

PAYMENT FOR DUAL ELIGIBLE MEMBERS

Addendum

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I. Definitions

WellCare of Texas, Inc. entered into an agreement with the State of Texas Health and Human Services Commission (“HHSC”) effective February 1, 2008 whereby it has agreed to pay certain Member Expenses for **Dual Eligible Members** as that term is defined below.

Dual Eligible Member means an MA Member who is also entitled to medical assistance under a state plan under Title XIX (“Medicaid”) of the Social Security Act (the “Act”).

MA Member(s) means those designated individuals eligible for traditional Medicare under Title XVIII of the Social Security Act and CMS rules and regulations and enrolled with WellCare.

Member Expenses means copayments, coinsurance, deductibles and/or other cost-share amounts due from the MA Member for services rendered by Provider.

State Medicaid Plan the state of Texas’ (“State”) plan for medical assistance developed in accordance with Section 1902 of the Act and approved by CMS.

II. Payment for Dual Eligible Member Expenses

Payment for such Dual Eligible Member Expenses is as follows:

Provider acknowledges and agrees that it shall not bill Dual Eligible Members the balance of (“balance-bill”), and that such Dual Eligible Members are not liable for, the Medicare Part A and B Member Expenses for which the State of Texas is responsible under the State Medicaid Plan – regardless of whether the amount Provider receives is less than the allowed Medicare amount or Provider’s billed charges due to limitations on additional reimbursement provided in the State Medicaid Plan. Provider agrees that it will accept Health Plan’s payment as payment in full or will bill the appropriate State source. If Health Plan has assumed the State’s financial responsibility under an agreement between Health Plan and the State, Health Plan shall be considered the “appropriate State source”.

- Provider shall not have any recourse against the State of Texas for Member Expenses attributable to Dual Eligible Members covered under the Health Plan’s agreement with the State of Texas. Specifically, if the payment rate under this Agreement for Covered Services provided to Dual

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Eligible Members less any applicable Member Expense is less than the HHSC published Medicaid allowable rate available on the date of service, Health Plan will pay the difference between the rate set forth in this Agreement and such higher HHSC Medicaid allowable rate. If the payment rate under this Agreement for Covered Services rendered to Dual Eligible Members less any Member Expenses equals or exceeds the HHSC Medicaid allowable rate, Provider's reimbursement is capped at the higher rate under this Agreement less any Member Expense. In such situation, Provider is not entitled to any additional payment from Health Plan, Dual Eligible Member, or the State of Texas for the Member Expense.

- Changes to the HHSC Medicaid allowable rate will be implemented by Health Plan prospectively on their effective date if they are published at least forty-five (45) days prior to such effective date. If such changes are published less than forty-five (45) days prior to such effective date, the changes will be applied prospectively to Claims with dates of service no later than forty-five (45) days following publication.