MOLINA HEALTHCARE OF ILLINOIS, INC.
PROVIDER SERVICES AGREEMENT

SIGNATURE PAGE

In consideration of the promises, covenants, and warranties stated, the Parties agree as set forth in this Agreement. The Authorized Representative acknowledges, warrants, and represents that the Authorized Representative has the authority and authorization to act on behalf of its Party. The Authorized Representative further acknowledges he/she received and reviewed this Agreement in its entirety.

The Authorized Representative of Provider acknowledges the Provider Manual was available for review prior to entering into this Agreement, and agrees that Provider will comply with the provisions set forth under the Provider Manual section and other applicable provisions related to the Provider Manual in the Agreement.

The Authorized Representative for each Party executes this Agreement with the intent to bind the Parties in accordance with this Agreement.

Effective Date of Agreement ("Effective Date"):

Provider Signature and Information.

Provider's Legal Name ("Provider") – Matching the applicable tax form (i.e. W-9, Line 1): Joyful ABA LLC	
Authorized Representative's Signature: leslie smith	Authorized Representative's Name – Printed: Leslie Smith
Authorized Representative's Title: Owner	Authorized Representative's Signature Date: 04/22/2024
Telephone Number: (708)-625-4836	Fax Number – Official Correspondence: 708.570.2797
Mailing Address – Official Correspondence: 2045 W Grand Ave Ste B 292316, Chicago, IL 60612-1576	Payment Address – If different than Mailing Address: Same as mailing address
IRS 1099 Address – If different than Mailing Address: Same as mailing address	Tax ID Number – As listed on corresponding tax form: 93-1768031
NPI – That corresponds to the above Tax ID Number: 1295519916	Email Address – Official Correspondence: leslie@joyfulaba.org

Health Plan Signature and Information.

Molina Healthcare of Illinois, Inc., an Illinois Corporation ("Health Plan")	
Authorized Representative's Signature:	Authorized Representative's Name – Printed: Tom Rodakowski
Authorized Representative's Title: Vice President of Network Management & Operations	Authorized Representative's Countersignature Date:
Mailing Address – Official Correspondence: 1520 Kensington Drive, Suite 212 Oak Brook, IL 60523	Email Address – Official Correspondence: Tom.Rodakowski@molinahealthcare.com

PROVIDER SERVICES AGREEMENT

Health Plan and Provider enter into this Agreement as of the Effective Date set forth on the Signature Page of this Agreement. The Provider and Health Plan each are referred to as a "Party" and collectively as the "Parties".

RECITALS

A. WHEREAS, Health Plan is a corporation licensed and approved by required agencies to operate a health care service plan, including without limitation, to issue benefit agreements covering the provision of health care and related services and enter into agreements with Participating Providers;

B. WHEREAS, Provider is approved to provide health care or related services and desires to provide services to eligible recipients; and

C. WHEREAS, the Parties intend by entering into this Agreement they will make health care or related services available to eligible recipients enrolled in various Products covered under this Agreement.

NOW, THEREFORE, in consideration of the promises, covenants, and warranties stated herein, the Parties agree as follows:

ARTICLE ONE – DEFINITIONS

1.1 Capitalized words or phrases in this Agreement have the meaning set forth below.

a. **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care, when the Member is not competent to make a health care decision as determined under Law.

b. **Affiliate** means an entity owned or controlled by Health Plan or Molina Healthcare, Inc.

c. **Agreement** means this Provider Services Agreement between Provider and Health Plan and all attachments, exhibits, addenda, amendments, and incorporated documents or materials.

d. **Centers for Medicare and Medicaid Services ("CMS")** means the agency responsible for Medicare and certain parts of Medicaid, CHIP, Medicare-Medicaid Program, and the Health Insurance Marketplace.

e. **Claim** means a bill for Covered Services provided by Provider.

f. **Clean Claim** means a Claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider or from a third party.

g. **Covered Services** mean those health care services and supplies, including Emergency Services, provided to Members that are Medically Necessary and are benefits of a Member's Product.

h. **Cultural Competency Plan** means a plan that ensures Members receive Covered Services in a manner that takes into account, but is not limited to, developmental disabilities, physical disabilities, differential abilities, cultural and ethnic backgrounds, and limited English proficiency.

i. **Date of Service** means the date on which Provider provides Covered Services or, for inpatient services, the date the Member is discharged.

j. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage, Medicaid, or MMP Products below the level of the arrangement between Health Plan (or applicant) and Provider. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

k. **Emergency Services** mean covered inpatient and outpatient services furnished by a provider who is qualified to furnish these services and such services are needed to evaluate or stabilize an emergency medical condition.

l. **Encounter Data** means all data captured during the course of a single health care encounter that specifies: (i) the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative) pharmaceuticals, medical devices, and equipment associated with a Member receiving services during the encounter; (ii) the identification of the Member receiving and the provider providing the health care services during the single encounter; and (iii) a unique and unduplicated identifier for the single encounter.

m. **Government Contracts** mean those contracts between Health Plan and state and federal agencies for the arrangement of health care and related services for Government Programs.

n. **Government Programs** mean various government sponsored health products in which Health Plan participates.

o. **Government Program Requirement** means the requirements of governmental agencies for a Government Program, which includes, but is not limited to, the requirements set forth in the Government Contract.

p. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.

q. **Health Insurance Marketplace** means those health insurance products/programs required by Title I of 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), referred to collectively as the Affordable Care Act, including all implementing statutes and regulations.

r. **Health Plan** means Molina Healthcare of Illinois, Inc., an Illinois Corporation.

s. **Law** means all statutes, codes, and regulations applicable to this Agreement.

t. **Medicaid** means the joint federal-state program provided for under Title XIX of the Social Security Act, as amended.

u. **Medically Necessary or Medical Necessity** means health care services provided to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance with generally accepted standards of medical practice; (ii) appropriate for the symptoms, diagnosis, or treatment of the Member's condition, disease, illness or injury; (iii) not primarily for the convenience of the Member or health care provider; and (iv) not more costly than an alternative service, or site of services, at least as likely to produce equivalent results.

v. **Medicare Advantage ("MA")** means a program in which private health plans provide health care and related services through a Government Contract with CMS, which is authorized under Title XVIII of the Social Security Act, as amended (otherwise known as "Medicare"). Medicare Advantage also includes Medicare Advantage Special Needs Plans ("MA-SNP").

w. **Medicare-Medicaid Program ("MMP")** means a program in which private health plans provide health care and related services to beneficiaries eligible for both Medicaid and Medicare through a Government Contract with CMS and the State.

x. **Member** means a person enrolled in a Product and who is eligible to receive Covered Services.

y. **Molina Marketplace** means the Products offered and sold by Health Plan under the requirements of the Health Insurance Marketplace.

z. **Overpayments** mean a payment Provider receives, which after applicable reconciliation, Provider is not entitled to receive pursuant to Laws, Government Program Requirements, or this Agreement.

aa. **Participating Provider** means a healthcare facility or practitioner contracted with and, as applicable, credentialed by Health Plan or Health Plan's designee.

bb. **Product** means the various health insurance programs offered by Health Plan to Members in which Provider agrees to be a Participating Provider, identified on Attachment A, Products, and which will include any successors to such Products.

cc. **Provider** means the entity identified on the Signature Page of this Agreement and includes any person or entity performing Covered Services on behalf of Provider and for which: (i) an entity of the Provider bills under an owned tax identification number; and (ii), when applicable, such person or entity has been approved by Health Plan as a Participating Provider. Each entity or person shall be considered an "Individual Provider".

dd. **Provider Manual** means Health Plan's provider manuals, policies, procedures, documents, educational materials, and, as applicable, Supplemental Materials, setting forth Health Plan's requirements and rules that Provider is required to follow.

ee. **Quality Improvement Program ("QI Program")** means the policies and procedures, interventions, and systems, developed by Health Plan for monitoring, assessing, and improving the accessibility, quality, and continuity of care provided to Members.

ff. **Responsible Entity** means an entity that is financially responsible for certain Covered Services and pays Claims that are part of its financial responsibility.

gg. **Subcontractor** means an individual or organization, including Downstream Entity, with which Provider contracts for the provision of Covered Services or administrative functions related to the performance of this Agreement. For the avoidance of doubt, a Subcontractor does not include Individual Providers.

hh. **Utilization Review and Management Program ("UM Program")** means the policies, procedures, and systems developed by Health Plan for evaluating and monitoring the Medical Necessity, appropriateness, efficacy, or efficiency of core health care benefits and services, procedures or settings and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective reviews, including, but not limited to, under-utilization and over-utilization.

ARTICLE TWO – PROVIDER OBLIGATIONS

2.1 **Provider Standards.**

a. **Standard of Care.** Provider agrees to provide Covered Services within the scope of Provider's business. Provider will ensure all services and interactions with Members are at a level of care and competence that equals or exceeds generally accepted and professionally recognized standards of practice, rules, and standards of professional conduct, Laws and Government Program Requirements.

b. **Facilities, Equipment, and Personnel.** Provider's facilities, equipment, personnel, and administrative services will be at a level and quality necessary to perform Provider's duties and responsibilities under this Agreement and to comply with Laws and Government Program Requirements.

c. **Prior Authorization.** For Covered Services that require prior authorizations, Provider will obtain prior authorization from Health Plan before providing such Covered Service. Provider will not have to obtain prior authorizations before providing Emergency Services.

d. **Use of Participating Providers.** Except in the case of Emergency Services or when Provider obtains prior authorization, Provider will only utilize Participating Providers to provide Covered Services. If a Participating Provider is not available, Provider will notify Health Plan so Health Plan can determine the appropriate provider to perform such services.

e. **Prescriptions.** When prescribing medications that a Member gets through a pharmacy, Provider will follow Health Plan's Drug Formulary/Prescription Drug List, and prior authorization and prescription policies. Provider acknowledges the authority of pharmacies to substitute generics or low cost alternative prescriptions for the prescribed medication.

f. **Provider-Member Communication.** Health Plan encourages open Provider-Member communication regarding Medical Necessity, appropriate treatment, and care. Provider is free to communicate all treatment options to Members regardless of limitations on Covered Services.

g. **Member Eligibility Verification.** Provider will verify eligibility of Members before providing services unless the situation involves the provision of Emergency Services.

h. **Availability of Services.** Provider will make necessary and appropriate arrangements to ensure availability of Covered Services twenty-four (24) hours a day, seven (7) days a week. Provider will meet applicable standards for timely access to care and service in accordance with Laws and Government Program Requirements.

i. **Admission Notifications.** Provider will immediately notify Health Plan of Member hospital admissions, including inpatient admissions and Members referred to the emergency department.

j. **Staffing Privileges for Providers.** Provider will have staff privileges with at least one (1) Health Plan contracted hospital as necessary to provide Covered Services. Provider will authorize each hospital to notify Health Plan if disciplinary or other action of any kind is initiated against Provider, which could result in the suspension, reduction, or modification of Provider's hospital privileges. If Provider does not have staff

privileges with at least one (1) Health Plan contracted hospital, Provider must provide an acceptable arrangement to Health Plan that ensures Member continuity of care.

2.2 **Rights of Members.** Provider will observe, protect, and promote the rights of Members.

2.3 **Use of Name.** Provider will display Health Plan's promotional materials as practical and will cooperate in reasonable Health Plan marketing efforts that do not violate Laws or Government Program Requirements. Provider will not use Health Plan's name in advertising or promotional materials without the prior written consent of Health Plan. Health Plan may use Provider's name and related information in: (i) publications to identify Provider as a Participating Provider; and (ii) as may be required to comply with the Laws and Government Program Requirements.

2.4 **Non-Discrimination in Enrollment.** Provider will not differentiate or discriminate in providing Covered Services because of race, color, religion, national origin, ancestry, age, sex, marital status, sexual orientation, physical, sensory or mental handicap, socioeconomic status, or participation in publicly financed programs of health care services. Provider will provide Covered Services in the same location, in the same manner, in accordance with the same standards, and within the same time or availability, regardless of payer.

2.5 **Recordkeeping.**

a. **Maintaining Member Record.** Provider will maintain a medical and billing record ("Record") for each Member to whom Provider provides health care services. The Member's Record will contain all information required by Laws, generally accepted and prevailing professional practices, applicable Government Program Requirements, and Health Plan's policies and procedures. Provider will retain such Record for as long as required by Laws and Government Program Requirements. This section will survive any termination.

b. **Confidentiality of Member Record.** Provider will comply with all Laws, including, but not limited to, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act, Health Plan's policies and procedures, and Government Program Requirements regarding privacy and confidentiality. Provider will not disclose or use Member names, addresses, social security numbers, identities, other personal information, treatment modalities, or Record without obtaining appropriate authorization. This section does not affect or limit Provider's obligation to make available the Record, Encounter Data, and information concerning Member care to Health Plan, a state or federal agency, or another provider of health care. This section will survive any termination.

c. **Delivery of Member Information.** Provider will promptly deliver to Health Plan, upon request or as may be required by Laws, Government Program Requirements, Health Plan's policies and procedures or third party payers, any information, statistical data, Encounter Data, or Record pertaining to a Member. Provider is responsible for the fees associated with producing the above items. Provider will further give direct access to the items as requested by Health Plan or as required by a state or federal agency. Health Plan has the right to withhold compensation from Provider if Provider fails or refuses to give the items to Health Plan promptly. This section will survive any termination.

d. **Member Access to Member Record.** Provider will give Members access to Members' Record and other applicable information, in accordance with Laws, Government Program Requirements, and Health Plan's policies and procedures. This section will survive any termination.

2.6 **Program Participation.**

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

b. **Participation in Quality Improvement Program.** Provider will participate in and comply with Health Plan's QI Program, and will cooperate in conducting peer reviews and audits of care provided by Provider.

c. **Participation in Utilization Review and Management Program.** Provider will participate in and comply with Health Plan's UM Program. Provider will cooperate with Health Plan in audits to identify, confirm, and assess utilization levels of Covered Services.

d. **Participation in Credentialing.** Provider will participate in and satisfy credentialing criteria established by Health Plan before the Effective Date and throughout the term of this Agreement. Notwithstanding the previous sentence, when Health Plan is prohibited from conducting its own credentialing process pursuant to a Law or Government Program Requirement, Provider will satisfy Health Plan's initial credentialing criteria if it is credentialed by a state or federal agency or enrolled with the state or federal agency's system for credentialing providers pursuant to a Law or Government Program requirement. Provider will promptly notify Health Plan in writing of any change in the information submitted or relied upon by Provider to achieve or maintain credentialed status. In accordance with Health Plan's policies and procedures, Provider must be credentialed by Health Plan or Health Plan's designee before providing Covered Services and be in compliance with Health Plan's policies and procedures for the selection and retention of Providers.

e. **Health Education/Training.** Provider will participate in and comply with Health Plan's Provider education and training efforts, which includes the Cultural Competency Plan and such standards, policies, and procedures as may be necessary for Health Plan to comply with Laws and Government Program Requirements.

2.7 **Provider Manual.** Provider will comply with the Provider Manual, which is incorporated by reference into this Agreement and may be unilaterally amended from time to time by Health Plan. Provider acknowledges the Provider Manual is available to Provider at Health Plan's website. A physical copy of the Provider Manual is available upon request.

2.8 **Supplemental Materials.** Health Plan may periodically issue bulletins or other written materials in order to supplement the Provider Manual or to give additional instruction, guidance, or information ("Supplemental Materials"). Health Plan may issue Supplemental Materials in an electronic format, which includes, but is not limited to, posting on Health Plan's interactive web-portal, and a physical copy is available upon request. Supplemental Materials become binding upon Provider as of the effective date indicated on the Supplemental Materials or, if applicable, the effective date will be determined in accordance with this Agreement.

2.9 **Health Plan's Electronic Processes and Initiatives.** Provider will 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 medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice, electronic fund transfers, and registration and use of Health Plan's interactive web-portal.

2.10 **Information Reporting and Changes.** Provider will deliver to Health Plan a complete list of all health care providers, facilities, and business/practice locations it uses to provide Covered Services every thirty (30) days, together with specific information required for credentialing and administration. If Provider does not deliver such information, Health Plan will use the last information received from Provider. Notwithstanding the above, if a Law or Government Program Requirement requires the delivery of information described in this section in another matter or different timeframe, Provider will notify Health Plan in accordance with the Law or Government Program Requirement. Health Plan also reserves the right to request such information at any time.

2.11 **Standing.**

a. **Licensure.** Provider warrants and represents it has the appropriate licenses to provide Covered Services. This includes having and maintaining a current narcotics number issued by proper authorities when appropriate. Provider will deliver evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status. Provider will promptly notify Health Plan of changes in its licensure status, including, but not limited to, disciplinary action taken or proposed by any agency responsible for oversight of Provider.

b. **Unrestricted Status.** Provider represents as of the Effective Date of this Agreement that, to its best knowledge, information, and belief, neither it, nor any of its employees, temporary employees, volunteers, consultants and members of its board of directors, officers or contractors (collectively, "Personnel") have been excluded from participation in the Medicare Program, any state or the District of Columbia's Medicaid Program, or any other federal health care program (collectively "Federal Health Care Program"). Provider agrees that it must check the Department of Health and Human Services Office of Inspector General List of Excluded Individuals and Entities ("LEIE" list), the General Services Administration Excluded Parties Lists System ("EPLS") and every state and the District of Columbia's Medicaid exclusion lists to determine whether Provider or any of its Personnel have been excluded from participation in any Federal Health Care Program. These databases must be

checked for any new Personnel and thereafter not less than monthly. Provider shall notify Health Plan immediately in writing if Provider determines that Provider or any of its Personnel are suspended or excluded from any Federal Health Care Program. Provider agrees that it is subject to 2 CFR Part 376 and shall require its Personnel to agree that they are subject to 2 CFR Part 376. If a governmental agency imposes a financial adjustment or penalty on Health Plan due to Provider's non-compliance with this provision, Health Plan shall not be obligated to provide subsequent payments owed to Provider under this Agreement and Health Plan shall treat any prior payments, financial adjustments or penalties assessed as an Overpayment.

c. **Malpractice and Other Actions.** Provider will give prompt written notice to Health Plan of: (i) a malpractice claim asserted against it by a Member, a payment made by or on behalf of Provider in settlement or compromise of such a claim, or a payment made by or on behalf of Provider pursuant to a judgment rendered upon such a claim; (ii) a criminal investigation or proceeding against Provider; (iii) a conviction of Provider for crimes involving moral turpitude or felonies; and (iv) a civil claim asserted against Provider that may jeopardize Provider's financial soundness. This section will survive any termination.

d. **Liability Insurance.** Provider will maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and health care activities, and in compliance with Laws and Government Program Requirements. If the coverage is claims made or reporting, Provider agrees to purchase similar "tail" coverage upon termination of the Provider's present or subsequent policy. Provider will deliver copies of such insurance policy to Health Plan within five (5) business days of a written request by Health Plan. Provider will deliver advance written notice fifteen (15) business days before any change, reduction, cancellation, or termination of such insurance coverage. This section will survive any termination.

2.12 **Non-Solicitation of Members.** Provider will not solicit or encourage Members to select another health plan.

2.13 **Laws and Government Program Requirements.**

a. **Compliance with Laws and Government Program Requirements.** Provider will comply with Laws that are applicable to this Agreement. Provider acknowledges Health Plan entered into Government Contracts and Provider will comply with the applicable Government Program Requirements that must be satisfied under this Agreement. Upon written request, Health Plan will give Provider a redacted copy of applicable Government Contracts.

b. **Fraud and Abuse Reporting.** Provider will comply with Laws and Government Program Requirements related to fraud, waste, and abuse. Provider will establish and maintain policies and procedures for identifying and investigating fraud, waste, and abuse. In the event Provider discovers an occurrence of fraud, waste, or abuse, Provider will promptly notify Health Plan. Provider will participate in investigations conducted by Health Plan or by state or federal agencies. This section will survive any termination.

c. **Advance Directive.** Provider will comply with Laws and Government Program Requirements related to Advance Directives.

d. **Ownership Disclosure Information.** If applicable, Provider must disclose to Health Plan the name and address of each person, entity, or business with an ownership or control interest in the disclosing entity before the Effective Date and throughout the term of this Agreement. Provider or disclosing entity must also disclose to Health Plan whether any person, entity, or business with an ownership or control interest in the disclosing entity are related to another as spouse, parent, child, or sibling before the Effective Date and throughout the term of this Agreement. Furthermore, there must be disclosure of the name of any other disclosing entity in which a person with an ownership or controlling interest in the Provider or disclosing entity also has an ownership or control interest.

2.14 **Reciprocity Agreements.** Provider will cooperate with Affiliates and agrees to ensure reciprocity of health care services to Affiliate's enrollees. For Affiliate enrollees, Provider will be compensated for Clean Claims that are determined to be payable in accordance with Laws and Government Program Requirements. If there is not a Law or Government Program Requirement governing reimbursement, Provider will be compensated at the rates set forth in this Agreement. Provider will follow the hold harmless provisions of this Agreement for Affiliate's enrollees.

2.15 **Transfer of Members.** Provider will not unilaterally assign or transfer Members to another Participating Provider or non-Participating Provider without the prior written approval of Health Plan.

2.16 **Members Condition Changes.** Upon becoming aware of a significant change in a Member's health or functional status, a Member is being abused or neglected, or a Member death, Provider will notify Health Plan's Member Services department as soon as possible, but not later than seven (7) days.

2.17 **Continuity of Care.** In the event the Agreement is terminated for any reason except quality of care issues or disciplinary proceedings by the State licensing board, Provider agrees to continue to provide Covered Services: (i) for ninety (90) days from the date the Member receives notice that the Provider is terminating their Agreement for Members who have an ongoing course of treatment; and (ii) for Members who are in the third trimester of pregnancy on the date the Agreement is terminated, which shall also include the provision of post-partum care directly related to the delivery, if Provider continues to accept the compensation rates in this Agreement, the terms of this Agreement and Laws and Government Program Requirements.

ARTICLE THREE – HEALTH PLAN'S OBLIGATIONS

3.1 **Member Eligibility Determination.** Health Plan will maintain data on Member eligibility and enrollment. Health Plan will promptly verify Member eligibility at the request of Provider.

3.2 **Prior Authorization Review.** Health Plan will respond with a determination on a prior authorization request in accordance with the time frames governed by Laws and Government Program Requirements after receiving all necessary information from Provider.

3.3 **Medical Necessity Determination.** Health Plan's determination with regard to Medical Necessity, including, but not limited to, determinations of level of care and length of stay, will govern. The primary concern with respect to Medical Necessity determinations is the interest of the Member.

3.4 **Member Services.** Health Plan will provide services to Members, including, but not limited to, assisting Members in selecting a primary care physician, processing Member complaints and grievances, informing Members of Health Plan's policies and procedures, providing Members with membership cards, providing Members with information about Health Plan, and providing Members with access to Health Plan's Provider Directory.

3.5 **Provider Services.** Health Plan will make available a provider services department that, among other Health Plan duties, is available to assist Provider with questions about this Agreement.

3.6 **Corrective Action.** Health Plan, and state and federal agencies routinely monitor the level, manner, and quality of Covered Services provided as well as Provider's compliance with this Agreement. If a deficiency is identified, Health Plan or an agency, in its sole discretion, may choose to issue a corrective action plan. Provider is required to accept and implement such corrective action plan. Provider is not entitled to a corrective action plan prior to any termination.

3.7 **Reassignment of Members.** Health Plan reserves the right to reassign, limit, or deny the assignment or selection of Members to Provider if Health Plan determines that Provider poses a threat to Members' health and safety or during a termination notice period. If Provider requests reassignment of a Member, Health Plan, in its sole discretion, will make the determination regarding reassignment based upon good cause shown by the Provider. When Health Plan reassigns Member, Provider will forward copies of the Member's medical records to the new provider within ten (10) business days of receipt of the Health Plan's or the Member's request to transfer the records.

3.8 **Quality Bonus Payment Program.** Health Plan may offer Provider the opportunity to participate in Health Plan's Quality Bonus Payment Program ("QBPP"). If offered, the QBPP will promote quality of care. Payments under the QBPP are available to Provider based on qualifying criteria and events as described in the Provider Manual and related Supplemental Materials. QBPP payments are not guaranteed and are paid separately from and in addition to the compensation terms of this Agreement.

a. **Eligibility**. To be eligible for the QBPP, Provider must register with Health Plan's interactive web portal. Additionally, Provider must remain in full compliance with this Agreement, which includes, but is not limited, timely and accurate submission of Clean Claims and/or Encounter Data, and remittance of funds due to Health Plan under this Agreement. QBPP documentation submitted by Provider is subject to audit by Health Plan and the program is subject to Laws and Government Program Requirements.

b. **Terms and Conditions.** QBPP payments are subject to terms set forth in the program, which may be modified at any time by Health Plan without notice or amendment. Modifications may include, but are not limited to,

exclusions or removal of measures from the program and changes to the calculation and payment methodologies. In the event of a conflict between the Agreement and QBPP, the QBPP will prevail.

ARTICLE FOUR – CLAIMS PAYMENT

4.1 **Payment Claims.** Provider will promptly submit to Health Plan Claims for Covered Services in a standard form that is acceptable to Health Plan. Provider is not eligible for payment on Claims submitted after one hundred and eighty (180) days from the Date of Service, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. When Health Plan is the secondary payer, Provider is not eligible for payment for Claims submitted after ninety (90) days from the date the primary payer adjudicated the Claim, unless Health Plan is required to follow a different timeframe pursuant to a Law or Government Program Requirement. Provider will include all medical records pertaining to the Claim if requested by Health Plan and as may be required by Health Plan's policies and procedures.

4.2 **Compensation.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within the timeframe required by Laws or Government Program Requirements. Provider agrees to accept such payments, applicable co-payments, co-insurances, deductibles, and coordination of benefits collections as payment in full for Covered Services. Provider's failure to comply with the terms of this Agreement may result in non-payment to Provider.

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

4.4 **Member Hold Harmless.** Provider agrees in no event, including, but not limited to, non-payment, insolvency, or breach of this Agreement by Health Plan, will Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or person acting on Member's behalf, for services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-payments, co-insurances, or deductibles as specifically provided in the Member's evidence of coverage or fees for non-Covered Services provided in accordance with Laws and Government Program Requirements. This section will survive any termination, regardless of the reason for the termination, including insolvency of Health Plan.

4.5 **Coordination of Benefits.** Health Plan is a secondary payer where another payer is primary payer. Provider will make reasonable inquiry of Members to learn if 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. Provider will promptly notify Health Plan of said entitlement. In the event a coordination of benefits occurs, Provider will 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 the Compensation Schedule of this Agreement.

4.6 **Offset.** In the event of an Overpayment, Health Plan may recover the amount owed by: (i) recoupment; or (ii) by way of offset from current or future amounts due Provider. If required, such recoupment or offset will be done in a manner that is compliant with Laws and Government Program Requirements. As a material condition to Health Plan's obligations under this Agreement, Provider agrees the offset and recoupment rights set forth in this Agreement will be deemed to be and to constitute rights of offset and recoupment authorized under Law or in equity to the maximum extent legally permissible. Such rights will not be subject to any requirement of prior or other approval from a court or other governmental agency that may now or hereafter have jurisdiction over Health Plan or Provider. This section will survive any termination.

4.7 **Claim Review.** Claims will be reviewed and paid in accordance with industry standard billing and payment rules, including, but not limited to, Uniform Billing ("UB") manual and editor, Current Procedural Terminology ("CPT") and Healthcare Common Procedure Coding System ("HCPCS"), federal, and state billing and payment rules, National Correct Coding Initiatives ("NCCI") Edits, and Federal Drug Administration ("FDA") definitions and determinations of designated implantable devices and implantable orthopedic devices. Furthermore, Provider acknowledges Health Plan's right to conduct Medical Necessity reviews and apply clinical practice standards to determine appropriate payment. Payment may exclude certain items not billed in accordance with industry standard billing and payment rules or that do not meet Medical Necessity criteria. This section will survive any termination.

4.8 **Claim Auditing.** Provider acknowledges Health Plan's right to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of claims and payments by providing access at reasonable times to requested claims information, all supporting medical records, Provider's charging policies, and other related data. Health Plan will use established industry claims adjudication, and clinical practices, state and federal guidelines, and Health Plan's policies and data to determine the appropriateness of the billing, coding, and payment. This section will survive any termination.

4.9 **Financially Responsible Entity Payments.** If Provider provides Covered Services that are the responsibility of a Responsible Entity, Provider will look solely to Responsible Entity for payment of such Covered Services. Pursuant to Health Plan's contract with Responsible Entity, Responsible Entity is to compensate Provider at the rate set forth in Provider's contract with Responsible Entity. If Responsible Entity and Provider do not have a contract or have not agreed to compensation terms, Provider will be reimbursed, as determined by Provider and Responsible Entity, at: (i) one hundred percent (100%) of the governing rates provided by Law specific to the Member's Product in place on the Date of Service; or (ii) at the rates set forth in this Agreement specific to the Member's Product in place on the Date of Service. Except as specifically stated in this section, Provider agrees that the compensation provisions of this Agreement will be binding upon Provider and that Provider will follow the hold harmless provisions of this Agreement.

4.10 **Timely Submission of Encounter Data.** Provider understands Health Plan may have certain contractual reporting obligations that require timely submission of Encounter Data. If a Clean Claim does not contain the necessary Encounter Data, Provider will submit Encounter Data to Health Plan. This section will survive any termination.

ARTICLE FIVE – TERM AND TERMINATION

5.1 **Term.** This Agreement will commence on the Effective Date indicated by Health Plan and will continue in effect until terminated by either Party in accordance with the provisions of this Agreement.

5.2 **Termination without Cause.** This Agreement, an individual Product, or an Individual Provider under this Agreement, may be terminated without cause at any time by either Party by giving at least ninety (90) days prior written notice to the other Party.

5.3 **Termination with Cause.** In the event of a breach of a material provision of this Agreement, the Party claiming the breach will give the other Party written notice of termination setting forth the facts underlying its claim that the other Party breached this Agreement. The Party receiving the notice of termination will have sixty (60) 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 sixty (60) day period, the Parties agree to meet as reasonably necessary and to confer 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 sixty (60) day period, the Party who delivered the notice of termination has the right to immediately terminate this Agreement, or an individual Product or an Individual Provider under this Agreement, upon expiration of the sixty (60) day period. Notwithstanding the forgoing, either Party may immediately terminate this Agreement, an individual Product, or an Individual Provider under this Agreement, without providing the other Party the opportunity to cure a material breach should the terminating Party reasonably believe the material breach of this Agreement to be non-curable.

5.4 **Immediate Termination.** Notwithstanding any other provision of this Agreement, this Agreement, an individual Product, or an Individual Provider under this Agreement, may immediately be terminated upon written notice to the other Party in the event any of the following occurs:

a. Provider's license or any other approvals needed to provide Covered Services is limited, suspended, or revoked or disciplinary proceedings are commenced against Provider by applicable regulators and accrediting agencies;

b. Either Party fails to maintain adequate levels of insurance;

c. Provider has not or is unable to comply with Health Plan's credentialing requirements, including, but not limited to, having or maintaining credentialing status;

d. Either Party 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 or Health Plan is appointed by appropriate authority;

e. If Provider is capitated and Health Plan determines Provider is financially incapable of bearing capitation or other applicable risk-sharing compensation methodology;

f. Health Plan reasonably determines that Provider's facility or equipment is insufficient to provide Covered Services;

g. Either Party is excluded from participation in state or federal health care programs;

h. Provider is terminated as a provider by any state or federal health care program;

i. Either Party engages in fraud or deception, or permits fraud or deception by another in connection with each Party's obligations under this Agreement;

j. Health Plan reasonably determines that Covered Services are not being properly provided, or arranged for by Provider, and such failure poses a threat to Members' health and safety;

k. Provider violates any state or federal law, statute, rule, regulation or executive order; or

l. Provider fails to satisfy the terms of a corrective action plan.

5.5 **Notice to Members.** In the event of any termination, Health Plan will give reasonable advance notice to Members who are currently receiving care in accordance with Laws and Government Program Requirements.

5.6 **Transfer Upon Termination.** In the event of any termination, Health Plan may transfer Members to another provider.

ARTICLE SIX – GENERAL PROVISIONS

6.1 **Indemnification.** Each Party will 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 or its officers, directors, shareholders, employees, agents, and representatives under this Agreement.

6.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will 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 this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the Parties. Nothing herein contained will prevent the Parties from entering into similar arrangements with other parties. Each Party will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will it be construed to create, any right in any third party to enforce this Agreement.

6.3 **Governing Law.** The laws of the State of Illinois will govern this Agreement.

6.4 **Entire Agreement.** This Agreement, including attachments, addenda, amendments, Supplemental Materials, and incorporated documents or materials, contains the entire agreement between the Parties relating to the rights granted and obligations imposed by this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, between the Parties and relating to the subject matter of this Agreement, are of no force or effect.

6.5 **Severability.** If a 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 will remain in full force and effect and will in no way be affected, impaired, or invalidated as a result of such decision.

6.6 **Headings and Construction.** The headings in this Agreement are for reference purposes only and are not considered a part of this Agreement in construing or interpreting its provisions. It is the Parties' desire that if a provision of this Agreement is determined to be ambiguous, then the rule of construction that such provision is construed against its drafter will not apply to the interpretation of the ambiguous provision. The following rules of construction apply to this Agreement: (i) the word "day" means calendar day unless otherwise specified; (ii) the term "business day" means Monday through Friday, except federal holidays; (iii) all words used in this Agreement will be construed to be of such gender or number as circumstances require; (iv) references to specific statutes, regulations, rules or forms, such as CMS-1500, include subsequent amendments or successors to them; and (v) references to any government department or agency include any successor departments or agencies.

6.7 **Non-exclusivity.** This Agreement will not be construed to be an exclusive Agreement between the Parties. Nor will it be deemed to be an Agreement requiring Health Plan to refer Members to Provider.

6.8 **Amendments.**

a. **Regulatory Amendments.** Health Plan may immediately amend this Agreement to maintain consistency or compliance with applicable policy, directive, Law, or Government Program Requirement at any time and without Provider's consent. Such regulatory amendment will be binding upon Provider.

b. **Non-Regulatory Amendments.** Notwithstanding the Regulatory Amendments section, Health Plan may otherwise amend this Agreement upon thirty (30) days prior written notice to Provider. If Provider does not deliver a written disapproval to such amendment within the thirty (30) day period, the amendment will be deemed accepted by and binding upon Provider. If Health Plan receives a written disapproval within the thirty (30) day period, the Parties agree to meet and confer in good faith to determine if a revised amendment can be accepted by and binding upon the Parties.

6.9 **Delegation or Subcontract.** Upon the Effective Date, Provider will submit to Health Plan a list identifying each of Provider's Subcontractors and a description of the services the Subcontractor provides. After the Effective Date, Provider will not subcontract with a Subcontractor without the prior written consent of Health Plan. Such arrangement with a Subcontractor will be in writing and will bind Subcontractor to the terms required by Health Plan.

6.10 **Assignment.** Provider may not assign or transfer, 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 Parties and respective successors in interest and assignees. Neither the acquisition of Health Plan nor a change of its legal name shall be deemed an assignment.

6.11 **Dispute Resolution.**

a. **Meet and Confer.** Any claim or controversy arising out of or in connection with this Agreement will first be resolved, to the extent possible, via "Meet and Confer". The Meet and Confer will begin when one Party delivers written notice to the other that it intends to arbitrate a dispute and the basis for its belief that it will prevail in arbitration. After providing notice of the intent to arbitrate, the Meet and Confer will be held as an informal face-to-face meeting held in good faith between appropriate representatives of the Parties and at least one (1) person authorized to settle outstanding claims and pending arbitration matters. The Parties will commence the face-to-face portion of the Meet and Confer within forty-five (45) days of receiving notice of an intent to arbitrate or service of an arbitration demand. Such face-to-face Meet and Confer discussion will occur at a time and location agreed to by the Parties (within the forty-five (45) days) and if both Parties agree that more face-to-face discussions would be beneficial, the Parties can agree to have more than one (1) in person settlement discussion or a combination of in person, phone meetings and exchange of correspondence.

b. **Binding Arbitration.** The Parties agree that any dispute not resolved via Meet and Confer will be settled in binding arbitration administered by Judicial Arbitration and Mediation Services ("JAMS"), or if mutually agreed upon, pursuant to another agreed upon Alternative Dispute Resolution ("ADR") provider in accordance with that ADR provider's Commercial Arbitration Rules, in Chicago, Illinois. However, matters that primarily involve Provider's professional competence or conduct i.e., malpractice, professional negligence, or wrongful death will not be eligible for arbitration.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds one million dollars ($1,000,000.00) will be resolved by a panel of three (3) arbitrators. In the event a panel of three (3) arbitrators will be used, the claimant will select one (1) arbitrator; the respondent will select one (1) arbitrator; and the two (2) arbitrators selected by the claimant and respondent will select the third arbitrator whose determination will be final and binding on the Parties. If possible, each arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is equal to or exceeds five hundred thousand dollars ($500,000.00), but less than one million dollars ($1,000,000.00), the claimant and respondent will each select a single arbitrator and the two (2) arbitrators selected by the claimant and respondent will select a single arbitrator who will be responsible for the arbitration proceedings ("Selected Arbitrator"). Each Party can strike

no more than one (1) Selected Arbitrator. The Selected Arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

Any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) will be resolved by a single arbitrator. In the event a single arbitrator is used, the arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years of experience in managed health care.

The arbitrator will apply Illinois substantive law and Federal substantive law where State law is preempted. Civil discovery for use in such arbitration may be conducted in accordance with federal rules of civil procedure and federal evidence code, except where the Parties agree otherwise. The arbitrator selected will have the power to enforce the rights, remedies, duties, liabilities, and obligations of discovery by the imposition of the same terms, conditions, and penalties as can be imposed in like circumstances in a civil action by a court in the same jurisdiction. The provisions of federal rules of civil procedure concerning the right to discovery and the use of depositions in arbitration are incorporated herein by reference and made applicable to this Agreement. However, in any arbitration in which the total amount disputed by one Party is less than one million dollars ($1,000,000.00) the Parties agree that each Party will have the right to take no more than three (3) depositions of individuals or entities, excluding deposition of expert witnesses, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. The Parties agree that in any arbitration in which the total amount disputed by one Party is less than five hundred thousand dollars ($500,000.00) each Party will have the right to take no more than one (1) deposition of individuals or entities and one (1) expert witness, and the Parties agree to exchange copies of all exhibits and demonstrative evidence to be used at the arbitration prior to the arbitration as deemed appropriate by the arbitrator. Regardless of the amount in dispute, rebuttal and impeachment evidence need not be exchanged until presented at the arbitration hearing.

The arbitrator will have no authority to give a remedy or award damages that would not be available to such prevailing Party in a court of law, nor will the arbitrator have the authority to award punitive or liquidated damages. The arbitrator will deliver a written reasoned decision within thirty (30) days of the close of arbitration, unless an alternate agreement is made during the arbitration. The Parties agree to accept any decision by the arbitrator, which is grounded in applicable law, 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. The award may be reviewed, vacated, or modified pursuant to the Federal Arbitration Act ("FAA"), 9 USC sections 9-11. Grounds for vacating an award, include where the award was procured by corruption, fraud, or undue means, and where the arbitrators were guilty of misconduct, exceeded their powers, evident material miscalculation, evident material mistake, imperfect(ions) in (a) matter of form not affecting the merits, and where a decision is not grounded in applicable law. When a decision is not grounded in applicable law, any Party will have the right to appeal the decision in addition to those rights to vacate or appeal already existing pursuant to the FAA or applicable state arbitration laws. Any such appeal may be made to a court having jurisdiction over the Parties or the dispute. Notice of intent to Appeal based on failure to render a decision grounded in law must be given to the other Party within fifteen (15) days after the decision is communicated to the Parties; and the appeal must be formally initiated by filing in court within thirty (30) days after the decision is communicated to the Parties. If a court decides it will not hear an appeal because it deems appeals from arbitration not subject to appeal, there is no right for any additional appeal in any other venue.

Each Party shall bear its own costs and expenses, including its own attorneys' fees, and shall bear an equal share of the arbitrator and administrative fees of arbitration. The Parties agree that one or the other may request a court reporter transcribe the entire proceeding, in which case the Parties will split the cost of the court reporter, but each may elect to purchase or forego purchasing a transcript.

Arbitration must be initiated within (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 will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

6.12 **Notice.**

a. **Delivery.** All notices required or permitted by this Agreement, except for Supplemental Materials, will be in writing and delivered: (i) in person; (ii) by U.S. Postal Service ("USPS") registered, certified, or express mail with postage prepaid; (iii) by overnight courier that guarantees next day delivery; (iv) by facsimile transmission; or (v) by email. Notice is deemed given: (i) on the date of personal delivery; (ii) on the second day after the postmark date for USPS registered, certified, or express mail with postage prepaid; (iii) on the date of delivery shown by overnight courier; or (iv) on the date of transmission for facsimile or email.

b. **Addresses.** The mailing address, email address, and facsimile number set forth under the Signature Page will be the particular Party's information for delivery of notice. Each Party may change its information through written notice in compliance with this section without amending this Agreement. Notice will be sent to the attention of the Authorized Representative.

6.13 **Waiver.** A failure or delay of a Party to exercise or enforce any provision of this Agreement will not be deemed a waiver of any right of that Party. Any waiver must be specific, in writing, and executed by the Parties.

6.14 **Execution in Counterparts and Duplicates.** This Agreement may be executed in counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument. The Parties agree facsimile signatures, pdf signatures, photocopied signatures, electronic signatures, or signatures scanned and sent via email will have the same effect as original signatures.

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

6.16 **Force Majeure.** Neither Party will be liable or deemed to be in default for any delay or failure to perform any act under this Agreement resulting directly or indirectly, from acts of God, civil or military authority, acts of a public enemy, war, accident, fire, explosion, earthquake, flood, strikes by either Party's employees, or any other similar cause beyond the reasonable control of such Party.

6.17 **Confidentiality.** Any information disclosed by either Party in fulfillment of its obligations under this Agreement, including, but not limited to, health care information, compensation rates, and the terms of the Agreement, will be kept confidential. Information provided to Provider, including, but not limited to, Member lists, QI Program, credentialing criteria, compensation rates, and any other administrative protocols or procedures of Health Plan, is the proprietary property of Health Plan and will be kept confidential. Provider will not disclose or release such material to a third party without the written consent of Health Plan. This section will survive any termination.

ATTACHMENT A

Products

1.1 **Medicaid** – including, but not limited to, HealthChoice Illinois and any other Medicaid programs Health Plan offers in the future.

1.2 **Medicare Advantage** – including, but not limited to, Molina Medicare Options, Molina Medicare Options Plus and any other Medicare Advantage programs Health Plan offers in the future.

1.3 **Medicare-Medicaid Program** – including, but not limited to the Medicare Medicaid Alignment Initiative ("MMAI").

1.4 **Health Insurance Marketplace** – including, but not limited to, Molina Marketplace.

ATTACHMENT B

Compensation Schedule

1.1 **Compensation for Medicaid.**

a. Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services, that are not laboratory or durable medical equipment ("DME") Covered Services, provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Illinois in effect for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate, Covered Services, that are not laboratory or DME Covered Services, that are determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography) for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate and there is not a Medicare Fee-For-Service Program allowable payment rate, such code will be paid at twenty percent (20%) of billed charges, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

b. Health Plan agrees to compensate Provider on a fee-for-service basis for laboratory Covered Services, provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to fifty percent (50%) of the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Illinois in effect for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate, laboratory Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to fifty percent (50%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography) for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate and there is not a Medicare Fee-For-Service Program allowable payment rate, such code will be paid at twenty percent (20%) of billed charges, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Provider will only be reimbursed for laboratory Covered Services if they are separately reimbursable from another Covered Service.

c. Health Plan agrees to compensate Provider on a fee-for-service basis for DME Covered Services, provided under the Medicaid Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to seventy percent (70%) of the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Illinois in effect for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate, DME Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to seventy percent (70%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography) for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate and there is not a Medicare Fee-For-Service Program allowable payment rate, such code will be paid at twenty percent (20%) of billed charges, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Provider will only be reimbursed for DME Covered Services if they are separately reimbursable from another Covered Service.

d. Notwithstanding any other provision in this Agreement, the following will also apply:

i. A Claim that uses a code that is not on the State of Illinois Medicaid Fee-For-Service Program fee schedule will not be payable and Provider is not entitled to reimbursement for the services provided.

ii. Payment for Covered Services under 1.1.a., will not exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), for the Date of Service, or the Provider's billed charges, whichever is less. Payment for laboratory Covered Services under 1.1.b., will not exceed an amount equivalent to fifty percent (50%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), for the Date of Service, or the Provider's billed charges, whichever is less. Payment for DME Covered Services under 1.1.c., will not exceed an amount equivalent to seventy percent (70%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), for the Date of Service, or the Provider's billed charges, whichever is less.

iii. Unless prohibited by Law or Government Program Requirement, Provider agrees that if there is a retroactive change to the Medicaid or Medicare Fee-For-Service Program allowable payment rate, Health Plan will determine if Claims will be reprocessed when payment has already been issued to Provider.

1.2 **Compensation for Medicare Advantage.**

a. Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services, that are not laboratory or durable medical equipment ("DME") Covered Services, provided under the Medicare Advantage Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates.

b. Health Plan agrees to compensate Provider on a fee-for-service basis for laboratory Covered Services provided under the Medicare Advantage Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to fifty percent (50%) of the Medicare Fee-For-Service Program allowable payment rate.

c. Health Plan agrees to compensate Provider on a fee-for-service basis for DME Covered Services provided under the Medicare Advantage Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to seventy percent (70%) of the Medicare Fee-For-Service Program allowable payment rates.

d. Notwithstanding any other provision in this Agreement, the following will also apply:

i. A Claim that uses a code that is not on the Medicare Fee-For- Service Program fee schedule will not be payable and Provider is not entitled to reimbursement for the services provided.

ii. Unless prohibited by Law or Government Program Requirements, Provider agrees that if there is a retroactive change to the Medicare Fee-For-Service Program allowable payment rate, Health Plan will determine if Claims will be reprocessed when payment has already been issued to Provider.

1.3 **Compensation for Medicare-Medicaid Program.** Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services provided under the Medicare-Medicaid Program Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties pursuant to the methodology described below.

a. For Covered Services that are primary to Medicare:

i. Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services, that are not laboratory or durable medical equipment ("DME") Covered Services, provided under the MMP Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable

Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rates.

ii. Health Plan agrees to compensate Provider on a fee-for-service basis for laboratory Covered Services provided under the MMP Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to fifty percent (50%) of the Medicare Fee-For-Service Program allowable payment rate.

iii. Health Plan agrees to compensate Provider on a fee-for-service basis for DME Covered Services provided under the MMP Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to seventy percent (70%) of the Medicare Fee-For-Service Program allowable payment rates.

b. For Covered Services that are primary to Medicaid:

i. Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services, that are not laboratory or DME Covered Services, provided under the MMP Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Illinois in effect for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate, Covered Services, that are not laboratory or DME Covered Services, that are determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography) for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate and there is not a Medicare Fee-For-Service Program allowable payment rate, such code will be paid at twenty percent (20%) of billed charges, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any.

ii. Health Plan agrees to compensate Provider on a fee-for-service basis for laboratory Covered Services, provided under the MMP Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to fifty percent (50%) of the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Illinois in effect for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate, laboratory Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to fifty percent (50%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography) for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate and there is not a Medicare Fee-For-Service Program allowable payment rate, such code will be paid at twenty percent (20%) of billed charges, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Provider will only be reimbursed for laboratory Covered Services if they are separately reimbursable from another Covered Service.

iii. Health Plan agrees to compensate Provider on a fee-for-service basis for DME Covered Services, provided under the MMP Product that are determined by Health Plan to be payable and submitted on a Clean

Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to seventy percent (70%) of the Medicaid Fee-For-Service Program allowable payment rate set forth by the State of Illinois in effect for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate, DME Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at an amount equivalent to seventy percent (70%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography) for the Date of Service. If there is a code in the State of Illinois Medicaid Fee-For-Service Program fee schedule for the Date of Service, but there is no payment rate and there is not a Medicare Fee-For-Service Program allowable payment rate, such code will be paid at twenty percent (20%) of billed charges, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any. Provider will only be reimbursed for DME Covered Services if they are separately reimbursable from another Covered Service.

c. Notwithstanding any other provision in this Agreement, the following will also apply:

   i. A Claim that uses a code that is not on the State of Illinois Medicaid Fee-For-Service Program fee schedule or on the Medicare Fee-For- Service Program fee schedule will not be payable and Provider is not entitled to reimbursement for the services provided.

   ii. Payment for Covered Services under 3.1b.i. will not exceed an amount equivalent to the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), for the Date of Service, or the Provider's billed charges, whichever is less. Payment for laboratory Covered Services under 3.1.b.ii, will not exceed an amount equivalent to fifty percent (50%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), for the Date of Service, or the Provider's billed charges, whichever is less. Payment for DME Covered Services under 3.1.b.iii, will not exceed an amount equivalent to seventy percent (70%) of the Medicare Fee-For-Service Program allowable payment rate set forth by CMS (adjusted for locality or geography), for the Date of Service, or the Provider's billed charges, whichever is less.

   iii. The Medicare Fee -For- Service Program allowable payment rate deducts any cost sharing amounts, including, but not limited to, co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties that would have been deducted if the Member were enrolled in the Medicare Fee-For-Service Program.

   iv. Unless prohibited by Law or Government Program Requirement, Provider agrees that if there is a retroactive change to the Medicaid or Medicare Fee-For-Service Program allowable payment rates, Health Plan will determine if Claims will be reprocessed when payment has already been issued to Provider.

1.4 **Compensation for Health Insurance Marketplace.**

a. Health Plan agrees to compensate Provider on a fee-for-service basis for Covered Services, that are not laboratory or durable medical equipment (DME) Covered Services, provided under the Marketplace Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at one-hundred percent (100%) of the Medicare Fee Schedule (adjusted for locality or geography). If there is no payment rate under the Medicare Fee Schedule, Covered Services, that are not laboratory or DME Covered Services, that are determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to the Medicaid Fee Schedule set forth by the State of Illinois

b. Health Plan agrees to compensate Provider on a fee-for-service basis for laboratory Covered Services provided under the Marketplace Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by

other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to fifty percent (50%)of the Medicare Fee Schedule (adjusted for locality or geography). If there is no payment rate under the Medicare Fee Schedule, laboratory Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to fifty percent (50%) of the Medicaid Fee Schedule set forth by the State of Illinois. Provider will only be reimbursed for laboratory Covered Services if they are separately reimbursable from another Covered Service.

c. Health Plan agrees to compensate Provider on a fee-for-service basis for DME Covered Services provided under the Marketplace Product that are determined by Health Plan to be payable and submitted on a Clean Claim, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) at an amount equivalent to seventy percent (70%) of the Medicare Fee Schedule (adjusted for locality or geography). If there is no payment rate under the Medicare Fee Schedule, DME Covered Services determined by Health Plan to be payable and submitted on a Clean Claim will be paid on a fee-for-service basis, less any applicable Member co-payments, deductibles, co-insurance, or amounts paid or to be paid by other liable third parties, if any, at the lesser of the following amounts in effect for the Date of Service: (i) Provider's billed charges; or (ii) an amount equivalent to seventy percent (70%) of the Medicaid Fee Schedule set forth by the State of Illinois. Provider will only be reimbursed for DME Covered Services if they are separately reimbursable from another Covered Service.

d. Notwithstanding any other provision in this Agreement, the following will also apply:

    i. Unless prohibited by Law or Government Program Requirement, Provider agrees that if there is a retroactive change to the Medicaid or Medicare Fee Schedule, Health Plan will determine if Claims will be reprocessed when payment has already been issued to Provider.

ATTACHMENT C

State of Illinois Required Provisions

State Laws

This attachment sets forth applicable State Laws or other provisions necessary to reflect compliance with State Laws. 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 does not apply to the Medicare Advantage Product or the Medicare-Medicaid Product to the extent such Products are preempted by Federal Law.

1.1 **Hold Harmless/Cost Sharing.** Provider agrees that in no event, including but not limited to, nonpayment by the Health Plan of amounts due the Provider under this Agreement, insolvency of the organization, or any breach of this Agreement by the organization, will the Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Member, persons acting on the Member's behalf (other than the organization), the employer, or group contract holder for services provided pursuant to this Agreement except for the payment of applicable co-payments or deductibles for services covered by the organization or fees for services not covered by the organization. The requirements of this clause will survive any termination of this Agreement for services rendered prior to such termination, regardless of the cause of such termination. The Health Plan's Members, the persons acting on the Member's behalf (other than the organization) and the employer or group contract holder will be third party beneficiaries of this clause. This clause supersedes any oral or written agreement now existing or hereafter entered into between the provider and the enrollee, persons acting on the Member's behalf (other than the organization) and the employer or group contract holder.

1.2 **Participation in Quality Improvement Program.** Provider agrees to participate in Health Plan's quality assurance program.

1.3 **Program Participation.**

a. Provider will assure that all nurses and other ancillary and paramedic personnel that perform services pursuant to this Agreement are licensed, certified, or registered, as required to perform their duties.

b. Descriptions of the arrangements for the provision of each of the types of services included in the Evidence of Coverage are set forth in this Agreement. Descriptions of how Provider will ensure that Members will receive health care services at all times are set forth in this Agreement. Provider's responsibilities within the HMO self-evaluation structure and activities described in 77 Ill. Adm. Code 240.60 are set forth in this Agreement.

ATTACHMENT D

Medicaid

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements or other provisions necessary to reflect compliance for the Medicaid Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the Medicaid Product. 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 a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Medicaid Product.

1.1 **Medically Necessary or Medical Necessity** means a Covered Service that is appropriate, no more restrictive than that used in the State of Illinois Medicaid program, including quantitative and non-quantitative treatment limits, as indicated in State of Illinois statutes and regulations, the Illinois State Plan, and other State of Illinois policy and procedures, and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with Health Plan's guidelines, policies, or procedures, for the diagnosis or treatment of a covered illness or injury; for the prevention of future disease; to assist in the Member's ability to attain, maintain, or regain functional capacity; for the opportunity for a Member receiving Long term support services ("LTSS") to have access to the benefits of community living, to achieve person centered goals, and live and work in the setting of the Member's choice; or for an Member to achieve age-appropriate growth and development.

1.2 **Subcontractors.** Subcontractor means an entity which Health Plan has entered into a written agreement for the purpose of delegating responsibilities applicable to Health Plan under its contract with Illinois Department of Healthcare and Family Services ("HFS"), as provided in 42 CFR 438.2. The following sections apply to Providers that are Subcontractors.

a. **Right to Audit.** Provider will maintain books and records relating to the performance of this Agreement and necessary to support amounts charged to the State of Illinois under this Agreement. Books and records, including but not limited to, information stored in databases or other computer systems, will be maintained by Provider for a period of three (3) years from the later of the date of final payment under the contract between Health Plan and HFS or the completion of the contract between Health Plan and HFS. If federal funds are used to pay Agreement costs, Provider must retain the books and records for ten (10) years. Books and records required to be maintained under this section will be available for review or audit by representatives of the HFS, Auditor General, Executive Inspector General, Chief Procurement Officer, State of Illinois internal auditors or other governmental entities with monitoring authority, upon reasonable notice and during normal business hours. Provider will cooperate fully with any such audit and with any investigation conducted by any of these entities. Failure to maintain books and records required by this section will establish a presumption in favor of the State of Illinois for the recovery of any funds paid by the State of Illinois under this Agreement for which adequate books and records are not available to support the purported disbursement. Provider will not impose a charge for audit or examination of the books and records.

b. **Confidentiality.** Each party, including its agents and subcontractors, may have or gain access to confidential data or information owned or maintained by the other party in the course of carrying out its responsibilities under this Agreement. Provider will presume that all information received from the State or to which it gains access pursuant to this Agreement is confidential. No confidential data collected, maintained, or used in the course of performance of the Agreement will be disseminated except as authorized by law and with the written consent of the disclosing party, either during the period of the Agreement or thereafter, or as otherwise set forth in the contract between Health Plan and HFS. Provider must return all data collected, maintained, created, or used in the course of the performance of the Agreement, in whatever form it is maintained, promptly at the end of the Agreement, or earlier at the request of the Health Plan, or notify Health Plan in writing of its destruction. The foregoing obligations will not apply to confidential data or information: (i) lawfully in the receiving party's

possession prior to its acquisition from the disclosing party;(ii) received in good faith from a third-party not subject to any confidentiality obligation to the disclosing party; (iii) now is or later becomes publicly known through no breach of confidentiality obligation by the receiving party; or (iv) independently developed by the receiving party without the use or benefit of the disclosing party's confidential information.

c. **Compliance with Laws and Regulations.** Provider will comply with all applicable federal, state, and local laws, rules, ordinances, regulations, orders, federal circulars, and all license and permit requirements in the performance of this Agreement.

d. **Agency Handbook.** Provider, who provides Covered Services under this Agreement at a location controlled by HFS, or any other State agency, shall abide by applicable provisions of the controlling agency's employee handbook.

e. **Gifts.** Provider is prohibited from giving gifts to CMS and HFS employees, and from giving gifts to, or accepting gifts from, any person who has a contemporaneous contract with the CMS or HFS involving duties or obligations related to Health Plan's contract with CMS and HFS.

1.3 **Hold Harmless/Cost Sharing.** Provider will not seek or obtain funding through fees or charges to any Member receiving Covered Services pursuant to the contract between Health Plan and HFS, except as permitted or required by HFS in 89 Ill. Adm. Code 125 and HFS's Fee-For-Service co-payment policy then in effect, and subject to the contract between Health Plan and HFS. Provider acknowledges that imposing charges in excess of those permitted under its contract with HFS is a violation of §1128B (d) of the Social Security Act and subjects to criminal penalties.

1.4 **Claims Payment.** Notwithstanding any other provision of this Agreement, for Covered Services provided to HealthChoice Illinois Members, a "Clean Claim" means a claim from a Provider for Covered Services that can be processed without obtaining additional information from the Provider of the service or from a Third Party, except that it shall not mean a claim submitted by or on behalf of a Provider who is under investigation for fraud or abuse, or a Claim that is under review for determining whether it was Medically Necessary. For purposes of a Member's admission to a Nursing Facility, a "Clean Claim" means that the admission is reflected on the patient credit file that Health Plan receives from the Illinois Department of Health and Human Services. Health Plan shall pay add on payments and minimum data set rates when required and in accordance with Law and Government Program Requirement.

1.5 **Cultural Considerations.** Provider will comply with Health Plan's Cultural Competency Plan. Provider may utilize its own education and training programs, as long as it is equivalent to Health Plan's program, with Health Plan's approval. Cultural Competency Plan training will be completed upon initial employment and annually thereafter. Provider will supply proof of such training in order for Health Plan to meet state and federal requirements.

1.6 **Corrective Action.** Health Plan monitors Provider performance under this Agreement on an ongoing basis, formal reviews will be conducted on a triennial basis, and, to the extent that deficiencies or areas for improvement are identified during review, Health Plan may require Provider take corrective action.

1.7 **Provider Participation.**

a. Providers shall offer hours of operation that are no less than the hours of operation offered to individuals who are not Medicaid Members.

b. Providers, who are physicians, will have and maintain admitting privileges and, as appropriate: (i) delivery privileges at a hospital that is an Participating Provider of Health Plan; or, (ii) in lieu of these admitting and delivery privileges, Provider will have a written referral agreement with a physician who is a Participating Provider of Health Plan and who has such privileges at a hospital that is a Participating Provider of Health Plan. Provider will inform Health Plan of its hospital affiliation. Provider must transfer medical records and coordination care between Provider and Participating Provider.

c. Provider will report events involving the use of restrictive interventions as a reportable incident and report to appropriate investigating authorities if it rises to the level of abuse, neglect, or exploitation.

d. If Provider provides Covered Services under a The Illinois Department of Human Services ("DHS") HCBS Waiver, under the Medicaid Clinic Option, or under the Medicaid Rehabilitation Option, or sub-acute

alcoholism and substance abuse treatment services pursuant to 89 Ill. Admin. Code 148.340-148.390 and 77 Ill. Admin. Code Part 2090. Provider will enter any data regarding Members that is required under State of Illinois rules, or, when applicable, the contract between the Provider and DHS, into any subsystem maintained by DHS, including, but not limited to, the Department's Automated Reporting and Tracking System ("DARTS").

e. Provider will be bound by the terms and conditions of the contract between Health Plan and HFS that are appropriate to the service or activity Provider is performing pursuant to this Agreement. Such requirements include, but are not limited to, the record keeping and audit provisions of the contract between Health Plan and HFS, such that the HFS or authorized persons will have the same rights to audit and inspect Provider, as they have to audit and inspect Health Plan.

f. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Provider will complete and submit a Federal Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Such Disclosure Form may be obtained by request from the Illinois Department of Healthcare and Family Services, Bureau of Fiscal Operations.

g. Provider certifies to the best of his knowledge and belief that:

   i. No federal appropriated funds have been paid or will be paid by or on behalf of the Provider to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

   ii. Its subcontractors have and will comply with Executive Order No. 1 (2007). The Order generally prohibits Health Plans and subcontractors, including Provider, from hiring the then-serving Governor's family members to lobby procurement activities of the State of Illinois, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over twenty-five thousand dollars ($25,000). This prohibition also applies to hiring for that same purpose any former State of Illinois employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.

h. Health Plan shall remain responsible for the performance of any of its responsibilities delegated to Providers.

i. This Agreement cannot terminate the legal responsibilities of Health Plan to HFS to assure that all the activities under Health Plan's contract with HFS are carried out.

j. Providers providing Covered Services for Health Plan under this Agreement must be enrolled as providers in the HFS Medical Program. Health Plan shall not contract or subcontract with an excluded person or a person who has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. Health Plan may immediately terminate this Agreement in the event Health Plan determines Provider violated this section.

k. Provider will immediately report any suspected fraud, waste, or abuse to Health Plan and will cooperate in any investigation related to fraud, waste, or abuse.

l. In the event Provider is a Primary Care Provider ("PCP") or specialist provider, Provider will provide coverage for their respective practices twenty-four (24) hours a day, seven (7) days a week and have a published after hours telephone number; voice mail alone is not acceptable.

m. Provider will perform all duties within the United States. Health Plan will not enter into any agreement whose central office is located outside the United States.

1.8 **Laboratory Providers.** Laboratory testing sites must have either a Clinical Laboratory Improvement Amendment ("CLIA") certificate or waiver of a certificate of registration along with a CLIA identification number.

1.9 **Additional Termination.** Notwithstanding any other provision of this Agreement, Health Plan may immediately terminate this Agreement:

a. If Provider is terminated, barred, suspended, or voluntarily withdrawn as a result of a settlement agreement, under either Section 1128 or Section 1128A of the Social Security Act, from participating in any program under federal law including any program under Titles XVIII, XIX, XX or XXI of the Social Security Act, or are otherwise excluded from participation in the HFS medical program;

b. If the performance of Provider is inadequate as determined by HFS or Health Plan. Additionally, Health Plan may impose sanctions if the performance of Provider is inadequate as determined by HFS or Health Plan.

1.10 **Agreement Review.** HFS retains the right to reject or require amendments to this Agreement if it does not comply with HFS requirements or Health Plan's contract with HFS. Health Plan may amend this Agreement to ensure compliance with this requirement.

1.11 **Grievance.** Providers shall be furnished with information about Health Plan's grievance and appeal procedures at the time the Provider enters into an agreement with Health Plan and within fifteen (15) days following any substantive change to such procedures.

1.12 **Home Health.** If Provider provides home health services and upon the implementation of Section 1861(o)(7) of the Social Security Act by CMS, Health Plan will not pay, nor will Health Plan have an obligation to pay, for a service or item (other than an Emergency Service or item furnished in an emergency room of a hospital) for home health care services provided by an agency or organization, unless the agency or organization provides the State of Illinois with a surety bond as specified in Section 1861(o)(7) of the Act.

1.13 **Reporting.** Provider agree to the reporting requirements in 42 CFR §447.26(d) as a condition of receiving payment from Health Plan. Health Plan shall not pay, nor will Health Plan have an obligation to pay, Provider for provider-preventable conditions that are identified in the State Plan. Health Plan, however, is not prohibited from paying a Provider for such provider-preventable conditions that existed prior to the initiation of treatment for a Member with a provider-preventable condition by that Provider.

1.14 **Nursing Facilities.** The following provisions apply to Nursing Facilities.

a. Provider agrees to provide access to Health Plan's care management team by: (i) acting upon the team's credentialing applications in accordance with generally applicable standards; (ii) permitting qualified members of the team to write medication and lab orders; and (iii) permitting access to Members in order to conduct physical examinations and to serve as Primary Care Providers ("PCP") for Members.

1.15 **Emergency Home Response Services.** If Provider is an emergency home response services provider, as defined in 89 Ill. Admin. Code 240.235, Provider will follow and comply with the requirements of 89 Ill. Admin. Code 240.235.

1.16 **Mobile Crisis Response Services.** The following provisions apply to Providers providing Mobile Crisis Response ("MCR") Services to Members.

a. Provider will deliver MCR services consistent with all service requirements established by the Department including, but not limited to, those outlined in the Department's Handbook for Providers of Community-Based Behavioral Services, such as the usage of the IM-CAT as the standardized MCR screening tool

b. Provider will provide Members and their family with contact information that may be used at any time, twenty-four (24) hours a day, to contact Provider in moments of Behavioral Health Crisis in lieu of utilizing the CARES line.

c. Providers will provide immediate and sufficient crisis and stabilization services to stabilize a Member in the community when at all possible and appropriate for the Enrollee.

d. **Crisis Safety Plans.**

i. Provider will create, or review and update, a Crisis Safety Plan for all Members that present in Behavioral Health Crisis, in collaboration with the Member and their family, consistent with the following timelines: (i) Prior to the completion of crisis intervention and stabilization services necessary to stabilize an Enrollee in the community following an MCR screening; and (ii) prior to the Member's discharge from an inpatient psychiatric hospital setting for any Member admitted to such a facility. When applicable, the MCR Provider shall coordinate the completion of the Crisis Safety Plan with the Member's CCSO

ii. Provider will provide Members and their families with physical copies of the Crisis Safety Plan consistent with the timelines in section.

iii. Provider will educate and orient the Member's family to the components of the crisis safety plan, to ensure that the plan is reviewed with the family regularly and explain to the Member and their family how the plan is updated as necessary.

iv. Provider will share the crisis safety plan with all necessary medical professionals, including care coordinators and the Member's CCSO, consistent with the authorizations established by consent or release.

e. Provider will facilitate the Member's admission to an appropriate inpatient institutional treatment setting, including arranging for the necessary transportation when the Member in crisis cannot be stabilized in the community.

f. Provider will inform the Member and the Member's parents, guardian, or caregivers, as applicable, about all of the available inpatient network providers and any pertinent policies needed to allow the involved parties to select an appropriate inpatient institutional treatment setting.

g. Providers will notify Contractor or the MCR provider, as appropriate, at least twenty-four (24) hours in advance of any discharge from inpatient hospital stays, as applicable.

1.17 **Inpatient Psychiatric.** The following provision applies to Providers providing inpatient psychiatric services to Members. Provider will administer a physical examination to the Member within twenty-four (24) hours after admission when a Member requires admission to an appropriate inpatient institutional treatment setting.

1.18 **Exclusion.** Prior to engaging in any services under this Agreement, Provider must disclose if it or any of its current and prospective employees, contractors, and sub-contractors, are excluded individuals/entities, as defined in contract between Health Plan and HFS, by reviewing the list of sanctioned persons maintained by the OIG, the DHS-OIG List of Excluded Individuals/Entities ("LEIE"), the excluded parties list system maintained by the US General Services Administration, and any other such database that is required by state or federal law. Health Plan may immediately terminate this Agreement upon learning of Provider meeting the definition of an excluded individual/entity. Provider will not be entitled to any reimbursement for Covered Services provided during any period in which the Provider was excluded.

1.19 **Compensation Model.** Provider-compensation models shall reimburse for Covered Services provided and may reimburse for performance. Health Plan shall not permit any payment to a Provider for Covered Services other than the payment made by Health Plan, except when specifically required by the contract between Health Plan and HFS or applicable law as provided in 42 CFR 438.60.

1.20 **FQHCs and RHCs Reimbursement**. Any contract or subcontract between Health Plan and a Federally Qualified Health Center ("FQHC") or a Rural Health Clinic ("RHC") shall be executed in accordance with Sections 902(a)(13)(C) and 1903(m)(2)(A)(ix) of the Social Security Act, as amended by the Balanced Budget Act of 1997, and shall provide payment that is not less than the level and amount of payment that Health Plan would make for the Covered Services if the services were furnished by a Provider that was not an FQHC or a RHC.

ATTACHMENT E

Medicare Advantage

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the Medicare Advantage Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the Medicare Advantage Product. 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 a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to the Medicare Advantage Product.

1.1 **Definitions.**

a. **Completion of Audit** means a completion of audit by United States Department of Health and Human Services ("HHS"), the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or Related Entity.

b. **Downstream Entity** means any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the Medicare Advantage benefit, below the level of the arrangement between a Medicare Advantage Organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider for health and administrative services.

c. **Final Contract Period** means the final term of the contract between CMS and the Medicare Advantage Organization.

d. **First Tier Entity** means any party that enters into a written arrangement, acceptable to CMS, with a Medicare Advantage Organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the Medicare Advantage program.

e. **Medicare Advantage Organization** means a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the Medicare Advantage contract requirements.

f. **Related Entity** means any entity that is related to the Medicare Advantage Organization by common ownership or control and; (i) performs some of the Medicare Advantage Organization's management functions under contract or delegation; (ii) furnishes services to Medicare enrollees under an oral or written agreement; or (iii) leases real property or sells materials to the Medicare Advantage Organization at a cost of more than $2,500 during a contract period.

1.2 **Right to Audit.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the First Tier Entity, Downstream Entity, and Related Entity, through ten (10) years from the final date of the Final Contract Period of the contract entered into between CMS and the Medicare Advantage Organization or from the date of completion of any audit, whichever is later.

1.3 **Right to Audit Directly from FDR.** HHS, the Comptroller General, or their designees have the right to audit, evaluate, collect, and inspect any records under Section 1.2, of this attachment, directly from any First Tier Entity, Downstream Entity, and Related Entity. For records subject to review under Section 1.2, except in exceptional circumstances, CMS will provide notification to the Medicare Advantage Organization that a direct request for information has been initiated.

1.4 **Confidentiality.** Provider will comply with the confidentiality and Member record accuracy requirements, including: (i) abiding by all Laws regarding confidentiality and disclosure of medical records, or other health and enrollment information; (ii) ensuring that medical information is released only in accordance with applicable Law,

or pursuant to court orders or subpoenas; (iii) maintaining the records and information in an accurate and timely manner; and (iv) ensuring timely access by Members to the records and information that pertain to them.

1.5 **Hold Harmless.** Members will not be held liable for payment of any fees that are the legal obligation of the Medicare Advantage Organization.

1.6 **Cost Sharing.** For all Members eligible for both Medicare and Medicaid, Members will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. Provider may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (i) accept the Health Plan payment as payment in full; or (ii) bill the appropriate State source.

1.7 **Delegation.** Any services or other activity performed in accordance with a contract or written agreement by Provider or a Downstream Entity of Provider are consistent and comply with the Medicare Advantage Organization's contractual obligations.

1.8 **Prompt Payment.** Health Plan will pay Provider for Clean Claims for Covered Services, that are determined to be payable, in accordance with Laws, Government Program Requirements, and this Agreement. Health Plan will make such payment within sixty (60) days.

1.9 **Compliance with Medicare Laws.** Provider will comply with all applicable Medicare Laws, regulations, and CMS instructions.

1.10 **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.

1.11 **Accountability.** Health Plan may only delegate activities or functions to a Downstream Entity in a manner that is consistent with the requirements set forth in Health Plan’s contractual obligations.

1.12 **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.

ATTACHMENT F

Medicare-Medicaid Program

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements, or other provisions necessary to reflect compliance for the MMP Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the MMP Product. 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 a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to MMP Product.

1.1 **Definitions.**

a. **Medically Necessary or Medical Necessity** means Covered Services that are appropriate, reasonable, and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 USC 1395y, covered by the Illinois Department of Healthcare and Family Services, and meets the standards of good medical practice in the medical community, as determined by the Provider in accordance with MMAI guidelines, policies and procedures based on applicable standards of care and, as approved by CMS or the Illinois Department of Healthcare and Family Services if necessary, for the diagnosis and treatment of a covered illness or injury, for the prevention of future disease, to assist in the Member's ability to attain, maintain or regain functional capacity, or to achieve age-appropriate growth.

1.2 **Downstream Compliance.** Provider and Provider's first tier, downstream and related entities agree that any functions being performed on behalf of Health Plans related to the operation of the Medicare-Medicaid plan are in compliance with 42 CFR 422.504, 42 CFR 423.505, and 42 CFR 438.6(1).

1.3 **Right to Audit.** CMS, Illinois Department of Healthcare and Family Services ("HFS"), United States Department of Health and Human Services ("HHS"), Comptroller General, HFS Office of the Inspector General, the Medicaid Fraud Control Unit of the Illinois State Police, the Illinois Auditor General, and other state and federal department/agencies, as well as their agents and designees, have the right to audit, evaluate, and inspect any pertinent information, including but not limited to, books, contracts, records, 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 and HFS or as the appropriate regulatory department/agency may deem necessary to enforce Health Plan's contract with CMS and HFS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities, and equipment, as well as pertinent information relating to its Members, and any additional relevant information that CMS, HFS, HHS, Comptroller General, and other state and federal department/agencies, as well as their agents and designees, may require. These rights to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS and HFS or completion of audit, whichever is later.

1.4 **Confidentiality.** Provider agrees to safeguard Member privacy and the confidentiality of Member health records and Provider will abide by all federal and state laws and regulations regarding confidentiality and disclosure of medical records, and other health and enrollment information. Provider must ensure that medical information is released in accordance with applicable federal or state laws, and pursuant to court orders and subpoenas. Providers must maintain Member medical records and information in an accurate and timely manner. Providers must ensure timely access by Members to the records and information that pertain to them.

1.5 **Hold Harmless/Cost Sharing.** Provider agrees it may not under any circumstance, including but not limited to, nonpayment of moneys due to Providers by 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. This Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. In addition:

a. 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 Member.

b. Notwithstanding the foregoing, Provider may bill Members for pharmacy co-payments, if applicable.

1.6 **Accountability.** Health Plan may only delegate activities or functions to a Downstream Entity in a manner that is consistent with the requirements set forth in Health Plan's contractual obligations.

1.7 **Delegation.** Any services or other activity performed by a first tier, downstream, or related entity, which is preformed pursuant to a contract or written agreement between Provider and the first tier, downstream, or related entity, will be consistent and comply with Health Plan's contract with CMS and HFS, and the terms of this Agreement.

1.8 **Claims Payment.**

a. Notwithstanding any other provision of this Agreement, Health Plan shall not make any payment or pay any Claim, nor does Health Plan have any obligation to make any payment or pay any Claim, to a Provider:

i. Excluded, terminated, or suspended from the Medicare program, Medicaid program, or other state or federally funded health care program. This includes, but is not limited to, Providers excluded for fraud, abuse, or waste;

ii. For a provider preventable condition as defined in 42 CFR 447.26(b); or

iii. That has not complied with reporting requirements on provider preventable conditions as described at 42 CFR 447.26(d), or by Health Plan or HFS.

b. Health Plan will ensure that ninety percent (90%) of Clean Claims received from physicians will be paid within thirty (30) days after the date of receipt of the Clean Claim. The Contractor must ensure that ninety-nine percent (99%) of Clean Claims from Providers for Covered Services will be paid within ninety (90) days after the date of receipt of the claim.

1.9 **Reporting.** Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in Health Plan's contract with CMS and HFS. When applicable, Provider must provide all information CMS and HFS require:

a. Under Health Plan's contract with CMS and HFS related to the performance of the responsibilities under the MMAI program, including non-medical information for the purposes of research and evaluation;

b. To comply with applicable federal or state laws and regulations; or

c. For external rapid cycle evaluation including, but not limited to, program expenditures, service utilization rates, rebalancing from institutional to community settings, Member satisfaction, Member complaints and appeals, and enrollment/disenrollment rates.

1.10 **Compliance with Laws and Regulations**. Provider will comply with all federal and state laws, regulations, and CMS and HFS instructions. This includes, but is not limited to, laws, regulations, and instructions that pertain to the Medicare and Medicaid programs.

1.11 **Benefit Continuation.** Provider agrees to provide for the continuation of Member health care benefits: (i) for all Members, for the duration of the period for which CMS and HFS has made payments to Health Plan for MMAI services; and (ii) for Members who are hospitalized on the date Health Plan's contract with CMS and HFS terminates, or, in the event of insolvency, through discharge.

1.12 **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.

1.13 **Corrective Action.** Health Plan monitors Provider performance under this Agreement on an ongoing basis and Health Plan may impose corrective action as necessary to address instances of noncompliance.

1.14 **Federal Emergency Medical Treatment and Labor Act.** As applicable to Provider, Provider must comply with the Federal Emergency Medical Treatment and Labor Act ("EMTALA") and all requirements outlined in 42 USC 1395dd. Health Plan will not create any policies that conflict with the Provider's obligations under EMTALA.

1.15 **Physician Incentive Plans.** Provider shall comply with all applicable requirements governing physician incentive plans, including but not limited to, 42 CFR 417, 42 CFR 422, 42 CFR 434, 42 CFR 438.6(h), and 42 CFR 1003.

1.16 **Indemnification.** Provider is not required to indemnify Health Plan for any expenses and liabilities, including without limitation, judgments, settlements, attorney's fees, court costs and any associated charges, incurred in connection with any claim or action brought against Health Plan based on Health Plan's management decisions, utilization review provisions, or other policies, guidelines or actions. For the avoidance of doubt, nothing in this section creates any conflict with the Section 6.1, Indemnification, in the Agreement.

1.17 **Provider Participation.**

a. Provider shall offer hours of operation that are no less than the hours of operation offered to individuals who are not MMAI Members.

b. Provider may not close or otherwise limit its acceptance of Members as patients unless the same limitations apply to all commercially insured individuals.

c. Providers will comply with Health Plan's requirements for the delivery of preventive health services.

d. Provider shall offer hours of operation that are no less than the hours of operation offered to individuals who are not MMAI Members.

e. Provider must notify the Member's PCP of a Member's screening and treatment.

f. If a Member files a grievance with Provider, Provider must promptly forward it to Health Plan.

g. Provider is required to meet the same federal and state financial and program reporting requirements as Health Plan.

h. Providers will not bill Members for missed appointments or refuse to provide services to Members who have missed appointments. Provider will work with Members and Health Plan to assist Members in keeping their appointments.

i. Provider may not refuse to provide Covered Services to a Member because the Member has an outstanding debt with Provider from a time prior to the Member being covered by Health Plan.

j. Provider shall report any events involving the use of restraint or seclusion.

k. Provider shall provide to Health Plan all state and federally required disclosures and comply with state and federal requirements for disclosure of ownership and control, business transactions, and information of persons convicted of crimes against federal and state health care programs as described in 42 CFR 455, 42 CFR 1002.3, and as specified by HFS and CMS.

l. Provider will be bound by the terms and conditions of the Health Plan's contract with CMS and HFS that are appropriate to the service or activity Provider is performing pursuant to this Agreement.

m. Provider is prohibited from giving gifts to CMS and HFS employees, and from giving gifts to, or accepting gifts from, any person who has a contemporaneous contract with the CMS or HFS involving duties or obligations related to Health Plan's contract with CMS and HFS.

n. If any funds other than federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with this federal contract, grant, loan, or cooperative agreement, the Provider will complete and submit a Federal Standard Form LLL, "Disclosure Form to Report Lobbying," in accordance with its instructions. Such Disclosure Form may be obtained by request from the Illinois Department of Healthcare and Family Services, Bureau of Fiscal Operations.

o. Provider certifies to the best of his knowledge and belief that:

i. No federal appropriated funds have been paid or will be paid by or on behalf of the Provider to any person for influencing or attempting to influence an officer or employee of any agency, a member of Congress, an officer or employee of Congress, or an employee of a member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

ii. Provider warrants and certifies that it and, to the best of its knowledge, its subcontractors have and will comply with Executive Order No. 1 (2007). The Order generally prohibits Health Plans and subcontractors, including Provider, from hiring the then-serving Governor's family members to lobby procurement activities of the State of Illinois, or any other unit of government in Illinois including local governments if that procurement may result in a contract valued at over twenty-five thousand dollars ($25,000). This prohibition also applies to hiring for that same purpose any former State of Illinois employee who had procurement authority at any time during the one-year period preceding the procurement lobbying activity.

p. Providers providing Medicare Covered Services for Health Plan under this Agreement must be enrolled as providers in the Medicare program in order to submit claims for reimbursement or otherwise participate in Medicare. Providers providing Covered Services for Health Plan under this Agreement must be enrolled as providers in the HFS Medical Program. Health Plan shall not contract or subcontract with an excluded person or a person who has voluntarily withdrawn from the HFS Medical Program as the result of a settlement agreement. Health Plan may immediately terminate this Agreement in the event Health Plan determines Provider violated this section.

1.18 **Provider Protection.**

a. Health Plan may not refuse to contract or pay a Provider for the provision of Covered Services solely because such Provider has in good faith:

i. 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 Health Plan's benefit plans as they relate to the needs of such Provider's patients; or

ii. 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 Health Plan for services provided to the patient.

b. Health Plan shall notify Providers in writing of modifications in payments, modifications in Covered Services, or modifications in 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 Provider, 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 Health Plan and the Provider or unless such change is mandated by CMS or HHS without thirty (30) days prior notice.

c. Health Plan may not impose a financial risk on medical Providers for the costs of medical care, services, or equipment provided or authorized by another physician or health care provider unless such contract includes specific provisions with respect to the following:

i. Stop-loss protection;

ii. Minimum patient population size for the physician or physician group; and

iii. Identification of the health care services for which the physician or physician group is at risk.

1.19 **Laboratory Providers.** Laboratory testing sites must have either a Clinical Laboratory Improvement Amendment ("CLIA") certificate or waiver of a certificate of registration along with a CLIA identification number.

1.20 **Transitioning Members.** Provider has the right to terminate the contract or a product/program with cause upon sixty (60) days' notice, and without cause upon one hundred and twenty (120) days' notice. Provider shall assist with transitioning Members to new providers, including sharing the Member's medical record and other relevant Member information as directed by Health Plan or Member.

1.21 **FQHCs and RHCs Reimbursement.** Health Plan shall ensure that its payments to Federally Qualified Health Centers ("FQHC") and a Rural Health Clinics ("RHC") for services to Enrollees are no less than the sum of the level and amount of payment that the Health Plan would make for such services if the services had been furnished by an entity providing similar services that was not a FQHC or RHC.

ATTACHMENT G

Molina Marketplace

Laws and Government Program Requirements

This attachment sets forth applicable Laws and Government Program Requirements or other provisions necessary to reflect compliance for the Molina Marketplace Product. This attachment will be automatically modified to conform to subsequent changes to Laws or Government Program Requirements. 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 for the Molina Marketplace Product. 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 a Law or Government Program Requirement will not be effective and will be interpreted in a manner that is consistent with the applicable Law and Government Program Requirement. This attachment only applies to Molina Marketplace Product.

1.1 **Definitions.** The following definitions apply only in this attachment:

a. **Delegated Entity** means any party that enters into an agreement with a qualified health plan ("QHP") issuer to provide administrative services or health care services to qualified individuals and their dependents.

b. **Downstream Entity** means any party that enters into an agreement with a Delegated Entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the Delegated Entity and the QHP issuer. The term is intended to reach the entity that directly provides administrative services or health care services to qualified individuals and their dependents.

Consistent with the above definitions, Provider is a Delegated Entity and Health Plan is a QHP issuer.

1.2 **Health Plan Accountability.** Notwithstanding any relationship Health Plan may have with Provider, as Delegated Entity, and any Downstream Entity, Health Plan maintains responsibility for its compliance, as well as the compliance of the Provider and any Downstream Entity, with all applicable standards enumerated at 45 CFR 156.340(a). (45 CFR 156.340(a))

1.3 **Delegated Entity and Downstream Entity Compliance.** If any of Health Plan's issuer activities and obligations, in accordance with 45 CFR 156.340(a), are delegated to Provider, then Provider, as Delegated Entity, agrees to the following. Provider further agrees that it will require the same of any Downstream Entities. (45 CFR 156.340(b))

a. **Standards for Downstream and Delegated Entities.** The Agreement, including, when applicable, any delegated services attachment/addendum, specifies the delegated activities and reporting responsibilities. (45 CFR 156.340(b)(1))

b. **Revocation of Delegated Activities.** In the event the United States Department of Health and Human Services ("HHS") or Health Plan determines, in its sole discretion, that Provider or any Downstream Entity have not performed the delegated activities and reporting obligations satisfactorily, consistent with applicable standards enumerated at 45 CFR 156.340(a), then the delegated activities and reporting obligations shall be revoked. The foregoing does not preclude the employment of other remedies in lieu of revocation of the delegated activities or reporting responsibilities if deemed appropriate by HHS or Health Plan, as applicable. (45 CFR 156.340(b)(2))

c. **Compliance with Laws.** Provider will perform such activities and obligations in compliance with all applicable laws and regulations relating to the standards specified in 45 CFR 156.340(a). (45 CFR 156.340(b)(3))

d. **Right to Audit.** Provider and any Downstream Entity shall permit access to the relevant Health Insurance Marketplace authority, the Secretary of HHS, and the Office of the Inspector General, or their designees, to evaluate through audit, inspection, or other means, Provider's or Downstream Entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to Health Plan's obligations in accordance with the standards enumerated at 45 CFR 156.340(a), as applicable, until ten (10) years from the final date of the Agreement period. (45 CFR 156.340(b)(4)-(5))

1.4 **Privacy and Security of Personally Identifiable Information.** Provider must adhere to privacy and security standards and obligations to which Health Plan has agreed to in its contract or agreement with the Health Insurance Marketplace authority. (45 CFR 155.260(b)(2)(v)).

1.5 **Consolidated Appropriations Act of 2021.** The Consolidated Appropriations Act of 2021, Section 201, prohibits Health Plan from entering into a contract with Provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict Health Plan from: (i) providing provider-specific cost or quality of care information or data to referring providers, plan sponsors, participants, beneficiaries, or enrollees, or individuals eligible to become participants, beneficiaries, or enrollees of the plan or coverage; (ii) electronically accessing de-identified claims and encounter data for each participant, beneficiary, or enrollee; or (iii) sharing such information, consistent with applicable privacy Laws. Notwithstanding anything to the contrary in this Agreement, Provider agrees that Health Plan is in compliance with this provision with respect to this Agreement and nothing in this Agreement will prohibit Health Plan from complying with this provision.