Molina Healthcare of Ohio, Inc.
Provider Summary Disclosure Form

(1) Compensation Terms

a. Manner of Payment

i. Medicaid (CFC, ABD, AEP)

☐ Fee-For-Service:

☒ Other: See Attachment D Compensation Schedule

ii. Medicare (SNP)

☐ Fee-For-Service:

☒ Other: See Attachment D Compensation Schedule

iii. Medicare-Medicaid Program (ICDS, CFAD)

☐ Fee-For-Service:

☒ Other: See Attachment D Compensation Schedule

iv. Health Insurance Marketplace Product (HIM)

☐ Fee-For-Service:

☒ Other: See Attachment D-X Compensation Schedule for Health Insurance Marketplace

b. Medicaid Fee schedule available at: https://medicaid.ohio.gov/wps/portal/gov/medicaid/resources-for-providers/billing/fee-schedule-and-rates/fee-schedule-and-rates

c. Medicare Fee schedule available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/feeschedulegeninfo

(2) List of products or networks covered by this contract:

☒ Medicaid (Covered Families and Children (CFC); Aged, Blind, or Disabled (ABD); Adult Extension Population (AEP))

☒ Medicare

☒ Medicare-Medicaid Program (MMP) Ohio Integrated Care Delivery System (ICDS); Capitated Financial Alignment Demonstration (CFAD)

☒ Health Insurance Marketplace Product (HIM)

(3) Term of this contract: Evergreen

a. Effective: _____ (To be completed by Health Plan upon execution of contract)

(4) Contracting entity or payer responsible for processing payment available at (855) 322 – 4079.

a. Contract excludes:

i. Routine Dental Services

a. Medicaid and MMP – Contact Scion Dental at (855) 322 – 4079, Dental option #7

b. Medicare – Contact Delta Dental at (888) 818-7932 or www.deltadentalins.com/molinahealthcare

ii. Routine Hearing Services

a. Medicare – Contact HearUSA at (855) 823-4632 or www.hearusa.com/members/molina-medicare

iii. Routine Vision Services

a. Medicaid, Medicare, MMP – Contact March Vision at (844) 756 – 2724

b. Health Insurance Marketplace Product (HIM) – Contact VSP at (855) 868 – 4561

iv. Retail Pharmacy

a. Medicaid, Medicare, MMP, Marketplace – Contact Caremark Pharmacy at (800) 364 – 6331

v. Non-emergency Transportation Services

a. Medicaid – Contact Access2Care Transportation at (866) 642 – 9279

b. Medicare – Medicaid Program (MMP) – Contact Access2Care Transportation at (844) 491 – 4761 (Non-Waiver only)

c. Medicare – Contact Access2Care Transportation at (844) 557 – 5326

(5) Molina Healthcare of Ohio, Inc. phone number for resolving disputes regarding contract terms: (855) 322 – 4079.

(6) Addenda to contract

a. Medicaid Addendum ODM Addendum for Medicaid

(7) Telephone number to allow a participating provider to receive the information in (1) through (6) from the payer: (855) 322 – 4079

IMPORTANT INFORMATION – PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Provider Service Agreement as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Agreement constitute the rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Agreement. When you sign the Agreement, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Agreement.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.

Molina Healthcare of Ohio, Inc.
Hospital Services Agreement

This Hospital Services Agreement ("Agreement") is entered by and between Molina Healthcare of Ohio, Inc., an Ohio corporation ("Health Plan"), and _____ ("Provider").

RECITALS

A. Health Plan arranges for the provision of certain health care services to Members pursuant to contracts with various government sponsored health programs. Health Plan intends to participate in additional government sponsored health programs and offer other health products as the opportunities become available.

B. Health Plan arranges for the provision of certain health care services to Members by entering into provider service agreements with individual physicians, groups of physicians, individual practice associations, hospitals, clinics, ancillary health providers, and other health providers.

C. Provider is licensed to render hospital inpatient and outpatient services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for Health Care Services for Health Plan's Members.

Now, therefore, in consideration of the promises, covenants and warranties stated herein, Health Plan and Provider agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Provider means the health care professional(s), or entity(ies) identified in Attachment A to this Agreement.

1.2 Capitalized words or phrases in this Agreement shall have the meaning set forth in Attachment B.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 Serving as a Panel Provider. Provider shall provide hospital inpatient and/or outpatient services to Members, as are specifically set forth in Attachment C. Provider agrees that its practice information may be used in Health Plan's provider directories, promotional materials, advertising and other informational material made available to the public and Members. Facility Information includes, but is not limited to, name, address, telephone number, hours of operation, and services. Provider shall promptly notify Health Plan of any changes in this practice information.

2.2 Standards for Provision of Care.

a. **Provision of Covered Services.** Provider shall provide Covered Services to Members, within the scope of Provider's license, in accordance with this Agreement, Health Plan's policies and procedures, the terms and conditions of the Health Plan product which covers the Member, and the requirements of any applicable government sponsored program.

b. **Standard of Care.** Provider shall provide Covered Services to Members at a level of care and competence that equals or exceeds the generally accepted and professionally recognized standard of practice at the time of treatment, all applicable rules and/or standards of professional conduct, and any controlling governmental licensing requirements.

c. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel and administrative services shall be at a level and quality as necessary to perform Provider's duties and responsibilities under this Agreement and to meet all applicable legal requirements, including the accessibility requirements of the Americans with Disabilities Act.

d. **Prior Authorization.** Provider shall verify eligibility of Members prior to rendering services. Prior to admitting any Member either on an inpatient or outpatient basis, Provider shall obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. For Emergency Services that result in an admission, Provider shall notify Health Plan or its agent within twenty-four (24) hours of admission and shall request authorization from Health Plan prior to the provision of any post-stabilization care. For non-emergent services, regardless of whether prior authorization was received, Provider shall cooperate and participate in Health Plan's notification procedures described in Provider Manual for all inpatient admissions (acute, rehabilitation, mental health and SNF) including admissions resulting from an outpatient visit, and Provider shall notify Health Plan on the same day of admission or at a maximum within twenty-four (24) hours of admission. Upon and following such referral,

Provider shall coordinate the provision of such Covered Services to Members and ensure continuity of care. Covered Services requiring Prior Authorization are specified in the Provider Manual.

e. **Contracted Providers.** Except in the case of Emergency Services or upon prior authorization of Health Plan, Provider shall use only those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan ("Participating Providers").

f. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered and administered for in-patient and outpatient hospital services, Provider shall abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

g. **Subcontract Arrangements.** Any subcontract arrangement entered into by Provider for the delivery of Covered Services to Members shall be in writing and shall bind Provider's subcontractors to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance, and billing of Members for Covered Services.

h. **Availability of Services**. Provider shall make Covered Services available twenty-four (24) hours a day, seven (7) days a week. Provider shall meet the applicable standards for timely access to care and services, taking into account the urgency of the need for the services.

i. **Hospital Services.** Hospital Services are those Health Plan benefits to include short term inpatient or outpatient general hospital services including room with customary furnishings and equipment, meals (including special diets as medically necessary), general nursing care, use of operating room and related facilities, intensive care unit and services, emergency services, drugs, including drugs to be dispensed at time of emergency room visit in amount sufficient to last until such time Member can reasonably be expected to fill a prescription, medications, biological, anesthesia and oxygen services, ambulatory care services, diagnostic laboratory and x-ray services, special duty nursing as medically necessary, physical therapy, respiratory therapy, administration of blood and blood products, and diagnostic, therapeutic and rehabilitative services as appropriate, and coordinated discharge planning including the planning of such continuing care as may be necessary, both medically and as a means of preventing possible early re-hospitalization.

2.3 Standards for Hospital Providers.

a. **Hospital Providers.** Provider shall have a sufficient number of Hospital Providers to provide Covered Services and meet the needs of Health Plan and its Members as determined by Health Plan's Quality Improvement Program and in accordance with state and federal law. Provider shall be responsible for the Covered Services provided by Hospital Providers.

b. **Contract with Hospital Providers.** Provider's contract with its Hospital Providers shall be in writing and shall bind Hospital Providers to the terms and conditions of this Agreement including, but not limited to, terms relating to licensure, insurance and billing of Members for Covered Services.

c. **Hospital Provider Information**. Upon request, Provider shall provide Health Plan with a complete list of its Hospital Providers, together with the provider specific information required by Health Plan for credentialing and for administration of its health programs.

d. **Restriction, Suspension or Termination of Hospital Provider(s).** Provider shall immediately restrict, suspend or terminate Hospital Providers(s) from providing Covered Services to Members in the following circumstances: (i) the Hospital Provider(s) ceases to meet the licensing/certification requirements or other professional standards as specified in this Article; or (ii) Health Plan or Provider reasonably determine that there are serious deficiencies in the quality of care of the applicable Hospital Provider(s) which affects or could adversely affect the health or safety of Members.

e. **Staffing Privileges.** Provider agrees to use its best efforts to arrange staff privileges or other appropriate access for Health Plan's Participating Providers, Health Plan's medical directors and hospitalist providers who are qualified medical or osteopathic physicians, provided they meet the reasonable standard of practice and credentialing standards established by Provider's medical staff and the bylaws, rules and regulations of Provider.

f. **Notification**. Provider shall notify Health Plan within five (5) business days of becoming aware of any of its Hospital Provider(s) who cease to meet the licensing/certification requirements or other professional standards as described in this Agreement. Provider will notify Health Plan within five (5) business days should any

disciplinary or other action of any kind be initiated against any Health Plan contracted provider, medical director or hospitalist provider which could result in any suspension, reduction or modification of his/her hospital privileges. Provider's notification to Health Plan shall state Provider's actions taken against the Hospital Provider or Health Plan provider. If Provider fails to act as required by this Article with respect to any of its Hospital Provider(s) or Health Plan reasonably determines and provides documentation to Provider that there are serious deficiencies in the professional competence, conduct, or quality of care of the Hospital Provider which could adversely affect the health and safety of Members, Health Plan shall have the right to prohibit such Hospital Provider(s) from continuing to provide Covered Services to Members.

2.4 Nondiscrimination.

a. **Enrollment.** Provider shall not differentiate or discriminate in providing Covered Services to Members because of race, color, religion, gender, disability, national origin, military status, genetic information, ancestry, age, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, health status, or need for health services, or participation in publicly financed programs of health care. Provider shall render Covered Services to Members in the same location, in the same manner, in accordance with the same standards, and within the same time availability regardless of payor.

b. **Employment.** Provider shall not differentiate or discriminate against any employee or applicant for employment, with respect to their hire, tenure, terms, conditions or privileges of employment, or any matter directly or indirectly related to employment, because of race, color, religion, gender, disability, national origin, military status, genetic information, ancestry, age, height, weight, marital status, sexual orientation, physical, sensory or mental disability, health status, or need for health services unrelated to the individual's ability to perform the duties of the particular job or position.

2.5 Recordkeeping.

a. **Maintaining Member Medical Record.** Provider shall maintain a medical record for each Member to whom Provider renders health care services. Provider shall open each Member's medical record upon the Member's first encounter with Provider. The Member's medical record shall contain all information required by state and federal law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider shall retain all such records for as long as required under applicable law.

b. **Confidentiality of Member Health Information.** Provider shall comply with all applicable state and federal laws, Health Plan's policies and procedures, government sponsored program requirements regarding privacy and confidentiality of Members' health information and medical records, including mental health records. Provider shall not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or medical records without obtaining appropriate authorization to do so. This provision shall not affect or limit Provider's obligation to make available medical records, encounter data and information concerning Member care to Health Plan, any authorized state or federal agency, or other Providers of health care upon authorized referral.

c. **HIPAA.** To the extent Provider is considered a covered entity under the Health Insurance Portability and Accountability Act ("HIPAA"), Provider shall comply with all provisions of HIPAA including, but not limited to, provisions addressing privacy, security, and confidentiality.

d. **National Provider Identifier ("NPI").** Provider shall comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.). Provider shall use its NPI to identify itself on all claims and encounters (both electronic and paper formats) submitted to Health Plan. Provider shall report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change.

e. **Delivery of Patient Care Information.** Provider shall promptly deliver to Health Plan or Health Plan designee(s), upon request and/or as may be required by state or federal law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payers, any patient care information pertaining to managed care activities, including, but not limited, to medical or billing records, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including, but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS studies, Health Plan's Quality Improvement Program, Consumer Assessment of Health Plans (CAHPS), or claims payment. Provider shall further provide direct access during its normal business hours to said patient care

information as requested by Health Plan and/or as required to any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan shall have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan.

f. **Member Access to Health Information.** Provider shall give Health Plan and Members access to Members' health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law, applicable government sponsored health programs, and Health Plan's policies and procedures.

2.6 Program Participation.

a. **Participation in Grievance Program.** Provider shall participate in Health Plan's Grievance Program and shall cooperate with Health Plan in identifying, processing, and promptly resolving all Member complaints, grievances, or inquiries.

b. **Participation in Quality Improvement Program.** Provider shall participate in Health Plan's Quality Improvement Program and shall cooperate with Health Plan in conducting peer review and audits of care rendered by Provider.

c. **Participation in Utilization Review and Management Program.** Provider shall participate in and comply with Health Plan's Utilization Review and Management Program, including all policies and procedures regarding prior authorizations, and shall cooperate with Health Plan in audits to identify, confirm, and/or assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Except as otherwise provided by law or provided by government sponsored program requirements, Provider shall participate in Health Plan's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and re-credentialing criteria established by the Health Plan. Provider shall immediately notify Health Plan of any change in the information submitted or relied upon by Provider to achieve credentialed status. If Provider's credentialed status is revoked, suspended or limited by Health Plan, Health Plan may at its discretion terminate this Agreement and/or move Members to another hospital.

e. **Provider Manual.** Provider shall comply and render Covered Services in accordance with the contents, instructions and procedures set forth in Health Plan's Provider Manual, which may be amended from time to time at Health Plan's sole discretion. Health Plan's Provider Manual is incorporated in this Agreement by this reference.

f. **Health Plan's Electronic Processes and Initiatives.** Provider will use best efforts to participate in and comply with Health Plan's electronic processes and initiatives, including, but not limited to, electronic submission of prior authorization, access to electronic health records ("EHR"), electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's web-portal, in accordance with the Provider Manual. Meaningful use of EHRs and other electronic health information methods enable Provider and other providers to render higher quality and safer care for Members by enabling quicker access to Member records for more coordinated and efficient care, and by securely transmitting this information with Members and other providers using electronic means.

In accordance with Ohio Department of Medicaid requirements and the Provider Manual, hospital Providers must provide admission, discharge and transfer ("ADT") data to any established health information exchange ("HIE") operating in Ohio. In addition to providing a basic level of interoperability among EHRs, HIE systems help prevent errors by ensuring that everyone involved in a Member's care has access to the same information, thereby potentially reducing healthcare costs and improving health outcomes.

g. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through government sponsored programs. Provider shall comply with any term or condition of those government sponsored program contracts that are applicable to the services to be performed under this Agreement.

h. **Health Education/Training.** Provider shall participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider shall also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider shall promptly deliver to medical staff, all informational, promotional,

educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

2.7 Promotional Activities. At the request of Health Plan, Provider shall display Health Plan promotional materials in its offices and facilities as practical. Provider shall not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.8 Licensure and Standing.

a. **Licensure.** Provider warrants and represents that it is appropriately licensed as a general acute care hospital to render health care services. Provider shall provide evidence of licensure to Health Plan upon request. Provider shall maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider shall immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider warrants and represents that it has not been convicted of crimes as specified in Section 1128 of the Social Security Act (42 U.S.C. 1320a-7), excluded from participation in the Medicare or Medicaid program, assessed a civil penalty under the provisions of Section 1128, entered into a contractual relationship with an entity convicted of a crime specified in Section 1128, or taken any other action that would prohibit it from participation in Medicaid and/or state health care programs.

c. **Malpractice and Other Actions.** Provider shall give immediate notice to Health Plan of: (a) any malpractice claim asserted against it by a Member, any payment made by or on behalf of Provider in settlement or compromise of such a claim, or any payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (b) any criminal investigations or proceedings against Provider; (c) any convictions of Provider for crimes involving moral turpitude or felonies; and (d) any civil claim asserted against Provider that may jeopardize Provider's accreditation, certification, financial soundness, and licensure.

d. **Staffing Privileges for Providers.** As applicable and consistent with community standards, every physician Provider shall have staff privileges with at least one Health Plan contracted Hospital as necessary to provide services to members under this Agreement, and shall authorize each hospital at which he/she maintains staff privileges to notify Health Plan should any disciplinary or other action of any kind be initiated against such provider which could result in any suspension, reduction or modification of his/her hospital privileges.

e. **Liability Insurance.** Provider shall maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Provider shall provide Health Plan with not less than ten (10) days advance written notice of any reduction or cancellation of such coverage. Provider shall deliver copies of such insurance policies to Health Plan within five (5) business days of a written request by Health Plan.

2.9 Claims Payment.

a. **Submitting Claims.** Provider shall promptly submit to Health Plan claims for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by Health Plan, and shall include any and all medical records pertaining to the claim if requested by Health Plan or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by law or provided by government sponsored program requirements, any claims that are not submitted by Provider to Health Plan within one hundred twenty (120) days of providing the Covered Services that are the subject of the claim shall not be eligible for payment, and Provider hereby waives any right to payment therefore.

b. **Compensation.** Health Plan shall pay Provider for Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable law and regulations and in accordance with the compensation schedule set forth in Attachment D and its applicable sub-attachments. Provider shall accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider shall not balance bill Members for any Covered Services.

c. **Co-payments and Deductibles**. Provider is responsible for collection of co-payments and deductibles, if any.

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider shall make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider shall immediately notify Health Plan of said entitlement. In the event that coordination of benefits occurs, Provider shall be compensated in an amount equal to the

allowable Clean Claim less the amount paid by other health plans, insurance carriers and payers, not to exceed the amount specified in Attachment D and its applicable sub-attachments.

e. **Payments which are the Responsibility of a Capitated Provider.** In the event a Participating Provider (such as a medical group, IPA, PHO or any other similar entity/organization) is contractually reimbursed by Health Plan on a capitation payment basis and is responsible for providing or arranging for Covered Services for certain Members (a "Capitated Provider"), such Capitated Provider, not Health Plan, is financially responsible for paying related claims, and Provider shall look to such Capitated Provider for payment of Covered Services rendered by Provider for such Members. In the event Health Plan receives any claims for Covered Services rendered by Provider that are the responsibility of a Capitated Provider, Health Plan shall return such claims to Provider and/or, at its election and upon written notice to Provider, redirect such claims to the Capitated Provider.

f. For Health Plan's Medicaid line of business, in accordance with Ohio Department of Medicaid requirements, Provider shall return any episode, quality, or other value-based payments to Health Plan in the event that (i) Provider is convicted of fraud and (ii) the time period of the fraudulent activity overlaps with the time period that the episode, quality, or other value-based payment is based.

2.10 Claims Review.

a. **Emergency Room.** For admissions through the Emergency Room in which there is: (a) a direct admission to Provider's intensive care units for the provision of Emergency Services, (b) a direct transfer to Provider's operating room for the provision of Emergency Services, or (c) an authorization by Health Plan or its agents for the provision of post-stabilization care, Health Plan will not retrospectively deny payment for the day of admission. For all other services, including those admissions through the Emergency Room that resulted in a one (1) day admission, Health Plan reserves the right to retrospectively review such claims to determine if such services were Medically Necessary and may deny payment for any such services which do not constitute Covered Services. Notwithstanding the foregoing, Provider is not required to obtain authorization from Health Plan prior to the provision of Emergency Services and care necessary to stabilize a Member's emergency medical condition. Health Plan will not retrospectively deny payment for any services rendered by Provider in good faith pursuant to the prior authorization of Health Plan.

b. **Authorized Services.** Health Plan is responsible for the authorization of medical services provided to Members. If Provider has obtained concurrent or prior authorization for a Covered Service provided to a Member, Health Plan will not retrospectively deny payment for such authorized Covered Service, unless Provider's claim and/or medical record for such services do not support the specific services and/or level of care authorized by Health Plan. Health Plan shall conduct medical management throughout the course of treatment. Provider acknowledges that initial and subsequent authorizations shall be obtained as necessary.

c. **Reporting Requirements.** Provider's failure to comply with Health Plan's requirements regarding Provider's identification and reporting of institutional and outpatient services, admissions, and/or related services to Health Plan or to obtain authorization as required may result in non-payment to Provider for all days and charges until the day that notification is received and services are authorized.

d. **Offset.** Except as otherwise provided by law or provided by government sponsored program requirements, in the event that Health Plan determines that a claim has been overpaid or paid in duplicate, or that funds were paid which were not provided for under this Agreement, Health Plan may automatically recover the amounts owed by way of offset or recoupment from current or future amounts due Provider. Provider may, but is not obligated to, exercise its appeal rights under this Agreement upon receipt of Health Plan's notice of any such offset or recoupment. As a material condition to Health Plan's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein shall be deemed to be and to constitute rights of offset and recoupment authorized in state and federal law or in equity to the maximum extent legally permissible, and that such rights shall not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan and/or Provider.

e. **Claims Review and Audit.** Provider acknowledges Health Plan's right to review Provider's claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current UB manual and editor, current CPT and HCPCS coding, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices and/or implantable orthopedic devices.

Provider acknowledges Health Plan's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan deems appropriate, and Health Plan's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider shall cooperate with Health Plan's audits of claims and payments by providing access to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan shall use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's policies and data to determine the appropriateness of the billing, coding and payment.

2.11 Compliance with Applicable Law. Provider shall comply with all applicable state and federal laws governing the delivery of Covered Services to Members including, but not limited to, Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that this Agreement and all Covered Services rendered pursuant to this Agreement are subject to applicable state licensing statutes and regulations. Accordingly, Provider shall abide by those provisions set forth in Attachment E.

b. Provider acknowledges that all Covered Services rendered in conjunction with the state Medicaid programs and the ICDS program are subject to the additional provisions set forth in Attachment F.

c. Provider acknowledges that all Covered Services rendered to Medicare beneficiaries are subject to the additional provisions set forth in Attachment H and Attachment H-1, the effect of which provisions is limited solely to activities and Covered Services related to the Medicare program.

d. For Covered Services rendered to Members enrolled in a Health Insurance Marketplace Product, Medicaid statutes and regulations referenced in this Agreement are inapplicable, and Provider shall comply with all statutory and regulatory requirements applicable to the Health Insurance Marketplace, including the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), and referred to collectively as the Affordable Care Act; regulations at 45 CFR Parts 153, 155, and 156 and Attachments E & E-1.

e. Provider acknowledges that all Covered Services rendered pursuant to the Medicare-Medicaid Program are subject to the additional provisions set forth in Attachment J, Attachment J-1 and the applicable State of Ohio Medicaid Addendum, Attachment F.

2.12 Provider Non-solicitation Obligations. Provider shall not unilaterally assign or transfer patients served under this Provider Services Agreement to another hospital without the prior written approval of Health Plan. Nor shall Provider solicit or encourage Members to select another health plan for the primary purpose of securing financial gain for Provider. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

2.13 Fraud and Abuse Reporting. Provider shall report to Health Plan's compliance officer all cases of suspected fraud and/or abuse, as defined in Title 42, of the Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) state working days of the date when Provider first becomes aware of, or is on notice of, such activity. Provider shall establish policies and procedures for identifying, investigating, and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medicaid program. Upon the request of Health Plan and/or the state, Provider shall consult with the appropriate state agency prior to and during the course of any such investigations.

2.14 Advance Directive. Provider shall document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other appropriate laws.

2.15 Reassignment of Members. Health Plan reserves the right to reassign Members from Provider to another provider or to limit or deny the assignment or selection of new Members to Provider during any termination notice period or if Health Plan determines that assignment to Provider poses a threat to the Members' health and safety. If Provider requests reassignment of a Member, Health Plan, in its sole discretion and in compliance with state regulations, will make the determination regarding reassignment based upon good cause shown by the Provider. When the Plan

reassigns Member(s), Provider shall forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Plan's or the Member's request to transfer the records.

2.16 Reciprocity Agreements. Provider agrees to provide Covered Services to Members who are enrolled in various government sponsored health products/programs offered by Health Plan's affiliates. Provider agrees to cooperate with such affiliate's Participating Providers in coordinating and scheduling such services, and agrees that all applicable terms of this Agreement, including compensation and rules on Member billing, shall apply to Provider to the extent any such services are provided to Members of Health Plan's affiliates. In the event Provider is or becomes a Capitated Provider, the parties are encouraged to make ad hoc contractual arrangements for Covered Services rendered by Provider to Members of Health Plan's affiliate. However, in the event the parties are unable to make such arrangements, Provider agrees to accept usual and customary allowable rates, and adhere to/comply with applicable billing rules in effect in the geographic area, for Covered Services provided to beneficiaries of the government-sponsored program (i.e., Medicaid, Medicare) that covers such Member(s).

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 Compensation. Health Plan shall pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D and its applicable sub-attachments.

3.2 Member Eligibility Determination. Health Plan shall maintain data on Member eligibility and enrollment. Health Plan shall promptly verify Member eligibility at the request of Provider.

3.3 Prior Authorization Review. Health Plan shall timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 Medical Necessity Determination. Health Plan's determination with regard to Medically Necessary services and scope of Covered Services, including determinations of level of care and length of stay benefits available under the Member's health program shall govern. The primary concern with respect to all medical determinations shall be in the interest of the Member.

3.5 Provider Directory. Health Plan will provide Members with access to Health Plan's Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan contracted providers.

3.6 Provider Services. Health Plan will maintain a Provider Manual describing Health Plan's policies and procedures, Covered Services, limitations and exclusions, and coordination of benefits information. Health Plan will maintain a Provider Services Department available to educate Provider regarding Health Plan's policies and procedures.

3.7 Medical Director. Health Plan will employ a physician as medical director who shall be responsible for the management of both the; (a) medical, and (b) medically-related scientific and technical aspects of Health Plan.

3.8 Notice of Provider or Hospital Provider Termination(s). In the event of termination of Provider or any of its Hospital Providers, and upon notice by Provider of such termination(s) in accordance with the applicable notice provisions set forth in this Agreement, Health Plan shall (in accordance with all applicable state and federal laws, government sponsored program requirements, and Health Plan accreditation standards, if any, and as set forth in Health Plan's Provider Manual) notify all Members who are receiving treatment from Provider, or any of its Hospital Providers, prior to the effective date of any such termination(s).

3.9 Summary Disclosure Form. In accordance with ORC §3963.03, the summary disclosure form that precedes this Agreement includes all of the information specified at ORC §3963.03(A).

ARTICLE FOUR – TERM AND TERMINATION

4.1 Term. This Agreement shall commence on the effective date indicated by Health Plan on the signature page of this Agreement ("Effective Date") and shall continue in effect for one (1) year; it shall automatically renew for successive one (1) year terms unless and until terminated by either party in accordance with the provisions of this Agreement or in accordance with applicable state and federal provisions set forth in the Attachments.

4.2 Termination without Cause. This Agreement may be terminated without cause by either party on at least ninety (90) days prior written notice to the other party.

4.3 Termination with Cause. In the event of a breach of any material provision of this Agreement, the party claiming the breach may give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination shall have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an

attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination shall have the right to immediately terminate this Agreement.

4.4 Termination for Non-Participation in New Product(s) Offers. In the event Provider refuses to accept any new products by Health Plan; Health Plan may terminate this Agreement and transfer Member(s) to another provider by giving no sooner than one hundred eighty (180) days written notice to Provider. (ORC §3963.02(B)(3)(b)).

4.5 Immediate Termination. Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement and transfer Member(s) to another provider by giving notice to Provider in the event of any of the following:

a. Provider's license or certificate to render health care services is limited, suspended or revoked, or disciplinary proceedings are commenced against Provider by the state licensing authority;

b. Provider fails to maintain insurance required by this Agreement;

c. Provider loses credentialed status;

d. Provider becomes insolvent or files a petition to declare bankruptcy or for reorganization under the bankruptcy laws of the United States, or a trustee in bankruptcy or receiver for Provider is appointed by appropriate authority;

e. Health Plan determines that Provider's facility and/or equipment is insufficient to render Covered Services to Members;

f. Provider is excluded from participation in Medicare and state health care programs pursuant to Section 1128 of the Social Security Act or otherwise is terminated as a provider by any state or federal health care program;

g. Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Agreement;

h. Health Plan determines that health care services are not being properly provided, or arranged for by Provider, and that such failure poses a threat to Members' health and safety.

4.6 Termination Notification to Members. Upon receipt of termination of this Agreement by either Health Plan or Provider, Health Plan will inform affected Members within sixty (60) days of the expected termination without cause effective date, within fifteen (15) days of the expected termination with cause effective date, and in accordance with applicable state and federal laws and government sponsored program requirements. Members may then be required to select another provider contracted with Health Plan prior to the effective date of termination of this Agreement.

ARTICLE FIVE – GENERAL PROVISIONS

5.1 Indemnification. Each party shall indemnify and hold harmless the other party and its officers, directors, shareholders, employees, agents, and representatives from any and all liabilities, losses, damages, claims, and expenses of any kind, including costs and attorneys' fees, which result from the duties and obligations of the indemnifying party and/or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

5.2 Relationship of the Parties. Nothing contained in this Agreement is intended to create, nor shall it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained shall prevent any of the parties from entering into similar arrangements with other parties. Each of the parties shall maintain separate and independent management and shall be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor shall be construed to create, any right in any third party, including but not limited to Health Plan's Members. Nor shall any third party have any right to enforce the terms of this Agreement.

5.3 Entire Agreement. This Agreement, together with Attachments, Amendments, and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid products offered by Health Plan and listed in Attachment C, the contract between the state and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements,

promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

5.4 Severability. If any term, provision, covenant, or condition of this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall remain in full force and effect and shall in no way be affected, impaired, or invalidated as a result of such decision.

5.5 Non-exclusivity. This Agreement shall not be construed to be an exclusive Agreement between Health Plan and Provider. Nor shall it be deemed to be an Agreement requiring Health Plan to refer Members to Provider for health care services.

5.6 Amendment. Notwithstanding the Notice Amendment provisions set forth in Section 5.7 (Notice Amendments) and its subparts, Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement. Health Plan may otherwise amend this Agreement in accordance with Section 5.7 a.

5.7 Notice Amendments. The parties intend "Material Amendment" shall have the meaning specified at ORC §3963.01. Generally, a Material Amendment means an amendment to this Agreement that decreases Provider's payment or compensation, changes the administrative procedures in a way that may reasonably be expected to significantly increase Provider's administrative expenses, or adds a new product. However, the statute specifies numerous exceptions, including that a Material Amendment does not include any change in a Medicaid or Medicare fee schedule that is the basis for Provider's compensation. (ORC §3963.01).

a. If an amendment to this Agreement is not a Material Amendment, Health Plan shall provide Provider notice of the amendment at least fifteen (15) days prior to the effective date. Health Plan shall provide all other notices to Provider pursuant to Section 5.11 (Notice).

b. A Material Amendment shall occur only if Health Plan provides the Material Amendment in writing and notifies Provider not later than ninety (90) days prior to the effective date.

c. If within fifteen (15) days after receiving the Material Amendment Provider objects in writing and there is no resolution of the objection, either party may terminate this Agreement upon written notice provided to the other party not later than sixty (60) days prior to the effective date of the Material Amendment.

d. If Provider does not object to the Material Amendment in the manner described herein, the Material Amendment shall be effective as specified in the notice.

5.8 Assignment. Provider may not assign, transfer, subcontract or delegate, in whole or in part, any rights, duties, or obligations under this Agreement without the prior written consent of Health Plan. Subject to the foregoing, this Agreement is binding upon, and inures to the benefit of the Health Plan and Provider and their respective successors in interest and assigns. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

5.9 Arbitration. Any claim or controversy arising out of or in connection with this Agreement shall be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions between appropriate representatives of the parties. Any remaining claim or controversy shall be resolved through binding arbitration conducted by a single arbitrator in accordance with the American Arbitration Association (hereinafter "AAA") Commercial Arbitration Rules, then in effect, in Columbus, OH. If possible, the arbitrator shall be an attorney with at least fifteen (15) years' experience, including at least five (5) years in managed health care. The parties shall conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator shall have no authority to award damages or provide a remedy that would not be available to such prevailing party in a court of law or award punitive damages. Each party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator's and administrative fees. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one (1) year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered, with reasonable diligence; otherwise it shall be deemed waived. The use of binding arbitration shall not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

5.10 Attachments. Each of the Attachments identified below is hereby made a part of this Agreement:

Attachment A – Provider Identification Sheet

Attachment B – Definitions
Attachment C – Products/Programs
Attachment D – Compensation Schedule
Attachment D-X– Compensation Schedule for Health Insurance Marketplace Product
Attachment D-1– Charge Description Master (CDM) Limit Protection
Attachment E – Required Provisions (State Licensing Provisions)
Attachment E-1– Department of Insurance Requirements for Health Insurance Marketplace Product
Attachment F – Required Provisions (Medicaid Program Provisions)
Attachment G – Acknowledgment of Receipt of Provider Manual
Attachment H – Medicare Program Requirements-Health Care Services
Attachment H-1– Medicare Program Requirements-Delegated Services
Attachment J – Medicare-Medicaid Program Requirements
Attachment J-1– Medicare-Medicaid Program Requirements – Delegated Services
Attachment K – Coronavirus Disease Requirements

5.11 Notice. All notices required or permitted by this Agreement shall be in writing and may be delivered in person or may be sent by registered or certified mail or U.S. Postal Service Express Mail, with postage prepaid, or by Federal Express or other overnight courier that guarantees next day delivery, or by facsimile transmission, and shall be deemed sufficiently given if served in the manner specified in this Section. The addresses below shall be the particular party's address for delivery or mailing of notice purposes:

If to Molina:	If to Provider:	
Molina Healthcare of Ohio, Inc.:		_____
3000 Corporate Exchange Drive:		_____
Columbus, OH 43231		_____
Attention: President/CEO	Attention:	_____

The parties may change the names and addresses noted above through written notice in compliance with this Section. Any notice sent by registered or certified mail, return receipt requested, shall be deemed given on the date of delivery shown on the receipt card, or if no delivery date is shown, the postmark date. Notices delivered by U.S. Postal Service Express mail, Federal Express or overnight courier that guarantees next day delivery shall be deemed given twenty-four (24) hours after delivery of the notice to the United States Postal Service, Federal Express or overnight courier. If any notice is transmitted by facsimile transmission or similar means, the notice shall be deemed served or delivered upon telephone confirmation of receipt of the transmission, provided a copy is also delivered via delivery or mail.

5.12 Conflict with Health Plan Product. Nothing in this Agreement modifies any benefits, terms or conditions contained in the Member's Health Plan product. In the event of a conflict between this Agreement and the benefits, terms, and conditions of the Health Plan product, the benefits, terms or conditions contained in the Member's Health Plan product shall govern.

***** SIGNATURE PAGE TO FOLLOW *****

IN WITNESS WHEREOF, the parties hereto have agreed to and executed this Agreement by their officers thereunto duly authorized as of the Effective Date set forth by Health Plan below. The individual signing below on behalf of Provider acknowledges, warrants, and represents that said individual has the authority and proper authorization to execute this Agreement on behalf of Provider and its constituent providers, if any, and does so freely with the intent to fully bind Provider, and its constituent providers, if any, to the provisions of this Agreement.

Molina Healthcare of Ohio, Inc. **an Ohio Corporation ("Health Plan")**	
Health Plan Signature:	
Signatory Name (Printed):	
Signatory Title (Printed):	
Signature Date:	
Mailing Name and Address:	Molina Healthcare of Ohio, Inc. 3000 Corporate Exchange Drive Columbus, OH 43231 Attention: President

"Provider"	
Provider Signature:	
Signatory Name (Printed):	
Signatory Title (Printed):	
Signature Date:	
Mailing Name and Address:	

Effective Date: _____

ATTACHMENT A
Provider Identification Sheet

Mark applicable category(ies) below. For those Providers representing multiple health care professional(s) or entity(ies), please check all the categories that apply.

_____ Group (a list of employed constituent members is attached and incorporated herein)
_____ Hospital
_____ Ancillary Provider: Type:_____
_____ Pharmacy
_____ Other: Type:_____

Practitioners listed below are employed by Provider. (Please note: if practitioner is not employed, a separate Provider Services Agreement is required). Please complete the Practice Site information for each tax ID number, and office location.

PRACTICE SITE 1 **Clinic Name:** _____

Physical Address: _____

City, ST, Zip: _____

Physical Phone # _____ Physical Fax #: _____

Billing Address: _____

City, ST, Zip: _____

Tax ID #: _____ NPI: _____

PROVIDER NAME	**SPECIALTY**	**PCP (Y/N)**
		☐ Y ☐ N
		☐ Y ☐ N
		☐ Y ☐ N
		☐ Y ☐ N

(Use continuation pages if multiple providers under common ownership will submit bills under this Agreement)

I, the undersigned, am authorized to and do hereby verify the accuracy of the foregoing Provider information.

_____
Provider Signature

_____
Signatory Name (Printed)

_____
Signatory Title (Printed)

_____
Signature Date

ATTACHMENT A
Provider Identification Sheet
Continuation Page

Use one or more continuation pages as necessary. Please enter "N/A" for the following if not applicable:

PRACTICE SITE 2 **Clinic Name:** _____

Physical Address: _____

City, ST, Zip: _____

Physical Phone # _____ Physical Fax #: _____

Billing Address same as Practice Site 1? ☐ Y ☐ N (If no, please complete billing information below):

Billing Address: _____

City, ST, Zip: _____

Tax ID #: _____ NPI: _____

PROVIDER NAME	SPECIALTY	PCP (Y/N)
		☐ Y ☐ N
		☐ Y ☐ N
		☐ Y ☐ N
		☐ Y ☐ N

PRACTICE SITE 3 **Clinic Name:** _____

Physical Address: _____

City, ST, Zip: _____

Physical Phone # _____ Physical Fax #: _____

Billing Address same as Practice Site 1? ☐ Y ☐ N (If no, please complete billing information below):

Billing Address: _____

City, ST, Zip: _____

Tax ID #: _____ NPI: _____

PROVIDER NAME	SPECIALTY	PCP (Y/N)
		☐ Y ☐ N
		☐ Y ☐ N
		☐ Y ☐ N
		☐ Y ☐ N

(Add additional Attachment A continuation pages as needed)

ATTACHMENT B
Definitions

1. **Advance Directive** is a Member's written instructions, recognized under state law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under state law. Examples of Advance Directives are living wills and durable powers of attorney for health care.
2. **Capitated Financial Alignment Demonstration (CFAD) Product** means the managed care program, which is a component of the MMP, established by the Centers for Medicare and Medicaid Services (CMS) through the capitated financial alignment demonstration in which the State of Ohio, CMS and Health Plan have entered into a three-way contract that governs the provision of health care services to Members eligible for both Medicaid and Medicare.
3. **CMS** is the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.
4. **CMS Agreement** is the Medicare Advantage contract between Health Plan and CMS.
5. **Agreement** means this Hospital Services Agreement, all Attachments, and incorporated documents or materials.
6. **Claim** means an invoice for services rendered to a Member by Provider, submitted in a format approved by Health Plan, and with all service and encounter information required by Health Plan.
7. **Clean Claim** means a Claim that can be processed without obtaining additional information from Provider. Clean Claims do not include payments made to a Provider where the timing of the payment is not directly related to submission of a completed claim by Provider (e.g., capitation). A Clean Claim also does not include a Claim from Provider if Provider is under investigation for fraud or abuse, or a claim under review for medical necessity.
8. **Covered Services** means those health care services that are Medically Necessary, are within the normal scope of practice and licensure of Provider, and are benefits of the Health Plan product which covers the Member.
9. **Emergency Services** are Covered Services necessary to evaluate or stabilize a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so as to cause a prudent layperson, who possesses an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in: (i) placement of the Member's health (or the health of the Member's unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part. For Health Plan's Medicaid/Medi-Cal members, Emergency Services also includes any services defined as emergency services under 42 CFR §438.114.
10. **Grievance Program** means the procedures established by Health Plan to timely address Enrollee and Provider complaints or grievances.
11. **Health Insurance Marketplace** means the federal health benefit exchange established for Ohio pursuant to the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, and referred to collectively as the Affordable Care Act; and regulations at 45 CFR Parts 153, 155, and 156.
12. **Health Insurance Marketplace Product** means those health benefit programs offered and sold by Health Plan to individuals or employers who obtain health coverage through the Health Insurance Marketplace.
13. **Health Plan** means Molina Healthcare of Ohio, Inc.
14. **HEDIS Studies** means Healthcare Effectiveness Data and Information Set.
15. **Hospital Provider** are hospital-based physicians and independent licensed non-physician health care professionals who are employed by, contract with, or on the medical staff of Provider to provide Covered Services to Members.
16. **Integrated Care Delivery System (ICDS)** means a program, which is a component of the MMP, in which Members can choose not to participate in the CFAD and receive their Medicare benefits through Fee for Service (FFS) Medicare and a standalone Medicare Part D Plan; Program of All-inclusive Care for the Elderly (PACE); or a Medicare Advantage Part C plan and only receive Medicaid services through a managed care plan.
17. **IPA** means Independent Practice Association.
18. **Medically Necessary** means those medical services and supplies which are provided in accordance with professionally recognized standards of practice which are determined to be: (i) appropriate and necessary for the symptoms, diagnosis or treatment of the Member's medical condition; (ii) provided for the diagnosis and direct care

and treatment of such condition; (iii) not furnished primarily for the convenience of the Member, the Member's family, the treating provider, or other provider; (iv) furnished at the most appropriate level which can be provided consistent with generally accepted medical standards of care; and (v) consistent with Health Plan policy.

19. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.
20. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare-eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D services.
21. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.
22. **Medicare-Medicaid Program (MMP)** means the MyCare Ohio program administered by CMS and the Ohio Department of Medicaid for providing integrated care to Medicare-Medicaid Beneficiaries.
23. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to receive Covered Services.
24. **Provider** means the person(s) and/or entity identified in Attachment A to this Agreement. Provider means and includes all constituent physicians, allied health professionals and staff persons who provide health care services to Members by and/or through the Hospital. All of said persons are bound by the terms of this Agreement.
25. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere.
26. **Quality Improvement Program** means the policies, procedures and systems developed by Health Plan for monitoring, assessing and improving the accessibility, quality and continuity of care provided to Members.
27. **Utilization Review and Management Program** means the policies, procedures and systems developed by Health Plan for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

ATTACHMENT C
Products/Programs

Provider agrees to be a Participating Provider for the following products/programs:

Medicaid Programs – including but not limited to:

(a) Covered Families and Children (CFC)
(Description of benefits available upon request)

(b) Aged, Blind or Disabled (ABD)
(Description of benefits available upon request)

(c) Adult Extension Population (AEP)
(Description of benefits available upon request)

Medicare Program – including but not limited to:

(a) Medicare Advantage
(Description of benefits available upon request)

(b) Medicare Advantage Special Needs Plan
(Description of benefits available upon request)

Medicare-Medicaid Programs (MMP) – including but not limited to:

(a) Capitated Financial Alignment Demonstration (CFAD)
(Description of benefits available upon request)

(b) Integrated Care Delivery System (ICDS)
(Description of benefits available upon request)

Health Insurance Marketplace (HIM) – including but not limited to:

(a) Health Insurance Marketplace Product (HIM)
(Description of benefits available upon request)

ATTACHMENT D
Compensation Schedule

Fee for Service Payments

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with products/programs as specified in Attachment C, on a fee-for-service basis, at the lesser of; (i) Provider's billed charges, or (ii) the allowable amounts set forth below, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

I. Medicaid (ABD, AEP, CFC):

Covered Services shall be paid at an amount equivalent to XXX percent (XXX%) of the payable rate under the State of Ohio Medicaid Program fee schedule in effect on the date of service.

Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Ohio Medicaid Program fee schedule as of the date(s) of service, shall not exceed an amount equivalent to XXX percent (XXX%) of the Medicare Fee-For-Service Program allowable payment rate (adjusted for locality or geography), as of the date of service.

II. Medicare:

Covered Services shall be paid at an amount equivalent to XXX percent (XXX%) of the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

III. Medicare-Medicaid (MMP):

Capitated Financial Alignment Demonstration (CFAD)

Covered Services shall be paid at an amount equivalent to XXX percent (XXX%) of the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

In instances where a service is covered by Medicaid but not Medicare, Covered Services shall be paid per the Medicaid ICDS Compensation Schedule outlined below.

Integrated Care Delivery System (ICDS)

Covered Services shall be paid at an amount equivalent to XXX percent (XXX%) of the payable rate under the State of Ohio Medicaid Program fee schedule in effect on the date of service.

Notwithstanding the above, payment for Covered Services, including, but not limited to, certain Covered Services where there is no payment rate in the State of Ohio Medicaid Program fee schedule as of the date(s) of service, shall not exceed an amount equivalent to XXX percent (XXX%) of the Medicare Fee-For-Service Program allowable payment rate (adjusted for locality or geography), as of the date of service.

ATTACHMENT D-X

Compensation Schedule for Health Insurance Marketplace Product

Health Plan agrees to compensate Provider for Clean Claims for Covered Services rendered to Members, in accordance with the Health Insurance Marketplace Product, on a fee-for-services basis, at the lesser of: (i) Provider's billed charges, or (ii) the amounts set forth below; less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any:

I. Health Insurance Marketplace Product:

Covered Services shall be paid at an amount equivalent to XXX percent (XXX%) of the Medicare Fee-For-Service Program allowable payment rates (adjusted for locality or geography), as of the date of service.

If there is no payment rate in the Medicare Fee-For-Service Program as of the date(s) of service, payment shall be at XXX percent (XXX%) of the prevailing Ohio Medicaid Fee-For-Service Program allowable payment rates, as of the date(s) of service.

If there is no payment rate in the Ohio Medicaid Program as of the date(s) of service, payment shall be at XXX percent (XXX%) of Provider's allowable billed charges, as of the date(s) of service.

ATTACHMENT D-1
Charge Description Master (CDM) Limit Protection

Health Plan and Provider hereby agree to the terms and conditions relating to Provider's schedule of charges, charge master, or other charge based methodology (collectively referred to herein as Charge Description Master or "CDM"), and any increases by Provider to its CDM ("CDM Increases"), as set forth in this Attachment.

Notification of CDM Increases. Provider shall notify Health Plan in writing if any increase is made to its CDM during the term of this Agreement. Such written notice shall be made at least sixty (60) days prior to the effective date of such increase, and shall include information in an electronic format acceptable to Health Plan for Health Plan to calculate and verify the amount of the increase including, but not limited to, Provider's prior and current calendar year CDM with rates, industry standard coding and effective dates.

In the event Health Plan determines that Provider has increased its CDM and failed to notify Health Plan as set forth above, Health Plan shall have the right to; (i) adjust compensation payments and rates as set forth below ("Adjustment to Compensation"), and (ii) recoup from Provider a reprocessing fee of ten dollars ($10) for each claim Health Plan in its sole discretion determines must be reprocessed by Health Plan as a result of the CDM Increase. Health Plan may recoup any adjustments to compensation and reprocessing fees by way of offset against Provider's claim payments.

Health Plan shall have the right to audit Provider's CDM in order to calculate and verify any increase to Provider's CDM during the term of this Agreement.

Limit on CDM Increases. For all payments and rates based on Provider's CDM, percent of CDM reimbursements, and impacted by CDM Increases, including fixed rates, Health Plan shall calculate Provider's payment and rate during the first twelve (12) months following the Effective Date of this Agreement pursuant to Provider's CDM in effect on the Effective Date of this Agreement (the "CDM Restricted Period"). Thereafter, Provider is limited to an annual CDM Increase not to exceed three percent (3%) for each twelve (12) month period following the first anniversary of the Effective Date of this Agreement (the "CDM Limit").

Adjustment to Compensation. In the event Provider increases its CDM during the CDM Restricted Period or, thereafter, increases its CDM by more than the CDM Limit, Health Plan shall adjust compensation impacted by any such CDM Increases downwards in order to compensate Provider at an amount consistent with Provider's CDM prior to such CDM Increase, including, but not limited to, fee for service payments and/or fixed or flat payment rates. Health Plan's adjustment shall be retroactive to the date determined by Health Plan to be the effective date of Provider's CDM Increase. Health Plan shall have the right to offset Provider's compensation to recoup overpayments resulting from Provider increasing its CDM during the Restricted Period and/or increasing its CDM more than the CDM Limit. Offsets will be implemented in accordance with any applicable offset notification provisions of this Agreement or required by law.

Adjustment to Compensation Examples:

Compensation adjustment calculations for first twelve (12) months following the Effective Date:

- Provider's CDM Increase: 9%
- Compensation Payment Rate: 30% of Provider's CDM
- Compensation Adjustment Calculation = 0.30 / 1.09 = 27.52% of Provider's CDM

Compensation adjustment calculations for each twelve (12) month period following the first anniversary after the Effective Date:

- Provider's CDM Increase: 9%
- CDM Limit: 3%
- Compensation Payment Rate: 30% of Provider's CDM
- Compensation Adjustment Calculation = 1.03 / 1.09 x 0.30 = 28.35% of Provider's CDM

ATTACHMENT E
Required Provisions
State Licensing Provisions
(Ohio Health Insuring Corporations)

The following provisions are required by (i) federal statutes and regulations applicable to Health Plan, or (ii) state statutes and regulations applicable to health insuring corporations. These provisions shall be automatically modified to conform to subsequent amendments to such statutes, regulations, and agreements. Further, any purported modifications to these provisions inconsistent with such statutes, regulations, and agreements shall be null and void.

1) Provider agrees that in no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan, or breach of this Agreement, shall Provider bill, charge or collect a deposit from, seek remuneration from or have any recourse against, a Member, person to whom health care services have been provided, or person acting on behalf of the Member, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to the persons referenced above, nor from any recourse against Health Plan or its successor.

   Prior to collecting fees for non-Covered Services delivered on a fee-for-service basis, Provider shall inform the Member that said services are not covered by Health Plan and obtain a written acknowledgment that documents the understanding and agreement of the Member.

   This provision shall survive the termination of the Agreement regarding Covered Services delivered while the Agreement was in effect, regardless of the reason for termination, including the insolvency of Health Plan.

2) Provider shall continue to provide Covered Services to Members as needed and to complete any Medically Necessary procedure begun but not finished at the time Health Plan's insolvency or discontinuance of operations.

   If this Agreement terminates while the Member is receiving inpatient care at a health care facility, then Provider shall continue to provide Covered Services which shall terminate at the earliest occurrence of any of the following: (a) upon the Member's discharge from the health care facility; (b) the attending physician determines that inpatient care is no longer medically indicated; or (c) the Member has used up his/her contractual benefit.

   In no event shall this provision require Provider to continue to provide any Covered Service after the occurrence of any of the following: (a) the end of the thirty (30) day period following the entry of a liquidation order under R.C. Chapter 3903; (b) the end of the Member's period of coverage for a contractual prepayment or premium; (c) the Member obtains equivalent coverage with another plan; (4) the Member or the Member's employer terminates coverage under its contract with Health Plan; or (5) the liquidator effects a transfer of Health Plan's contractual obligation under the Ohio Revised Code ("R.C.") 3903.21(A)(8).

3) Provider shall assure that the Covered Services provided to Members are performed in the same manner, on the same basis and in accordance with the same standards offered to all of the other respective patients of Provider and are available and accessible to all Members. It is understood that Provider shall not unlawfully differentiate or discriminate in the treatment of Members or in the quality of the health care services delivered to Members on the basis of race, color, religion, sex, sexual preference, age, disability, national origin, Veteran's status, ancestry, health status, need for health care services and without regard to the source of payments made for health care services rendered to a patient. In addition, Provider shall acknowledge his/her intent to observe, protect and promote Member rights as patients, including patient rights to privacy.

4) Provider will ensure that it discloses to Health Plan all persons or entities that are required to be disclosed to Health Plan pursuant to 42 CFR §1001.1001(a)(1), 42 CFR §438.608(c), 42 CFR §438.610, 42 CFR §455.104 , 42 CFR §455.106 and applicable government contracts. Such disclosure will be made within the required timeframe and will include all the information required pursuant to the aforementioned regulations and government contract(s). For this purpose, Provider shall use the Ownership and Control Disclosure Form made available by Health Plan.

ATTACHMENT E-1

Required Provisions

Department of Insurance Requirements for Health Insurance Marketplace Product

This Attachment E-1 sets forth the Department of Insurance requirements that are required to be incorporated into contracts and/or agreements between a Health Plan and their Participating Providers for the Health Insurance Marketplace Product. The provisions of this Attachment shall only apply to Health Plan's Members enrolled in the Health Insurance Marketplace Product. In the event that any provisions in Attachment E-1, conflict with the Agreement or other Attachments of the Agreement, Attachment E-1 shall govern for Members enrolled in the Health Insurance Marketplace Product. The Agreement and this Attachment shall be automatically modified to conform to subsequent regulatory requirements.

1. **Definitions**
   A. Unless specified below, terms in this Attachment have the same meanings ascribed to them as in the Agreement.
      (1) "Contracting Entity" means any person or entity that has a primary business purpose of contracting with providers for the delivery of health care services.
      (2) "Electronic Claims Transport" means to accept and digitize Claims or to accept Claims already digitized, to place those Claims into a format that complies with the electronic transaction standards issued by the United States Department of Health and Human Services ("DHHS") pursuant to the "Health Insurance Portability and Accountability Act of 1996," 110 Stat. 1955, 42 U.S.C. 1320d, et seq., as those electronic standards are applicable to the parties and as those electronic standards are updated from time to time, and to electronically transmit those Claims to the appropriate Contracting Entity, payer, or third-party administrator.
      (3) "Health Care Contract" means a contract entered into, materially amended, or renewed between a Contracting Entity and a provider for the delivery of basic health care services, specialty health care services, or supplemental health care services to Members.
      (4) "Most Favored Nation Clause" means a provision in a Health Care Contract that does any of the following:
         (a) Prohibits, or grants a Contracting Entity an option to prohibit, a Provider from contracting with another Contracting Entity to provide health care services at a lower price than the payment specified in the contract;
         (b) Requires, or grants a Contracting Entity an option to require, the Provider to accept a lower payment in the event the Provider agrees to provide health care services to any other Contracting Entity at a lower price;
         (c) Requires, or grants a Contracting Entity an option to require, termination or renegotiation of the existing Health Care Contract in the event the Provider agrees to provide health care services to any other Contracting Entity at a lower price;
         (d) Requires the Provider to disclose the Provider's contractual reimbursement rates with other contracting entities.

2. **Terminating Provider**
   A. Except as provided in section (D) of this section, prior to terminating Provider on the basis of Provider's failure to meet Health Plan's standards for quality or utilization in the delivery of Covered Services, Health Plan shall give Provider notice of the reason or reasons for its decision to terminate Provider and an opportunity to take corrective action. Health Plan shall develop a performance improvement plan in conjunction with Provider. If after being afforded the opportunity to comply with the performance improvement plan, Provider fails to do so, Health Plan may terminate Provider.
   B. Appeal:
      (1) If Provider is terminated under section (A) of this section it may appeal the termination to the appropriate medical director of Health Plan. The medical director shall give Provider an opportunity to discuss with the medical director the reason or reasons for the termination.
      (2) If a satisfactory resolution of Provider's appeal cannot be reached under section (B)(1) of this section, Provider may appeal the termination to a panel composed of providers who have comparable or higher levels

of education and training than Provider making the appeal. A representative of the Provider's specialty shall be a member of the panel, if possible. This panel shall hold a hearing, and shall render its recommendation in the appeal within thirty (30) days after holding the hearing. The recommendation shall be presented to the medical director and to Provider.

(3) The medical director shall review and consider the panel's recommendation before making a decision. The decision rendered by the medical director shall be final.

C. Provider's status as a Provider shall remain in effect during the appeal process set forth in section (B) of this section unless the termination was based on any of the reasons listed in section (D) of this section.

D. Notwithstanding section (A) of this section, Provider may be immediately terminated if Provider's conduct presents an imminent risk of harm to Members; or if there has occurred unacceptable quality of care, fraud, patient abuse, loss of clinical privileges, loss of professional liability coverage, incompetence, or loss of authority to practice in Provider's field; or if a governmental action has impaired Provider's ability to practice.

E. Sections (A) to (D) of this section apply only to providers who are natural persons.

F. Application:

(1) Nothing in this section prohibits Health Plan from rejecting a provider's application for participation, or from terminating a Provider's Agreement, if Health Plan determines that the health care needs of its Members are being met and no need exists for the provider's services.

(2) Nothing in this section shall be construed as prohibiting Health Plan from terminating a Provider if Provider does not meet the terms and conditions of the Agreement.

(3) Nothing in this section shall be construed as prohibiting Health Plan from terminating this Agreement pursuant to any provision of the Agreement described in section (3963.02 of the Revised Code, except that, notwithstanding any provision of an Agreement described in that section, this section applies to the termination of the Agreement for any of the causes described in sections (A), (D), and (F)(1) and (2) of this section.

G. The superintendent of insurance may adopt rules as necessary to implement and enforce sections 1753.06, 1753.07, and 1753.09 of the Revised Code. Such rules shall be adopted in accordance with Chapter 119 of the Revised Code.

3. **Retroactively Denying Authorizations**

A. If Health Plan authorizes a proposed admission, treatment, or Covered Service based upon the complete and accurate submission of all necessary information relative to an eligible Member it shall not retroactively deny this authorization if the Provider renders the Covered Service in good faith and pursuant to the authorization and all of the terms and conditions of the Agreement.

4. **Internal Technology Assessment Process**

A. A description of Health Plan's internal technology assessment process will be made available to Provider and Members, upon request.

B. A copy of Health Plan's specific coverage protocols and procedures will be made available to Provider and Members upon the request of a Member who has been denied coverage for a drug, device, protocol, procedure, or other therapy on the basis that it has been assessed as not being safe or efficacious for a particular indication or condition.

5. **Assignment of Rights Under Agreement**

A. **Third Parties**

(1) Neither Health Plan nor Provider shall sell, rent, or give a third party the Contracting Entity's rights to a provider's services pursuant to the Contracting Entity's Health Care Contract with the provider unless one of the following applies:

(a) The third party accessing the provider's services under the Health Care Contract is an employer or other entity providing coverage for health care services to its employees or members, and that employer or entity has a contract with the Contracting Entity or its affiliate for the administration or processing of Claims for payment for services provided pursuant to the Health Care Contract with the provider.

(b) The third party accessing the provider's services under the Health Care Contract either is an affiliate or subsidiary of the Contracting Entity or is providing administrative services to, or receiving administrative services from, the Contracting Entity or an affiliate or subsidiary of the Contracting Entity.

(c) The Health Care Contract specifically provides that it applies to network rental arrangements and states that one purpose of the contract is selling, renting, or giving the Contracting Entity's rights to the services of the provider, including other preferred provider organizations, and the third party accessing the provider's services is any of the following:

i. A payer or a third-party administrator or other entity responsible for administering Claims on behalf of the payer;

ii. A preferred provider organization or preferred provider network that receives access to the provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the provider that is in compliance with section (A)(1)(c) of this section, and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary provider network is bound under its contract with the provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; or

iii. An entity that is engaged in the business of providing Electronic Claims Transport between the Contracting Entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the Contracting Entity's contract with the Provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

(2) The Contracting Entity that sells, rents, or gives the Contracting Entity's rights to the provider's services pursuant to the Contracting Entity's Health Care Contract with the provider as provided in section (A)(1) of this section shall do both of the following:

(a) Maintain a web page that contains a listing of third parties described in sections (A)(1)(b) and (c) of this section with whom a Contracting Entity contracts for the purpose of selling, renting, or giving the Contracting Entity's rights to the services of participating providers that is updated at least every six (6) months and is accessible to all providers, or maintain a toll-free telephone number accessible to all providers by means of which providers may access the same listing of third parties;

(b) Require that the third party accessing the provider's services through the provider's Health Care Contract is obligated to comply with all of the applicable terms and conditions of the contract, including, but not limited to, the products for which the provider has agreed to provide services, except that a payer receiving administrative services from the Contracting Entity or its affiliate shall be solely responsible for payment to the provider.

(3) Any information disclosed to a Provider under this section shall be considered proprietary and shall not be distributed by the Provider.

(4) Except as provided in section (A)(1) of this section, no entity shall sell, rent, or give a Contracting Entity's rights to the provider's services pursuant to a Health Care Contract.

B. **Products**

(1) Neither Health Plan nor Provider shall require, as a condition of contracting with the Contracting Entity, that a provider provide services for all of the products offered by the Health Plan.

(2) Section (B)(1) of this section shall not be construed to do any of the following:

(a) Prohibit any provider from voluntarily accepting an offer by a Contracting Entity to provide health care services under all of the Contracting Entity's products;

(b) Prohibit any Contracting Entity from offering any financial incentive or other form of consideration specified in the Health Care Contract for a provider to provide health care services under all of the Contracting Entity's products;

(c) Require any Contracting Entity to contract with a provider to provide health care services for less than all of the Contracting Entity's products if the Contracting Entity does not wish to do so.

(3) Future Products.

(a) Notwithstanding section (B)(2) of this section, Health Plan shall not require, as a condition of contracting with the Health Plan, that the Provider accept any future product offering that the Contracting Entity Health Plan makes.

(b) If a Provider refuses to accept any future product offering that the Health Plan makes, the Health Plan may terminate the Agreement based on the Provider's refusal upon written notice to the Provider no sooner than one hundred eighty (180) days after the refusal.

(4) Once the Contracting Entity and the Provider have signed the Health Care Contract, it is presumed that the financial incentive or other form of consideration that is specified in the Health Care Contract pursuant to section (B)(2)(b) of this section is the financial incentive or other form of consideration that was offered by the Contracting Entity to induce the Provider to enter into the contract.

C. Neither Health Plan nor Provider shall require, as a condition of contracting with the Contracting Entity, that a provider waive or forego any right or benefit expressly conferred upon a provider by state or federal law. However, this section does not prohibit a Contracting Entity from restricting a provider's scope of practice for the services to be provided under the Agreement.

D. No Health Care Contract shall do any of the following:

(1) Prohibit any Provider from entering into a Health Care Contract with any other Contracting Entity;

(2) Prohibit any Contracting Entity from entering into a Health Care Contract with any other provider;

(3) Preclude its use or disclosure for the purpose of enforcing this chapter or other state or federal law, except that a Health Care Contract may require that appropriate measures be taken to preserve the confidentiality of any proprietary or trade-secret information.

E. **Termination**

(1) In addition to any other lawful reasons for terminating a Health Care Contract, a Health Care Contract may only be terminated under the circumstances described in section (A)(3) of section 3963.04 of the Revised Code.

(2) If the Health Care Contract provides for termination for cause by either party, the Health Care Contract shall state the reasons that may be used for termination for cause, which terms shall be reasonable. Once the Contracting Entity and the Provider have signed the Health Care Contract, it is presumed that the reasons stated in the Health Care Contract for termination for cause by either party are reasonable. Subject to section (E)(3) of this section, the Health Care Contract shall state the time by which the parties must provide notice of termination for cause and to whom the parties shall give the notice.

(3) Nothing in sections (E)(1) and (2) of this section shall be construed as prohibiting Health Plan from terminating a Provider’s contract for any of the causes described in sections (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code. Notwithstanding any provision in a Health Care Contract pursuant to section (E)(2) of this section, section 1753.09 of the Revised Code applies to the termination of a Provider's contract for any of the causes described in sections (A), (D), and (F)(1) and (2) of section 1753.09 of the Revised Code.

(4) Subject to sections 3963.01 to 3963.11 of the Revised Code, nothing in this section prohibits the termination of a Health Care Contract without cause if the Health Care Contract otherwise provides for termination without cause.

F. **Disputes**

(1) Disputes among parties to a Health Care Contract that only concern the enforcement of the contract rights conferred by section 3963.02, sections (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code are subject to a mutually agreed upon arbitration mechanism that is binding on all parties. The arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this section to the prevailing party.

(2) The arbitrator shall make the arbitrator's decision in an arbitration proceeding having due regard for any applicable rules, bulletins, rulings, or decisions issued by the department of insurance or any court concerning the enforcement of the contract rights conferred by section 3963.02, sections (A) and (D) of section 3963.03, and section 3963.04 of the Revised Code.

(3) A party shall not simultaneously maintain an arbitration proceeding as described in section (F)(1) of this section and pursue a complaint with the superintendent of insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the department of insurance, the superintendent may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The superintendent may request to receive a copy of the results of the arbitration. If the superintendent of insurance notifies Health Plan in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or Health Plan, the arbitration proceeding shall be stayed at the request of the insurer or Health Plan pending the outcome of the market conduct investigation by the superintendent.

6. **Prohibited Conduct**

A. Health Plan shall not do any of the following:

(1) Offer to a provider a Health Care Contract that includes a Most Favored Nation Clause;

(2) Enter into a Health Care Contract with a provider that includes a Most Favored Nation Clause;

(3) Amend or renew an existing Health Care Contract previously entered into with a provider so that the contract as amended or renewed adds or continues to include a Most Favored Nation Clause.

7. **Application of Sections**

A. The provisions of Chapter 3963 of the Revised Code do not apply with respect to any of the following:

(1) A contract or provider agreement between a provider and the state or federal government, a state agency, or federal agency for health care services provided through a program for Medicaid or Medicare;

(2) A contract for payments made to providers for rendering health care services to claimants pursuant to claims made under Chapter 4121., 4123., 4127., or 4131. of the Revised Code;

(3) An exclusive contract between Health Plan and a single group of providers in a specific geographic area to provide or arrange for the provision of health care services.

8. **Stop Loss or Reinsurance**

A. Health Plan, upon written request, shall assist Providers in finding stop-loss or reinsurance carriers.

9. **Hold Harmless**

A. Provider agrees that in no event, including but not limited to nonpayment by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, Member, person to whom health care services have been provided, or person acting on behalf of the Member, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for non Covered Services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against the Health Plan or its successor. This provision shall survive the termination of the Agreement with respect to Covered Services provided under the Agreement during the time the Agreement was in effect, regardless of the reason for the termination, including the insolvency of the Health Plan.

10. **Continuity of Care**

A. Provider will be required to continue to provide Covered Services to Members in the event of the Health Plan's insolvency or discontinuance of operations. Provider is required to continue to provide Covered Services to Members as needed to complete any Medically Necessary procedures commenced but unfinished at the time of the Health Plan's insolvency or discontinuance of operations. The completion of a Medically Necessary procedure shall include the rendering of all Covered Services that constitute Medically Necessary follow-up care for that procedure. If a Member is receiving necessary inpatient care at a hospital, the provisions may limit the required provision of Covered Services relating to that inpatient care in accordance with section (D)(3) of section 1751.11 of the Revised Code, and may also limit such required provision of Covered Services to the period ending thirty days after the Health Plan's insolvency or discontinuance of operations. In the event that any of the following occur, Provider will not be required to continue to provide any Covered Services:

(1) The end of the thirty (30) day period following the entry of a liquidation order under Chapter 3903. of the Revised Code;

(2) The end of the Member's period of coverage for a contractual prepayment or premium;

(3) The Member obtains equivalent coverage with another Health Plan or insurer, or the Member's employer obtains such coverage for the Member;

(4) The Member or the Member's employer terminates coverage under their benefit agreement;

(5) A liquidator effects a transfer of the Health Plan's obligations under the Agreement under section (A)(8) of section 3903.21 of the Revised Code.

11. **Administrative Policies and Programs**

A. Health Plan and Provider will follow all the terms of the Agreement and any federal or state program or laws with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, and confidentiality requirements.

12. **Definitions**

A. All the terms used in the Agreement and that are defined by ORC 1751, shall be used in the Agreement in a manner consistent with those definitions in ORC 1751.

13. **Intermediary Organizations**

A. Health Plan must approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

B. Any intermediary organization that is not a health delivery network contracting solely with self-insured employers subcontracts with a provider or health care facility, the subcontract with the provider or health care facility shall do all of the following:

(1) Contain the provisions required by ORC 1751 (C) and (G), as made applicable to an intermediary organization, without the inclusion of inducements or penalties described in ORC 1751 (D);

(2) Acknowledge that the Health Plan is a third-party beneficiary to the agreement;

(3) Acknowledge the Health Plan’s role in approving the participation of the provider or health care facility, pursuant to ORC 1751 (E).

14. **Oversight of Health Plan**

A. Health Plan shall monitor and oversee the offering of Covered Services to its Members.

15. **Health plan Agreements**

A. All agreements with an intermediary organization that accepts compensation shall include provisions requiring the intermediary organization to provide the superintendent with regulatory access to all books, records, financial information, and documents related to the provision of health care services to Members under the agreement. The intermediary organization is required to maintain such books, records, financial information, and documents at its principal place of business in this state and to preserve them for at least three (3) years in a manner that facilitates regulatory review.

16. **Notification to Members for Termination of Provider**

A. Health Plan shall notify its affected Members of the termination of this Agreement for the provision of Covered Services between the Health Plan and a primary care physician or hospital, by mail, within thirty days after the termination of the Agreement.

(1) Notice shall be given to Members of the termination of this Agreement if the Member has received Covered Services from the primary care physician within the previous twelve (12) months or if the Member has selected the physician as the Member’s primary care physician within the previous twelve (12) months.

(2) Notice shall be given to Members of the termination of a contract with a hospital if the Member, has received health care services from that hospital within the previous twelve (12) months.

B. Health Plan shall pay, in accordance with the terms of the Agreement, for all Covered Services rendered to a Member by a primary care physician or hospital between the date of the termination of the Agreement and five (5) days after the notification of the Agreement termination is mailed to a subscriber at the subscriber's last known address.

17. **Prompt Pay**

A. **Process for Payment and Denial of Claims**

(1) Unless section(s) 2-10 of this section applies, Health Plan shall pay or deny a Claim not later than thirty (30) days after receipt of the Claim when Health Plan receives from a Provider or Member a Claim on the standard Claim form prescribed in rules adopted by the superintendent of insurance under section 3902.22 of the Revised Code. When Health Plan denies a Claim, the Health Plan shall notify the Provider and the Member. The notice shall state, with specificity, why the Health Plan denied the Claim.

(2) Unless section 8 of this section applies, when a Provider or Member has used the standard Claim form, but Health Plan determines that reasonable supporting documentation is needed to establish the Health Plan's responsibility to make payment, the Health Plan shall pay or deny the Claim not later than forty-five (45) days after receipt of the Claim. Supporting documentation includes the verification of employer and Member coverage under a benefits contract, confirmation of premium payment, medical information regarding the Member and the services provided, information on the responsibility of another third-party payer to make payment or confirmation of the amount of payment by another third-party payer, and information that is needed to correct material deficiencies in the Claim related to a diagnosis or treatment or the provider's identification.

(3) Not later than thirty (30) days after receipt of the Claim, the Health Plan shall notify all relevant external sources that the supporting documentation is needed. All such notices shall state, with specificity, the supporting documentation needed. If the notice was not provided in writing, the provider, Member, or Health Plan may request the Health Plan to provide the notice in writing, and the Health Plan shall then provide the notice in writing. If any of the supporting documentation is under the control of the Member, the Member shall provide the supporting documentation to the Health Plan.

(4) The number of days that elapse between the Health Plan's last request for supporting documentation within the thirty (30) day period and the Health Plan's receipt of all of the supporting documentation that was requested shall not be counted for purposes of determining the Health Plan's compliance with the time period of not more than forty-five (45) days for payment or denial of a Claim. Except as provided in section 5, of this section, if the Health Plan requests additional supporting documentation after receiving the initially requested documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall be counted for purposes of determining the Health Plan's compliance with the time period of not more than forty-five (45) days.

(5) If a Health Plan determines, after receiving initially requested documentation, that it needs additional supporting documentation pertaining to a Member's preexisting condition, which condition was unknown to the Health Plan and about which it was reasonable for the Health Plan to have no knowledge at the time of its initial request for documentation, and the Health Plan subsequently requests this additional supporting documentation, the number of days that elapse between making the request and receiving the additional supporting documentation shall not be counted for purposes of determining the Health Plan's compliance with the time period of not more than forty-five (45) days.

(6) If a Health Plan determines that supporting documentation related to medical information is routinely necessary to process a Claim for payment of a particular health care service, the Health Plan shall establish a description of the supporting documentation that is routinely necessary and make the description available to providers in a readily accessible format.

(7) Health Plan and Provider shall, in connection with a Claim, use the most current CPT code in effect, as published by the American medical association, the most current ICD-10 code in effect, as published by the United States department of health and human services, the most current CDT code in effect, as published by the American dental association, or the most current HCPCS code in effect, as published by the United States health care financing administration.

(8) When a Provider or Member submits a Claim by using the standard Claim form prescribed in the superintendent's rules, but the information provided in the Claim is materially deficient, Health Plan shall notify the Provider or Member not later than fifteen (15) days after receipt of the Claim. The notice shall state, with specificity, the information needed to correct all material deficiencies. Once the material deficiencies are corrected, Health Plan shall proceed in accordance with section 1-8 of this section.

(9) It is not a violation of the notification time period of not more than fifteen (15) days if Health Plan fails to notify a Provider or Member of material deficiencies in the Claim related to a diagnosis or treatment or the provider's identification. Health Plan may request the information necessary to correct these deficiencies after the end of the notification time period. Requests for such information shall be made as requests for supporting

documentation under section 2-8, of this section, and payment or denial of the Claim is subject to the time periods specified in that section.

(10) If a dispute exists between a provider and a Health Plan as to the day a Claim form was received by the Health Plan, both of the following apply:

(a) If the Provider or a person acting on behalf of the Provider submits a Claim directly to a Health Plan by mail and retains a record of the day the Claim was mailed, there exists a rebuttable presumption that the Claim was received by the Health Plan on the fifth (5) business day after the day the Claim was mailed, unless it can be proven otherwise.

(b) If the Provider or a person acting on behalf of the Provider submits a Claim directly to Health Plan electronically, there exists a rebuttable presumption that the Claim was received by the Health Plan twenty-four (24) hours after the Claim was submitted, unless it can be proven otherwise.

(11) Health Plan shall transmit electronically any payment with respect to Claims that the Health Plan receives electronically and pays to a Provider under this section and under sections 3901.383, 3901.384, and 3901.386 of the Revised Code. A provider shall not refuse to accept a payment made under this section or sections 3901.383, 3901.384, and 3901.386 of the Revised Code on the basis that the payment was transmitted electronically.

B. **Capitated Providers**

(1) In the event that the Health Plan enters into an Agreement with a Provider in which the payments are capitated or other payment method in which there are periodic payments, Health Plan will begin making the payments not later than sixty (60) days after the Member is assigned to the Provider. The specificity of the payments shall be in the Provider's Compensation Schedule.

C. **Untimely Claims Process**

(1) Subject to section (2) of this section, if Health Plan requires timely submission of Claims for payment for Covered Services, Health Plan will process a Claim that is not submitted in a timely manner if a Claim for the same services was initially submitted to a different third-party payer or state or federal program that offers health care benefits and that payer or program has determined that it is not responsible for the cost of the Covered Services. When a Claim is submitted later than one (1) year after the last date of service for which reimbursement is sought under the Claim, the Health Plan shall pay or deny the Claim not later than ninety (90) days after receipt of the Claim or, alternatively, pursuant to the requirements of sections 3901.381 to 3901.388 of the Revised Code. The Health Plan must make an election to process such Claims either within the ninety (90) day period or under section 3901.381 of the Revised Code. If the Claim is denied, Health Plan shall notify the Provider and the Member. The notice shall state, with specificity, why the third-party payer denied the Claim.

(2) Health Plan may refuse to process a Claim submitted by a Provider if the Provider submits the Claim later than forty-five (45) days after receiving notice from the different third-party payer or a state or federal program that that payer or program is not responsible for the cost of the Covered Services, or if the Provider does not submit the notice of denial from the different third-party payer or program with the Claim. The failure of a Provider to submit a notice of denial in accordance with this section shall not affect the terms of a benefits contract.

(3) For purposes of this section, both of the following apply:

(a) A determination that a third-party payer or state or federal program is not responsible for the cost of health care services includes a determination regarding coordination of benefits, preexisting health conditions, ineligibility for coverage at the time services were provided, subrogation provisions, and similar findings; and

(b) State and federal programs that offer health care benefits include Medicare, Medicaid, workers' compensation, the civilian health and medical program of the uniformed services and other elements of the Tricare program offered by the United States department of defense, and similar state or federal programs.

D. **Reimbursement Contract- Reimbursements to be Made directly to Hospital**

(1) Notwithstanding section 1751.13 or section (I)(2) of section 3923.04 of the Revised Code, a reimbursement Agreement, between Health Plan and a hospital requires that reimbursement for any service provided by a

hospital pursuant to a reimbursement contract and covered under a benefits contract shall be made directly to the hospital.

(2) If Health Plan and the hospital have not entered into an Agreement regarding the provision and reimbursement of Covered Services, Health Plan shall accept and honor a completed and validly executed assignment of benefits with a hospital by a Member, except when the Health Plan has notified the hospital in writing of the conditions under which the Health Plan will not accept and honor an assignment of benefits. Such notice shall be made annually.

(3) Health Plan may not refuse to accept and honor a validly executed assignment of benefits with a hospital pursuant to section (2) of this section for Medically Necessary hospital services provided on an emergency basis.

E. **Duplicative Claims**

(1) When a Provider or Member submits a duplicative Claim for payment for Covered Services before the time periods specified in section 3901.381 of the Revised Code have elapsed for the original Claim submitted, the Health Plan may deny the duplicative Claim. Denials of Claims determined to be duplicative by the department of insurance shall not be considered by the department in a market conduct examination of Health Plan's compliance with section 3901.381 of the Revised Code. The superintendent of insurance shall have the discretion to exclude an original Claim in determining a violation under section 3901.381 of the Revised Code.

(2) Health Plan shall inform Providers and Members of the mechanisms that may be used to gain access to the system used for information regarding the status of a Claim for payment of Covered Services.

F. **Payment Considered Final-Overpayments**

(1) A payment made by Health Plan to Provider in accordance with sections 3901.381 to 3901.386 of the Revised Code shall be considered final two (2) years after payment is made. After that date, the amount of the payment is not subject to adjustment, except in the case of fraud by the Provider.

(2) Health Plan may recover the amount of any part of a payment that Health Plan determines to be an overpayment if the recovery process is initiated not later than two (2) years after the payment was made to the Provider. Health Plan shall inform the Provider of its determination of overpayment by providing notice in accordance with section (4) of this section. Health Plan shall give the Provider an opportunity to appeal the determination. If the Provider fails to respond to the notice sooner than thirty (30) days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, the third-party payer may initiate recovery of the overpayment.

(3) When a Provider has failed to make a timely response to the notice of the third-party payer's determination of overpayment, Health Plan may recover the overpayment by deducting the amount of the overpayment from other payments the Health Plan owes the Provider or by taking action pursuant to any other remedy available under the Revised Code. When a Provider elects not to appeal a determination of overpayment or appeals the determination but the appeal is not upheld, Health Plan shall permit a Provider to repay the amount by making one or more direct payments to the Health Plan or by having the amount deducted from other payments the Health Plan owes the Provider.

(4) The notice of overpayment a Health Plan is required to give a Provider under section (2) of this section shall be made in writing and shall specify all of the following:

(a) The full name of the Member who received the Covered Services for which overpayment was made;

(b) The date or dates the services were provided;

(c) The amount of the overpayment;

(d) The Claim number or other pertinent numbers;

(e) A detailed explanation of basis for the Health Plan's determination of overpayment;

(f) The method in which payment was made, including, for tracking purposes, the date of payment and, if applicable, the check number;

(g) That the Provider may appeal the Health Plan's determination of overpayment, if the provider responds to the notice within thirty (30) days;

(h) The method by which recovery of the overpayment would be made, if recovery proceeds under section (2) of this section.

(5) If Health Plan delegates the processing of payments to another entity, Health Plan shall require the entity to comply with division (2) of this section on behalf of Health Plan.

G. **Interest**

(1) If Health Plan fails to comply with section 3901.381 of the Revised Code, or any contractual payment arrangement entered into under section 3901.383 of the Revised Code, Health Plan shall pay interest in accordance with this section.

(2) Interest shall be computed based upon the number of days that have elapsed between the date payment is due in accordance with section 3901.381 of the Revised Code or the contractual payment arrangement entered into under section 3901.383 of the Revised Code, and the date payment is made. The interest rate for determining the amount of interest due shall be equal to an annual percentage rate of eighteen percent (18%).

(3) For purposes of this section, if a dispute exists between a Provider and Health Plan as to the day a payment was made by the Health Plan, both of the following apply:

(a) If the Health Plan or a person acting on behalf of the Health Plan submits a payment directly to a Provider by mail and retains a record of the day the payment was mailed, there exists a rebuttable presumption that the payment was made five (5) business days before the day the payment was received by the Provider, unless it can be proven otherwise.

(b) If the Health Plan or a person acting on behalf of the Health Plan submits a payment directly to a Provider electronically, there exists a rebuttable presumption that the payment was made twenty-four (24) hours before the date the payment was received by the Provider, unless it can be proven otherwise.

(4) Interest due in accordance with this section shall be paid directly to the Provider at the time payment of the Claim is made and shall not be used to reduce benefits or payments otherwise payable under a benefits contract.

H. **Complaints by Provider or Member**

(1) A Provider or Member aggrieved with respect to any act of Health Plan that the Provider or Member believes to be a violation of sections 3901.381 to 3901.388 of the Revised Code may file a written complaint with the superintendent of insurance regarding the violation.

(2) Health Plan shall not retaliate against Provider or Member who files a complaint under section (1) of this section. If a Provider or Member is aggrieved with respect to any act of the Health Plan that the Provider or Member believes to be retaliation for filing a complaint under section (1) of this section, the Provider or Member may file a written complaint with the superintendent regarding the alleged retaliation.

ATTACHMENT F
Required Provisions
Medicaid Program Provisions

The attached Medicaid Addendum is made part of this agreement referenced hereto and incorporated herein.

ATTACHMENT G
Acknowledgment of Receipt of Provider Manual(s)

Provider hereby acknowledges receipt of Health Plan's Provider Manual(s) and acknowledges that Health Plan's Provider Manual(s) were made available to Provider for review prior to Provider's decision to enter into this Agreement. Health Plan's Provider Manual(s) are available at the Health Plan's website: http://www.molinahealthcare.com.

ATTACHMENT H
Medicare Program Requirements – Health Care Services

This attachment sets forth the applicable Government Program requirements, covering the provision of health care and related services, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).
2. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR422.504(i)(2)(ii)).
3. Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).
4. Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii)). In addition, for Members who are dually eligible for Medicare and Medicaid and enrolled in a Medicare Advantage Special Needs Plan will not be held liable for Medicare Part A and B cost sharing when the State or another payor such as a Medicaid Managed Care Plan is responsible for paying such amounts. Health Plan will inform providers of applicable Medicare and Medicaid benefits and rules for eligible Members. Provider agrees to accept payment from Health Plan as payment in full, or bill the appropriate State source, for any Medicare Part A and B cost sharing that is covered by Medicaid. Collection from the Member of copayments or supplemental charges in accordance with the terms of the Member's contract with the Health Plan, or charges for services not covered under the Member's contract, may be excluded from this provision.
5. Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment H-1 of this Agreement. (42 CFR 422.504(i)(3)(ii)).
6. Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4)).
7. Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for services that are covered by Medicare within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. Any Claims for services that are covered by Medicare that are not submitted to Health Plan within one-hundred twenty (120) days of providing the services that are subject of the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Health Plan reserves the

right to deny any Claims that are not in accordance with the Medicare Claims Processing Manual and Medicare rules for billing. (42 CFR 422.520(b)).

8. Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8)).
9. Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).
10. Benefit Continuation. Provider agrees to provide for continuation of Member health care benefits (i) for all Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 42 CFR 422.504(g)(2)(ii) and 42 CFR 422.504(g)(3)).
11. Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. (42 CFR 112(a)(8)).

ATTACHMENT H-1

Medicare Program Requirements – Delegated Services

This attachment sets forth the applicable Government Program requirements, covering the delegation to Provider of any management responsibilities or administrative services if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) clients or providers of health care or related services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).
2. Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).
3. Confidentiality. Provider will comply with the confidentiality and Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).
4. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii)).
5. Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 422.504(i)(4)(i) and 42 CFR 422.504(a)(8)).
6. Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii)).
7. Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii)).
8. Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5)).
9. Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4)).

10. Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5).

ATTACHMENT J

Medicare-Medicaid Program Requirements

This attachment sets forth the applicable Medicare-Medicaid Program requirements, covering the provision of health care services that are required by CMS and the State of Ohio to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS and the State of Ohio requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare-Medicaid Program Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).
2. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts and records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare-Medicaid Program Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii)).
3. Confidentiality. Provider will comply with the confidentiality and Medicare-Medicaid Program Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).
4. Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Medicare-Medicaid Program Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii)). In addition, Medicare-Medicaid Program Members will not be held liable for any Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services will be provided at zero-cost share to the Medicare-Medicaid Program Member.
5. Accountability. Health Plan may only delegate activities or functions to a first tier, downstream, or related entity, in a manner that is consistent with the provisions set forth in Attachment J-1 of this Agreement. (42 CFR 422.504(i)(3)(ii)).
6. Delegation. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(3)(iii) and 42 CFR 422.504(i)(4)).
7. Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for Covered Services, which are determined by Health Plan to be payable, within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. (42 CFR 422.520(b)).
8. Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8)).
9. Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).
10. Benefit Continuation. Provider agrees to provide for continuation of Medicare-Medicaid Program Member health care benefits (i) for all Medicare-Medicaid Program Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Medicare-Medicaid Program Members who are

hospitalized on the date Health Plan's contract with CMS terminates, or, in the event of insolvency, through discharge. (42 CFR 422.504(g)(2)(i), 42 CFR 422.504(g)(2)(ii) and 42 CFR 422.504(g)(3)).

11. Cultural Considerations. Provider agrees that services are provided in a culturally competent manner to all Medicare-Medicaid Program Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. (42 CFR 422.112(a)(8)).
12. Provider will render all services associated with this Agreement in compliance with 42 CFR §§ 422.504, 423.505, and 438.6(l) and OAC 5160-58-01.1 and 5160-26-05.
13. Provider must maintain Medicare-Medicaid Program Member records and information in an accurate and timely manner.
14. Provider must comply with the Federal Emergency Medical Treatment and Labor Act (EMTALA) and all requirements outlined in 42 U.S. Code § 1395dd and Health Plan will not create any policies that conflict with the Provider's obligations under EMTALA.
15. Provider may not close or otherwise limit its acceptance of Medicare-Medicaid Program Members as patients unless the same limitations apply to all commercially insured Medicare-Medicaid Program Members.
16. Health Plan may not refuse to contract or pay an otherwise eligible health care provider for the provision of Covered Services solely because such provider has in good faith:
    a. Communicated with or advocated on behalf of one or more of his or her prospective, current or former patients regarding the provisions, terms or requirements of the Health Plan's health benefit plans as they relate to the needs of such provider's patients; or
    b. Communicated with one or more of his or her prospective, current, or former patients with respect to the method by which such provider is compensated by the Health Plan for services provided to the patient.
17. Provider is not required to indemnify Health Plan for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against the Health Plan based on the Health Plan's management decisions, utilization review provisions or other policies, guidelines or actions.
18. Provider must comply with the Health Plan's requirements for the delivery of preventive health services.
19. Health Plan will notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in the Health Plan's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of the providers, and the effective date of the modifications. The notice shall be provided thirty (30) days before the effective date of such modification unless such other date for notice is mutually agreed upon between the Health Plan and the Provider or unless such change is mandated by CMS or the Ohio Department of Medicaid without thirty (30) days prior notice.
20. Provider must comply with all applicable requirements governing physician incentive plans, including but not limited to such requirements appearing at 42 CFR Parts 417, 422, 434, 438, and 1003.
21. Health Plan shall make no payment to Provider for a provider preventable condition as defined by law.
22. Additionally, for Medicare-Medicaid Program Members enrolled in only the ICDS program, Health Plan is not required to pay for services not covered by the Ohio Medicaid program, except as otherwise specified in OAC rule 5160-58-03 and/or this Agreement.

ATTACHMENT J-1

Medicare-Medicaid Program Requirements – Delegated Services

This attachment sets forth the applicable Medicare-Medicaid Program requirements, covering the delegation to Provider of any management responsibilities or administrative services, if any, that are required by CMS to be included in contracts and/or agreements between; (i) health plans/health maintenance organizations, and (ii) providers of health care services, authorized assignees, delegates or subcontractors. This attachment is hereby incorporated into the Agreement, and both will be automatically modified to conform to subsequent changes or amendments by CMS to any Government Program requirements set forth herein. All terms and conditions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of any inconsistency between this attachment and the Agreement, the terms and conditions of this attachment will control, notwithstanding anything to the contrary in the Agreement. Capitalized terms utilized in this attachment will have the same meanings ascribed to them in the Agreement unless otherwise set forth in this attachment and the applicable statute(s).

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(s) that provide any services benefiting Health Plan's Medicare-Medicaid Program Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).
2. Medicare Compliance. Provider agrees to require all of its downstream, related entity(s) and transferees to comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v)).
3. Confidentiality. Provider will comply with the confidentiality and Medicare-Medicaid Program Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13)).
4. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, contracts, records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare-Medicaid Program Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR 422.504(i)(2)(ii)).
5. Responsibilities and Reporting Arrangements. The Agreement specifies the delegated activities and reporting responsibilities, if any. To the extent applicable, Provider will support Health Plan in complying with the reporting requirements set forth in 42 CFR 422.516 and 42 CFR 310 by providing relevant data. (42 CFR 422.504(i)(4)(i) and 42 CFR 422.504(a)(8)).
6. Revocation of Delegated Activities. In the event CMS or Health Plan determines, in its sole discretion, that Provider has not performed the delegated activities or functions satisfactorily, the delegated activities will be revoked. (42 CFR 422.504(i)(4)(ii)).
7. Accountability. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's contract with CMS. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(3)(iii)).
8. Credentialing. If Provider is delegated credentialing activities, Provider's credentialing process will be reviewed and approved by Health Plan, and such credentialing process will be audited by Health Plan on an ongoing basis; further, Provider agrees that its credentialing process will comply with all applicable NCQA standards. Health Plan retains the right to approve, suspend, or terminate any credentialing delegation arrangement. (42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5)).
9. Monitoring. Notwithstanding any relationship(s) Health Plan may have with first tier, downstream, and related entities, Health Plan maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with the Health Plan's

contractual obligations. Health Plan will monitor the performance of first tier, downstream, and related entities. (42 CFR 422.504(i)(1) and 42 CFR 422.504(i)(4)).

10. Further Requirements. Any services or other activity performed by a first tier, downstream, or related entity in accordance with a contract or written agreement will be consistent and comply with Health Plan's contractual obligations. If Health Plan delegates selection of the providers, contractors, or subcontractor to another organization, Health Plan retains the right to approve, suspend, or terminate any such arrangement. (42 CFR 422.504(i)(3)(iii), 42 CFR 422.504(i)(4) and 42 CFR 422.504(i)(5)).

ATTACHMENT K

Coronavirus Disease Requirements

This attachment sets forth applicable Coronavirus Disease ("COVID") requirements which are required to be included by Law as stated below. This attachment will be automatically modified to conform to subsequent changes to Law. All provisions of the Agreement not specifically modified by this attachment remain unchanged and will control. In the event of a conflict between this attachment and any other provision in the Agreement, the provisions in this attachment will control. Capitalized terms used in this attachment will have the same meaning ascribed to them in the Agreement unless otherwise set forth in this attachment. Any purported modification or any provision in this attachment that is inconsistent with Law will not be effective and will be interpreted in a manner that is consistent with the applicable Law. For the avoidance of doubt, this attachment applies to the Medicare Advantage Product and the Medicare-Medicaid Product.

1.1 **Executive Order 14042.** Ensuring Adequate COVID-19 Safety Protocols for Federal Contractors for Subcontractors Over the Simplified Acquisition Threshold of Two Hundred and Fifty Thousand Dollars ($250,000).

a. **Definition.** As used in this section, "United States or its outlying areas" means:

i. The fifty States;

ii. The District of Columbia;

iii. The commonwealths of Puerto Rico and the Northern Mariana Islands;

iv. The territories of American Samoa, Guam, and the United States Virgin Islands; and

v. The minor outlying islands of Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, Midway Islands, Navassa Island, Palmyra Atoll, and Wake Atoll.

b. **Authority.** This clause implements Executive Order 14042, Ensuring Adequate COVID Safety Protocols for Federal Contractors, dated September 9, 2021 (published in the Federal Register on September 14, 2021, 86 FR 50985).

c. **Compliance.** Provider, a subcontractor, shall comply with all guidance, including guidance conveyed through Frequently Asked Questions, as amended during the performance of this Agreement, for contractor or subcontractor workplace locations published by the Safer Federal Workforce Task Force ("Task Force Guidance") at https:/www.saferfederalworkforce.gov/contractors/.

Subcontracts. Provider shall include the substance of this clause, including this paragraph (d), in subcontracts at any tier that exceed the simplified acquisition threshold, as defined in Federal Acquisition Regulation 2.101 on the date of subcontract award, and are for services, including construction, performed in whole or in part within the United States or its outlying areas.