DENTAL PROVIDER AGREEMENT

THIS DENTAL PROVIDER AGREEMENT (“Agreement”) is made and entered into this [_____] day of [_______], 20___ (“Effective Date”), by and between [____________________] (“Provider”) and Managed Care of North America, Inc., d/b/a/ MCNA Dental Plans (“MCNA”).

WHEREAS, Provider is actively engaged in the practice of dentistry as a primary care or specialty Provider, and is duly licensed and practicing in accordance with the laws of the State;

WHEREAS, MCNA Insurance Company (“MIC”) is licensed to operate as an Accident and Health Insurance Company in the State of Texas and has been contracted by the State of Texas, Health and Human Services Commission (“HHSC”) to arrange for the provision of covered dental services to eligible Medicaid and CHIP recipients;

WHEREAS, MCNA is a licensed third party administrator in the State of Texas, and has been contracted by MIC to provide various administrative services and to arrange for the provision of covered dental services as required by the State Contract; and

WHEREAS, the agreement between MCNA and MIC is referred to as the “Payor Contract” and the contract between MIC and HHSC is referred to as the “State Contract”;

WHEREAS, Provider agrees that such contracts shall control in the interpretation of this Agreement;

WHEREAS, MCNA wishes to contract with Provider to provide certain Covered Services to Covered Persons.

WHEREAS, Provider desires to provide the Covered Services specified in this Agreement to Covered Persons for the consideration, and under the terms and conditions, set forth in this Agreement;

NOW, THEREFORE, in consideration of the premises and mutual promises herein stated, the parties hereby agree as follows:

ARTICLE I

Page 1 of 30
DEFINITIONS

As used in this Agreement and each of its Attachments, each of the following terms (and the plural thereof, when appropriate) shall have the meaning set forth herein:

“Affiliate(s)” means a person or entity controlling, controlled by, or under common control with MCNA.

“Attachment(s)” means the attachment(s) to this Agreement, including addenda and exhibits, incorporated herein by reference. Attachments are state specific or product specific, and supplement the terms and conditions of this Agreement and are intended to be incorporated herein.

“Clean Claim” has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, “Clean Claim” shall have the meaning set forth in the Provider Manual.

“Covered Person” means a person eligible for, and enrolled in, MCNA or an Affiliate to receive Covered Services.

“Covered Services” means those Medically Necessary dental care services covered under the terms of the applicable Payor Contract and rendered in accordance with the Provider Manual.

“Emergency or Emergency Care” has, as to each particular product, the meaning set forth in the Attachment pertaining to each such product. If there is no definition for a particular product, Emergency Care shall mean inpatient and outpatient Covered Services furnished by a qualified provider that are needed to evaluate or stabilize an Emergency Medical Condition.

“Emergency Medical Condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.

“Dental Director” means a duly licensed Provider or his/her Provider designee designated by MCNA to monitor and evaluate the appropriate utilization of Covered Services by Covered Persons.
“Medically Necessary” means, unless otherwise defined in the applicable Attachment, any dental care services determined by MCNA’s Dental Director or Dental Director’s designee to be required to preserve and maintain a Covered Person’s oral health, provided in the most appropriate setting and in a manner consistent with the most appropriate type, level, and length of service, which can be effectively and safely provided to the Covered Person, as determined by acceptable standards of medical practice and not solely for the convenience of the Covered Person, Covered Person’s Provider, Provider or other health care provider.

“Participating Dental Care Provider” means any Provider, or other dental care provider that has contracted directly or indirectly with MCNA to provide Covered Services to Covered Persons and is credentialled in accordance with the MCNA’s credentialing criteria.

“Payor” means MIC.

“Payor Contract” means MCNA’s contract with any Payor that governs the provision of Covered Services to Covered Persons.

“Provider Manual” means the MCNA manual of policies, procedures, and requirements to be followed by Participating Dental Care Providers. The Provider Manual includes, but is not limited to, utilization management, quality management, grievances and appeals, and Payor-specific program requirements, and may be changed from time to time by MCNA.

“State” is defined as the state set forth in the Attachment(s) attached hereto.

ARTICLE II
MCNA’S OBLIGATIONS

1. Administration. MCNA shall be responsible for the administrative activities necessary or required for the commercially reasonable operation of an administrative services organization. Such activities shall include, but are not limited to, quality improvement, utilization management, grievances and appeals, claims processing, and maintenance of provider directory and records.

2. Provider Manual. MCNA shall make the Provider Manual available to Provider via MCNA’s website and upon Provider’s request. MCNA shall post changes to the Provider Manual on MCNA’s website and provide Provider with prior written notice of material changes to the Provider Manual. The Provider Manual is specifically incorporated herein and made a part of this Agreement. Provider and MCNA intend for, and shall be bound by this Agreement, any Attachments, and the Provider Manual, as one integrated contract.

3. Identification Cards. MCNA shall issue to Covered Persons an identification card that shall bear the name of the Covered Person and a unique identification number.

4. Benefits and Eligibility Verification. MCNA or HHSC, as determined by the Payor or State Contract, shall be responsible for all eligibility and benefit determinations regarding
Covered Services and all communications to Covered Persons regarding final benefit determinations, eligibility, bills, and other matters relating to their status as Covered Persons.

5. **MCNA’s Dental Director.** MCNA shall provide a Dental Director to be responsible for the professional and clinical operations of MCNA.

**ARTICLE III**

**PROVIDER’S OBLIGATIONS**

1. **Covered Services.** Provider shall provide to Covered Persons those Covered Services described in the applicable Attachment(s) in accordance with the Provider Manual and according to the generally accepted standards of dental practice in the Provider’s community, the scope of Provider’s license, and the terms and conditions of this Agreement. Provider shall make necessary and appropriate arrangements to assure the availability of Covered Services to Covered Persons on a twenty-four (24) hour per day, seven (7) day per week basis, including arrangements to assure coverage of Covered Persons after-hours or when Provider is otherwise absent. Provider further agrees that such arrangements will be with a Provider that is a Participating Health Care Provider.

2. **Provider Qualifications.** Provider shall be licensed to practice dentistry in the State and shall maintain good professional standing at all times. Evidence of such licensure shall be submitted to MCNA upon request. Finally, Provider shall be a duly qualified provider under the Medicaid program of the State.

3. **Compliance with MCNA Policies and Procedures.** Provider shall at all times cooperate and comply with the policies and procedures of MCNA, including, but not limited to, the following:
   
   A. MCNA’s credentialing criteria;
   B. MCNA’s Provider Manual;
   C. MCNA’s dental management program including quality improvement, utilization management, disease management, and case management;
   D. MCNA’s grievance and appeal procedures; and
   E. MCNA’s coordination of benefits and third party liability policies.

4. **Determination of Covered Person Eligibility.** Provider shall verify, in accordance with the Provider Manual, whether an individual seeking Covered Services is a Covered Person. If MCNA determines that such individual was not eligible for Covered Services at the time the services were rendered, such services shall not be eligible for payment under this Agreement, and Provider may bill the individual or other responsible entity for such services.
5. **Emergency Care.** Provider shall provide Emergency Care in accordance with applicable federal and State laws and the State Contract. Provider shall notify MCNA within twenty-four (24) hours or by the next business day of rendering or learning of the rendering of Emergency Care to a Covered Person.

6. **Acceptance of New Patients.** To the extent that Provider is accepting new patients, Provider must also accept new patients who are Covered Persons. Provider shall provide MCNA forty-five (45) days written notice prior of Provider’s decision to no longer accept Covered Persons. In no event shall any established patient of Provider who becomes a Covered Person be considered a new patient.

7. **Referrals; Reporting to Primary Care Providers.** If Provider is a specialist, the following shall apply: Provider shall provide Covered Services to Covered Persons upon referral from a MCNA primary dental care provider (“PDP”) or MCNA, and shall arrange for any appropriate referrals of Covered Persons in accordance with the requirements of the Provider Manual. Provider shall, within a reasonable time following consultation with, or testing of, a Covered Person (not to exceed one (1) week), make a complete written report to the Covered Person’s PDP, provided that, with respect to findings which may indicate a need for immediate or urgent follow-up treatment or testing or which may indicate a need for further or follow-up care outside the scope of the referral authorization or outside the scope of Provider’s area of expertise, Provider shall provide an immediate oral report to the Covered Person’s PDP, not to exceed twenty-four (24) hours from the time of Provider’s consultation or Provider’s receipt of the report of the testing, as applicable.

8. **Preferred Drug List/Drug Formulary.** If applicable to the Covered Person’s coverage, Provider shall abide by MCNA’s formulary or preferred drug list when prescribing medications for Covered Persons.

9. **Treatment Decisions.** MCNA shall not be liable for, nor will it exercise control over, the manner or method by which Provider provides or arranges for Covered Services. Provider understands that MCNA’s determinations, if any, to deny payments for services which MCNA does not deem to constitute Covered Services or which were not provided in accordance with the requirements of this Agreement, the Attachments or the Provider Manual, are administrative decisions only. Such a denial does not absolve Provider of Provider’s responsibility to exercise independent judgment in Covered Person treatment decisions. Nothing in this Agreement is intended to interfere with Provider’s provider-patient relationship with Covered Person(s).

10. **Covered Person Communication.** Provider shall obtain MCNA’s approval for Covered Person communication as required by the Payor or State Contract and applicable State and federal law. Nothing in this Agreement shall be construed as limiting Provider’s ability to communicate with Covered Persons with regard to quality of health care or medical treatment decisions or alternatives regardless of Covered Service limitations under the Payor Contract.
11. **Dental Office Space.** Provider agrees that the dental office space at which Covered Services are provided hereunder shall be maintained in accordance with applicable federal and State laws and the standards contained in the Provider Manual.

12. **Disparagement Prohibition.** Provider agrees not to disparage Payor or MCNA in any manner during the term of this Agreement or in connection with any expiration, termination or non-renewal of this Agreement. Provider shall not interfere with MCNA’s contractual relationships including, but not limited to, those with other Participating Dental Care Providers. Nothing in this provision, however, shall be construed as limiting Provider’s ability to inform patients that this Agreement has been terminated or otherwise expired or to promote Provider to the general public or to post information regarding other health plans consistent with Provider’s usual procedures, provided that no such promotion or advertisement is directed at any specific Covered Person or group of Covered Persons.

13. **Nondiscrimination.** Provider will provide services to Covered Persons without discrimination on account of race, sex, sexual orientation, age, color, religion, national origin, place of residence, health status, type of payor, source of payment, physical or mental disability or veteran status, and will ensure that its facilities are accessible as required by Title III of the Americans With Disabilities Act of 1991 (“ADA”). Provider recognizes that as a governmental contractor, MCNA is subject to various federal laws, executive orders and regulations regarding equal opportunity and affirmative action, which also may be applicable to subcontractors.

14. **Written Notice.** Provider shall give written notice to MCNA of: (i) any action involving Provider’s hospital privileges or conditions relating to Provider’s ability to admit patients to any hospital or inpatient facility; (ii) any situation which develops regarding Provider, when notice of that situation has been given to the State agency that licenses Provider, or any other licensing agency or board, or any situation involving an investigation or complaint filed by the State agency that licenses Provider, or any other licensing agency or board, regarding a complaint against Provider’s license; (iii) when a change in Provider’s license to practice dentistry is affected or any form of reportable discipline is taken against such license; (iv) suspension or exclusion under a federal health care program, including but not limited to, Medicaid; (v) any government agency request for access to records; or (vi) any lawsuit or claim filed or asserted against Provider alleging professional malpractice, regardless of whether the lawsuit or claim involves a Covered Person. In any such instance described above, Provider must notify MCNA in writing within ten (10) days from the date Provider first receives notice, whether written or oral, with the exception of those lawsuits or claims which do not involve a Covered Person, with respect to which Provider has thirty (30) days to notify MCNA.

15. **Use of Name.** Provider agrees that MCNA may use Provider’s name, address, phone number, type of practice, and an indication of Provider willingness to accept additional Covered Persons in MCNA’s roster of Participating Dental Care Providers and marketing materials.
ARTICLE IV
COMPLIANCE WITH LAW

1. Compliance with Law and Payor Contracts. Provider and MCNA agree that each party shall carry out its obligations in accordance with terms of the Payor or State Contract and applicable federal and State laws and regulations, including, but not limited to, the requirements of the Stark law (42 U.S.C. § 1395nn) and applicable federal and State self-referral and fraud and abuse statutes and regulations. If, due to Provider’s noncompliance with law, the State Contract, the Payor Contract or this Agreement, sanctions or penalties are imposed on MCNA, MCNA may, in its sole discretion, offset sanction or penalty amounts against any amounts due Provider from MCNA or require Provider to reimburse MCNA for the amount of any such sanction or penalty.

2. HIPAA Compliance. Provider and MCNA shall abide by the administrative simplification provisions of the Health Insurance Portability and Accountability Act (“HIPAA”), its implementing regulations [42 C.F.R. parts 160 and 164] and all other federal and State laws regarding confidentiality and disclosure of medical records and other health and Covered Person information, including safeguarding the privacy and confidentiality of any protected health information (“PHI”) that identifies a particular Covered Person. The Provider will also comply with the Health Information Technology For Economic and Clinical Health Act (HITECH) provisions of the American Recovery and Reinvestment Act of 2009. Provider shall assure its own compliance and that of its business associates with HIPAA and HITECH.

ARTICLE V
CLAIMS SUBMISSION, PROCESSING, AND COMPENSATION

1. Claims or Encounter Submission. Provider shall submit to MCNA claims or encounters for Covered Services in accordance with the Provider Manual. MCNA reserves the right to deny payment to Provider if Provider fails to submit its claims in accordance with the Provider Manual. If applicable based on Provider’s compensation arrangement, Provider shall submit encounter data to MCNA in a timely fashion, which shall contain such statistical and descriptive dental and patient data and identifying information as specified in the Provider Manual.

2. Compensation. MCNA shall pay Clean Claims from Provider for Covered Services provided to Covered Persons in accordance with Attachment B less any applicable co-payments, cost-sharing or other amounts that are the Covered Person’s financial responsibility. If a Provider provides any Covered Service not specified in the State Contract or any non-covered Service, Provider shall not be entitled to any compensation for such services. Provider shall accept such compensation with the exception of applicable copayments, and/or deductibles (Co-payments) as payment in full for all services provided by Provider except as otherwise provided by this Agreement.

3. Financial Incentives. Nothing in this Agreement shall, or shall be construed to, create any financial incentive for Provider to withhold Medically Necessary services.
4. **Covered Person Hold Harmless.** Provider agrees that in no event including, but not limited to, non-payment by MCNA, MCNA insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Covered Person for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or other amounts that are the Covered Person’s financial responsibility. This provision shall survive termination or expiration of this Agreement for any reason, shall be construed for the benefit of Covered Persons, and supersedes any oral or written agreement entered into between the Provider and a Covered Person.

5. **Recoupment Rights.** Payor or MCNA shall have the right to immediately recoup any and all amounts owed by Provider to Payor, MCNA or any Affiliate against amounts owed by Payor, MCNA or Affiliate to Provider. Provider agrees that all recoupment and any offset rights under this Agreement shall constitute rights of recoupment authorized under State or federal 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 Provider.

6. **Coordination of Benefits:** Provider shall bill and process forms for any and all third-party payors who have primary liability, prior to submission to MCNA. To collect any amounts due, Provider shall supply MCNA such relevant information as it has collected from Covered Persons regarding coordination of benefits. If Provider fails to commence such billing and processing within ninety (90) days of the rendition of care, MCNA shall have the exclusive right, at its sole discretion, to pursue such collections and retain all funds received. MCNA shall perform coordination of benefits for all other services and shall be entitled to retain all funds collected. Provider shall only bill MCNA for the difference, if any, between the amount due from all other third-party payors and the amount due under this Agreement as set forth in Attachment B, to the extent that such other payments do not constitute payment in full by such other third-party payors under applicable laws, regulations or any agreement between Provider and other third-party payors. MCNA shall reimburse said difference from Provider according to applicable state and federal laws.

**ARTICLE VI**

**RECORDS/INSPECTIONS**

1. **Dental Records.** Provider shall maintain a complete and accurate permanent dental record for each Covered Person to whom Provider renders services under this Agreement and shall include in that record all reports from Participating Dental Care Providers and all documentation required by applicable law, regulations, professional standards. The Provider Manual, and State Contract. Dental records of Covered Persons shall be treated as confidential so as to comply with all federal and State laws and regulations regarding the confidentiality of the patient records.

2. **Records.** Provider shall maintain records related to services provided to Covered Persons and provide such dental, financial and administrative information to MCNA and State and federal government agencies as may be necessary for compliance by Payor or MCNA with State and federal law and accreditation standards, as well as for the administration of this Agreement.
and the State Contract. MCNA shall have access at reasonable times to books, records, and papers of the Provider relating to the dental care services provided to Covered Persons for Covered Services.

3. **Consent to Release Dental Records.** Provider shall obtain Covered Person authorizations relative to the release of dental information required by applicable law to provide MCNA or other authorized parties with access to Covered Persons’ records.

4. **Access.** In accordance with applicable law, Provider shall provide access to Provider’s records to the following, including any designee or duly authorized agent:

   A. Payor and MCNA during regular business hours and upon three (3) days prior notice;

   B. government agencies, to the extent such access is necessary to comply with regulatory requirements that apply to MCNA or Payor; and

   C. accreditation agencies.

Provider shall provide copies of records at no expense.

5. **Record Transfer.** Subject to applicable law, the State Contract and Payor Contract requirements, Provider shall cooperate in the timely transfer of Covered Persons’ dental records to any other health care provider at no charge and when required.

6. **On-Site Inspections.** Provider agrees that dental office space or its facilities, as applicable, shall be maintained in accordance with applicable federal and State regulatory requirements, and the MCNA Provider Manual. Provider shall cooperate in on-site inspections of dental office space by MCNA, authorized government officials, and accreditation bodies. Provider shall compile any and all information in a timely manner required to evidence Provider’s compliance with this Agreement, as requested by such agency(ies), or as otherwise necessary for the expeditious completion of such on-site inspection.
ARTICLE VII
INSURANCE

1. Provider Insurance. During the term of this Agreement, Provider shall maintain policies of general and professional liability insurance and other insurance that are necessary to insure Provider and any other person providing services hereunder on Provider’s behalf, against any claim(s) of personal injuries or death alleged or caused by Provider’s performance under this Agreement. Such insurance shall include, but not be limited to, tail or prior acts coverage necessary to avoid any gap in coverage. Insurance shall be through a licensed carrier, and in a minimum amount of one million dollars ($1,000,000) per occurrence, and have an annual aggregate of no less than three million dollars ($3,000,000) unless a lesser amount is accepted by MCNA or where State law mandates otherwise. Provider will provide MCNA with at least fifteen (15) days notice of such cancellation, non-renewal, lapse, or adverse material modification of coverage. Upon MCNA’s request, Provider will furnish MCNA with evidence of such insurance.

2. Other Insurance. All parties to this Agreement shall maintain in full force and effect appropriate workers’ compensation protection and unemployment insurance as required by law.

ARTICLE VIII
INDEMNIFICATION

1. MCNA Indemnification. Provider agrees to indemnify and hold harmless (and at MCNA’s request defend) MCNA, its Affiliates, officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney’s fees, and attorney’s fees to enforce this indemnity), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omissions of Provider, its agents or employees in the performance of Provider’s obligations under this Agreement.

2. Provider Indemnification. MCNA agrees to indemnify and hold harmless (and at Provider’s request defend) Provider, its officers, employees and agents from and against any and all claims, loss, damages, liability, costs, expenses (including reasonable attorney’s fees and attorney’s fees to enforce this indemnity), judgments, or obligations arising from or in connection with third party claims alleging any negligence or otherwise wrongful act or omission of MCNA, its agents or employees in the performance of MCNA’s obligations under this Agreement.

ARTICLE IX
DISPUTE RESOLUTION

1. Informal Dispute Resolution. Any disputes between the parties arising with respect to the performance or interpretation of this Agreement (“Dispute”) shall first be resolved by exhausting the processes available in the Provider Manual, then 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 for negotiation, either party may initiate arbitration in accordance with the Arbitration section of this Agreement by providing written notice to the other party.

2. **Arbitration.** If a Dispute is not resolved in accordance with the Informal Dispute Resolution section of this Agreement, 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”). In no event may any arbitration be initiated more than one (1) year following the end of the sixty (60) day negotiation period of the Informal Dispute Resolution section of this Agreement. Arbitration proceedings shall be conducted at a mutually agreed upon location within the State. 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. During an arbitration proceeding, each party shall continue to perform its obligations under this Agreement pending the decision of the arbitrator. The site of arbitration shall be at the corporate offices of MCNA in Dade County, Florida or such other location as MCNA shall choose.

**ARTICLE X**
**TERM AND TERMINATION**

1. **Term.** This Agreement shall have an initial term of ____ (__) year(s), commencing on the Effective Date. Thereafter, this Agreement shall automatically renew for terms of one (1) year each. Notwithstanding the foregoing, this Agreement may terminate in accordance with the Termination sections below.

2. **Termination of Agreement.** This Agreement may be terminated under any of the following circumstances:

   A. By either party upon ninety (90) days prior written notice effective at the end of the initial term or at the end of any renewal term;

   B. By either party upon thirty (30) days prior written notice if the other party is in material breach of this Agreement, except that such termination shall not take place if the breach is cured within thirty (30) days following the written notice;

   C. Immediately upon written notice by MCNA if there is imminent harm to patient health or fraud or malfeasance is suspected;

   D. Immediately upon written notice by either party if the other party becomes insolvent or has bankruptcy proceedings initiated against it;
E. Immediately upon written notice by Provider if MCNA loses, relinquishes, or has materially affected its certificate of authority to operate as an administrative services organization; or

F. Immediately upon written notice by MCNA if Provider fails to adhere to MCNA’s credentialing criteria, including, but not limited to, if Provider (1) loses, relinquishes, or has materially affected its license to provide Covered Services in the State, (2) fails to comply with the insurance requirements set forth in this Agreement; or (3) is convicted of a criminal offense related to involvement in any Medicare or Medicaid program or has been terminated, suspended, barred, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from any Medicare or Medicaid program.

3. Rights and Obligations Upon Termination. Upon termination, the rights of each party hereunder shall terminate, provided, however, that such action shall not release the Provider or MCNA of their obligations with respect to: (a) payments accrued to Provider prior to termination; (b) Provider’s agreement not to seek compensation from Covered Persons for Covered Services prior to termination; and (c) completion of treatment of Covered Persons who are receiving care until continuation of the Covered Person’s care can be arranged by MCNA as determined by the Dental Director or as required by applicable law or the Payor Contract or the State Contract. Services provided during continuation of care shall be reimbursed in accordance with the terms of this Agreement.

4. Notification of Specialist Termination. If Provider is a specialist, Provider acknowledges the right of MCNA to inform Covered Persons of Provider’s termination. In the event this Agreement is terminated, MCNA shall provide written notice within thirty (30) business days of receipt, or issuance of a notice of termination, to all Covered Persons who are seen on a regular basis by Provider, regardless of whether the termination was for cause or without cause.

5. Survival of Obligations. Any obligations that cannot be fully performed prior to the termination of this Agreement including, but not limited to, obligations in the following provisions set forth in this Section, shall survive the termination of this Agreement: Article III Section 0 (Disparagement Prohibition); Article IV (Compliance With Law); Article V Section 0 (Covered Person Hold Harmless); Article VI (Records/Inspection); Article VII (Insurance); Article VIII (Indemnification); Article IX (Dispute Resolution); Article X Section 3 (Rights and Obligations Upon Termination).
ARTICLE XI
MISCELLANEOUS

1. **Relationship of Parties.** The relationship among the parties is that of independent contractors. None of the provisions of this Agreement are intended to create, or to be construed as creating, any agency, partnership, joint venture, employee-employer, or other relationship. Neither party shall have or exercise any control or direction over the means or methods by which the other shall perform such work or render or perform such services and functions. MCNA shall have no right to control the means, methods, manner or scope by which Provider renders or performs Covered Services.

2. **Conflicts Between Certain Documents.** If there is any conflict between this Agreement and the Provider Manual, this Agreement shall control. In the event of any conflict, however, between this Agreement and any Attachment hereto, the Attachment shall be controlling as to the product described in that Attachment. In the event of any conflicts between this Agreement, or any Attachment hereto, and the applicable Payor Contract with respect to what services constitute Covered Services, the Payor Contract shall control. In the event of any conflicts between this Agreement, or any Attachment hereto, and the applicable State Contract with respect to what services constitute Covered Services and other obligations indicted herein, the State Contract shall control.

3. **Assignment; Delegation of Duties.** This Agreement is intended to secure the services of and be personal to Provider, and shall not be assigned, sublet, delegated or transferred by Provider without the prior written consent of MCNA. In the event that Provider is a professional corporation, professional association or partnership rather than an individual dentist or provider, Provider agrees that all of the terms set forth herein applicable to a Provider shall apply with equal force to both the professional corporation, professional association or partnership and the individual dentist or Providers associated with such entity.

4. **Headings/Recitals.** The headings of the sections of this Agreement are inserted merely for the purpose of convenience and do not, expressly or by implication, limit, define, or extend the specific terms of the section so designated. The Recitals are incorporated into this Agreement.

5. **Governing Law.** All matters affecting the interpretation of this Agreement and the rights and obligations of the parties hereto shall be governed by and construed in accordance with applicable federal and State laws of the State where the Covered Services are provided pursuant to this Agreement.

6. **Third Party Beneficiary.** Except as specifically provided herein, the terms and conditions of this Agreement shall be for the sole and exclusive benefit of Provider and MCNA. Nothing herein, express or implied, is intended to be construed or deemed to create any rights or remedies in any third party.
7. **Amendment.** This Agreement, including all Attachments, may be amended at any time by mutual written agreement of the parties. This Agreement and any of its Attachments may also be amended by MCNA furnishing Provider with any proposed amendments. Unless Provider objects in writing to such amendment during the thirty (30) day notice, Provider shall be deemed to have accepted the amendment. Notwithstanding the foregoing, this Agreement shall be automatically amended as necessary to comply with any applicable State or federal law or regulation and applicable provision of the Payor Contract or State Contract.

8. **Entire Agreement.** This Agreement, its Attachments, and the Provider Manual contain all the terms and conditions agreed upon by the parties and supersede all other agreements, oral or otherwise, of the parties hereto, regarding the subject matter of this Agreement.

9. **Severability.** The invalidity or unenforceability of any terms or provisions hereof shall in no way affect the validity or enforceability of any other terms or provisions.

10. **Waiver.** The waiver by either party of the violation of any provision or obligation of this Agreement shall not constitute the waiver of any subsequent violation of the same or other provision or obligation.

11. **Notices.** Any notice required to be given pursuant to the terms and provisions hereof shall be in writing and shall be sent by certified mail, return receipt requested, postage prepaid, or by recognized courier service, addressed as follows:

<table>
<thead>
<tr>
<th>To MCNA at:</th>
<th>To Provider at:</th>
</tr>
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</table>
| Attn: General Counsel  
MCNA Dental Plans  
200 W. Cypress Creek Blvd.  
Suite 500  
Ft. Lauderdale, Fl. 33309 |                                |
12. **Force Majeure.** Neither party shall be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting, directly or indirectly, from acts of God, civil or military authority, acts of public enemy, war, accidents, fires, explosions, earthquake, flood, strikes or other work stoppages by either party’s employees, or any other similar cause beyond the reasonable control of such party.

13. **Confidentiality.** Neither party shall disclose the substance of this Agreement nor any information acquired from the other party during the course of or pursuant to this Agreement to any third party, unless required by law. Provider acknowledges and agrees that all information relating to MCNA’s programs, policies, protocols and procedures is proprietary information and further agrees not to disclose such information to any person or entity without MCNA’s express written consent.

14. **Authority.** The parties whose signatures are set forth below represent and warrant that they are duly empowered to execute this Agreement.

**THIS AGREEMENT CONTAINS A BINDING ARBITRATION PROVISION THAT MAY BE ENFORCED BY THE PARTIES.**

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

Managed Care of North America, Inc., d/b/a/ MCNA Dental Plans, a Florida corporation

[Provider]

By: ________________________________
Printed Name: ________________________________
Title: ________________________________
Signature Date: ________________________________
ATTACHMENT A

STATE OF TEXAS MEDICAID AND CHIP MANAGED CARE PROGRAM
PRODUCT AND STATE MANDATED ATTACHMENT

This State of Texas Product and State Mandated Attachment (the “Attachment”) is
incorporated into the Dental Provider Agreement (the “Agreement”) entered into by and between
________________________ (in this Product Attachment referred to as “Provider”) and Managed Care
of North America, Inc., d/b/a MCNA Dental Plans (“MCNA”).

ARTICLE I
PRELIMINARY STATEMENTS

1.1 MCNA is licensed to operate as a third party administrator in the State of Texas and has
been contracted by MCNA Insurance Company (“MIC”) to arrange for the provision of
covered dental services to eligible Medicaid members assigned to said MIC. All terms
defined, have the same meaning as contained in the Agreement, unless otherwise defined
herein.

1.2 Provider has entered into the Agreement with MCNA. This Product Attachment is
intended to supplement the Agreement by setting forth the parties’ rights and
responsibilities related to the provision of Covered Services to Covered Persons as it
pertains to the Texas Medicaid and CHIP programs. In the event of a conflict between
the terms and conditions of the Agreement and the terms and conditions of this Product
Attachment, this Product Attachment shall govern.

1.3 Notwithstanding any provisions set forth in this Product Attachment, to the extent
applicable, Provider shall comply with all duties and obligations under the Agreement,
the Provider Manual and this Product Attachment. Provider agrees and understands that
Covered Services shall be provided in accordance with the MCNA clinical guidelines
contained in the Provider Manual, any applicable State handbooks or policy and
procedure guides, and all applicable State and federal laws and regulations. To the extent
Provider is unclear about Provider’s duties and obligations, Provider shall request
clarification from MCNA.

ARTICLE II
DEFINITIONS

The definitions listed below will supersede any meanings contained in the Agreement.

“Covered Persons or Member” means a person eligible to receive covered services from MIC.

“Department” means the State of Texas, Health and Human Services Commission (“HHSC”),
or its designee.

“Emergency Medical Condition” means the following, as defined in 42 USC 1395dd(e) and
CFR 438.114:

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

(1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
(2) serious impairment of bodily functions, or
(3) serious dysfunction of any bodily organ or part; or

“Emergency Medical Services or Emergency Care” means care for a condition as defined in 42 USC 1395dd and 42 CFR 438.114.

“Medically Necessary or Medical Necessity” means Covered Services which are medically necessary as defined under 42 CFR §440.230, including children’s services pursuant to 42 U.S.C. 1396d(r).

“Primary Dental Provider or PDP” means a licensed or certified dentist or health clinic including a FQHC or rural health clinic that functions within the scope of licensure or certification and agrees to provide twenty-four (24) hours per day, seven (7) days a week primary dental care services to Members. The PDP is the patient’s initial and most important contact with MCNA.

“State” means the State of Texas, as represented through any agency, department, board, or commission.

“State Contract” has the same meaning as given in the Agreement.

“Urgent Care” means care for a condition not likely to cause death or lasting harm but for which treatment should not wait for a normally scheduled appointment.

ARTICLE III
PRODUCT REQUIREMENTS

3.1 **Compliance with State Contract.** Provider shall comply with all applicable federal, State and local laws and regulations, and all amendments thereto. Provider understands and agrees that this Product Attachment and/or the Agreement shall be deemed automatically amended as necessary to comply with any applicable State or federal or regulation, or any applicable provision of the State Contract.

3.2 **Emergency and Urgent Care.** Emergency Care provided by Provider shall be available to Covered Persons twenty-four (24) hours, seven (7) days a week. Urgent care services
shall be provided within forty-eight (48) hours of receipt of the request for Urgent Care services.

3.3 **Encounter Records.** Provider shall comply with MCNA’s electronic health encounter records submission in a format to be provided by MCNA to Provider and as required by the Department. Such encounter records shall be submitted in a timely fashion as directed by MCNA. Provider shall submit encounter records in the format specified by Department so that the MCNA can meet Department’s specifications.

3.4 **Dental Records.** Provider shall keep Covered Persons dental records in paper and electronic format. Complete dental records include, but are not limited to, charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals’ findings, appointment records, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided under the Agreement. Such records shall be retained by Provider for the period of time required by all applicable laws or regulations, but in no event less than the later of seven (7) years from the date the service was rendered or termination of the Agreement. Provider shall allow MCNA, the Department and the Office of Inspector General, and other authorized State and federal agents access to all medical records of Covered Persons for the purposes of auditing.

3.5 **Cultural Consideration and Competency.** Provider shall deliver Covered Services in a culturally competent manner to all Covered Persons, including those with limited English proficiency and diverse cultural and ethnic backgrounds.

3.6 **Qualifications and Credentialing Criteria.** Provider shall hold all necessary licenses, registrations and/or certifications required under State or federal law to provide the services contracted for hereunder and shall at all times meet, maintain and adhere to the policies and procedures of MCNA and other requirements, including but not limited to (1) policies and procedures of MCNA relating to certification to participate in any federal or State health care program including but not limited to the Medicaid and CHIP program; (2) the Provider Manual; (3) requirements of the Department; and (4) policies and procedures relating to licensure, certification, accreditation, utilization management/quality assurance (including requirements for review of Provider’s services by MCNA personnel and committees), complaints/appeals, and administrative policies such as those (by way of example but not limitation) relating to claims submission, coordination of benefits, and coverage verification. Provider will be subject to re-credentialing by MCNA three (3) years from the Provider’s credentialing committee approval date. Providers shall give immediate notice to MCNA of any event that causes Providers to be out of compliance with its ability to fulfill its obligations under this Agreement, or of any change in Providers’ name, ownership, control, or taxpayer identification number.

3.7 **Nondiscrimination by MCNA.** MCNA shall not discriminate against Provider who services high-risk populations or who specializes in conditions that require costly treatment or based upon that Provider’s licensure or certification.
3.8 **Ethical Reasons for Non-Performance of Medical Treatment.** MCNA shall not require Provider to perform any treatment or procedure which is contrary to the Provider’s conscience, religious beliefs, or ethical principles and shall meet the requirements of 42 C.F.R. 438.102. In such instances, Provider shall consult MCNA when referring the Covered Person to another health care provider licensed, certified or accredited to provide care for the individual service or assigned to another PDP licensed to provide care appropriate to the Covered Person’s dental condition.

3.9 **Covered Person Communications.** Nothing in the Agreement shall be construed as imposing restrictions upon the Provider’s free communication with a Member about the Member’s medical conditions, treatment options, MIC referral policies, and other MIC or MCNA policies, including financial incentives or arrangements and all managed care plans with whom the Provider contracts.

3.10 **Representation and Warranty.** Provider represents and warrants that neither Provider nor any individual who has a direct or indirect ownership or controlling interest of 5% or more of the Provider, nor any officer, director, agent or managing employee (i.e., general manager, business manager, administrator, director or like individual who exercises operational or managerial control over Provider or who directly or indirectly conducts the day-to-day operation of Provider) is an entity or individual (1) who has been convicted of any offense under Section 1128(a) of the Social Security Act (42 U.S.C. §1320a-7(a)) or of any offense related to fraud or obstruction of an investigation or a controlled substance described in Section 1128(b)(1)-(3) of the Social Security Act (42 U.S.C. §1320a-7(b)(1)-(3)); or (2) against whom a civil monetary penalty has been assessed under Section 1128A or 1129 of the Social Security Act (42 U.S.C. §1320a-7a; 42 U.S.C. §1320a-8); or (3) who has been excluded from participation in a program under Title XVIII, 1902(a)(39) and (41) of the Social Security Act, Section 4724 of the BBA or under a Commonwealth health care program.

3.11 **Compliance with Laws.** Provider understands and agrees that it is subject to all state and federal laws, rules, regulations, waivers, policies and guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that apply to this Agreement and the State Contract, and all persons or entities receiving state and federal funds. The Provider understands and agrees that any violation by a provider of a state or federal law relating to the delivery of services pursuant to this Agreement, or any violation of the State Contract could result in liability for money damages, and/or civil or criminal penalties and sanctions under state and/or federal law.

Provider understands and agrees that the following laws, rules, and regulations, and all amendments or modifications thereto, apply to the Agreement and shall comply with the following laws, among others:

A) Title VI of the Civil Rights Act of 1964 (Public Law 88-352);

B) Rules and regulations prescribed by the United States Department of Labor in accordance with 41 C.F.R. Parts 60-741;
C) Regulations of the United States Department of Labor recited in 20 C.F.R. Part 741, and Section 504 of the Federal Rehabilitation Act of 1973 (Public Law 93-112);


E) Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112);

F) Americans with Disabilities Act of 1990 (Public Law 101-336); and

G) Title 40, Texas Administrative Code, Chapter 73;


J) Environmental protection laws:

a. Pro-Children Act of 1994 (20 U.S.C. §6081 et seq.) regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products;


c. Clean Air Act and Water Pollution Control Act regulations (Executive Order 11738, "Providing for Administration of the Clean Air Act and Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, and Loans");

d. State Clean Air Implementation Plan (42 U.S.C. §740 et seq.) regarding conformity of federal actions to State Implementation Plans under §176(c) of the Clean Air Act; and


3.12 Access to Premises. Provider shall allow duly authorized agents or representatives of the State or federal government or the independent external quality review organization required by Section 1902 (a)(30)(c) of the Social Security Act, 42 U.S. Code Section
1396a(a)(30), access to their premises during normal business hours, and shall cause similar access or availability to their premises to inspect, audit, investigate, monitor or otherwise evaluate the performance of Provider, as applicable. Provider shall forthwith produce all records, documents, or other data requested as part of such review, investigation, or audit.

In the event right of access is requested under this Section, Provider shall provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State, federal, or external quality review personnel conducting the audit, investigation, or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Provider's activities. All information obtained will be accorded confidential treatment as provided under applicable laws, rules and regulations.

The Provider agrees to provide the HHSC:

A) All information required under the State Contract, including but not limited to the reporting requirements and other information related to the Provider’s performance of its obligations under the Agreement; and

B) Any information in its possession sufficient to permit HHSC to comply with the federal Balanced Budget Act of 1997 or other federal or state laws, rules, and regulations.

All information must be provided in accordance with the timelines, definitions, formats, and instructions specified by the Department.

3.13 **Provider Indemnity.** Provider shall indemnify, defend and hold harmless the State, its officers, agents, and employees, MIC and each and every Covered Person from any liability whatsoever arising in connection with this Agreement for the payment of any debt of or the fulfillment of any obligation of Provider. Provider further covenants and agrees that in the event of a breach of this Agreement by MCNA, termination of this Agreement, or insolvency of MCNA, Provider shall provide all services and fulfill all of its obligations pursuant to the Agreement for the remainder of any month for which MICCO has made payments to MCNA, and shall fulfill all of its obligations respecting the transfer of Covered Persons to other providers, including record maintenance, access and reporting requirements, all such covenants, agreements, and obligations of which shall survive the termination of this Agreement.

3.14 **State as Third Party Beneficiary.** Provider acknowledges and agrees that the State is the intended third-party beneficiary of this Agreement and, as such, the State is entitled to all remedies available to third-party beneficiaries under Texas law.

3.15 **Incorporation of State Contract.** All provisions of the State Contract are incorporated herein to the fullest extent applicable to the service or activity delegated pursuant to this Agreement, including without limitation, the obligation to comply with all applicable federal and State law and regulations, including but not limited to, Texas Code, Human
Resource Code, Title 2, Subtitle C, “Assistance Programs” , all rules, policies and procedures of HHSC, and all standards governing the provision of Covered Services and information to Covered Persons, all QAPI requirements, all record keeping and reporting requirements, all obligations to maintain the confidentiality of information.

3.16 **Suspected Fraud and Abuse.** Provider shall immediately report all suspected fraud and abuse to MCNA.

3.17 **Coordination of Benefits.** Provider must report all COB information to MCNA. Provider shall not pursue collection of any COB payment from any Covered Person.

3.18 **Accreditation.** Provider shall provide MCNA with a copy of its current certificate of accreditation from NCQA/URAC or other national accreditation body, if and as applicable, together with a copy of any survey report in connection therewith, subject to the applicable restrictions of such accrediting body.

3.19 **Non-Discrimination by Provider.** At all times during the performance of this Agreement, the Provider agrees as follows:

A) Provider shall not discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. Provider will take affirmative action to ensure that applicants are employed, and that employees are treated during employment, without regard to their race, color, religion, sex or national origin. Such action shall include, but not be limited to the following: employment, upgrading, demotion, or transfer; recruitment or recruitment advertising; layoff or termination; rates of pay or other forms of compensation; and selection for training, including apprenticeship. Provider agrees to post in conspicuous places, available to employees and applicants for employment, notices to be provided by the contracting officer setting forth the provisions of this nondiscrimination clause.

B) Provider will, in all solicitations or advertisements for employees placed by or on behalf of Provider, state that all qualified applicants will receive consideration for employment without regard to race, color, religion, sex or national origin.

C) Provider will send to each labor union or representative of workers with which he has a collective bargaining agreement or other contract or understanding, a notice, to be provided by the agency contracting officer, advising the labor union or workers' representative of Provider's commitments under Section 202 of Executive Order No. 11246 of September 24, 1965, and shall post copies of the notice in conspicuous places available to employees and applicants for employment.

D) Provider will comply with all provisions of Executive Order No. 11246 of Sept. 24, 1965, and of the rules, regulations, and relevant orders of the Secretary of Labor.
E) Provider will furnish all information and reports required by Executive Order No. 11246 of September 24, 1965, and by the rules, regulations, and orders of the Secretary of Labor, or pursuant thereto, and will permit access to his books, records, and accounts by the contracting agency and the Secretary of Labor for purposes of investigation to ascertain compliance with such rules, regulations, and orders.

F) In the event of Provider's noncompliance with the nondiscrimination clauses of this contract or with any of such rules, regulations, or orders, this contract may be cancelled, terminated or suspended in whole or in part and Provider may be declared ineligible for further Government contracts in accordance with procedures authorized in Executive Order No. 11246 of Sept. 24, 1965, and such other sanctions may be imposed and remedies invoked as provided in Executive Order No. 11246 of September 24, 1965, or by rule, regulation, or order of the Secretary of Labor, or as otherwise provided by law.

G) Provider will include the provisions of paragraphs (A) through (G) in every subcontract or purchase order unless exempted by rules, regulations, or orders of the Secretary of Labor issued pursuant to Section 204 of Executive Order No. 11246 of September 24, 1965, so that such provisions will be binding upon each subcontractor or vendor. The contractor will take such action with respect to any subcontract or purchase order as may be directed by the Secretary of Labor as a means of enforcing such provisions including sanctions for noncompliance. Provided, however, that in the event Provider becomes involved in, or is threatened with, litigation with a subcontractor or vendor as a result of such direction, Provider may request the United States to enter into such litigation to protect the interests of the United States.

ARTICLE IV
STATE MANDATED REQUIREMENTS

4.1 Any Willing Provider. MCNA shall not discriminate against any provider who is located within the geographic coverage area of the MIC and is willing to meet the terms and conditions for participation established by the MCNA.

4.2 Audit or Investigation. The Provider agrees to provide the following entities or their designees with prompt, reasonable, and adequate access to this Agreement and any records, books, documents, and papers that are related to this Agreement and/or the Provider’s performance of its responsibilities under this contract:

A) HHSC and MIC personnel from HHSC;

B) U.S. Department of Health and Human Services;

C) Office of Inspector General and the Texas Medicaid Fraud Control Unit;
D) An independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;

E) State or federal law enforcement agency;

F) Special or general investigation committee of the Texas Legislature;

G) The U.S. Comptroller General;

H) The Office of the State Auditor of Texas; and

I) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

The Provider must provide access wherever it maintains such records, books, documents, and papers. The Provider must provide such access in reasonable comfort and provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described herein. Requests for access may be for, but are not limited to: examination; audit; investigation; contract administration; the making of copies, excerpts, or transcripts; or any other purpose HHSC deems necessary for contract enforcement or to perform its regulatory functions.

Provider understands and agrees that the acceptance of funds under this Agreement acts as acceptance of the authority of the State Auditor’s Office (“SAO”), or any successor agency, to conduct an investigation in connection with those funds. Provider further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested.

4.3 Changes to Compensation and Fee Schedules. If MCNA decides to make any changes to the Provider’s fee schedule or payment for Covered Services, MCNA shall provide Provider at least ninety (90) days notice prior to the effective date of the change.

4.4 Claims Payment. In accordance with the Balanced Budget Act (BBA) Section 4708, MCNA shall ensure that all Provider claims for which no further written information or substantiation is required in order to make payment, are paid or denied within thirty (30) days of the date of receipt of such claims, and that all claims are processed within ninety (90) days of the date of receipt of such claims. In addition, MCNA will comply with the claims payment requirements within §§ 2.1, 3.4 and Attachment B-1 of the State Contract, as may be amended. The following additional terms for claims payment are also applicable:

A) The method of payment applicable to this Agreement is set forth on Attachment B hereto and in the Provider Manual.

B) In order to submit a clean claim, Provider must attach all of the information as required in the Provider Manual for each claim submittal.
C) MCNA will provide the Provider at least 90 days notice prior to implementing a change in the above-referenced claims guidelines, unless the change is required by statute or regulation in a shorter timeframe.

D) Provider must submit claims for processing and/or adjudication to MCNA at the place and in the manner described in the Provider Manual.

E) MCNA will notify Provider in writing of any changes in its list of claims processing or adjudication entities at least 30 days prior to the effective date of change. If MCNA is unable to provide 30 days notice, MIC or MCNA must give Provider a 30-day extension on their claims filing deadline to ensure claims are routed to the correct processing center.

F) MCNA will pay Provider interest at a rate of 1.5% per month (18% per annum) on all clean claims that are not adjudicated within 30 days.

4.5 **Complaints and Appeals.** The complaint and appeal processes that apply to the Provider is contained in the Provider manual. The Provider understands and agrees that HHSC reserves the right and retains the authority to make reasonable inquiry and to conduct investigations into Provider and Member complaints.

4.6 **Confidentiality.** Provider must treat all information that is obtained through the performance of the services included in this Agreement as confidential information to the extent that confidential treatment is provided under state and federal laws, rules, and regulations. This includes, but is not limited to, information relating to applicants or recipients of HHSC Programs. Provider shall not use information obtained through the performance of this Agreement in any manner except as is necessary for the proper discharge of obligations and securing of rights under this contract. Provider shall protect the confidentiality of Member Protected Health Information (PHI), including patient records. Provider must comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.

4.7 **Continuation of Care.** Provider shall, upon termination of the Agreement for reasons other than a quality of care issue or fraud, continue to provide and be compensated for Covered Services to Covered Persons under the terms and conditions of the Agreement until the earlier of such time that: (1) such Covered Person has completed his/her course of treatment; or (2) reasonable and medically appropriate arrangements have been made for a Participating Dental Care Provider to render health care services to the Covered Person. In the case of a pregnant woman, Provider shall continue to provide services through the end of the post-partum period if the pregnant woman is in her fourth or later month of pregnancy. If Provider is a facility, Provider shall continue to provide and be paid for Covered Services to Covered Persons under the same terms and conditions of the Agreement until such Covered Person is discharged from the facility. For purposes of
this provision, “discharge” shall mean the Covered Person’s physical release from the facility. This provision shall survive the termination of the Agreement.

4.8 **Costs of Non-covered Services.** Provider must inform Members of the costs for non-covered services prior to rendering such services and must obtain a signed Private Pay form from such a Member.

4.9 **Enrollment Period.** Provider acknowledges that all providers in good standing who wish to apply to participate in MCNA’s plans shall be able to do so at any time.

4.10 **Fraud and Abuse.** Provider understands and agrees to the following:

A) HHSC Office of Inspector General (“OIG”) and/or the Texas Medicaid Fraud Control Unit must be allowed to conduct private interviews of Provider and its employees, agents, contractors, and patients;

B) Requests for information from such entities must be complied with, in the form and language requested;

C) Provider and its employees, agents, and contractors must cooperate fully with such entities in making themselves available in person for interviews, consultation, grand jury proceedings, pre-trial conference, hearings, trials and in any other process, including investigations at the Network Provider’s own expense; and

D) Compliance with these requirements will be at the Provider’s own expense.

Provider understands and agrees to the following:

A) Provider is subject to all state and federal laws and regulations relating to fraud, abuse or waste in health care and the Medicaid and/or CHIP Programs, as applicable;

B) Provider must cooperate and assist HHSC and any state or federal agency that is charged with the duty of identifying, investigating, sanctioning or prosecuting suspected fraud, abuse or waste;

C) Provider must provide originals and/or copies of any and all information, allow access to premises, and provide records to the Office of Inspector General, HHSC, the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services, FBI, TDI, the Texas Attorney General’s Medicaid Fraud Control Unit or other unit of state or federal government, upon request, and free-of-charge;
D) If the Provider places required records in another legal entity's records, such as a hospital, the Provider is responsible for obtaining a copy of these records for use by the above-named entities or their representatives; and

E) Provider must report any suspected fraud or abuse including any suspected fraud and abuse committed by MIC, MCNA or a Member to the HHSC Office of Inspector General.

4.11 **Liability.** In the event the MIC or MCNA becomes insolvent or ceases operations, the Provider understands and agrees that its sole recourse against the MIC or MCNA will be through the MIC’s or MCNA’s bankruptcy, conservatorship, or receivership estate. Provider understands and agrees that the MIC’s Members may not be held liable for the MIC’s or MCNA’s debts in the event of the entity’s insolvency. Provider understands and agrees that HHSC does not assume liability for the actions of, or judgments rendered against, the MIC, MCNA, their employees, agents or subcontractors. Further, the Provider understands and agrees that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to the Provider by the MIC or MCNA or any judgment rendered against the MIC or MCNA. HHSC’s liability to the Provider, if any, will be governed by the Texas Tort Claims Act, as amended or modified (Tex. Civ. Pract. & Rem. Code §101.001 et seq.).

MIC or MCNA has full authority to initiate and maintain any action necessary to stop a Provider or employee, agent, assign, trustee, or successor-in-interest from maintaining an action against HHSC, an HHS Agency, or any Member to collect payment from HHSC, an HHSC Agency, or any Member, excluding payment for non-covered services. This provision does not restrict Provider from collecting allowable copayment and deductible amounts from Members. Additionally, this provision does not restrict Provider from collecting payment for services that exceed a CHIP Member’s benefit cap.

Provider understands and agrees that HHSC is not liable or responsible for payment for Covered Services rendered pursuant to the Provider contract.

4.12 **Marketing.** Provider agrees to comply with HHSC’s marketing policies and procedures, as set forth in the State Contract (which includes HHSC’s Uniform Managed Care Manual). Provider is prohibited from engaging in direct marketing to Members that is designed to increase enrollment in a particular health plan. The prohibition should not constrain Providers from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

4.13 **Material Changes.** If MCNA makes any material changes to the Agreement or any attachments and exhibits thereto, MCNA will provide written notice to Provider within ninety (90) days of the material change. Notwithstanding the foregoing, MCNA shall make any material changes to this Agreement or any attachments and exhibits as a result of any applicable State or federal law or regulation and applicable provision of the State Contract. In the event Provider wishes to opt out of any material change to the Agreement, Provider shall send written notice to MCNA no later than forty-five (45) days
prior to the effective date of the material change. If MCNA makes changes to prior authorization, precertification, notification or referral protocols, MCNA will provide Provider fifteen (15) days prior notice to such change.

4.14 **Participation in Other MCNA Benefit Plans.** MCNA shall not require Provider, as a condition of participation under the Agreement, to participate in any of MCNA’s other dental benefit plans without affording Provider the opportunity to opt out. MCNA will give Provider thirty (30) days advance notice of any additional dental benefit plans to be offered and Provider may opt out of such additional plans by giving written notice to MCNA within ten (10) days of its receipt of the MCNA notice.

4.15 **Professional Conduct.** While performing the services described in the Agreement, the Provider agrees to:

A) Comply with applicable state laws, rules, and regulations and HHSC’s requests regarding personal and professional conduct generally applicable to the service locations; and

B) Otherwise conduct themselves in a businesslike and professional manner.

4.16 **Provider’s Disclosure to Covered Persons.** MCNA shall not limit, penalize or terminate the Agreement due to Provider’s disclosure to a Covered Person who is Provider’s patient (i) all treatment options with the Covered Person; (ii) any information that the Provider determines to be in the best interest of the Covered Person; and (iii) financial incentives and financial arrangements between the Provider and MCNA.

4.17 **Provider Subcontracts.** In the event Provider enters into any subcontract agreement with another provider to provide Covered Services to Covered Persons, such agreement shall meet all requirements of the Agreement.

4.18 **Termination by MCNA.** In addition to the termination provisions provided in Article X of the Agreement, MCNA shall not have the right to terminate the Agreement without complying with the following requirements:

A) All Texas Insurance Code and TDI regulations.

B) The procedures outlined in §843.306 of the Texas Insurance Code if terminating a contract with a provider, including an STP.

C) At least 30 days before the effective date of the proposed termination of the Agreement, MCNA must provide a written explanation to the Provider of the reasons for termination.

D) MCNA may immediately terminate the Agreement if the provider presents imminent harm to patient health, actions against a license or practice, fraud or malfeasance.
E) Within 60 days of the termination notice date, Provider may request a review of MCNA’s proposed termination by an advisory review panel, except in a case in which there is imminent harm to patient health, an action against a private license, fraud or malfeasance. The advisory review panel will be composed of physicians and providers, as those terms are defined in §843.306 of the Texas Insurance Code, including at least one representative in the provider’s specialty or a similar specialty, if available, appointed to serve on the standing quality assurance committee or utilization review committee of MCNA. The decision of the advisory review panel must be considered by MCNA but is not binding on MCNA. MCNA must provide to the affected provider, on request, a copy of the recommendation of the advisory review panel and MCNA’s determination.

Provider may not offer or give anything of value to an officer or employee of HHSC or the State of Texas in violation of state law. A “thing of value” means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment and charitable contributions. The term does not include contributions to public office holders or candidates for public office that are paid and reported in accordance with state and/or federal law. MCNA may terminate this Network Provider contract at any time for violation of this requirement.

4.19 **Third Party Recovery.** Provider understands and agrees that it may not interfere with or place any liens upon the state’s right or the MIC’s or MCNA’s right, acting as the state’s agent, to recovery from third party resources.
ATTACHMENT B

STATE OF TEXAS MEDICAID AND CHIP MANAGED CARE PROGRAM

Please see MCNA’s "Covered Services, Fee Schedules, and Guidelines" document for the Medicaid and CHIP fee schedules.