreement
Exhibit F – Business Associate Agreement

The Parties agree that each of the above Attachments that is marked for inclusion in this Agreement and attached hereto is incorporated herein and binding upon them.

IN WITNESS WHEREOF, the Parties have caused this Agreement to be executed by their duly authorized representatives as of the Effective Date.

HEALTH PLAN

Sunshine State Health Plan, Inc.

By: _____
Print Name: _____
Title: _____
Date: _____

VENDOR

St. Johns County Board of County Commissioners

By: _____
Print Name: _____
Title: _____
Date: _____
Tax Identification Number: _____
NPI Number: _____

INSURANCE ADDENDUM

1.0 Prior to the commencement of work, Vendor shall deposit with Health Plan's designated representative evidence of insurance protection in the form of certificates (ACORD). All insurance policies maintained to provide the coverages required herein shall be issued by insurance companies authorized to do business in the state in which work is performed, and by companies rated, at a minimum, "A X" by A.M. Best. The amounts will not be less than those specified below:

Insurance Coverage	Limits of Liability
a. Workers Compensation	Statutory
b. Employers Liability	$1,000,000
c. General Liability -coverage	$1,000,000 per occurrence BI &PD/to be at least as broad as the current $2,000,000 aggregate ISO approved form
d. Professional Liability	$1,000,000 per claim/ $3,000,000 aggregate This coverage shall be maintained for a minimum of two (2) years following termination or completion of Vendor's work pursuant to the Agreement.
e. Automobile Liability – owned, hired and non-owned.	$1,000,000 Combined Single Limit
f. Privacy Liability and Network Security Insurance	$1,000,000 per occurrence/$3,000,000 aggregate. This coverage shall be maintained for a minimum of five (5) years following termination of Vendor's work pursuant to the Agreement.

2.0 Vendor agrees to waive any rights of subrogation that Vendor may have against Company under applicable insurance policies related to the work performed by Vendor. Indemnification by Vendor shall not be limited or reduced by any insurance coverage limitations. Centene Corporation and its affiliates and subsidiaries shall be named as an additional insured on all policies (excluding Workers Compensation) and evidenced on the certificate of insurance. All certificates of insurance shall provide that the insurer give thirty (30) days' written notice to Health Plan prior to the effective date of expiration, any material change or cancellation. Said notice shall be submitted to a Health Plan Strategic Sourcing representative.

3.0 Notwithstanding any insurance coverages of Vendor, nothing in this Insurance Addendum shall be deemed to limit or nullify Vendor's indemnification obligations under the Agreement. Vendor agrees that it shall work solely at Vendor's risk.

4.0 Vendor shall make certain that any and all Subcontractors hired by Vendor are insured in accordance with this Agreement. If any Subcontractor's coverage does not comply with the provisions herein, Vendor shall indemnify and hold Company (and if applicable, Payor) harmless of and from any and all damage, loss, cost or expense, including attorneys' fees, incurred by Company (and, if applicable, Payor) as a result thereof.

EXHIBIT A
COMPENSATION SCHEDULE

Monthly Payment. Effective as of the Effective Date of this Agreement, Health Plan will pay Vendor for Vendor's obligations under this Agreement. As compensation to Vendor for all of Vendor's obligations under this Agreement, Health Plan shall pay Vendor $8,000 ***("Payment")*** each month. Vendor agrees to accept the Payment as provided herein as payment in full under this Agreement.

Quality Incentive Program. Vendor agrees to participate in Health Plan pay-for-performance quality incentive program.

EXHIBIT B

REPORTS

The following are the reports that must be submitted by Vendor to Health Plan. The timeframes covered by the report and reports due dates are defined.

Report / Spec Name	File Name	Report Technology	Due Date to Health Plan	Notes
OPERATIONAL STANDARDS REPORTS				
Media Inquiry Notification	N/A	Email	Immediate Notification	Vendor to notify the Health Plan immediately of any media inquiry regarding services provided to a Covered Person as well as any media inquiry that can possibly have a negative impact on Vendor's perception of services, including services provided on behalf of another Health Plan.
Unaudited Financial Statements	[Vendor]_Unaudited_Finacial_Statements_[YYYYQ#]	PDF File	Quarterly, within 60 days of the quarter's end	Report showing Vendors unaudited financials for the previous quarter.
QUALITY REPORTS				
Critical Adverse Incident Report	Subject: PQI [Member initials]	Email	Per occurrence the same day critical incident is identified	Notification of adverse and critical incidents that negatively impact the health, safety or welfare of enrollees. Email occurrences to: SUN_PQOC@sunshine.health.com.
Adverse Incident and Sentinel Events Reporting	N/A	Email	Immediate Notification, no later than next business day	Vendor shall report all Adverse Incidents and Sentinel Events through the Health Plan designated process no later than the next business day from the Vendor becoming aware of the incident. These Adverse Incidents and Sentinel Events will be submitted in writing to Health Plan's Compliance Department utilizing a specified email address SUN_PQOC@sunshine.health.com.
Vendor Member Complaint Log	[Vendor]_Daily_Complaint_Report_[YYYYMMDD]	Excel File; provided in approved Health Plan format	Nightly before 10:30pm EST.	Same day summary of complaints, grievances, appeals from members, which should have also been warm transferred to the Health Plan
QFAAR Template (FWA)	[Vendor]_QFAAR_[YYYYQ#]	Excel File; provided in approved Health Plan format	Quarterly, by the 5th of the month following the quarter's end	Reporting all FWA related activities referred to the State and Federal Oversight agencies in accordance with applicable laws and contractual requirements, Health Plan Compliance-FWA in tandem with our Corp SIU, request your assistance in disseminating the attached templates to the appropriate parties within your organization. Of note – the "New Investigation" spreadsheet has been replaced with the "MPI Referral Checklist" at the request of OIG-MPI. Report all FWA activities reported during the quarter on template with updated investigative data.

Report / Spec Name	File Name	Report Technology	Due Date to Health Plan	Notes
MPI Referral Checklist (FWA)	[Subject: MPI Referral Checklist YYYMMDD	Word document; provided in approved Health Plan format	Ad hoc as suspected FWA is identified	FWA Referral Checklist on reporting monthly FWA activities. Please Note: This is sent with an email summary to the Plan (COMPLIANCEFL@CENTENE.COM) within ten (10) days of identifying a potential FWA related incident, following an initial investigation. Please note summary must cover all items on the checklist.
Quality of Service (QOS) and Isolated Incidents	[Vendor]_QOS_Report_Response_[REPORTING PERIOD MMDDYYYY-MMDDYYYY]	Excel File; provided in approved Health Plan format	Monthly, by the 5th	Vendor monthly responses to quality of service and isolated incident complaints that were not forwarded real time during the month.
CARE COORDINATION				
To Be Determined (TBD)	TBD	TBD	TBD	Health Plan reserves the right to require additional reports which will be incorporated here upon thirty (30) day's notice to Vendor.
AD HOC REPORTING				
Ad Hoc Reports	TBD	TBD	TBD	As requested - Ad hoc reports or data requests that are not listed in this Agreement or available as an existing (pre-programed) report through Vendor's system will be subject to mutually accepted delivery time. If report is a regulatory requirement, report will be developed at no additional cost to the Health Plan.

Additional provisions:

1. All reports must be submitted to the Health Plan's secured FTP site.
2. Vendor must demonstrate through the appropriate reports and documentation that the performance standards have been met.
3. Vendor is to supply all reports to Health Plan monthly, quarterly, and annually on or before the 15th of the following month, end of the quarter, or end of the year, unless listed otherwise in the agreement. Vendor shall not be penalized for failure to meet the reports submission deadlines due to problems with Health Plan's FTP site. If a report due date falls on a weekend or holiday, the report will be due the business day prior to the due date that falls on the weekend or holiday.
4. Sanctions based on a PMPM amount shall be calculated based on Health Plan's entire book of business. If metric falls into more than one category, penalties shall not be duplicative and shall only be assessed once based upon metrics of sub-category.
5. If a report is not submitted timely, accurately, completely, and/or doesn't meet the required metrics/target, a Root Cause Analysis (RCA) must be submitted with the report via FTP. An RCA documents what caused said issue and how it will be mitigated moving forward.

EXHIBIT C

PERFORMANCE STANDARDS

Metric Category	Metric Sub-Category	Measured variable	Measurement Tool; Frequency	Target	Penalty
Eligibility	N/A	Number of days for Vendor to load eligibility files from data of file receipt from Health Plan, using a term by absence methodology.	Vendor to report to Health Plan in mutually agreed upon format; monthly	2 business days	$0.02 PMPM each month eligibility is not loaded.
Potential Quality of Care (PQI) or Critical Incidents (CI)	The staff of Vendor must notify the Health Plan of a potential quality of care or critical incident	Ad Hoc	Report by end of business same day PQI or CI is identified.	$500 per late response	Potential Quality of Care (PQI) or Critical Incidents (CI)
Adverse Incident and Sentinel Events Reporting	Vendor shall report all Adverse Incidents and Sentinel Events through the Health Plan designated process.	Ad Hoc	Immediate Notification, no later than next business day	No later than the next business day from the Vendor becoming aware of the incident.	$1,000 per occurrence for Adverse Incidents not submitted or not submitted timely. Sentinel Event notifications are not subject to penalty.
State Requirements	N/A	No sanctions or penalties will be assessed by State on Health Plan as a result of acts or omissions of Vendor.	N/A	N/A	100% remuneration to Health Plan for any penalty or sanction assessed by state as a result of acts or omissions of Vendor less $1,000 that cannot be passed on to the Vendor.
Vendor Audit	N/A	Annual Vendor Compliance audit score	Annually	90% or greater	$5,000 penalty not subject to any Maximum that may be agreed to
Care Coordination	Vendor shall complete Health Risk Assessment's in accordance with Exhibit E-2.	Ad Hoc	In accordance with Exhibit E-2.	95% or greater	N/A
Care Coordination	Health Plan reserves the right to require additional Performance Standards which will be incorporated here upon thirty (30) days' notice to Vendor.	TBD	TBD	TBD	TBD
Contract Compliance	N/A	Vendor Agreement Compliance	N/A	100%	$1,000 per occurrence in the event of a breach of this Vendor Agreement or Regulatory requirements; Penalties specifically listed supersedes this penalty.

EXHIBIT D
PRODUCT ATTACHMENT

SUBCONTRACTOR PRODUCT ATTACHMENT

THIS SUBCONTRACTOR PRODUCT ATTACHMENT (this "***Attachment***") is made and entered between Sunshine State Health Plan, Inc. ("***Health Plan***") and St. Johns County Board of County Commissioners ("***Subcontractor***").

WHEREAS, Health Plan and Subcontractor entered into that certain services agreement, as the same may have been amended and supplemented from time to time (the "***Agreement***"), pursuant to which Subcontractor provides services in connection with Products offered by or available from or through Health Plan; and

WHEREAS, the Agreement is modified or supplemented as hereafter provided.

NOW THEREFORE, in consideration of the recitals, the mutual promises herein stated, the parties hereby agree to the provisions set forth below.

1. Defined Terms. All capitalized terms not specifically defined in this Attachment will have the meanings given to such terms in the Agreement.

1.1 "***State***" shall mean the State of Florida.

2. Product Participation.

2.1 Florida Medicaid. This Attachment addresses the participation of Subcontractor in the Florida Medicaid Product (the "***Medicaid Product***"). The Medicaid Product includes those programs and health benefit arrangements offered by Health Plan pursuant to a contract (the "***State Contract***") with the State of Florida Agency for Health Care Administration ("***AHCA***"), or any successor thereto, to provide specified services and goods to covered beneficiaries, and to meet certain performance standards while doing so. This Attachment addresses the participation of Subcontractor in the following Product: Medicaid Product (which is sometimes referred to in this Attachment as this "***Product***"). The term "***Medicaid Product***" refers collectively to those programs and health benefit arrangements offered by Health Plan or another Company (each such program or arrangement a "***Medicaid Product Type***") that is administered, sponsored or regulated by the federal government (or any agency, department or division thereof), on its own or jointly with a State that administers or regulates such program or plan, and which for the purposes of Subcontractor may include one or more of the following: Managed Medical Assistance ("***Medicaid***"); a Child Welfare Specialty Plan ("***Child Welfare Plan***"); a Serious Mental Illness Specialty Plan ("***SMI Plan***"); the Children's Medical Services Managed Care Plan ("***CMS Plan***"); Long Term Care ("***Long Term Care***"); and/or other Medicaid Product Types. The Medicaid Product includes those Coverage Agreements entered into, issued or agreed to by a Payor under which a Company furnishes administrative services or other services in support of the Medicaid Product or a Medicaid Product Type. The Medicaid Product does not apply to any Coverage Agreements that are specifically covered by another Product Attachment to the Agreement. This Attachment applies only to the provision of health care services, supplies or accommodations (including Covered Services) to Covered Persons enrolled in the Medicaid Product (including one or more Medicaid Product Types).

2.2 Attachment. This Attachment constitutes the Subcontractor Product Attachment and Compensation Schedule for the Medicaid Product.

2.3 Construction. Except as expressly provided herein, the terms and conditions of the Agreement will remain unchanged and in full force and effect. In the event of a conflict between the provisions of the Agreement and the provisions of this Attachment, this Attachment will govern with respect to the services, supplies

or accommodations (including Covered Services) rendered to Health Plan with respect to the Medicaid Product or Covered Persons enrolled in the Medicaid Product. To the extent Subcontractor is unclear about its respective duties and obligations, Subcontractor shall request clarification from Health Plan. To the extent any provision of the Agreement (including any exhibit, attachment, or other document referenced herein) is inconsistent with or contrary to any provision of the State Contract, the relevant provision of the State Contract shall have priority and control over the matter.

3. Term. This Attachment will become effective as of the Effective Date, and will be coterminous with the Agreement unless a party terminates the participation of the Subcontractor in the Medicaid Product in accordance with the applicable provisions of the Agreement or this Attachment.

4. State Contract Requirements. Schedule A to this Attachment, which is incorporated herein by this reference, sets forth the special provisions that are applicable to the Medicaid Product under the State Contract.

5. Compensation Schedule. This Section sets forth or describes the Compensation Schedule applicable to the Medicaid Product.

5.1 Schedule. The Compensation Schedule for the Medicaid Product is set forth on Schedule B of this Attachment, which is incorporated herein by this reference.

5.2 Other Terms and Conditions. Except as modified or supplemented by this Attachment, the compensation hereunder for the provision of services with respect to the Medicaid Product is subject to all of the other provisions in the Agreement (including any documents incorporated therein) that affect or relate to compensation for the services.

SCHEDULE A
STATE CONTRACT REQUIREMENTS

This Schedule sets forth the special provisions that are specific to the Florida Medicaid Product under the State Contract.

1. Definitions. For purposes of this Schedule A, the following terms have the meanings set forth below. Terms used in this Schedule A and not defined in this Attachment or in the Agreement have the meaning set forth in the State Contract.

a. "AHCA" means the Florida Agency for Health Care Administration.

b. "DHHS" means the U.S. Department of Health and Human Services.

c. "Children's Medical Services Managed Care Plan" means a specialty plan for children with chronic conditions operated by the Florida Department of Health's Division of Children's Medical Services as specified in section 409.974(4), Florida Statutes. The Children's Medical Services Managed Care Plan may also be referred to herein as the "CMS Plan".

d. "MLTC" means the Managed Long Term Care Product under the Florida Statewide Medicaid Managed Care Product.

e. "MMA" means the Managed Medical Assistance Product under the Florida Statewide Medicaid Managed Care program.

f. "Medicaid Covered Person" or "Covered Person" means an individual enrolled in the Health Plan.

g. "Subcontractor" means any entity contracting with Health Plan to perform services or to fulfil any of the requirements requested in the Agreement or any entity that is a subsidiary of the Health Plan that performs services or fulfills requirements requested in the Agreement.

2. Any rights or obligations under this Attachment that pertain to AHCA for the SMMC Products shall be deemed to include, in addition to AHCA, all Governmental Authorities such as the Florida Department of Health and the CMS Plan, to the extent necessary to comply with the State Contract.

3. All provisions of the Agreement and this Attachment are cumulative. All provisions shall be given effect when possible. If there is inconsistent or contrary language between this Attachment and any other part of the Agreement, the provisions of this Attachment shall prevail with respect to the Services described in this Agreement. Subcontractor agrees to include the terms contained in the Attachment in its contracts with Subcontractors. Any obligation of the Health Plan in this Attachment shall apply to Subcontractors to the same extent that it applies to Subcontractor.

4. Subcontractor Provisions. Health Plan shall be responsible for all work performed under this Agreement and will obtain the prior written approval of AHCA to delegate performance of work required under this Agreement to Subcontractor. The Health Plan shall submit all subcontracts for AHCA review to determine compliance with State Contract requirements for subcontracts. If AHCA determines, at any time that a subcontract is not in compliance with the contract requirements, the Subcontractor shall promptly revise the subcontract to bring it into compliance. Subcontractor understands that if the submission to the Agency by Health Plan is for the management of covered services, the Health Plan is required to include the following:

a. subcontract which complies with subcontract requirements specified in AHCA Standard Contract, 42 CFR 438.230(c)(1)(i), and 42 CFR 438.3(k);
b. If applicable to the services, test PNV file as proof of network adequacy;
c. If applicable, a copy of applicable licensure;
d. If applicable to the services, the enrollee materials;
e. If applicable to the services, the population covered by the subcontract;
f. If applicable, provider/Subcontractor materials;
g. Model Agreement template as specified in Section VIII; and
h. If applicable, approximate number of impacted enrollees.

5. Contract Compliance. If AHCA determines, at any time, that a Subcontractor or the Agreement is not in compliance with the requirements of the State Contract, the Subcontractor shall agree to an amendment that revises the Agreement such that it complies with the State Contract, or undertake such other actions as may be required by AHCA. In addition, Subcontractor shall reimburse the Health Plan for any sanctions or liquidated damages to the extent such sanctions or liquidated damages are imposed on the Health Plan pursuant to Section XI, Sanctions and Section XIII, Liquidated Damages, of the State Contract, respectively, as a result of Subcontractor's acts or omissions.

6. Delegated Activities. Subcontractor agrees to perform the delegated activities and reporting responsibilities specified in compliance with Section XVI., Reporting Requirements, and the State Medicaid Managed Care Program Report Guide. Subcontractor shall not further delegate or sub-delegate any administrative services or activities delegated by Health Plan to Subcontractor unless set forth in the Agreement. If Subcontractor is permitted to subcontract or delegate its obligations under the Agreement, such subcontract or delegation shall be subject to the State Contract in all respects.

7. Insolvency or Bankruptcy. The Health Plan shall immediately advise AHCA of the insolvency of a Subcontractor or of the filing of a petition in bankruptcy by or against a principal Subcontractor.

8. Contingency Plan. The Subcontractor acknowledges that Health Plan is required to have a contingency plan for each Subcontractor to provide for continuity of care should the Subcontractor cease to provide services. Subcontractor will cooperate with the Health Plan as reasonably requested to develop and maintain this plan.

9. Network Management. The Health Plan shall not delegate provider network management to a Subcontractor that meets both of the following:

a. The Subcontractor is owner or has controlling interest in any provider(s) included in the network; and

b. The Subcontractor limits enrollee choice of network providers through a requirement for a referral/authorization process to access network providers.

10. Signature Required. All model and executed subcontracts and amendments used by the Health Plan under this contract shall be in writing, signed, and dated by the Health Plan.

11. Audit and Inspection.

a. Provide that AHCA, CMS, the DHHS Inspector General, the Comptroller General or their designees, and DHHS have the right to audit, evaluate, or inspect the Subcontractor's premises, physical facilities, equipment, books, records, contracts, computer, or other electronic systems of the Subcontractor, or of the Subcontractor's Subcontractor, pertaining to any aspect of services and activities performed, or determination of amounts payable under the Health Plan's Contract with the State. In accordance with 42 CFR 438.230(c)(3)(iii), the Subcontractor shall agree that the right to audit exists through 10 years from the final date of this Contract period or from the date of completion of any audit, whichever is later.

b. The Subcontractor shall make available for purposes of an audit, evaluation, or inspection its premises, physical facilities, equipment, books, records, contracts, computers, or other electronic systems relating to its Medicaid Covered Persons pertinent to the Agreement by AHCA, CMS, the DHHS, Inspector General, the Comptroller General or their designees, and DHHS; (42 CFR 438.3(h); s. 1903(m)(2)(A)(iv) of the Social Security Act.

c. Subcontractor shall give its full cooperation in any investigation by AHCA, MFCU, CMS, the DHHS Inspector General, the Comptroller General, or their designees, DOEA or other State or federal entity or any subsequent legal action that may results from such an investigation.

12. Compliance with Laws. Subcontractor and Health Plan agree to the extent applicable to comply with 42 CFR § 438.230, 42 CFR 438.3(k), 42 CFR § 455.104, 42 CFR § 455.105 and 42 CFR § 455.106 and all applicable Medicaid laws and regulations, including applicable sub-regulatory guidance and State Contract provisions, and any other applicable state or federal law.

13. Performance. No subcontract that Health Plan enters into with respect to performance under the State Contract shall, in any way, relieve Health Plan of any responsibility for the performance of duties under the State Contract. Health Plan shall assure that all tasks related to the subcontract are performed in accordance with the terms of the State Contract and shall provide AHCA with its monitoring schedule annually by December 1 of each year of the State Contract. Health Plan shall identify in its subcontracts any aspect of service that may be further subcontracted by Subcontractor.

14. Eligibility. Subcontractor must be eligible for participation in the Florida Medicaid program; however, Subcontractor is not required to participate in the Florida Medicaid Product as a provider.

15. Involuntary Termination from Medicaid. If Subcontractor was involuntarily terminated from the Florida Medicaid program other than for purposes of inactivity, Subcontractor is not considered an eligible Subcontractor.

16. Payments. Health Plan agrees to make payment to all Subcontractors in accordance with all state and federal laws, rules and regulations, including s. 409.967, Fla. Statutes; s. 409.975(6), Fla. Statutes; s. 409.982, Fla. Statutes; s. 641.3155, Fla. Statutes; 42 CFR 238.230; 42 CFR § 447.46 and 42 CFR §§ 447.45(d)(2), (3), (d)(5) and (d)(6), in addition to sub-regulatory guidance and the provisions of this . Contract, and shall meet the following requirements:

a. The conditions and method of payment are as indicated in the Agreement.

b. Subcontractor agrees to promptly submit all information required by Health Plan to make payment.

c. Provide for full disclosure of the method and amount of compensation or other consideration to be received from the Health Plan are indicated in the Agreement.

d. Require any claims processing vendors to maintain accurate Covered Person and provider information, including agreements reflecting the correct reimbursement rate and provider specialty, to ensure the correct adjudication of claims and proper payment to providers.

e. Subcontractor agrees to maintain an adequate record system for recording services, charges, dates and all other commonly accepted information elements for services rendered to Health Plan.

f. Require any payment to a provider be accompanied by an itemized accounting of the individual claims included in the payment, including but not limited to the Covered Person's name, the date of services, the procedure code, service units, the amount of reimbursement, and the identification of the Health Plan.

g. The Managed Care Plan shall assume responsibility for cost avoidance measures for third party collections in accordance Section XII., Financial Requirements.

17. Cost Avoidance. Health Plan agrees that it shall assume responsibility for cost avoidance measures for third party collections in accordance with Section XII, Financial Requirements in the State Contract.

18. Record Retention. In addition to record retention requirements for practitioner or provider licensure, requires Subcontractors shall retain, as applicable, the following information in accordance with 42 CFR 438.3(u): enrollee grievance and appeal records in 42 CFR 438.416; base data in 42 CFR 438.5(c); MLR reports in 42 CFR 438.8(k); and the data, information, and documentation specified in 42 CFR 438.604, 42 CFR 438.606, 42 CFR 438.608, and 42 CFR 438.610 for a period of not less than 10 years from the close of the State Contract and retained further if the records are under review or audit until the review or audit is complete. Subcontractor shall request and obtain prior approval for the disposition of records from Health Plan if the Agreement is continuous.

19. Monitoring. Subcontractor agrees that Health Plan may monitor all services provided by Subcontractor to Health Plan's Covered Persons.

20. Safeguarding. Subcontractor shall safeguard Covered Person information in accordance with 42 CFR § 438.224.

21. Exculpatory Clause. Subcontractor agrees that neither AHCA nor any Covered Person will be held liable for the debts of Subcontractor. This subsection shall survive any termination of this Agreement, regardless of the cause, including without limitation insolvency.

22. Indemnification. Subcontractor agrees to indemnify and hold harmless AHCA, its designees and Health Plan's Covered Persons from and against all claims, damages, causes of action, costs or expenses, including court costs and reasonable attorney fees to the extent proximately caused by any negligent act or other wrongful conduct arising from the Agreement. This subsection shall survive termination of the Agreement, including breach due to insolvency. AHCA may waive this requirement for itself, but not Covered Persons, for damages in excess of the statutory cap on

damages for public entities, if Subcontractor is a state agency or subdivision as defined by s. 768.28, Fla. Statutes, or a public health entity with statutory immunity. All such waivers must be approved and in writing by AHCA.

23. Insurance. Subcontractor agrees to secure and maintain during the life of the Agreement worker's compensation insurance (complying with Florida's Worker's Compensation Law) for all of its employees connected with the work under this Agreement unless such employees are covered by protection afforded by Health Plan. Such insurance shall comply with Florida's Workers' Compensation Law.

24. Waivers. Health Plan and Subcontractor agree to waive any provisions in the Agreement that, as they pertain to Covered Persons, that are in conflict with the specification of the State Contract.

25. Revocation and Sanctions. Subcontractor agrees that Health Plan shall have the right to revoke delegation of any function delegated to Subcontractor and/or impose other sanctions if Health Plan determines that Subcontractor's performance is inadequate.

26. Utilization Management. Health Plan and Subcontractor agree that compensation to individuals or entities that conduct utilization management activities is not structured so as to provide incentives for the individual or entity to deny, limit or discontinue medically necessary covered services to a Covered Person. (42 CFR 438.210(e)).

27. False Claims Act. The following information on the False Claims Act (31 U.S.C. §§ 3729 — 3733) is provided pursuant to section 6032 of the Deficit Reduction Act of 2005 and 42 CFR 438.608(a)(6); s. 1902(a)(68) of the Social Security Act:

a. The Federal False Claims Act imposes liability on any person or entity who knowingly files a false or fraudulent claim; or uses a false record or statement to obtain payment on a false or fraudulent claim from Medicare, Medicaid or other federally funded health care program. "Knowingly" means having actual knowledge that the information on the claim is false; or acting in deliberate ignorance or reckless disregard of whether the claim is true or false.

b. A person or entity found liable under the False Claims Act is, generally, subject to civil money penalties and three times the amount of damages that the government sustained because of the illegal act.

c. Under the False Claims Act individuals with knowledge of potential violations may file suit on behalf of the government in federal court. These individuals may be entitled to a percentage of the amount recovered by the government. An individual who brings action under the False Claims Act is called a qui tam relator or whistleblower. Federal law prohibits employers from retaliating against employees who file suits on behalf of the government under the False Claims Act.

d. The False Claims Act creates a system for preventing and detecting fraud, waste and abuse in federal and state health care programs by providing governmental agencies with the appropriate authority and mechanisms to investigate and punish fraudulent activity. Health Plan and Subcontractor shall be dedicated to detection and prevention of false claims.

28. Termination of Contract. Health Plan shall notify Subcontractor, AHCA and Covered Persons at least 60 calendar days prior to the effective date of the termination of Subcontractor. Health Plan shall provide AHCA the reasons for the termination if for cause and shall notify Covered Persons in accordance with the provisions of the State Contract. If the Agreement provides for termination without cause, Health Plan shall provide 60 calendar days, or if longer the time period set forth in the Agreement, advance written notice to Subcontractor and AHCA. Subcontractor shall provide Health Plan advance written notice of cancellation of a subcontract the longer of (i) 90 calendar days prior to the effective date or (ii) the time set forth in the Agreement.

29. Background Check and Screening. Subcontractor agrees that it is subject to a background check, the extent of which is dependent on the nature of the administrative services that Subcontractor will perform as a Subcontractor; in accordance with s. 408.809, F.S.

30. Minority Business. Health Plan and AHCA encourage use of minority business enterprise Subcontractors. See Section VI.0 of the State Contract for provisions and requirements specific to provider contracts and for other minority recruitment and retention requirements.

31. Maintaining Books and Records. Subcontractor shall:

a. Maintain books, records and documents• (including electronic storage media) pertinent to performance under the Agreement in accordance with generally accepted accounting procedures and practices which sufficiently and properly reflect all revenues and expenditures of funds provided under this Agreement.
b. Assure that the records shall be subject at all reasonable times to inspection, review or audit by state personnel and other personnel duly authorized by AHCA, as well as federal personnel.
c. Maintain and file with AHCA such progress, fiscal and inventory reports as specified in the State Contract and other reports as AHCA may require within the period of the State Contract. In addition, access to relevant computer data and applications which generated such reports should be made available upon request.
d. Subcontractor shall comply with public record laws as outlined in Section 119.0701, Florida Statutes.
e. The audit and record keeping requirements of this section shall be in all approved subcontracts and assignments.

33. Civil Rights Requirements. Subcontractor agrees to comply with the following:

a. Title VI of the Civil Rights Act of 1964, as amended, 42 USC 2000d et seq.; which prohibits discrimination on the basis of race, color, or national origin.
b. Section 504 of the Rehabilitation Act of 1973, as amended, 29 USC 794, which prohibits discrimination on the basis of handicap.
c. Title IX of the Education Amendments of 1972, as amended, 20 USC 1681 et seq. which prohibits discrimination on the basis of sex.
d. The Age Discrimination Act of 1975, as amended, 42 USC 6101 et seq., which prohibits discrimination on the basis of age.
e. Section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended, 42 USC 9849, which prohibits discrimination on the basis of race, creed, color, national origin, sex, handicap, political affiliation or beliefs.
f. The Americans with Disabilities Act of 1990, P.L. 101-336, which prohibits discrimination on the basis of disability and requires reasonable accommodation for persons with disabilities.
g. All regulations, guidelines, and standards as are now or may be lawfully adopted under or by the above statutes.

34. Compliance with Immigration and Nationality. Subcontractor shall comply with Section 274A(e) of the Immigration and Nationality Act. The employment of unauthorized aliens is a violation of the Act. If Subcontractor knowingly employs unauthorized aliens, such violation shall be cause for unilateral cancellation of the Agreement by Health Plan. Subcontractor shall be responsible for including this provision in all subcontracts with private organizations.]

35. E-Verify. The Immigration Reform and Control Act of 1986 and Section 448.095, Florida Statutes, prohibit employers from knowingly hiring unauthorized alien workers. Subcontractor shall only employ individuals who may legally work in the United States-either U.S. citizens or foreign citizens who are authorized to work in the U.S. Subcontractor shall use the U.S. Department of Homeland Security's E-Verify Employment Eligibility Verification

system, https://e-verify.uscis.gov/emp, to verify the employment status of all new employees hired by Subcontractor during the term of the State Contract and shall also include a requirement in its subcontracts that the Subcontractor utilize the E-verify system to verify the employment eligibility of all new employees hired by the Subcontractor performing work or providing services pursuant to the State Contract. The Subcontractor must provide the Health Plan with an affidavit stating that the Subcontractor does not employ, contract with, or subcontract with an unauthorized alien worker. The Health Plan will maintain a copy of Subcontractor's affidavit for the duration of the Contract. If Health Plan has a good faith belief that Subcontractor knowingly violated Section 448.095, Florida Statutes, and notifies the Subcontractor of such good faith belief, but the Subcontractor otherwise complied with the statute, the Subcontractor must immediately terminate the contract with the unauthorized alien worker.

36. Credentialing. Provide for monitoring and oversight by the Health Plan and the Subcontractor to provide assurance that all licensed medical professionals are credentialed in accordance with the Health Plan's and AHCA's credentialing requirements as found in Section VIII. Provider Services, if the Health Plan has delegated the credentialing to a Subcontractor.

37. Claims Processing. If the Health Plan delegates claims processing and payment or enters into a risk-bearing contract, the Subcontractor agrees to:

a. Submit to Health Plan quarterly unaudited financial statements within 60 days of end of the quarter and submit annual audited financial statement within 120 days of the end of the year.

b. Maintain an insolvency account to meets its obligations. The insolvency account shall be funded in an amount equal to two percent (2%) of the annual contract value. In the event subcontractor has filed for bankruptcy or has otherwise been determined to be insolvent by a regulating entity, the insolvency account may be drawn upon solely by Health Plan to disburse funds to meet Medicaid financial obligations incurred by the Subcontractor under the Agreement between Health Plan and Subcontractor. Documentation of the insolvency account, including account balances and governing agreements, shall be provided to AHCA upon request.

38. Solvency Requirements. Subcontractor shall establish, enforce, and monitor solvency requirements that provide assurance of the Subcontractor's ability to meet its obligations.

39. Directory Information. Subcontractor shall timely notify the Health Plan of changes in directory information.

40. Overpayments. Health Plan subcontracts with providers shall ensure that providers are obligated to cooperate with recovery efforts, including participating in audits and repay overpayments.

41. Claims Adjudication. All subcontracts for claims adjudication activities shall comply with 42 CFR 438.8(k)(3).

42. Termination Procedures. In accordance with the requirements of the Standard Contract, Section III., B., Termination, all provider agreements and subcontracts shall contain termination procedures.

43. Notice of Termination. All subcontracts shall require Subcontractors to submit notice of termination at least ninety (90) days before the effective date of such withdrawal.

44. Marketing. Subcontractor shall comply with the marketing requirements specified in Section W., Marketing.

45. Encounter Data. All model and executed subcontracts and amendments used by the Health Plan under this Contract shall require Subcontractors to submit timely, complete and accurate encounter data to the Health Plan in accordance with the requirements of Section X.D., Information Management Systems.

46. Excluded Parties. Subcontractor ensures that it has not been excluded from or ineligible for participation in (or on any exclusion list for) any state or federal health care program and does not employ or contract with individuals or

entities that are excluded form or ineligible for participation in (or on any exclusion list for) any state or federal health care program.

47. Ownership and Management Disclosure. Subcontractor shall comply with the ownership disclosure in accordance with 42 CFR 438.608(c).

48. Cooperation. Subcontractor shall fully cooperate in any investigation by Health Plan, AHCA, Medicaid Fraud Control Unit, CMS, the United States Department of Health and Human Services Inspector General, the Comptroller General, or their designees, Department of Elder Affairs, or other state or federal entity or any subsequent legal action that may result from such an investigation. In accordance with 20.055 F.S., Subcontractor shall cooperate with the OIG in any investigation, audit, inspection, review or hearing; and shall grant access to any records, data or other information the OIG deems necessary to carry out its official duties.

49. Confidentiality. In accordance with 42 CFR 438.224, Subcontractor shall comply with the privacy and security provisions of the Health Insurance Portability and Accountability Act of 1996. Subcontractor is held to the same confidentiality requirements as the Health Plan.

50. Breach of Personal Information. Subcontractor shall comply with the requirements of 501.171 F.S. and shall, in addition to the reporting requirements therein, report to AHCA any breach of personal information.

51. Behavioral Health. Subcontractor will comply with 42 CFR Section 438.3(n) with respect to functions relating to behavioral health services.

52. Contingency Plan. Subcontractor acknowledges that Health Plan is required to have a contingency plan for each Subcontractor to provide for continuity of care should the Subcontractor cease to provide services. Subcontractor will cooperate with the Health Plan as reasonably requested to develop and maintain this plan.

53. Electronic Communications. Subcontractor shall comply with state and federal law governing the monitoring, interception, recording, use or disclosure of wire, oral or electronic communications, including but not limited to the Florida Security of Communications Act, Sections 934.01, et seq., F.S. and the Electronic Communications Privacy Act, 18 USC 2510 et seq.

54. Compliance Reviews by AHCA. Subcontractor agrees to the following:

a. AHCA may conduct or have conducted, performance and/or compliance reviews, reviews of specific records or other data as determined by AHCA. AHCA may conduct a review of a sample of analyses performed by the Subcontractor to verify the quality of the Subcontractor's analyses. Reasonable notice shall be provided for reviews conducted at the Subcontractor's place of business.

b. Reviews may include, but shall not be limited to, reviews of procedures, computer systems, recipient records, accounting records, and internal quality control reviews. The Subcontractor shall work with any reviewing entity selected by AHCA.

c. During the State Contract, these records shall be available at the Subcontractor's office at all reasonable times. After the State Contract period and for 10 years following, the records shall be available at the Subcontractor's chosen location subject to the approval of AHCA. If the records need to be sent to AHCA, Subcontractor shall bear the expense of delivery. Prior approval of the disposition of the Subcontractor and its subcontractor records must be requested and approved by AHCA. This obligation survives termination of the State Contract.

d. Subcontractor shall comply with all applicable federal requirements pertaining to procurement, including but not limited to Chapter 2 of the CFR and any other final or interim rules with respect to audit requirements of Federal contracts administered through states and local public agencies.

55. Reporting Concerns. Subcontractor shall report to AHCA any health care facility providing services under the State Contract that may have violated the law. To report concerns pertaining to a health care facility, Subcontractor may contact the AHCA Complaint Hotline by calling 1-888-419-3456 or by completing the online complaint form found at https://apps.ahca.myflorida.com/hcfc. Subcontractor shall report to AHCA any areas of concern relative to the operation of any entity covered by the State Contract. To report such concerns, Subcontractor may contact the AHCA Complaint Hotline by calling 1-877-254-1055 or by completing the online complaint form found at https://apps.ahca.myflorida.com/smmc_cirts/. Reports relating to individuals receiving services who are at risk for, or have suffered serious harm, impairment, or death shall be reported to AHCA immediately and no later than 24 clock hours after the observation is made. Reports that reflect noncompliance that does not rise to the level of concern noted above shall be reported to AHCA within 10 calendar days of the observation.

56. Improvement Plan. If applicable to the Services by Subcontractor, and its performance does not meet AHCA performance standards according to an AHCA or Health Plan monitoring report, Subcontractor shall submit an improvement plan to Health Plan and AHCA within 14 business days of the deficient report.

57. Public Entity Crime. Subcontractor shall not subcontract with a person or affiliate who has been placed on the Florida convicted vendor list following a conviction for a public entity crime.

58. Co-brand Communications. Subcontractor shall work with Health Plan to co-brand all communications with Covered Persons and Providers. Subcontractor shall not send any communication to Covered Persons or Provider, as applicable, unless Health Plan reviews the content of the communication and endorses the communication prior to it being used by the Subcontractor.

EXHIBIT E

DELEGATED SERVICES AGREEMENT

This Delegated Services Agreement (together with all attachments, exhibits, schedules and addenda hereto, this "***Delegated Services Agreement***" or "***Attachment***"), effective as of April 1, 2024 by and between Sunshine State Health Plan, Inc. ("***Health Plan***") and St. Johns County Board of County Commissioners (such delegate to be referred to herein as "***Delegated Third Party***" or ***"Vendor")*** on behalf of itself and its contracted Vendors or Providers ("***Delegated Third Party Subcontractors***"), sets forth the terms and conditions under which Health Plan shall delegate to Delegated Third Party specific managed care activities.

WHEREAS, the parties have entered into a Vendor Services Master Agreement effective as of April 1, 2024 (the "***Delegated Third Party Agreement***" or the "***Agreement***"), to which this Attachment is attached and incorporated, whereby Delegated Third Party agrees to arrange for the provision of Covered Services to Covered Persons in exchange for certain compensation, and in connection with which the parties desire for Delegated Third Party to provide certain delegated administrative services pursuant to this Attachment; and

WHEREAS, the parties have determined that delegation of specific managed care activity(ies) would be beneficial to both parties.

NOW THEREFORE, the parties agree as follows:

1. Definitions. The following terms as used in this Attachment shall have the definitions as set forth below. Capitalized terms not defined herein shall be defined as set forth in the Delegated Third Party Agreement.

"***Agency***" means the DOI, State Medicaid Agency, Centers for Medicare and Medicaid Services, or other applicable federal or State governmental agency.

"***Covered Services,***" unless otherwise defined in the Delegated Third Party Agreement, means covered health care or other services, products or supplies that are rendered, or are sold or arranged for, by or on behalf of Health Plan, and that constitute covered benefits under the terms of a covered benefit plan entered into or sponsored by Health Plan or a related or third party health insurance company or health benefit program that contracts with Health Plan.

"***Covered Persons***" (or "***members***"), unless otherwise defined in the Delegated Third Party Agreement, means individuals entitled to receive Covered Services.

"***Delegated Third Party***" means either a Delegated Vendor or Delegated Provider.

"Delegated Provider" means a licensed individual health professional, group, or a health facility that has entered into an agreement to provide health care diagnosis and treatment services in alignment with contractual obligations with the health plan and regulatory agencies, that is also authorized to make decisions on the behalf of Centene or Centene subsidiaries including, but not limited to, participating and non-participating providers.

"Delegated Vendor" means an organization that is authorized to perform services and make decisions on behalf of Centene or any Centene subsidiary, to meet obligations as defined in regulatory contracts, guidelines or laws related to administering health benefits.

"***DOI***" means the applicable State Department of Insurance or equivalent regulatory agency or agencies with oversight over insurers, health maintenance organizations, or similar entities.

"***State***," unless otherwise defined in the Delegated Third Party Agreement, shall mean the state in which the applicable Covered Persons reside.

"***Regulatory Requirements***" means all applicable federal and state statutes, regulations, regulatory guidance, judicial or administrative rulings, requirements of governmental contracts, and standards and requirements of any accrediting or certifying organization, and where applicable, includes but is not limited to the requirements set forth in any Product Attachment attached to the Delegated Third Party Agreement.

1. CONDITION PRECEDENT

This Addendum is conditioned on Health Plan's pre-assessment review of Delegated Third Party's files, policies and procedures and the good faith approval of Delegated Third Party's substantial compliance with Health Plan's policies and procedures for Delegated Activities ("Pre-Delegation Audit"). No Delegated Activities are to be performed under this Attachment until Health Plan's review and approval of the delegation. If Health Plan performs the Pre-Delegation Audit and Health Plan informs Delegated Third Party that the Pre-Delegation Review has resulted in approval of the delegation in accordance with this Attachment, this Attachment shall be effective as of the date of such approval. In the event Health Plan informs Delegated Third Party that the Pre-Delegation Review fails to comply with Health Plan's policies and procedures for Delegated Activities, Health Plan shall provide a written statement of such deficiencies and will provide Delegated Third Party with 30 days within which to address and correct such deficiencies. If such deficiencies are not corrected by the end of such 30 day time period, this Attachment shall be of no force and effect unless otherwise agreed to in a separate writing, signed by both Parties.

2. Delegated Services. Pursuant to the Delegated Third Party Agreement and this Attachment, Health Plan hereby delegates to Delegated Third Party the activities set forth in Exhibit E-1 and E-2 to this Attachment (such services to be referred to as "Delegated Services"). All Delegated Third Party's programs, work plans, and policies and procedures shall be in accordance with the most current Health Plan standards and guidelines, as applicable, and shall comply with all Regulatory Requirements. For the purposes of this Attachment, all attachments, exhibits, schedules and addenda that are referenced herein and attached hereto are hereby incorporated in this Attachment.

3. Oversight of Delegated and Contracted Services. Health Plan is accountable to Government Contracts for the delegated and contracted services regardless of the provisions of this Attachment. Health Plan shall be entitled to evaluate Delegated Third Party's ability to perform the Delegated Services initially and on an ongoing basis. Delegated Third Party shall cooperate with Health Plan with respect to such evaluation and monitoring. Delegated Third Party hereby agrees to accept all responsibilities associated with the delegation provided under this Attachment, and specifically agrees to abide by the policies and procedures set forth or referenced in this Attachment. Delegated Third Party's material deviations from the policy and/or procedures set forth herein may result in review and action by Health Plan, including rescission or termination of this Attachment or any Delegated Services hereunder and/or the assessment of penalties as described herein. Nothing in this Attachment shall be construed in any way to limit Health Plan's authority or responsibility to comply with all Regulatory Requirements. Delegated Third Party shall, and Delegated Third Party acknowledges, that Health Plan may take whatever action is deemed necessary by Health Plan and/or any applicable Agencies to assure that Delegated Third Party shall, comply with all Regulatory Requirements relating to any function, duty, responsibility or delegation assumed by or carried out by Delegated Third Party.

   Health Plan's oversight shall include at a minimum:

   3.1 Initial Evaluation. Prior to the contract or services effective date, a pre-delegation audit will be conducted to evaluate and have assurance that policies and procedures meet contractual and regulatory requirements as well as, when applicable, accreditation requirements. In addition, to evaluating delegated services, the pre-delegation audit will include an evaluation of the Delegated Third Party's Compliance Program, Information Security Program, and, as applicable, Financial Solvency. In participation of this audit, the Delegated Third Party will complete a self-assessment and provide supporting policies and program descriptions.

3.2 Annual Evaluation. An annual audit is conducted to evaluate and have continued assurance that policies and procedures meet contractual and regulatory requirements and, when applicable, accreditation requirements.

3.2.1 Policy and Program Reviews. Similar to the Initial Evaluation, the Delegated Third Party will complete a self-assessment and provide supporting policies and program descriptions for delegated services, Compliance Program, Information Security, and as applicable, Financial Solvency.

3.2.2 File Reviews. Not limited to an annual evaluation, Delegated Third Party shall give Health Plan access, upon request, to Delegated Third Party's files for Health Plan's review. Such files may exclude bona fide confidential peer review files. At least annually, or more frequently if deemed necessary by Health Plan representatives, Delegated Third Party as applicable, will permit Health Plan to perform on-site performance compliance review, including without limitation review of any verification and re-verification files, upon not less than ten (10) days written notification by Health Plan. Upon request, Delegated Third Party shall provide copies of requested files (i) promptly following Health Plan's request if the request is made during such on-site review, and (ii) upon not less than ten (10) days following Health Plan's request if the request is made outside of any such on-site review.

3.3 Ongoing Monitoring. Delegated Third Party will submit monthly or quarterly reports (as defined in the exhibits to this Attachment and Delegated Third Party Agreement) to Health Plan's Quality Management Director or Director of Compliance, or such individual's designee. Delegated Third Party will have a quarterly oversight meeting with the Health Plan, the meeting may be in person or telephonic. Quarterly oversight activities will be comprehensive in nature. In addition to the monthly oversight reports, special focus will be placed upon observed trends, the results of actions initiated by Delegated Third Party, and the result of corrective actions taken. Delegated Third Party will be required to submit a quarterly report summarizing the activities completed during the quarter, identifying barriers to improvement in care and service, and the effectiveness of the improvement plans. More frequent reports may be required from Delegated Third Party if placed on a Corrective Action Plan ("CAP") as outlined hereunder.

3.4 Corrective Action Plans. If Health Plan receives information through its monitoring plan and/or audit processes that Delegated Third Party or one of its subcontractors is considered unsatisfactory by the Health Plan, in material violation of this Attachment or federal or state requirements or is operating in a condition that renders the continuance of its business hazardous to Covered Persons, Health Plan will raise the concern to Delegated Third Party by written and oral notice and initiate the corrective action plan process.

3.4.1 Each CAP will include, but is not limited to, the following:

3.4.1.1 Statement describing the deficiencies and root cause analysis;

3.4.1.2 Expected, measurable results indicating completion of the CAP;

3.4.1.3 Detailed action plan to complete activities required by the CAP;

3.4.1.4 Due date for completion of the CAP

3.4.2 Submission of the CAP will be made by the Delegated Third Party within the agreed upon timeframe and as expeditiously as may be required by the non-compliance with State and Federal requirements and or hazard to Covered Persons.

3.4.3 Implementation of the remediation activities will be completed by the mutually agreed upon timeframe. The remediation will accomplish the expected results and such results must be subsequently validated by the Health Plan. Failure of Delegated Third Party or any of its subcontractors to comply with this provision may result, at Health Plan's discretion, in the suspension of revocation of delegated services.

3.4.4 Health Plan will cooperate with Delegated Third Party or its subcontractors to correct any failure by Delegated Third Party to comply with the State or Federal regulatory requirements.

3.5 Reports. Delegated Third Party shall produce such reports as may reasonably be requested by Health Plan. Reports will be sent to Health Plan on or before the due dates and at the frequency set forth in the applicable Exhibits, at a minimum of semi-annually. The report requirements shall be subject to modification at Health Plan's discretion based on, among other things, new contract requirements or identified performance issues with Delegated Third Party. Additionally, Delegated Third Party must provide Health Plan with any reports that are intended to be sent to an Agency within the timeframes specified by Health Plan, which may include such time as may be necessary to review such reports for quality and accuracy.

3.6 Policy Notifications. Health Plan retains the right to modify relevant policies and procedures of Delegated Third Party, as necessary, to assure compliance with Regulatory Requirements. Delegated Third Party shall have thirty (30) calendar days following written notification from Health Plan to propose alternatives to Health Plan's modifications of Delegated Third Party's policies and procedures. In the event Delegated Third Party accepts Health Plan's modifications, or upon resolution of any issues related to the proposed modifications, Delegated Third Party shall provide Health Plan with an implementation plan with timelines for compliance to required modifications within ten (10) business days. Delegated Third Party shall have no more than sixty (60) calendar days to demonstrate compliance with modification requirements unless a lesser timeframe is required under Regulatory Requirements.

3.7 Health Plan's Decisions. Notwithstanding anything to the contrary in this Delegated Services Agreement or the Delegated Third Party Agreement generally, Health Plan retains the right, based on its sole judgment, to approve, suspend, or terminate any Delegated Third Party from participation in Health Plan's provider network system. Health Plan agrees to notify Delegated Third Party of its decision and Delegated Third Party shall have fourteen (14) calendar days from such notice to request reconsideration of such decision by Health Plan. Health Plan shall have the final decision on any such verification matter.

4. Sub-delegation. Any engagement by Delegated Third Party of a third party subcontractor (a "***Sub-Delegate***") to perform any Delegated Services hereunder shall be deemed a sub-delegation of such Delegated Services. Delegated Third Party may not sub-delegate its responsibilities under this Attachment without the prior written approval of Health Plan, which shall be at Health Plan's sole discretion. Requests to sub-delegate responsibilities must be presented to Health Plan in writing at least one hundred twenty (120) calendar days in advance of the effective date of such proposed sub-delegation. The written request must include an objective evaluation of the proposed Sub-delegate's ability to perform the functions and comply with applicable Regulatory Requirements. Health Plan reserves the right to perform an independent evaluation of the proposed Sub-delegate's capability to perform the functions in compliance with all requirements before rendering a decision whether to approve the sub-delegation. If Health Plan denies the request, the proposed Sub-delegate may not be brought forward for re-consideration as a potential Sub-delegate until nine (9) months after the denial decision is rendered.

If Health Plan approves the sub-delegation of a portion of the responsibilities delegated hereunder to a Sub-delegate, Delegated Third Party shall be responsible for conducting oversight of Sub-delegate's performance and for ensuring Sub-delegate's compliance with the terms of this Attachment, including at least an annual evaluation of policies and procedures, audits, and a review of reports as described herein. Delegated Third Party must report the status and results of its oversight activities to Health Plan on at least a quarterly basis. Delegated Third Party shall provide documentation and demonstrate its oversight of Sub-delegate by Delegated Third Party, which at minimum shall include:

a.) An executed agreement that defines: the delegated responsibilities of Delegated Third Party and Sub-delegate; the reporting requirements consistent with those outlined in this Attachment and Delegated Third Party Agreement; the process by which Delegated Third Party will evaluate Sub-delegate's compliance with performance requirements in this Attachment at least every twelve (12) months; and the remedies, including revocation of the sub-delegation, available to Delegated Third Party if Sub-delegate does not fulfill its obligations;

b.) An evaluation of Sub-delegate's capacity to perform the delegated activities prior to the execution of the contract; and

c.) An annual evaluation of performance in accordance with Health Plan's accreditation, regulatory and statutory standards.

The role of Delegated Third Party and any Subdelegate in relation to Health Plan is limited to performing those Delegated Services set forth herein, in accordance with Health Plan's standards and in compliance with Regulatory Requirements, and subject to Health Plan's oversight and monitoring of Delegated Third Party's performance.

Health Plan retains the right to modify, rescind or terminate, at any time, any one or all of the Delegated Services under this Attachment, notwithstanding the sub-delegation of such Delegated Services as set forth in this Attachment. In addition, CMS and any other applicable Agency reserves the right to revoke any one or all of the Delegated Services and reporting requirements under this Attachment, or to specify other remedies in instances where CMS or other applicable Agency Health Plan or the Payor determine that Delegated Third Party or any Sub-delegate has not performed satisfactorily.

5. Material Changes. Delegated Third Party shall provide written notice to Health Plan at least thirty (30) days prior to making any material changes to Delegated Third Party's quality improvement, verification and re-verification, utilization review or other procedures and processes relevant to the Delegated Services under this Attachment. Delegated Third Party shall provide written notice to Health Plan at least sixty (60) days prior to making any and all material changes to Delegated Third Party's invoice and claims processing and payment policies or procedures.

6. Compensation. The compensation to be paid by Health Plan to Delegated Third Party for performance of Delegated Services described herein, if any, shall be included in the compensation paid by Health Plan pursuant to the terms of the Delegated Third Party Agreement. No additional compensation shall be paid under the terms of this Attachment.

7. Termination. Health Plan reserves the right, upon written notice to Delegated Third Party, to terminate this Delegated Services Agreement or rescind any of the Delegated Services or activities delegated to Delegated Third Party herein as a result of Delegated Third Party's material deviations from the Policy or for business reasons as deemed necessary by Health Plan. Notwithstanding the foregoing, unless otherwise agreed to by the parties, this Attachment shall automatically terminate upon termination of the Delegated Third Party Agreement. Termination of this Attachment shall not affect the rights and obligations of the parties under the Delegated Third Party Agreement, except that delegation contemplated under the Delegated Third Party Agreement, as well as any payment for Delegated Services provided for under the Delegated Third Party Agreement, shall cease to be effective on the effective date of the termination or recession of such Delegated Services under this Attachment.

In the event this Attachment terminates, or the delegation of verification or re-verification services are rescinded hereunder, providers verified and re-verified by Delegated Third Party will be requested by Delegated Third Party to complete Health Plan's verification and re-verification process in order to maintain Health Plan participation, and Delegated Third Party shall provide any and all files and records as may be required to transfer verification and re-verification to Health Plan. Delegated Third Party shall obtain any and all physician and/or provider releases that may be necessary to effectuate such transfer.

8. Performance Standards. Delegated Third Party's performance of the delegated activities described in this Attachment shall be subject to the performance standards set forth in the Delegated Third Party Agreement, and Health Plan shall have the right to assess the penalties set forth in the Delegated Third Party Agreement against Delegated Third Party for the failure to meet such performance standards.

9. Penalties and Sanctions. Delegated Third Party shall be responsible for and shall reimburse Health Plan, within thirty (30) days upon written notice by Health Plan, for the cost of any penalty or administrative sanctions assessed against Health Plan by any Agency on the basis of late payment of invoices or claims or non-compliance by Delegated Third Party for Covered Services or other services as defined in the Delegated Third Party Agreement. Health Plan reserves the right to assess a penalty against Delegated Third Party for noncompliance with a material provision in this Attachment and Delegated Third Party Agreement. Health Plan shall provide Delegated Third Party with written notice of the noncompliance and, except in cases involving a threat of imminent harm to the safety and welfare of Covered Persons, shall provide Delegated Third Party with thirty (30) days to cure the area of noncompliance. Delegated Third Party shall notify Health Plan of any sanctions incurred or issued to Delegated Third Party following review by an Agency or voluntary accreditation agency.

10. Reporting Compliance. Delegated Third Party shall comply with the same encounter, utilization, quality, and financial reporting requirements as Health Plan must comply with under any applicable payor agreement, including but not limited to any contract that Health Plan may have with an Agency for the provision of managed care or other administrative services.

11. Delegated Third Party Materials. Delegated Third Party agrees that all member and provider materials related to the administration of this Delegated Services Agreement and Delegated Third Party Agreement will be co-branded with Health Plan's name and logo. Delegated Third Party shall provide Health Plan with a copy of its member and provider communication materials, including but not limited to education materials, for Health Plan approval and submission to the applicable Agency for approval prior to distribution of such materials.

12. Additional Delegated Third Party Requirements. Where the terms of the Delegated Third Party Agreement contemplate that Delegated Third Party will contract with physicians, other providers or subcontractors (e.g., for the provision of Covered or Delegated Services), or with respect to any Sub-Delegates hereunder (such physicians, providers, subcontractors and Sub-delegates to be collectively referred to herein as "Subcontractors"), in order to ensure that Delegated Third Party has an effective administrative system for providing timely and accurate reimbursement to Subcontractors, Delegated Third Party shall provide Health Plan the following:

(a) Proof of Delegated Third Party's financial viability, if requested;
(b) Evidence of both Delegated Third Party's financial solvency and financial ability to perform, such as a certified financial audit of Delegated Third Party conducted by independent certified public accountants, utilizing generally accepted accounting and auditing principles;
(c) A description of financial practices for tracking and reporting liabilities incurred but not reported;
(d) Monthly or other regular reporting of the following:
    i. If applicable, co-payments received by Delegated Third Party (on a monthly basis);
    ii. A summary of the amounts paid by Delegated Third Party to Subcontractors;
    iii. Methods by which Subcontractors were paid by Delegated Third Party (capitation, fee-for-services, other risk-sharing arrangements), and the percentage of Subcontractors paid for each payment category;
    iv. A summary of the amounts paid by Delegated Third Party for administrative services relating to Health Plan;
    v. Time period that invoices/claims and debts related to invoices/claims owed by Delegated Third Party have been pending, and the aggregate dollar amount of those invoices/claims and debts;
(e) Information required for Health Plan to be able to file claims for reinsurance, coordination of benefits, and subrogation; and
(f) A license number that certifies that Delegated Third Party (or any applicable Sub-delegate) is licensed as a third party administrator or utilization review agent, if required by State law.

12.1. Insolvency Protection (if delegated for Invoice/Claims Processing or a Risk Bearing Agreement):

Delegated Third Party will establish a restricted insolvency protection account with a federally guaranteed financial institution licensed to do business in Florida in accordance with s.1903(M) (1) of the Social Security Act (amended by s. 4706 of the Balanced Budget Act of 1997). Delegated Third Party will deposit monthly into that account five percent (5%) of the amount of the Health Plan monthly capitation payment until a maximum of total of two percent (2%) of the annualized total current Delegated Third Party amount is reached and maintained. No interest can be withdrawn from the account until the maximum amount is reached and the withdrawal of the interest will not cause the balance to fall below the maximum total of two (2%) percent of the annualized amount of the payment terms of this Agreement.

The restricted insolvency protection account may be drawn upon with the authorized signatures of two (2) persons designated by Delegated Third Party and two (2) representatives designated by Health Plan. Health Plan's Multiple Signature Verification Agreement Form must be submitted to Health Plan within thirty (30) days after the date that this Amendment is executed and will be resubmitted within thirty days after a change in authorized Delegated Third Party or Health Plan authorized persons occur. If there are no changes to the Delegated Third Party authorized persons, by April 1st of each year, Delegated Third Party will submit to Health Plan an attestation that the authorized persons remain the same. The address for submission of the documents is that noted in this Agreement for all communications related to the terms of the Agreement.

In the event that Health Plan determines the Delegated Third Party is insolvent, Health Plan will provide written notice to Delegated Third Party with the rationale for the determination. If Delegated Third Party disputes this decision, Delegated Third Party must respond within ten (10) calendar days of the date on Health Plan's notice. Delegated Third Party will have ten (10) days from the date of Health Plan's notice to review and respond with documentation of the facts to support the dispute. Health Plan has the ultimate decision on the insolvency status of Delegated Third Party.

Should Health Plan determine Delegated Third Party to be insolvent, Health Plan will draw from the restricted insolvency account with only the two authorized signatures of the Health Plan designated representatives. Health Plan will apply those withdrawn funds to meet the financial obligations of Delegated Third Party under the terms of this Agreement. Delegated Third Party will submit a statement of the restricted insolvency account balance to Health Plan within fifteen (15) calendar days of the date of the request from Health Plan.

Should Health Plan terminate this Agreement based on the terms in Article IX Term and Termination, the term of the Agreement expires or not renewed, Health Plan will request proof of outstanding obligations of Delegated Third Party under the terms of this Agreement. Delegated Third Party must submit such proof within five (5) business days of the date on the Health Plan notice of request. Health Plan will have five (5) business days to review such proof. Health Plan has the right to request additional documentation if what was provided by Delegated Third Party does not fully document the obligations. Upon Health Plan's determination that the outstanding obligations have been verified, Health Plan will release the balance of the restricted insolvency account to Delegated Third Party within thirty (30) days of such determination.

Furthermore, should Health Plan terminate or not renew this Agreement, and Delegated Third Party is deemed by Health Plan to be insolvent, Health Plan may draw upon the restricted insolvency account to meet the financial obligations of Delegated Third Party under the terms of this Agreement, including but not limited to overpayments made by Delegated Third Party and fines imposed under the terms if this Agreement, for which a final order has been issued.

Should Health Plan terminate or not renew this Agreement, and Delegated Third Party is not able to pay all of its outstanding debts to their providers, Health Plan and Delegated Third Party shall agree to the court appointment of an impartial receiver for the purpose of administering and distributing the funds in the restricted insolvency account. The appointed receiver shall give outstanding debts owed to Health Plan priority over other claims.

Should Delegated Third Party not agree with Health Plan's determination of the outstanding financial obligations under the terms of this Agreement, the terms of the arbitration section 10.14 of Article X Miscellaneous of this Agreement will apply.

Financial Statements:

Delegated Third Party will submit quarterly unaudited financial statements to Health Plan within sixty (60) days of the end of the quarter. Delegated Third Party will also submit annual audited financial statements to Health Plan within one hundred-twenty (120) days of the end of the calendar year. The quarterly and annual financial statements must reflect the specific activities performed on behalf of Health Plan. Statements that reflect the financial performance of Delegated Third Party's entire business or that of any applicable parent company cannot be submitted.

13. Confidentiality. Delegated Third Party shall comply with all Regulatory Requirements relating to patient confidentiality, including but not limited to HIPAA regulations. If the Delegated Services contemplated hereunder require that Delegated Third Party create, receive, transmit, maintain and/or disclose "protected health information" (as such term is defined under HIPAA) on behalf of Health Plan, Delegated Third Party shall not perform such Delegated Services until Delegated Third Party has executed a Business Associate Agreement with Health Plan.

14. Agreement Conflict. In the event of a conflict between this Attachment and the Delegated Third Party Agreement, the terms of this Attachment shall govern as to the delegation of responsibilities hereunder.

15. Member Experience/Clinical Performance. Health Plan agrees to provide member experience (i.e., member survey) and clinical performance data relating to Delegated Third Party's performance under this Attachment to Delegated Third Party within a reasonable time period following Delegated Third Party's request.

16. Standards: Delegated Third Party will maintain compliance with current NCQA Accreditation of Health Plans standards and/or URAC standards, as directed by Health Plan.

a. Delegated Third Party acknowledges that NCQA and/or URAC regularly changes and updates its accreditation and certification standards and requirements. NCQA and/or URAC requires that any such changes and updates to the standards and requirements be implemented at least six (6) months prior to the effective date of such change or update. Delegated Third Party shall maintain systems to monitor changes in NCQA and/or URAC standards and requirements, as applicable, and shall implement modifications as needed to maintain compliance with NCQA and/or URAC standards and requirements, as applicable, at least six (6) months prior to the effective date of any changes or updates to such standards and requirements.

b. If Delegated Third Party holds NCQA accreditation or certification for part or all of its delegated functions, in the event that NCQA declines to award automatic credit for Delegated Third Party's services, Delegated Third Party agrees to cooperate with and provide necessary documentation to Health Plan required to demonstrate compliance with the current NCQA requirements.

IN WITNESS WHEREOF, the parties hereto have executed this Delegated Services Agreement effective as of the date first set forth above.

HEALTH PLAN:	DELEGATED THIRD PARTY: St. Johns County Board of County Commissioners
BY:	BY:
NAME:	NAME:
TITLE:	TITLE:
DATE:	DATE:

EXHIBIT E-1

TO DELEGATED SERVICES AGREEMENT
CARE COORDINATION RESPONSIBILITIES

Responsibility	Responsible Party (Check One)	
	Health Plan	**Vendor**
Vendor shall educate caregivers and Dependency Case Managers, regarding the need for and importance of the following:		X
- Administering prescribed medications to Covered Persons consistently as prescribed		X
- The Covered Persons receipt of routine primary care physician, dental, and vision care		X
- Keeping appointments for behavioral health services, if applicable		X
- Knowing who is the Covered Person's PCP, what days and hours the PCP's office is open, and how to contact the PCP 24 hours a day		X
- Contacting the PCP on a timely basis when the Covered Person begins to have symptoms of illness, appropriate use of the emergency room, and alternatives such as urgent care		X
- Health Plan benefits, including expanded benefits and In Lieu of Service benefits		X
- Health Plan self-help and after hours resources		X
- Alternatives to unnecessary emergency department utilization		X
- Health Plan covered contraceptive options available and benefits covered for pregnant members		X
Vendor will provide approved education materials to caregivers and caseworkers for members as needed to ensure that they have access to information related to benefits. Caseload Education materials shall be provided to caseworkers and/or directly to the member/caregiver. Care Coordinators will make every possible effort to contact members identified for Care Coordination services. Care Coordinators will complete a pre-assessment, including a review of the available member records/information before each member outreach attempt. Outreach may include telephone calls, letters, and communication with treating providers.		X

Vendor shall assess on an ongoing basis and at placement change the Covered Person's needs, as well as the needs of the parent, foster parent and/or guardian. On an ongoing basis, Vendor will identify Covered Persons who may benefit from physical or behavioral health case management, health coaching or care coordination and refer such Covered Persons to Health Plan following established methods. The referral is to be made within two (2) business days of identification.		X
Vendor will view information provided in Health Plan's member health record portal, or client portal, to understand the service provided, identify services needed, and review attached documents.		X
Vendor shall assess needs and provide necessary referral or appointment assistance for members' routine and preventive health care including both physical health and behavioral health and provide that required assistance when applicable. Assistance with specialist care referrals or appointment assistance shall also be provided, as applicable.		X
Vendor shall assist the caregiver in obtaining any ordered psychotropic medication in a timely manner, to identify any potential medication compliance issues and to identify any issues with the caregiver obtaining the medications and will contact Health Plan for assistance, if needed.		X
Vendor shall educate members and families on benefits and facilitate member access to covered benefits, including expanded and in lieu of service benefits, when needed. This is applicable for requests such as Care Grants, Transition Assistance, or requests for other relevant benefits		X
Vendor will participate in Health Plan's discharge planning for any Covered Person who is admitted to a facility, including an Emergency Department visit, and will provide information that may assist in the development of an appropriate discharge plan to support the Covered Person safely in the community, and will manage any changes in placement. Discharge planning from a facility occurs prior to discharge, provided that Vendor is aware of the admission while Covered Person is hospitalized.		X
As part of discharge aftercare from an inpatient facility, Vendor is responsible to ensure that the enrollee has a seven (7) day post-discharge follow-up appointment for behavioral health services. For physical health follow-up, Health Plan will determine which party is responsible to make the seven (7) day post-discharge follow–up appointment based upon Case Management assignment and timely notification of discharge. As Covered Persons are discharged from the hospital, Vendor will follow-up with the caregiver to ensure that the Covered Person keeps the seven (7) day post-discharge appointment, any additional ordered medications are filled, and other ordered services such as durable medical equipment (DME) are scheduled. The Vendor will notify Health Plan immediately when any issues arise that may impact the Covered Person from keeping that seven (7) day appointment, filling ordered medications, or keeping appointments for other ordered services. Health Plan will facilitate communications among the providers.	X	X

When notified by Health Plan or when becoming aware of a member with an Emergency Department visit, Vendor shall assist with access to needed follow up services and benefits, including expanded benefits and in lieu of services.		X
For Covered Persons referred to Vendor by Health Plan or identified by the Vendor as needing care coordination, Vendor will assign the case to the applicable CBC staff within two (2) business days of identification. Vendor will document the activities required under this Agreement for the Covered Person using the Health Plan designated format and following the specified method. All documentation must be entered into the Health Plan designated location by the next business day of the interaction with the caregiver and/or Covered Person For Covered Persons identified for Health Plan case management, Vendor will collaborate with Health Plan to contact the applicable caregiver and Covered Person, provide additional information on the status of the Covered Person or support needs of the caregivers, coordinate needed home visits, and arrange for needed practitioner or ancillary provider appointments. Health Plan will collaborate with Vendor on outreach and case management activities to minimize confusion to the caregivers or Covered Person. Vendor shall assist in the development of the Covered Person's care plan.		X
For Covered Persons identified as Enhanced Care Coordination (ECC) or enrolled in Medical Foster Care, Vendor will collaborate with Health Plan staff to ensure that Care Coordination needs are met and will assist with facilitating communication between Health Plan and the caregiver, to ensure that the AHCA required care plans are completed as stipulated by AHCA. Vendor will assist with arranging for the caregivers to participate in the care plan and multidisciplinary meetings.		X
For planning for specialized service management when transitioning youth from the child welfare system, Vendor shall provide Health Plan with a copy of the full transition plan, if available, within sixty (60) days following upon a member's 17th birthday, along with any updates while the child remains in the Child Welfare Specialty Plan. Additionally, Vendor shall collaborate with Health Plan on transition planning for members one (1) year prior to the expected date upon which an enrollee will age-out of the child welfare system. Vendor shall participate in comprehensive treatment team meetings with Health Plan for the purposes of transition planning within the ninety (90) day period following a members 17th birthday.		X

Vendor shall notify Health Plan of an enrollee's pregnancy, whether identified through medical history, examination, testing, claims, or otherwise and provide care coordination to facilitate access to prenatal and post-partum care for pregnant members.		X
Vendor shall provide care coordination to facilitate access to prenatal and post-partum care for pregnant members.		X
On a monthly basis, Vendor will participate in meetings with Health Plan representation to discuss all services provided under this Agreement. These meetings will include but are not limited to a review of the Care Gap report provided by Health Plan monthly for the measurement year from April to December. This Care Gap report includes Covered Persons who are due or past due for routine primary care physician visits, immunizations, dental care, and other agreed upon health and wellness services. Vendor shall provide reports on progress or challenges to Health Plan. Vendor shall also participate with Health Plan utilization management integrated care team and multidisciplinary care team meetings regarding the needs of Covered Persons. Vendor will prepare a summary of the Covered Person's needs and recommendations for discussion at these meetings and follow up on actions as designated at the meetings and to document their actions in the designated Health Plan location.	X	X
Vendor and Health Plan staff will jointly participate in meetings or staffings regarding the needs of Covered Persons. Vendor and Health Plan staff who are managing the Covered Person will prepare a summary of the Covered Person's needs and recommendations for discussion at these meetings. Vendor and Health Plan staff will follow-up on actions as designated at the meetings and will document their actions in the designated Health Plan location. This healthcare function is applicable for members with health indicators related to case management services of Medical Foster Care (CMAT) and Multidisciplinary Team Meetings (MDT) or Child-Specific Staffings (CSS).	X	X
Vendor will track activities required under this agreement in a Health Plan approved format and method.	X	X
Health Plan will monitor Vendor compliance with any assigned service coordination, care coordination, or case management activity as noted above through regular monitoring of reports related to completed activities. That monitoring will be based on communication with Vendor, reports based on information in the Health Plan designated location, reports on services provided, and audits of Vendor.	X	X

Vendor shall assign a care coordinator to covered persons under the age of twenty-one (21) years who have special health care needs and are in need of out-of-home/residential treatment services (e.g., group home placement) to ensure timely placement and access to care. The assigned care coordinator shall assume a lead role in identifying a service provider that can meet the covered person's need even when there are multiple state agencies (i.e., DCF and APD) involved in the child's care. The Vendor shall coordinate and maintain routine contact with other state agencies involved in the covered person's care until placement is made. The Vendor shall document all efforts to find an appropriate placement in the covered person's record.	X	X
Vendor will provide information to support Health Plan's network strategy development for the Child Welfare population related to providers who traditionally serve the child welfare population or information related to access and availability issues to the current network.		X
Vendor shall identify the Nurse Care Coordinators and Behavioral Health Care Coordinators funded under this Agreement and provide that list of staff to Health Plan. Vendor shall notify Health Plan of any changes to funded staff.		X

EXHIBIT E-2: WELLNESS AND HEALTH PROMOTION TO DELEGATED SERVICES AGREEMENT

The Health Plan retains responsibility for any wellness and health promotion requirements related to accreditation, State, or Federal contract or statutory compliance not listed here.

	Responsible Party (Check one)		
Responsibility	**Health Plan**	**Vendor**	**Comments**
Vendor shall coordinate, collect, and submit initial Health Plan Risk Assessments for all Covered Persons within thirty (30) calendar days of such Covered Person's notification of enrollment from Health Plan into the Child Welfare Specialty Plan as evidenced in the AHCA enrollment files. If a member has a gap in coverage for ninety days or less a new Health Risk Assessment is not required. If the gap in coverage is greater than ninety day, a new Health Risk Assessment is required. Upon notification from Health Plan that a claim has been received for a Covered Person's diagnosis related to SMI, asthma or diabetes, a new Health Risk Assessment is required within sixty (60) days of receipt of notification.		X	

EXHIBIT E-3: COMPLAINTS AND GRIEVANCES
TO DELEGATED SERVICES AGREEMENT

Vendor is not delegated for Complaints and Grievances; however, Vendor Reporting requirements to the Health Plan is still required as outlined in the table below. This Exhibit only applies to member and grievance reporting requirements identified within the below table. The Health Plan retains responsibility for any complaints and grievances requirements related to accreditation, State, or Federal contract or statutory compliance not listed here.

	Responsible Party (Check one)		
Responsibility	**Health Plan**	**Vendor**	**Comments**
Member Complaints and Grievances Health Plan has not delegated the management of member complaints or grievances to Vendor. However, Vendor agrees to train their staff on how to identify if a member is voicing a complaint or grievance. Vendor must warm transfer all member complaint or grievance calls (including those on behalf of the member) to the Health Plan at the time of the call. Vendor must also notify the applicable Health Plan department and note that the notice was provided in the applicable Vendor documentation system. Vendor agrees to provide a report of any member complaint or grievance the same day the complaint or grievance has been identified. Vendor agrees to provide to Heath Plan information or documentation to support investigation of a member complaint or grievance. Vendor shall have policies and procedures that outline the process for registering, tracking and responding to oral and written complaints in accordance with Regulatory Requirements, NCQA Accreditation of Health Plan standards and/or Centene Standards. Vendor maintains a system for tracking complaints and providing reports to Health Plan accordance with contract requirements. In the event Health Plan handles complaints, any complaints related to the organization will be sent to the organization and will be tracked in the same manner as if delegated complaints. Vendor will respond to the complaints within the timeframes outlined by Health Plan or the performance metrics.		X	Vendor is not delegated for member complaints but is to comply in this training and reporting requirement accordingly.

EXHIBIT F

BUSINESS ASSOCIATE AGREEMENT

sunshine health

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement ("**BAA**") is between Sunshine State Health Plan, Inc., a Florida corporation ("**Covered Entity**"), and _____, a _____ ("**Business Associate**"; individually with Covered Entity a "**Party**" and together the "**Parties**") and is effective September 15, 2023. Capitalized terms not otherwise defined in this BAA have the meanings assigned to such terms in Section 1.

1. Covered Entity and/or one or more of its Affiliates desires to obtain services from Business Associate (or its Affiliates) that will result in the Use of Covered Entity's (or its Affiliate's) PHI pursuant to one or more contracts between Business Associate, on one hand, and Covered Entity and/or any of its Affiliates, on the other hand, in effect on or after the Effective Date (each contract, a "**Primary Agreement**"); and

2. Covered Entity and Business Associate desire and intend that this BAA govern the Use of all PHI under a Primary Agreement and all other Use of PHI by Business Associate and/or its Affiliates for or on behalf of Covered Entity.

The Parties agree as follows:

Section 1. Definitions.

The following terms (capitalized or not and including grammatical variants, such as "disclose" vs. "disclosure") in this BAA shall have the meaning set forth in the HIPAA Authorities, including Breach, Data Aggregation, Designated Record Set, Disclosure, Discover, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required By Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use. Business Associate is a "business associate" as defined at 45 CFR 160.103. Covered Entity is a "covered entity" as defined at 45 CFR 160.103.

"Affiliate" (capitalized or not) means any entity that controls, is controlled by or is under common control with a Party as well an any entity that is a subsidiary of an entity that controls a Party.

"ePHI" shall mean Electronic Protected Health Information.

"HIPAA Authorities" means the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"), and the implementing regulations thereunder, including but not limited to the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164, as amended.

"Incident" means (i) any successful Security Incident, (ii) Breach of Unsecured PHI, or (iii) any loss, destruction, alteration or other event in which PHI cannot be accounted for. Unless otherwise required by applicable laws, Successful Security Incidents shall not include pings and other broadcast attacks on

Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in or is related to unauthorized access, use or disclosure of PHI.

"Protected Health Information" or "PHI" collectively refers to Protected Health Information, ePHI, and any other data elements that identify an individual or that could be used to identify an individual, including but not limited to an individual's first name or initial and last name, all geographic subdivisions smaller than a state, all elements of dates (except year) for dates directly related to an individual including birth date, admission date, discharge date, date of death, telephone numbers, fax numbers, electronic mail addresses, social security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate or driver's license numbers, vehicle identifiers and serial numbers, including license plate numbers, device identifiers and serial numbers, web universal resource locators (URLs), internet protocol (IP) address numbers, biometric identifiers, including finger and voice prints, full face photographic images and any comparable images; and any other unique identifying number, characteristic, code, or combination that allows identification of an individual.

Section 2. Interpretation of Provisions of this BAA; Application of Agreement.

2.1 If there is an inconsistency between this BAA and the mandatory terms of the HIPAA Authorities, the HIPAA Authorities shall prevail. If there is a conflict between this BAA and a Primary Agreement, this BAA shall control, including with respect to any Primary Agreement executed after the effective date of this BAA. Any ambiguity in this BAA shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with the HIPAA Authorities and with Covered Entity's contract obligations to a government entity. A reference in this BAA to a section in the HIPAA Authorities means the section in effect or as amended. Titles or headings are used in this BAA for reference only and shall not have any effect on the interpretation of this BAA. A reference to Business Associate may be interpreted to include its Affiliate if a Business Associate Affiliate is a party to the applicable Primary Agreement.

2.2 This BAA governs the Use of all PHI that exists or arises in connection with a Primary Agreement between the Covered Entity or its Affiliate, on the one hand, and Business Associate or its Affiliate, on the other hand. Each Party hereto represents and warrants that (i) it is validly existing under the laws of the state of its formation; (ii) it has the full right, authority, capacity and ability to enter into this BAA for the benefit and, in the case of Business Associate, on the behalf of itself and each of its Affiliates and to carry out its and its Affiliates' obligations hereunder; (iii) this BAA is a legal and valid obligation binding upon it and it shall cause all of its Affiliates that Use PHI pursuant to the Primary Agreement to comply with the obligations hereunder of such Party; and (iv) its execution, delivery and performance of this BAA does not conflict with any agreement, instrument, obligation or understanding to which it or any of its Affiliates are bound.

Section 3. Permitted Uses and Disclosures.

Except as otherwise limited in this BAA, Business Associate may use or disclose PHI only as necessary to perform its obligations under the Primary Agreement, as long as such use or disclosure would not violate the Privacy Rule, or the policies and procedures of Covered Entity relating to the "Minimum Necessary Standard," if done by Covered Entity. If the Business Associate is permitted to de-identify PHI in a Primary Agreement, Business Associate shall de-identify PHI in accordance with 45 C.F.R. § 164.514 and not use

de-identified PHI except as expressly provided in the applicable Primary Agreement. Business Associate shall ensure that its Affiliates Use PHI in accordance with this BAA and shall be responsible for such Use. In addition, Business Associate may Use PHI:

3.1 To provide Data Aggregation services to Covered Entity as permitted by 42 CFR § 164.504(e)(2)(i)(B); and

3.2 For the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate, except that Use or disclosure of PHI under this paragraph is permissible only if (a) it is Required By Law, or (b) Business Associate has obtained reasonable assurances from the person to whom the PHI is disclosed that such PHI will remain confidential and used or further disclosed only as Required By Law or for the purpose for which such PHI was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the PHI has been breached.

Section 4. Obligations of Business Associate.

Business Associate shall:

4.1 Not Use or further Disclose PHI other than as permitted by this Agreement or as Required by Law;

4.2 Comply with changes in, or revocation of, permission by an Individual to use or disclose PHI of which it is informed by Covered Entity, and immediately notify Covered Entity of, and comply with, any request for a restriction on the use or disclosure of an Individual's PHI that Business Associate receives from such Individual;

4.3 Comply with the requirements of the Privacy Rule that apply to the Covered Entity to the extent Business Associate is carrying out one or more of the Covered Entity's obligations under the Privacy Rule;

4.4 Use reasonable and appropriate administrative, physical and technical safeguards to prevent the use or disclosure of PHI other than as provided for by the Primary Agreement and limit incidental Use or Disclosure of PHI;

4.5 Comply with the information security and data privacy requirements in the Primary Agreement applicable to the PHI and with the Security and Privacy Addendum attached to this BAA;

4.6 Mitigate, to the extent practicable and subject to Covered Entity's prior written approval, any harmful effect that is known to Business Associate of a use or disclosure of PHI by Business Associate in violation of the requirements of this BAA or the HIPAA Authorities and take prompt steps to prevent the recurrence of any Incident, including any action required by applicable federal and state laws and regulations;

4.7 With respect to an Incident, deliver to Covered Entity within 3 days after discovery of an Incident a written corrective action plan ("**CAP**") describing, at minimum, the measures Business Associate has taken and intends to take to halt or contain the Incident and mitigate the effects of the Incident as provided in paragraph 4.6, and, if the CAP is approved by Covered Entity, promptly and fully implement any remaining requirements of the CAP;

4.8 Notwithstanding any provision to the contrary in Section 8.10, notify Covered Entity in writing at **privacy@centene.com** as soon as reasonably practicable, but in no event longer than 24 hours, after discovery of any Incident;

4.9 Deliver to Covered Entity as soon as reasonably practicable, but no more than 7 calendar days following discovery of an Incident, a written report that includes: (a) a description of the circumstances under which the Incident occurred; (b) the date of the Incident and the date that the Incident was discovered; (c) a description of the types of PHI involved in the Incident; (d) identification of each Individual whose PHI is known or reasonably believed by the Business Associate to have been affected; and (e) any recommendations that the Business Associate may have regarding the steps that Individuals may take to protect themselves from harm;

4.10 Fully cooperate, coordinate with, and assist Covered Entity in gathering information necessary to notify the affected individuals and government agencies following an Incident to ensure that any notices sent in connection with the Incident are sent without unreasonable delay, and in no case more than 60 days after discovery of the Incident, and perform such notifications if so required by Covered Entity in its sole discretion;

4.11 Be solely responsible for all costs and expenses incurred as a result of an Incident, including costs associated with mitigation of the Incident and preparation and delivery of notices to affected individuals and government agencies;

4.12 Maintain the capability to identify the covered entity to which information involved in an Incident relates if Business Associate creates, receives, maintains, or transmits PHI on behalf of other covered entities in addition to Covered Entity;

4.13 Cooperate with any investigation (and/or risk assessment) of an Incident conducted by or on behalf of Covered Entity in connection, provide information necessary to notify individuals affected by an Incident of the Incident without unreasonable delay, and make itself and its applicable subcontractors and agents available to Covered Entity to testify as witnesses, or otherwise, in the event of an Incident;

4.14 With respect to any Subcontractor:

(a) Ensure that, before a Subcontractor (including any Affiliate that is a Subcontractor) creates, receives, maintains, or transmits PHI on behalf of Business Associate, the Subcontractor enters into a written agreement with the Business Associate (the "**Subcontractor Agreement**") obligating the Subcontractor: (i) to comply with the same HIPAA Authorities that apply to Business Associate under the Primary Agreement; and (ii) to comply with the same restrictions and conditions that apply to Business Associate through this BAA with respect to such PHI;

(b) Upon Business Associate's knowledge of a material breach of the Subcontractor Agreement by Subcontractor or of an act or omission of Subcontractor that would be a breach of this BAA if performed by Business Associate, (I) immediately notify Covered Entity in writing and (II) at Business Associate's option (unless otherwise directed by Covered Entity): (i) terminate the Subcontractor Agreement if Subcontractor does not cure the material breach within the cure period for material breach specified in the Primary Agreement after Business Associate notifies Subcontractor of the material breach, or if no

cure period is identified in the Primary Agreement, as specified by Covered Entity; or (ii) immediately terminate the Subcontractor Agreement if Business Associate (or Covered Entity) deems cure by the Subcontractor not to be possible; and

(c) Provide Covered Entity with a list of any and all of its Subcontractors and, in the event of an Incident, employees that create, receive, maintain or transmit PHI on behalf of Business Associate in in connection with Business Associate's obligations under the applicable Primary Agreement within thirty (30) days of such a request.

4.15 With respect to any Designated Record Set:

(a) At the request of Covered Entity and within 5 business days after such request, make available PHI in a Designated Record Set to Covered Entity or, as directed by Covered Entity, to an Individual, in a manner acceptable to Covered Entity and compliant with 45 CFR §164.524 and/or other applicable provisions of the HIPAA Authorities;

(b) Make any amendment(s) to PHI in a Designated Record Set to which the Covered Entity has agreed pursuant to 45 CFR §164.526 within5 business days of following a request by Covered Entity, or, as directed by Covered Entity, following a request of an Individual, and in a reasonable manner designated by Covered Entity, and otherwise assist Covered Entity in complying with Covered Entity's obligations under 45 CFR §164.526;

(c) Maintain any Designated Record Set for a period of 3 years and make such Designated Record Set available to Covered Entity upon request in an electronic and written format so that Covered Entity may meet its Disclosure accounting obligations under 45 C.F.R. § 164.528;

(d) Ensure that PHI in a Designated Record Set is available in an electronic format, in accordance with 45 C.F.R. § 164.524, as long as the request is made in accordance with HIPAA;

4.16 Make its internal practices, books and records available to Covered Entity or the Secretary and complete any written attestations required by Covered Entity, in each case for purposes of determining Covered Entity's compliance with the HIPAA Authorities, in a time and manner designated by Covered Entity or the Secretary, as applicable;

4.17 Document all disclosures of PHI (other than those expressly exempted from documentation requirements under the HIPAA Authorities) and information related to such disclosures (*i.e.*, (i) the date of the disclosure; (ii) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (iii) a brief description of the PHI disclosed; and (iv) a brief statement of the purpose of the disclosure that reasonably states the basis for the disclosure) as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528;

4.18 Provide an accounting of disclosures of PHI to Covered Entity or an Individual within 5 business days of the applicable request and in a reasonable manner designated by Covered Entity, as necessary to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of PHI in accordance with 45 CFR §164.528 or other applicable provision of the HIPAA Authorities;

4.19 Retain documentation of disclosures of PHI for a minimum of 6 years, unless otherwise provided under the HIPAA Authorities or the Primary Agreement;

4.20 Request, Use and/or Disclose only the amount and content of PHI that is the Minimum Necessary for Business Associate to fulfill its obligations under the terms and conditions of this Agreement and the Primary Agreement, including with respect to Uses and Disclosures by and among members of Business Associate's workforce as well as by or to third parties;

4.21 Promptly notify Covered Entity upon notification or receipt of any civil or criminal claims, demands, causes of action, lawsuits, or governmental enforcement actions ("**Actions**") arising out of or related to this Agreement or PHI, or relating to Business Associate's conduct or status as a business associate for any covered entity, regardless of whether Covered Entity and/or Business Associate are named as parties to such Actions;

4.22 Comply with the prohibition of sale of Protected Health Information without authorization unless an exception under 45 C.F.R. § 164.508 applies;

4.23 Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Covered Entity as required by the Security Rule; and

4.24 Comply with the requirements of Subpart E of 45 CFR Part 164 that apply to Covered Entity in the performance of Covered Entity's obligations under Subpart E of 45 CFR Part 164, to the extent Business Associate is to carry out on or more of those obligations.

Section 5. Obligations of Covered Entity.

Covered Entity shall:

5.1 Notify Business Associate of any limitation in Covered Entity's notice of privacy practices, to the extent that such limitation may affect Business Associate's use or disclosure of PHI;

5.2 Notify Business Associate of any changes in, or revocation of, permission by an Individual to use or disclose PHI, to the extent that such changes may affect Business Associate's permitted or required uses and disclosures of PHI;

5.3 Notify Business Associate of any restriction on the use or disclosure of PHI that Covered Entity has agreed to in accordance with 45 CFR § 164.522, to the extent such restriction may affect Business Associate's use or disclosure of PHI; and

5.4 Not request Business Associate to use or disclose PHI in any manner that would not be permissible under the Privacy Rule if done by Covered Entity, except as necessary for the Data Aggregation Services or management and administrative activities of the Business Associate as allowed in this BAA.

Section 6. Indemnification.

Business Associate shall defend, indemnify and hold harmless Covered Entity, its Affiliates and their respective directors, officers and employees from and against all claims, causes of action, damages and expenses (including reasonable attorneys' fees) arising out of or relating to any Incident or breach of this BAA by Business Associate and its Subcontractors and Affiliates. The exclusions and limits of liability, if any, provided in the Primary Agreement(s) shall not apply to damages arising from a breach of the foregoing obligations.

Section 7. Term and Termination.

7.1 Term. This BAA shall be effective beginning on the Effective Date, and shall remain in effect with respect to each Primary Agreement during the term of the Primary Agreement, unless earlier terminated as provided in this BAA.

7.2 Termination with Cause. Upon Covered Entity's knowledge of a material breach of this BAA by Business Associate or its Subcontractors, Covered Entity may, at its option: (a) provide an opportunity for Business Associate to cure the breach or end the violation and terminate this BAA and any applicable Primary Agreement if Business Associate does not cure the breach or end the violation within the cure period identified in the Primary Agreement, or if no cure period is identified in the Primary Agreement, as specified by Covered Entity; (b) immediately terminate this Agreement if Business Associate has breached a material term of this BAA and Covered Entity deems cure by Business Associate not to be possible; or (c) if neither termination nor cure are feasible, report the violation to the Secretary.

7.3 Effect of Termination.

(a) Except as provided in paragraph 7.3(b), upon termination of this BAA for any reason, Business Associate shall promptly return or destroy (at Covered Entity's election and in a manner compliant with Section 4.5 of this BAA), and shall retain no copies of, all PHI and, if applicable, de-identified PHI in the possession of Business Associate or its Subcontractors. Business Associate will provide written certification of destruction of data as required in this section that is acceptable to Covered Entity.

(b) If Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity written notification of the conditions that make return or destruction infeasible. Upon Covered Entity's written approval, which shall not be unreasonably withheld, Business Associate may retain the PHI ("**Retained PHI**"), but (1) the terms of this BAA shall apply to any Retained PHI for as long as Business Associate retains the PHI, even if the BAA has been terminated, and (2) Business Associate shall limit further Use and Disclosure of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI.

Section 8. Miscellaneous

8.1 Response to Subpoena. Business Associate shall be permitted to disclose PHI and Confidential Business Information that Business Associate is required to disclose pursuant to court order, subpoena or other compulsory legal process, provided that prior to making any disclosure thereunder, Business Associate shall provide Covered Entity within 5 calendar days prior written notice (or as much notice as reasonably practicable under the circumstances) of the intended disclosure, specifying the basis and nature of the same.

8.2 Compliance with Law. Business Associate will comply with all applicable laws, including the HIPAA Authorities. Requirements of the HIPAA Authorities that are made applicable with respect to business associates, or any other provision required to be included in this Agreement pursuant to the HIPAA Authorities, are incorporated into this Agreement by this reference.

8.3 Assignment; Waiver. This BAA shall be binding upon and inure to the benefit of the respective legal successors of the parties. Neither this BAA nor any rights or obligations hereunder may be assigned, in whole or in part, without the prior written consent of the other party. Except as provided herein, this BAA shall create no independent rights in any third party or make any third party a beneficiary hereof. No failure or delay by either party in exercising its rights under this BAA shall operate as a waiver of such rights, or of any prior, concurrent, or subsequent breach.

8.4 Property Rights. All PHI shall be and remain the exclusive property of Covered Entity. Business Associate agrees that it acquires no title or rights to the PHI, including any de-identified information, as a result of this BAA.

8.5 Right to Cure. Business Associate agrees that in the event Business Associate fails to cure a breach of this BAA pursuant to this BAA, Covered Entity has the right, but not the obligation, to cure the same. Expenses, costs or fines reasonably incurred in connection with Covered Entity's cure of Business Associate's breach of its obligations under this BAA shall be borne solely by Business Associate.

8.6 Injunctive Relief. Business Associate agrees that breach of the terms and conditions of this BAA shall cause irreparable harm for which there exists no adequate remedy at law. Covered Entity retains all rights to seek injunctive relief to prevent or stop any breach of the terms of this BAA, including but not limited to the unauthorized use or disclosure of PHI by Business Associate or any Subcontractor, contractor or third party that received PHI from Business Associate.

8.7 Survival; Severability. The respective rights and obligations of Business Associate under this BAA, including but not limited to Business Associate's indemnification obligations, shall survive the termination of this BAA. The parties agree that if a court determines that any of the provisions of this BAA are invalid or unenforceable for any reason, such determination shall not affect the enforceability or validity of the remaining provisions of this BAA.

8.8 Entire Agreement; Amendment. This document, together with any written Schedules, amendments and addenda, constitutes the entire agreement of the parties and supersedes all prior oral and written agreements or understandings between them with respect to the matters provided for herein. The parties agree to take such action as is necessary to amend this BAA from time to time as is necessary for Covered Entity and Business Associate to comply with the requirements of the HIPAA Authorities. Any modifications to this BAA shall be valid only if such modifications are in accordance with the HIPAA Authorities, are made in writing, and are signed by a duly authorized agent of both parties.

8.9 Governing Law. This BAA shall be governed by and construed in accordance with the laws of the State of Missouri to the extent that the HIPAA Authorities do not preempt the same.

8.10 Notice. Any notice required or permitted to be given by either party under this BAA shall be sufficient and effective if (a) in writing and hand delivered (including delivery by courier), or (b) delivered

by postage prepaid certified mail return receipt requested, in each case to the applicable address set forth below the receiving party's signature below. The party providing notice shall provide a copy of any notice under this section via email with return receipt requested to the email address in the signature block below or, if no email address is provided, to the primary business owner of the party receiving notice.

8.11 Independent Contractors. For purposes of this BAA, Covered Entity and Business Associate, and Covered Entity and any Subcontractor of Business Associate, are and will act at all times as independent contractors. None of the provisions of this BAA shall establish or be deemed or construed to establish any partnership, agency, employment agreement or joint venture between the parties.

8.12 Authority. Each party to this BAA warrants that it has full power and authority to enter into this BAA, and the person signing this BAA on behalf of either party warrants that he/she has been duly authorized and empowered to enter into this BAA.

Signatures:

COVERED ENTITY

By:_____
Name:_____
Title:_____
Date:_____

Notice Address:

Sunshine Health
Attention: Privacy Department
P.O. Box 459089
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BUSINESS ASSOCIATE

By:_____
Name:_____
Title:_____
Date:_____

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Attention: _____
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SECURITY & PRIVACY ADDENDUM

Security Governance, Risk Management and Compliance Management

1. Regulatory and Standards Implementation

    a) The Company must remain in compliance with HIPAA and all other applicable national and state privacy and security regulations.

    b) Confidential information, including PHI and ePHI, must never be stored outside of the United States.

    c) An information security officer must be assigned.

    d) A privacy officer must be assigned.

2. Security Training & Awareness

    a) An on-going and documented privacy and security awareness program must be established.

    b) Users must be aware of the company's privacy and security policies and the requirements to protect the information.

    c) Privacy and security awareness information must be distributed to all users on a defined periodic basis, no less than once per year.

    d) Mandatory privacy and security training must be delivered to, managed, and validated for all users at least once per year.

3. Privacy and Security Assessments

    a) An accurate and thorough assessment of the risks to the confidentiality, integrity, and availability of confidential information, including PHI and ePHI must be conducted at least once per year. Identified risks must be formally documented and managed through the risk management function and/or program.

4. Policies, Standards, and Procedure Management

    a) The following documented functions/ and/or programs must exist and be supported by executive management:
        i. risk management function and/or program
        ii. information security function and/or program
        iii. privacy function and/or program supported

    b) The risk management function and/or program must establish a repeatable process to assess gaps or deviations in the security posture for risk to the organization. Risk ownership and treatment must be identified by an appropriate level of management.

c) The information security function/program must establish security policies and standards that are enforced through automated systems, and administrative procedures that are maintained and updated as needed.

d) The privacy function/program must establish confidentiality policies that are maintained and updated as needed.

5. Issue and Corrective Action Management

a) Controls must be implemented to reduce risks and vulnerabilities to a reasonable and appropriate level, within the risk appetite.

b) A documented process must exist, and be adhered to, in order to report security issues affecting Centene to Centene's Information Security Officer.

c) A documented process must exist, and be adhered to, in order to report privacy issues affecting Centene PHI and ePHI to Centene's Privacy Officer.

6. Exception Management

a) Disciplinary measures for violations must be included in the Information Security and Privacy Program.

b) A documented security incident response plan must exist to ensure incidents are tracked, monitored, and investigated until closure is achieved.

c) A documented privacy incident response plan must exist to ensure that incidents are tracked, monitored, investigated and reported internally, and to Covered Entity until remediation and closure is achieved.

Third Party Risk Management

1. Evaluation & Selection

a) A documented process must exist to evaluate the privacy and security controls for the Company's agents, subcontractors and outsourced services prior to entering into any approved subcontracts.

2. Contract & Service Initiation

a) Subcontracted third parties with controls deviating from security requirements must be assessed for risk and have management action plans in place to mitigate to an acceptable risk level.

b) All subcontracts must contain all privacy and security requirements and protections as set forth in this Security Addendum.

c) Information containing PHI or ePHI must only be disclosed to third parties when a Business Associate Agreement and non-disclosure agreement are in effect.

3. Security & Compliance Review

    a) A documented process exists to review the privacy and security controls of agents, subcontractors and outsourced services on a periodic basis to reasonably assure they are maintaining the required level of protection.

4. Third Party Monitoring

    a) Agents, subcontractors, and outsourced services that perform critical services supporting this contract must be identified and documented.

    b) Agents, subcontractors, and outsourced services identified as providing critical services, or handling PHI must be monitored on an ongoing basis for contract compliance.

Identity & Access Management

1. User Account Management

    a) Access to systems and applications must require a unique identifier (e.g. user ID) and at minimum a password or equivalent control.

    b) User IDs must be locked after 5 consecutive unsuccessful login attempts.

    c) User IDs must be disabled after 60 days or less of inactivity.

    d) Passwords must be issued to users in a secure manner and be changed at first login.

    e) Password policies at a minimum must include minimum password length, alphanumeric composition, retention of password history, and password change frequency.

    f) Passwords must never be displayed on screens or on reports.

    g) Passwords must be encrypted in transmission and storage.

2. Access Management

    a) Access to confidential information, including PHI and ePHI, must be restricted to individuals that have a business need, and access control mechanisms must be implemented that limit access to confidential information.

    b) Security administration procedures must include procedures for

        - access requests for a new user,
        - changing access,
        - prompt deletion of terminated users,
        - user transfers and,
        - periodic verification of users and access rights.

c) All user access requests must be documented with management approval, including privileged users.

d) Documented remote access policies must exist and be enforced.

3. Privileged User Management

a) All default supplied user IDs must be disabled, renamed, or deleted wherever possible.

b) System IDs must be documented with descriptions of their functions and risks.

c) System IDs must be required to have passwords and documented risk analysis if password change frequency is not enforced.

d) System ID passwords must be stored in encrypted files.

e) System IDs must not be scripted into the application.

f) System IDs must not be accessible by an individual user for interactive use.

g) All vendor-supplied default passwords must be changed.

4. Data Platform Integration

a) All systems containing confidential information, including PHI and ePHI, must have system access controls to prevent unauthorized disclosure or modification.

b) Single sign on technologies must be leveraged wherever possible to eliminate the need for multiple access controls systems.

5. Access Reporting and Audit

a) All user access to systems containing confidential data, including PHI and ePHI, must be revalidated at least annually.

b) All User IDs and System IDs with privileged authorities must be revalidated at least quarterly.

6. Access Governance

a) User access must be defined by job roles to ensure segregation of duties.

b) User access must be logged and tracked to an individual for accountability.

7. Federation

a) Access to systems by agents, subcontractors, or outsourced services must be subject to the same Identity Management requirements as Company personnel.

Data Protection

1. Data Classification & Inventory

    a) A documented information classification scheme must be utilized to ensure proper protection, use, and destruction of Centene's data.

2. Data Lifecycle Analysis

    a) Systems containing confidential information, including PHI and ePHI, must be documented, including security and privacy controls.

    b) Documents showing the flow of sensitive data through systems and business processes must exist.

3. Data Encryption & Obfuscation

    a) Confidential information, including PHI and ePHI, must be encrypted with FIPS 140-2 compliant encryption protocols during storage on all devices including handhelds, laptops, workstations, and removable media.

    b) Information containing PHI and ePHI must be encrypted with FIPS 140-2 compliant encryption protocols during storage on servers.

    c) Confidential information, including PHI and ePHI, must be encrypted with FIPS 140-2 compliant encryption protocols during transmission over public or untrusted networks, including wireless or email transmissions.

    d) Business to business communications with confidential information, including PHI and ePHI, must be encrypted.

4. Data Loss Prevention

    a) A documented policy and process for the removal or movement of confidential information, including PHI and ePHI to unsecured systems or media must exist.

    b) Confidential information, including PHI and ePHI, stored on removable media must be secured with access restricted to those with a business need.

    c) Technical controls must exist to prevent transmission of confidential information, including PHI and ePHI to unauthorized recipients.

    d) Technical controls must exist to prevent storage of confidential information, including PHI and ePHI, on unsecured systems.

5. Data Retention and Destruction

    a) A documented policy and process for the removal or destruction of confidential information, including PHI and ePHI must exist. When appropriate, confidential

information, including PHI and ePHI, must be purged or destroyed using a NIST 800-88 approved process when no longer needed.

Secure Development Lifecycle

1. Security and Risk Requirements

    a) The System Development Life Cycle must include a documented process to conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of confidential information, including PHI and ePHI.

    b) Security controls must be considered throughout the System Development Life Cycle.

2. Security Design & Architecture

    a) Security controls must be designed to eliminate single points of failure.

    b) Systems must be designed to use a common security architecture.

    c) Production, test, and development environments must be physically and/or logically separated.

3. Application Role Design and Access Privileges

    a) Application security controls must be designed to ensure users can access only information they have an authorized business need for.

    b) Access must be controlled by a common access methodology or single sign on wherever feasible.

4. Secure Coding Guidelines

    a) Secure coding principles and practices must be documented and followed.

    b) Web application controls must be configured to prevent printing or downloading data to unauthorized workstation and/or mobile devices.

    c) Production information must not be used in development and test environments unless such environments are secured to the same level as production, or data has been de-identified as specified in HIPAA (45 CFR 164.514).

5. Secure Build

    a) New server and network equipment deployment procedures must ensure implementation of security configuration settings.

6. Security Testing

    a) All security controls must be tested prior to implementing new systems or upgrades into production.

    b) Where feasible, automated tools must be used for code review.

7. Roll-out and Go-live Management

    a) To retain separation of duties, staff other than developers must be responsible for moving systems or applications into the production environment.

    b) All non-standard access paths must be removed prior to being moved into production.

8. Application Security Administration

    a) Development staff must receive management approval to access production systems.

    b) Technical staff must not have access to production data, programs, or applications unless such access is required to perform their jobs.

Infrastructure, Operations and Network Security

1. Antivirus (AV) & Malware protection

    a) Documented policies and procedures for guarding against, detecting, and reporting malicious software must exist.

2. Intrusion Detection and Prevention

    a) Intrusion detection and prevention systems must be implemented for critical components of the network.

3. Network Access Controls

    a) Documented policies and procedures to prevent unauthorized/unsecured devices from accessing the network must exist.

4. Network and Application Firewalls

    a) Firewalls must be implemented and configured to deny all except authorized documented business services.

    b) Firewalls must be configured to fail in a prevent state.

5. Proxy/Content Filtering

    a) Documented policies and procedures to prevent confidential information, including PHI and ePHI, from being transmitted to unauthorized recipients or stored in unauthorized locations must exist.

6. Remote Access Controls

    a) Two-factor authentication must be implemented for all remote network access (*e.g.* VPN, Citrix, etc.).

7. Security Monitoring

    a) Documented policies and procedures to monitor networks, systems, and applications for potential security events must exist.

    b) A documented process to respond to potential security events on a 24x7x365 basis must exist.

    c) All significant computer security relevant events must be securely logged, and the logs must be periodically reviewed.

    d) Computer systems handling confidential information, including PHI and ePHI, must securely log all significant computer security relevant events, including the following:

        i. unauthorized attempts to enter the system,
        ii. unauthorized attempts to access protected information or resources,
        iii. all attempts to issue restricted commands,
        iv. security activities,
        v. special privileged user activities and
        vi. violation activities.

    e) All logs of computer security relevant events must be traceable to specific individuals wherever possible.

8. Wireless Security Controls

    a) Documented policies and procedures to prevent unauthorized wireless access to production systems must exist.

9. Database Security

    a) Documented policies and procedures to prevent unauthorized updates to databases must exist.

    b) All database access must be traceable to specific individuals.

10. Network Device Security

    a) All network devices supporting business critical systems must have physical and logical access controls.

    b) All network devices supporting business critical systems must have secured out-of-band management.

Cyber Threat and Vulnerability Management

1. OS Hardening & Secure Configuration

    a) Required security configuration settings must be selected and documented.

    b) Documented processes to periodically verify security configuration settings must exist.

    c) Any and all Workstations able to access any confidential information must actively and automatically blank the screen or enable a screen saver and require re-authentication after fifteen (15) minutes or less of inactivity.

2. Patch Management

    a) A documented patch management process must exist and be enforced.

    b) Security patches, service packs, & hot fixes must be promptly applied for all systems that store, process, manage, or control access to sensitive data, including PHI and ePHI.

3. Vulnerability Management

    a) Documented processes and procedures to identify, quantify, prioritize, track, and remediate vulnerabilities must exist.

4. Recurring Vulnerability Assessments and Penetration Testing

    a) Periodic third party penetration tests must be conducted from outside and within the network.

    b) Vulnerability assessment must be performed at least quarterly.

5. Incident and Problem Management

    a) A documented problem management system must exist.

    b) Audit logs must be implemented on all systems storing or processing critical or confidential information.

    c) Audit logs must be retained for a minimum of twelve (12) months.

d) Audit logs must be protected from unauthorized access and resistant to attacks including deactivation, modification or deletion.

e) Audit logs must be reviewed for inappropriate activities in a timely manner and appropriate actions must be taken to protect Centene associates, assets, systems, and data.

6. Capacity Management

a) A documented policy and process to evaluate current capacity against projected requirements must exist.

7. Configuration and Change Management

a) A three-tiered architecture must be deployed to isolate web applications from production information in the "internal" network.

8. Release Management

a) Segregation of duties between change management, developer, and infrastructure staff must be maintained.

b) Developers must not be able to update production resources without proper change management procedures for production updates/fixes.

c) All production systems and application resources must be changed through an enforced and documented change management process which includes appropriate reviews, testing, and management approvals.

d) Production code and systems must not allow undocumented changes or updates.

9. Asset and Configuration Management

a) Documented network diagrams must exist.

b) An auditable and documented inventory of information technology assets must exist in case of loss or theft.

Business Continuity, Enterprise Resilience, and Disaster Recovery

1. Business Impact Analysis:

a) Critical IT systems and components must be identified and documented, including recovery time objective and recovery point objective.

b) Business Associate must conduct a Business Impact Analysts (BIA) at a minimum of every two (2) years. The BIA must identify critical business processes, assets, and locations. The results of the BIA must be used to identify potential business disruptions, create mitigation and remediation plans, and enhance the resiliency of the organization.

2. Recovery Strategies

    a) The data center must maintain a back-up site(s).

    b) Mission critical information must be fully backed-up on a weekly basis and incremental changes must be backed up daily.

    c) Backed-up information must be stored encrypted with FIPS 140-2 compliant encryption protocols.

    d) Backed-up information must be stored in a secure off-site facility.

    e) Backed-up information must be stored off-line.

    f) Restoration of critical data back-ups must be no less semi-annually (every 6 months).

    g) Contracts for outsourced services must include disaster recovery agreements.

3. Recovery Plans and Procedures, and Maintenance

    a) A documented business continuity plan for business functions must be updated and maintained.

    b) The business continuity plan must be stored off-site in a secure location.

    c) Centene must be alerted of any deficiencies discovered in the business continuity plan that would adversely affect Centene.

    d) A documented disaster recovery plan for information technology must be updated and maintained.

    e) The disaster recovery plan must be stored off-site in a secure location.

    f) The disaster recovery plan must include policies and procedures for facility access during a disaster.

4. Testing and Exercising

    a) The business continuity plan for business functions must be tested periodically.

    b) The disaster recovery plan for information technology must be tested periodically.

5. Escalation and Crisis Management

    a) The business continuity plan must contain notification procedures to alert Centene of service disruptions including off-hour and weekend coverage.

    b) The disaster recovery plan must have notification procedures to alert Centene of service disruptions including off-hour and weekend coverage.

Physical Security

1. Policies, Standards, and Procedure Management

    a) A documented physical security function and/or program must exist.

    b) The physical security function/program must establish physical security policies and be enforced through automated systems and administrative procedures.

    c) All servers storing or processing confidential information, including PHI and ePHI, must be located in a secure data center or equivalent secure facility.

2. Facility Access Controls

    a) Employees must be required to wear identification badges at all times in sensitive facilities.

    b) Visitors must be required to be identified, sign in, wear temporary visitor badges, and be escorted in facilities containing Centene data.

    c) Data center access to sensitive areas, such as a computer room, must require two levels of authentication.

    d) Data center and other sensitive facilities access must be periodically reviewed to ensure that access is still valid.

    e) Facility access logs must be retained for at least six (6) months and be reviewed as needed.

3. Issue and Corrective Action Management

    a) Any known HIGH-risk physical security vulnerabilities affecting Centene must be communicated to Centene's Corporate Information Security Officer.

    b) Suspected cyber security incidents with a potential impact on Centene data and/or systems must be reported to Centene's Vice President of Cybersecurity within 24 hours. Examples include:

        a. Compromised email accounts that may affect Centene
        b. Compromised systems that have a trusted link to Centene networks
        c. Malware infections on systems used for Centene business

    c) Centene must have full control of messaging to media in the event of a potential security incident that affects Centene

    d) The Data Center facility must be equipped and maintained with fire detection/suppression, surge and brownout, air conditioning, and other computing

environment protection systems necessary to assure continued service for critical computer systems.

e) Policies and procedures must be in place to document repairs and modifications to physical components related to security (hardware, walls, doors and locks, etc.) of facilities where PHI and ePHI are stored.

f) All hardware and electronic media containing PHI and ePHI must be identified and tracked during movement.

g) A retrievable exact copy of PHI and ePHI must be created from equipment before being moved.

Changes

Centene may change the above security requirements by providing new requirements in writing to Business Associate. Business Associate shall comply with such new security requirements within thirty (30) days after receipt of notice. In the event Business Associate's compliance with the new requirements materially increases its cost to provide services under the Services Agreement(s), Business Associate shall notify Centene of the amount Business Associate believes is necessary to reimburse Business Associate for its actual and reasonable additional costs. If Centene elects not to reimburse Business Associate for such costs, then Centene may terminate this Agreement and/or any or all of the Services Agreements, in whole or in part, by sending written notice to Business Associate indicating which Services Agreements are being terminated and the effective date of termination. Such termination shall be without charge to Centene, except that Centene shall pay for all services under such terminated contract(s) that were properly rendered until the effective date of termination.