CONTRACT BETWEEN

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES)

and

TRIPLE-S ADVANTAGE, INC.

for

PROVISION OF MEDICAID WRAPAROUND COVERAGE FOR THE GOVERNMENT HEALTH INSURANCE MEDICARE AND MEDICAID DUAL-ELIGIBLE POPULATION

Contract No.: 2020-000001

TABLE OF CONTENTS

ARTICLE 1	DEFINITIONS	6
ARTICLE 2	SERVICE AREA	15
ARTICLE 3	ELIGIBILITY AND ENROLLMENT	15
ARTICLE 4	ENROLLEE NOTIFICATION	21
ARTICLE 5	COVERED SERVICES AND BENEFITS	30
ARTICLE 6	PROVIDER NETWORK	39
ARTICLE 7	PROVIDER CONTRACTING	46
ARTICLE 8	UTILIZATION MANAGEMENT	54
ARTICLE 9	QUALITY IMPROVEMENT AND PERFORMANCE PROGRAM	56
ARTICLE 10	FRAUD, WASTE, AND ABUSE	58
ARTICLE 11	GRIEVANCE AND APPEAL SYSTEM	66
ARTICLE 12	ADMINISTRATION AND MANAGEMENT	80
ARTICLE 13	PROVIDER PAYMENT MANAGEMENT	81
ARTICLE 14	INFORMATION MANAGEMENT AND SYSTEMS	84
ARTICLE 15	REPORTING	95
ARTICLE 16	ENFORCEMENT – INTERMEDIATE SANCTIONS	98
ARTICLE 17	ENFORCEMENT - LIQUIDATED DAMAGES AND OTHER REMEDIES	104
ARTICLE 18	CONTRACT TERM	111
ARTICLE 19	PAYMENT FOR SERVICES	111
ARTICLE 20	FINANCIAL MANAGEMENT	113
ARTICLE 21	RELATIONSHIP OF PARTIES	119
ARTICLE 22	INSPECTION OF WORK	119
ARTICLE 23	GOVERNMENT PROPERTY	119
ARTICLE 24	OWNERSHIP AND USE OF DATA AND SOFTWARE	120

ARTICLE 25 SUBCONTRACTS.......... 121

ARTICLE 26 REQUIREMENT OF INSURANCE LICENSE AND CERTIFICATE 122

OF SOLVENCY 122

ARTICLE 27 CERTIFICATIONS.......... 122

ARTICLE 28 RECORDS REQUIREMENTS.......... 123

ARTICLE 29 CONFIDENTIALITY.......... 125

ARTICLE 30 TERMINATION OF CONTRACT.......... 130

ARTICLE 31 PHASE-OUT AND COOPERATION WITH OTHER CONTRACTORS.......... 137

ARTICLE 32 COMPLIANCE WITH ALL LAWS.......... 138

ARTICLE 33 CONFLICT OF INTEREST AND CONTRACTOR INDEPENDENCE.......... 139

ARTICLE 34 CHOICE OF LAW OR VENUE.......... 139

ARTICLE 35 ATTORNEY'S FEES.......... 139

ARTICLE 36 SURVIVABILITY.......... 140

ARTICLE 37 PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED AND SUSPENDED.......... 140

ARTICLE 38 WAIVER.......... 140

ARTICLE 39 FORCE MAJEURE.......... 140

ARTICLE 40 BINDING.......... 141

ARTICLE 41 TIME IS OF THE ESSENCE.......... 141

ARTICLE 42 AUTHORITY.......... 141

ARTICLE 43 ETHICS IN PUBLIC CONTRACTING.......... 141

ARTICLE 44 CONTRACT LANGUAGE INTERPRETATION.......... 141

ARTICLE 45 ARTICLE AND SECTION TITLES NOT CONTROLLING.......... 141

ARTICLE 46 LIMITATION OF LIABILITY/EXCEPTIONS.......... 141

ARTICLE 47	**COOPERATION WITH AUDITS**	**142**
ARTICLE 48	**OWNERSHIP AND FINANCIAL DISCLOSURE**	**142**
ARTICLE 49	**AMENDMENT IN WRITING**	**144**
ARTICLE 50	**CONTRACT ASSIGNMENT**	**144**
ARTICLE 51	**SEVERABILITY**	**145**
ARTICLE 52	**ENTIRE AGREEMENT**	**145**
ARTICLE 53	**INDEMNIFICATION**	**145**
ARTICLE 54	**NOTICES**	**145**
ARTICLE 55	**OFFICE OF THE COMPTROLLER**	**146**
ARTICLE 56	**CONTRACT APPLICABILITY**	**146**

ATTACHMENTS

APPENDIX A	**SERVICE AREA**
APPENDIX B	**PREMIUM PAYMENTS**
APPENDIX C-1	**MEDICARE ADVANTAGE PLAN BENEFIT PACKAGE (PBP) 2020**
APPENDIX C-2	**MEDICAID WRAPAROUND 2020**
APPENDIX C-3	**SERVICES PROVIDER BY PR DEPARTMENT OF HEALTH**
APPENDIX C-4	**BID SUMMARY OF BENEFITS**
APPENDIX C-5	**COORDINATED CARE MODEL NORMS 2020**
APPENDIX C-6	**CO-PAYMENT CERTIFICATIONS**
APPENDIX C-7	**BENEFITS NOT COVERED BY WRAP AROUND SUPPLEMENTARY BENEFITS PART C 2020**
APPENDIX C-8	**CERTIFICATION ADDED VALUE SERVICES**
APPENDIX D	**ACTUARIAL CERTIFICATION**
APPENDIX E	**CMS CONTRACT 2020**

APPENDIX F	**GUIDELINES FOR THE PROCESSING OF MEDICARE PLATINO ENROLLMENTS AND DISENROLLMENT**
APPENDIX G	**BUSINESS ASSOCIATE AGREEMENT**
APPENDIX G-1	**GUIDELINES FOR THE DEVELOPMENT OF PROGRAM INTEGRITY PLAN**
APPENDIX H	**SWORN STATEMENTS X 2**
APPENDIX I	**FINANCIAL CERTIFICATION**
APPENDIX J	**RELEVANT PUERTO RICO AND FEDERAL LAWS AND REGULATION**
APPENDIX K	**INFORMATION DATA PROCESSES AND DATA EXCHANGE LAYOUT**
APPENDIX L	**DELIVERABLES**
APPENDIX M	**STRATEGIC PLAN FOR HEALTH INFORMATION ORGANIZATION (HIO)**
APPENDIX N	**HIV DRUG CERTIFICATION**
APPENDIX O	**CERTIFICATION CONSENT FOR STERILIZATION**
APPENDIX P	**ASEM CERTIFICATION**
APPENDIX Q	**GUIDELINES FOR MARKETING ACTIVITIES**
APPENDIX R	**MEDICARE PART D APPEALS PROCESS**

THIS CONTRACT is made and entered into by and between the Puerto Rico Health Insurance Administration (Administración de Seguros de Salud de Puerto Rico, hereinafter referred to as "ASES" or "the Administration"), a public corporation of the Government of Puerto Rico ("the Government" or "Puerto Rico"), with employer identification number 66-0500678 Triple-S Advantage, Inc.. ("the Contractor"), a managed care organization duly organized and authorized to do business under the laws of Puerto Rico, with employer identification number 66-0593034.

WHEREAS, pursuant to Title XIX of the Federal Social Security Act, codified as 42 U.S.C. Section 1396 et seq. (the "Social Security Act"), and Law 81 of March 14, 1912 (The Puerto Rico Health Department Act) and Law 72 of September 7, 1993 as amended (The Puerto Rico Health Insurance Administration Act), a comprehensive program of Medical Assistance for needy persons has been established in Puerto Rico, known as the Government Health Plan ("GHP" or "Vital" Program);

WHEREAS, the Government of Puerto Rico, in order to assist the Medicare and Medicaid dual-eligible population ("Dual-Eligibles") with the cost associated with prescription drug benefits, originally created the Medicare Platino Program, and where Medicare Platino now offers certain Medicaid wraparound services furnished by a Medicare Advantage Organization ("MAO") to Medicare and Medicaid Dual-Eligibles, as defined in this Contract, when such care and services are furnished in accordance with an agreement approved by ASES and that meets the requirements of State and federal law and regulations;

WHEREAS, the Contractor is has been certified under Chapter 19 of the Puerto Rico Insurance Code and has been determined to be an eligible MAO by the Centers for Medicare and Medicaid Services ("CMS") under 42 CFR 422.501; and has entered into a contract with CMS pursuant to Sections 1851 through 1859 of the Social Security Act to operate a Medicare Advantage plan, in compliance with 42 CFR 422.502 and other applicable federal statutes, regulations and policies;

WHEREAS, the Contractor has applied to participate in the Medicare Platino Program, and ASES has determined that the Contractor meets the qualification criteria established for participation; and

WHEREAS, ASES and the Contractor (each individually, a "Party" and collectively, the "Parties") have executed previous agreements for the Medicare Platino Program, but where this Contract and all future amendments supersedes any prior agreements and amendments between the Parties, under the terms and conditions contained herein.

NOW, THEREFORE, FOR AND IN CONSIDERATION of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Parties hereby agree as follows:

ARTICLE 1 DEFINITIONS

Whenever capitalized in this Contract, the following terms have the respective meaning set forth below, unless the context clearly requires otherwise.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and that result in unnecessary costs to the Medicare Platino Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for the provision of health care. It also includes Enrollee practices that result in unnecessary costs to the Medicare Platino Program.

Access: Adequate availability of Benefits to fulfill the needs of Enrollees.

Adverse Benefit Determination: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service, requirements for medical necessity appropriateness, setting or effectiveness of a covered benefit; the denial, in whole or part, of payment for a service (including in circumstances in which an Enrollee is forced to pay for a service); the failure to provide services in a timely manner (within the timeframes established by this Contract or otherwise established by ASES); the failure of the Contractor to act within the timeframes provided in 42 CFR 438.408(b); or the denial of an Enrollee's request to dispute a financial liability, including cost-sharing, co-payments, premiums, deductibles, co-insurance, and other Enrollee financial liabilities. For a resident of a rural area, the denial of an Enrollee's request to exercise his or her right, under 42 CFR 438.52(b)(2)(ii), to obtain services outside the network.

Administrative Law Hearing: The Appeal process administered by the Government and as required by Federal law, available to Enrollees after they exhaust the Contractor's Grievance System and Complaint Process.

Administrative Functions: The contractual obligations of the Contractor under this Contract, other than providing Covered Services; include, without limitation, Care Management, Utilization Management, Credentialing Providers, Network Management, Quality Improvement, Marketing, Enrollment, Enrollee Services, Claims Payment, Information Systems, Financial Management, and Reporting.

Advance Directive: A written instruction, such as a living will or durable power of attorney, granting responsibility over an individual's health care, as defined in 42 CFR 489.100, and as recognized under Puerto Rico law under Act 160 of November 17, 2001, as amended, relating to the provision of health care when the individual is incapacitated.

Agent: An entity that contracts with ASES to perform Administrative Functions, including, but not limited to: fiscal agent activities, outreach, eligibility and enrollment, and systems and technical support.

Appeal: An Enrollee request for a review of an Adverse Benefit Determination. It is a formal petition by an Enrollee, an Enrollee's Authorized Representative, or the Enrollee's Provider, acting on behalf

of the Enrollee with the Enrollee's written consent, to reconsider a decision in the case that the Enrollee or Provider does not agree with an Adverse Benefit Determination.

ASES: Administración de Seguros de Salud de Puerto Rico (the Puerto Rico Health Insurance Administration), the entity in the Government of Puerto Rico responsible for oversight and administration of the Vital and Medicare Platino Programs, or its Agent.

ASES Data: All Data created from Information, documents, messages (verbal or electronic), reports, or meetings involving, arising out of or otherwise in connection with this Contract.

ASES Information: All proprietary Data and/or Information generated from any Data requested, received, created, provided, managed and stored by Contractors, - in hard copy, digital image, or electronic format - from ASES and/or Enrollees (as defined in Article 1) necessary or arising out of this Contract, except for the Contractor's Proprietary Information.

At Risk: When a Provider agrees to accept responsibility to provide, or arrange for, any service in exchange for the Per Member Per Month Payment (PMPM).

Behavioral Health: The umbrella term for mental health conditions (including psychiatric illnesses and emotional disorders) and substance use disorders (involving addictive and chemical dependency disorders). The term also refers to preventing and treating co-occurring mental health and substance use disorders ("SUDs").

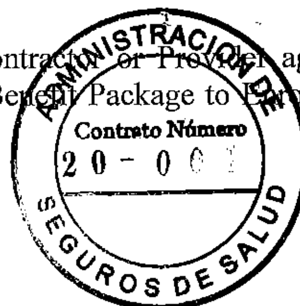
Benefits: The services set forth in this Contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible, including Basic Coverage, dental services, Special Coverage, and Administrative Functions.

Business Continuity and Disaster Recovery ("BC-DR") Plan: A documented plan (process) to restore vital and critical Information/health care technology systems in the event of business interruption due to human, technical, or natural causes. The plan focuses mainly on technology systems, encompassing critical hardware, operating and application software, and tertiary elements required to support the operating environment. It must support the process requirement to restore vital business Data inside the defined business requirement, including an emergency mode operation plan as necessary. The BC-DR also provides for continuity of health care in the event of plan terminations.

Business Days: Traditional workdays, including Monday, Tuesday, Wednesday, Thursday, and Friday. Puerto Rico Holidays, as defined in the Law for Compliance with the Fiscal Plan, Act No. 26 of April 29, 2017, or any other law enacted during the duration of this Contract regarding this subject, are excluded.

Calendar Days: All seven (7) days of the week.

Capitation: A contractual agreement through which a Contractor or Provider agrees to provide specified health care services under the Medicare Platino Benefit Package to Enrollees for a fixed amount per month.



Centers for Medicare & Medicaid Services ("CMS"): The agency within the US Department of Health and Human Services with responsibility for the Medicare, Medicaid, and the Children's Health Insurance Programs ("CHIP").

Claim: Whether submitted manually or electronically, a bill for services, a line item of services, or a bill detailing all services for one (1) Enrollee.

Clean Claim: A Claim received by the Contractor for adjudication, which can be processed without obtaining additional information from the Provider of the service or from a Third Party. It includes a Claim with errors originating in the Contractor's Claims system. It does not include a Claim from a Provider who is under investigation for Fraud, Waste, or Abuse, or a Claim under review to determine Medical Necessity.

Cold-Call Marketing: Any unsolicited personal contact by the Contractor with a Potential Enrollee, for the purposes of Marketing.

Co-Location: An integrated care model in which Behavioral Health Services are provided in the same site as primary care.

Complaint: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination that is resolved at the point of contact rather than through filing a formal Grievance.

Contract: The written agreement between ASES and the Contractor; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

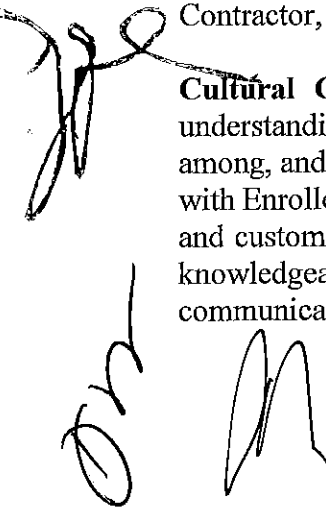
Contract Term: The duration of time that this Contract is in effect, as defined in Article 18 of this Contract.

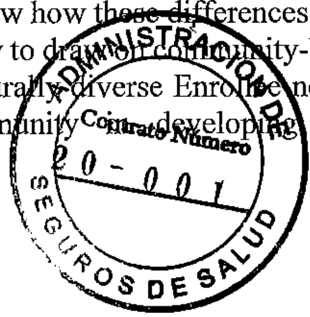
Covered Services: Those Medically Necessary health care services (listed in Article 5 of this Contract) provided to Enrollees by Providers, the payment or indemnification of which is covered under this Contract.

Credentialing: The Contractor's determination as to the qualification of a specific Provider to render specific health care services.

Credible Allegation of Fraud: Any allegation of Fraud that has been verified by another State, the Government of Puerto Rico, or ASES, or otherwise has been preliminary investigated by the Contractor, as the case may be, and that has indicia of reliability that comes from any source.

Cultural Competency: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among, and between groups and the sensitivity to know how these differences influence relationships with Enrollees. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Enrollee needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.





Deliverable: A document, manual, or report submitted to ASES by the Contractor to exhibit that the Contractor has fulfilled the requirements of this Contract.

Disenrollment: The termination of an individual's Enrollment in the Contractor's Medicare Platino Plan.

Dual Eligible Beneficiary or Dual Eligible: An Enrollee or Potential Enrollee eligible for both Medicaid and Medicare.

Effective Date of Contract: The day the Contract is executed by both Parties.

Effective Date of Disenrollment: The date, as defined in Section 3.3.3 of this Contract, on which an Enrollee ceases to be covered under the Contractor's Medicare Platino plan.

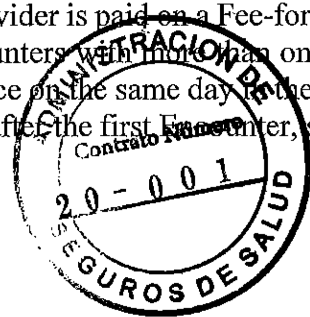
Effective Date of Enrollment: The date, as defined in Section 3.2.3 of this Contract, on which an Eligible Person becomes and Enrollee and acquires Coverage under the Contractor's Medicare Platino plan.

Eligible Person: A person eligible to enroll in the Medicare Platino Program, as provided in Section 3.1 of this Contract, by virtue of meeting all other conditions for Enrollment in the Medicare Platino Program as set forth in Section 3.1.2 of this Contract.

Emergency Medical Condition: As defined in 42 CFR 438.114, a medical or Behavioral Health condition, regardless of diagnosis or symptoms, manifesting itself in acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, serious dysfunction of any bodily organ or part, serious harm to self or other due to an alcohol or drug abuse emergency, serious injury to self or bodily harm to others, or the lack of adequate time for a pregnant women having contractions to safely reach a another hospital before delivery. The Contractor may not impose limits on what constitutes an Emergency Medical Condition based only, or exclusively, on diagnoses or symptoms.

Emergency Services: As defined in 42 CFR 438.114, any Physical or Behavioral Health Covered Services (as described in Section 5.3) furnished by a qualified Provider that are needed to evaluate or stabilize an Emergency Medical Condition or a Psychiatric Emergency that is found to exist using the prudent layperson standard.

Encounter: A distinct set of services provided to an Enrollee in a face-to-face setting on the dates that the services were delivered, regardless of whether the Provider is paid on a Fee-for-Service Capitated, salary, or alternative payment methodology basis. Encounters with more than one (1) Provider, and multiple Encounters with the same Provider, that take place on the same day in the same location will constitute a single Encounter, except when the Enrollee, after the first Encounter, suffers an illness or injury requiring an additional diagnosis or treatment.



Encounter Data: (i) All Data captured during the course of a single Encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices, and equipment associated with the Enrollee receiving services during the Encounter; (ii) The identification of the Enrollee receiving and the Provider(s) delivering the health care services during the single Encounter; and (iii) A unique (i.e. unduplicated) identifier for the single Encounter.

Enrollee: A person who is currently enrolled in the Contractor's Plan, as provided in this Contract, and who, by virtue of relevant Federal and Puerto Rico laws and regulations, is an Eligible Person listed in Section 3.1.2 of this Contract.

Enrollment: The process by which an Eligible Person becomes an Enrollee of the Contractor's Medicare Platino Plan.

Federally Qualified Health Center ("FQHC"): An entity that provides outpatient health programs pursuant to Section 1905(l)(2)(B) of the Social Security Act.

Fee-for-Service: A method of reimbursement based on payment for specific Covered Services on a service-by-service basis rendered to an Enrollee.

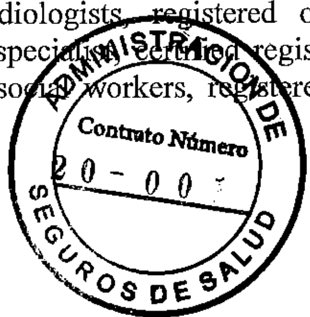
Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable Federal or Puerto Rico law.

The Government Health Plan (or "the GHP"): The government health services program (the "Vital" program, formerly referred to as "La Reforma" or "MI Salud") offered by the Government of Puerto Rico, and administered by ASES, which serves a mixed population of Medicaid Eligible, CHIP Eligible, and Other Eligible Persons, and emphasizes integrated delivery of physical and Behavioral Health Services.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

Grievance System: The overall system that includes Complaints, Grievances, and Appeals at the Contractor level, as well as Access to the Administrative Law Hearing process.

Health Care Provider or Provider: An individual engaged in the delivery of health care services as licensed or certified by Puerto Rico in which he or she is providing services, including but not limited to physicians, podiatrists, optometrists, chiropractors, psychologists, psychiatrists, licensed Behavioral Health practitioners, dentists, physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians.



Health Information Technology for Economic and Clinical Health ("HITECH") Act: Public Law 111-5 (2009). When referenced in this Contract, it includes all related rules, regulations, and procedures.

Immediately: Within twenty-four (24) hours, unless otherwise provided in this Contract.

Information: Data to which meaning is assigned, according to context and assumed conventions; meaningful fractal Data for decision support purposes.

List of Excluded Individuals and Entities ("LEIE"): A database of individuals and entities excluded from Federally-funded health care programs maintained by the Department of Health and Human Services Office of the Inspector General.

Marketing: Any communication from the Contractor to any Eligible Person or Potential Enrollee that can reasonably be interpreted as intended to influence the individual to enroll in the Contractor's Medicare Platino Plan, or not to enroll in another plan, or to disenroll from another plan.

Marketing Materials: Materials that are produced in any medium, by or on behalf of the Contractor, that can reasonably be interpreted as intended to market to Potential Enrollees.

Medicaid: The joint federal and state program of medical assistance established by Title XIX of the Social Security Act.

Medicaid Management Information System ("MMIS"): Computerized system used for the processing, collecting, analyzing, and reporting of Information needed to support Medicaid and CHIP functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manual.

Medical Record: The complete, comprehensive record of an Enrollee including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Enrollee's PCP, or Network Provider, that documents all health care services received by the Enrollee, including inpatient care, outpatient care, Ancillary, and Emergency Services, prepared in accordance with all applicable Federal and Puerto Rico rules and regulations, and signed by the Provider rendering the services.

Medically Necessary or Medically Necessary Services: The health care services that are necessary to prevent, diagnose, manage or treat conditions in the person that cause acute suffering, endanger life, result in illness or infirmity, interfere with such person's capacity for normal activity, the ability to achieve age appropriate growth and development and the ability to attain, maintain, or regain functional capacity, or threaten some significant handicap.

Medicare: The Federal program of medical assistance for persons over age sixty-five (65) and certain disabled persons under Title XVIII of the Social Security Act, and persons with End Stage Renal Disease.

Medicare Part A: The part of the Medicare program that covers inpatient hospital stays, skilled nursing facilities, home health, and hospice care.

Medicare Part B: The part of the Medicare program that covers physician, outpatient, home health, and Preventive Services.

Medicare Part C or Medicare Advantage: The part of the Medicare program that permits Medicare recipients to select coverage among various private insurance plans.

Medicare Part D: The part of the Medicare program that covers outpatient prescription drugs.

Medicare Platino: A program administered by ASES for Dual Eligible Beneficiaries, in which MAOs or other insurers under contract with ASES function as Part C plans to provide services covered by Medicare, and also to provide a "wrap-around" Benefit of Covered Services and Benefits under the GHP.

Medicare Platino Plan: The Medicaid wraparound services and benefits offered by the Contractor to Dual Eligible Enrollees as described in Appendix C-2 of this Contract.

National Provider Identifier ("NPI"): The 10-digit unique-identifier numbering system for Providers created by CMS, through the National Plan and Provider Enumeration System.

Network Provider: A Provider that has a Provider Contract with the Contractor under the respective Medicare Platino Plan.

Out-of-Network Provider: A Provider that does not have a Provider Contract with the Contractor under the respective Medicare Platino Plan.

Overpayment: Any funds that a person or entity receives which that person or entity is not entitled to under Title XIX of the Social Security Act as defined in 42 CFR 438.2. Overpayments shall not include funds that have been subject to a payment suspension or that have been identified as a Third-Party Liability as set forth in Section 20.2.

Patient's Bill of Rights Act: Law 194 of August 25, 2000, a law of Puerto Rico relating to patient rights and protection.

Patient Protection and Affordable Care Act ("PPACA"): Public Law 111-148 (2010) and the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152 (2010), including any and all rules and regulations thereunder.

Protected Health Information ("PHI"): As defined in 45 CFR 160.103, individually identifiable health Information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium.

Physician Incentive Plan ("PIP"): Any compensation arrangement between a Contractor and a physician or physician group that is intended to advance Utilization Management and is governed by 42 CFR 438.3(i).

Plan: The Contractor's Managed Care Plan, offering services to Enrollees under the Medicare Platino Program.

Post-Stabilization Services: Covered Services relating to an Emergency Medical Condition or Psychiatric Emergency that are provided after an Enrollee is stabilized, in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition.

Potential Enrollee: A person who has been Certified by the Puerto Rico Medicaid Program as eligible to enroll in Medicare Platino, but who has not yet enrolled with the Contractor.

Primary Care: All health care services and laboratory services customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, pediatrician, or other licensed practitioner as authorized by ASES, to the extent the furnishing of those services is legally authorized where the practitioner furnishes them.

Primary Care Physician ("PCP"): A licensed medical doctor (MD) who is a Provider and who, within the scope of practice and in accordance with Puerto Rico Certification and licensure requirements, is responsible for providing all required Primary Care to Enrollees. The PCP is responsible for determining services required by Enrollees, provides continuity of care, and provides Referrals for Enrollees when Medically Necessary. A PCP may be a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician.

Provider: Any physician, hospital, facility, or other Health Care Provider who is licensed or otherwise authorized to provide physical or Behavioral Health Services in the jurisdiction in which they are furnished.

Provider Contract: Any written contract between the Contractor and a Provider that requires the Provider to order, refer, provide or render Covered Services under this Contract. The execution of a Provider Contract makes the Provider a Network Provider

Psychiatric Emergency: A set of symptoms characterized by an alteration in the perception of reality, feelings, emotions, actions, or behavior, requiring immediate therapeutic intervention in order to avoid immediate damage to the patient, other persons, or property. A Psychiatric Emergency shall not be defined on the basis of lists of diagnoses or symptoms.

Quality Assessment and Performance Improvement Program ("QAPI"): A set of programs aimed at increasing the likelihood of desired health outcomes of Enrollees through the provision of health care services that are consistent with current professional knowledge; the QAPI Program includes incentives to comply with HEDIS standards, to provide adequate Preventive Services, and to reduce the unnecessary use of Emergency Services.

Remedy: ASES's means to enforce the terms of the Contract through liquidated damages and other sanctions.

Runoff Period: the period of time as explained in Section 30.1.5.

Rural Health Clinic or Center ("RHC"): A clinic that is located in an area that has a Provider shortage. An RHC provides primary Care and related diagnostic services and may provide optometric, podiatry, chiropractic, and Behavioral Health Services. An RHC employs, contracts, or obtains volunteer services from Providers to provide services.

Span of Control: Information Systems and telecommunications capabilities that the Contractor operates or for which it is otherwise legally responsible according to the terms and conditions of this Contract. The Contractor's Span of Control also includes systems and telecommunications capabilities outsourced by the Contractor.

Subcontract: Any written contract between the Contractor and a Subcontractor, to perform a specified part of the Contractor's obligations under this Contract.

Subcontractor: Any organization or person, including the Contractor's parent, subsidiary or Affiliate, who has a Subcontract with the Contractor to provide any function or service for the Contractor specifically related to securing or fulfilling the Contractor's obligations to the Government under the terms of this Contract. Subcontractors do not include Providers unless the Provider is responsible for services other than providing Covered Services pursuant to a Provider Contract.

Systems Unavailability: As measured within the Contractor's Information Systems' Span of Control, when a system user does not get the complete, correct full-screen response to an input command within three (3) minutes after pressing the "Enter" or any other function key.

Telecommunication Device for the Deaf ("TDD"): Special telephone devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones.

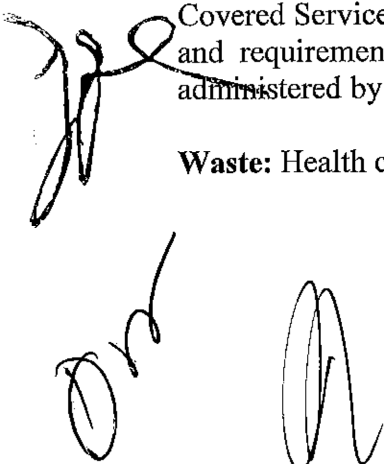
Third Party: Any person, institution, corporation, insurance company, public, private, or governmental entity who is or may be liable in Contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease, or disability of an Enrollee.

Third Party Liability ("TPL"): Legal responsibility of any Third Party to pay for health care services.

Utilization: The rate patterns of service usage or types of service occurring within a specified time frame.

Utilization Management ("UM"): A service performed by the Contractor which seeks to ensure that Covered Services provided to Enrollees are in accordance with, and appropriate under, the standards and requirements established by the Contract, or a similar program developed, established, or administered by ASES.

Waste: Health care spending that can be eliminated without reducing quality of care.



ARTICLE 2 SERVICE AREA

2.1 Service Area

2.1.1 The Service Area described in Appendix A of this Contract, which is hereby made a part of this Contract as if set forth fully herein, is the specific geographic area within which Eligible Persons shall enroll in the Contractor's Medicare Platino Plan.

2.1.2 Pursuant to 42 CFR 438.602(i), the Contractor cannot be located outside of the United States in order to enter into this Contract. Further, no Claims paid by the Contractor to a Provider, a Subcontractor, or a financial institution located outside of the United States shall be considered in the development of actuarially sound Capitation rates.

ARTICLE 3 ELIGIBILITY AND ENROLLMENT

3.1 Eligibility

3.1.1 The Government has sole authority to determine eligibility for the GHP and the Medicare Platino Program, as provided in Federal law and Puerto Rico's State Plan.

3.1.2 Eligible Persons must meet the following criteria in order to be eligible to enroll in the Contractor's Medicare Platino Program:

3.1.2.1 Must have evidence of coverage under Medicare Part A and B;

3.1.2.2 Must have GHP Eligibility; and

3.1.2.3 Must reside in the Service Area as defined in Appendix A of this Contract;

3.1.3 An individual who meets any of the following criteria is not eligible to enroll in the Contractor's Medicare Platino Program:

3.1.3.1 The individual is medically determined to have End Stage Renal Disease at the time of enrollment, unless determined eligible to enroll through the Seamless Conversion Enrollment Option, as specified in Section 3.2.2.2.

3.1.3.2 The individual is a resident of a long-term care nursing facility or intermediate care facility for the intellectually disabled;

3.1.3.3 The individual is a resident of a Residential Health Care Facility ("RHCF") at the time of Enrollment, whether the individual's stay in a RHCF is classified as permanent upon entry into the RHCF or is classified as permanent at a time subsequent to entry;

3.1.3.4 The individual is admitted to a hospice program prior to time of Enrollment. However, if an Enrollee enters a hospice program while enrolled in the Contractor's Medicare Platino Plan, he or she may remain enrolled in the Contractor's Medicare Platino Plan to maintain continuity of care with his or her PCP; or

3.1.3.5 The individual is incarcerated.

3.1.4 Change in Eligibility Status. The Contractor must report to the ASES any change in status of its Enrollees which may impact the Enrollee's eligibility for Medicare or Medicaid, within five (5) business days of such information becoming known to the Contractor. This information includes, but is not limited to, change of address, incarceration, permanent placement in a nursing home or other residential institution or program rendering the individual ineligible for enrollment in Medicare Platino, death, and disenrollment from the Contractor's Medicare Platino Plan.

3.1.4.1 To the extent practicable, ASES will follow-up with Enrollees when the Contractor provides documentation of any change in status which may affect the Enrollee's Medicaid and/or Medicare Platino Plan eligibility and enrollment.

3.2 Enrollment

3.2.1 Participation in the Medicare Platino Program and enrollment in the Contractor's Medicare Platino Plan shall be voluntary for all Eligible Persons. However, the Eligible Person must enroll in GHP and the Contractor's Medicare Platino Plan in order to participate in the Medicare Platino Program.

3.2.2 The Contractor shall coordinate with ASES or the Office of Medical Assistance Program as necessary for all Enrollment and Disenrollment functions as set forth in Appendix F.

3.2.2.1 The Contractor guarantees the maintenance, functionality, and reliability of all systems necessary for Enrollment and Disenrollment. The Contractor shall also provide Potential Enrollees with specific Information allowing for prompt, voluntary, and reliable Enrollment.

3.2.2.2 The Contractor may use the Seamless Conversion Enrollment Option or Default Enrollment Option for Newly Medicare Eligible Individuals as set forth in Chapter 2 of the Medicare Managed Care Manual. This option shall be available for individuals newly eligible for Medicare and must be performed only within the Contractor's Service Areas.

3.2.2.3 Medicare Advantage Enrollees who will become eligible to enroll in Medicaid coverage may elect to transfer to the Contractor's Medicare Platino Plan or to enroll in another Medicare Platino Plan if offered in the Enrollee's Service Area. A new Enrollment must be processed by

ASES and the Contractors to transfer the Medicare Advantage Enrollee to the Contractor's Medicare Platino Plan. To the extent possible, such enrollments shall be made effective the first (1st) day of the month that the Enrollee's Medicaid coverage is effective.

3.2.2.4 ASES or the Office of Medicaid Assistance Program may modify the guidance set forth in Appendix F at any time. Such modifications shall be effective and made part of this Contract without further action by the Parties upon sixty (60) days written notice of the modification to the Contractor.

3.2.3 Effective Date of Enrollment

3.2.3.1 An Enrollee's Effective Date of Enrollment shall be the first (1st) day of the first (1st) month during which the Enrollee is enrolled in the Contractor's Medicare Platino Plan and the first (1st) day of the first (1st) month during which Enrollee's name appears on the Prepaid Premium Plan Roster.

3.2.3.1.1 The monthly Prepaid Premium Plan Roster generated by ASES shall serve as the official list of Medicare Platino Program Enrollees for the purposes of MMIS Capitation billing and payment, subject to the ongoing eligibility of the Enrollees as of the first (1st) day of the enrollment month. Modifications to the first (1st) Roster may be made electronically or in writing by ASES prior to the end of the month in which the Roster is generated.

3.2.3.1.2 Contractor must have the ability to receive the Prepaid Premium Plan Roster from ASES electronically. If ASES notifies Contractor in writing or electronically of changes in the first (1st) Roster and provides supporting information as necessary prior to the effective date of the Roster, the Contractor will accept that notification in the same manner as the Roster.

3.2.3.1.3 The Office of Medicaid Assistance Program shall make data on eligibility determinations available to the Contractor and ASES to resolve discrepancies that may arise between the Prepaid Premium Plan Roster and the Contractor's enrollment files in accordance with the provisions in Appendix F and as set forth in Section 3.2.2.

3.2.3.2 The notice of Enrollment that the Contractor issues will clearly state the Effective Date of Enrollment. The notice of Enrollment will explain that the Enrollee is entitled to Covered Services allowed under the Contractor's Medicare Platino Plan. The notice will inform the Enrollee

of his or her limited right to disenroll, per Section 3.3 of this Contract. The notice of Enrollment shall inform the Enrollee that exercising the right to disenroll from the Medicare Platino Plan only means losing access to services under Medicare Platino.

3.2.3.2.1 All Enrollees must be notified at least annually of their disenrollment rights as set forth in Section 3.3 and 42 CFR 438.56. Such notification must clearly explain the process for exercising this disenrollment right, as well as the alternatives available to the Enrollee based on their specific circumstance.

3.2.3.3 If an Enrollee's Enrollment in the Contractor's Medicare Platino Plan is rejected by CMS, the Contractor must notify the local Medicare Platino Program within five (5) Business Days of learning of CMS's rejection of the Enrollment. In such instances, ASES shall delete the Enrollee's Enrollment in the Contractor's Medicare Platino Plan retroactive to the Effective Date of Enrollment.

3.2.4 Automatic Re-Enrollment. An Enrollee who is disenrolled from the Contractor's Medicare Platino Plan due to loss of Medicaid eligibility and who regains that eligibility within two (2) months will be automatically re-enrolled by the Contractor in the Contractor's Medicare Platino Plan.

3.2.5 The Contractor shall not discriminate against individuals eligible to enroll on the basis of religion, race, color, national origin, sex, sexual orientation, gender identity, or disability, and will not use any policy or practice that has the effect of discriminating on the basis of religion, race, color, national origin, sex, sexual orientation, gender identity, or disability, on the basis of health, health status, pre-existing condition, or need for health care services.

3.3 Disenrollment

3.3.1 The Contractor shall coordinate with ASES or the Office of Medical Assistance Program as necessary for all Disenrollment functions as set forth in Section 3.2.2 above and in Appendix F.

3.3.2 Disenrollment occurs only as determined by ASES. Disenrollment will be effected by ASES, and ASES will issue notification to the Contractor through the Prepaid Premium Plan Roster, along with any changes sent by ASES to the Contractor in writing or electronically.

3.3.2.1 Disenrollment decisions and processing are the responsibility of ASES or its representative; however, notice to Enrollees of Disenrollment shall be issued by the Contractor. The Contractor shall issue such notice in person or via surface mail to the Enrollee within five (5) Business Days of a final Disenrollment decision, as provided in Section 3.3.2.2.

3.3.2.2 Each notice of Disenrollment shall include information concerning:

3.3.2.2.1 The Effective Date of Disenrollment;

3.3.2.2.2 The reason for the Disenrollment;

3.3.2.2.3 The Enrollee's Appeal rights, including the availability of the Grievance System and of ASES's Administrative Law Hearing process, as provided by Act 72 of September 7, 1993;

3.3.2.2.4 The right to re-enroll in the Medicare Platino Program upon receiving a Recertification from ASES or its representative, if applicable; and

3.3.2.2.5 Disenrollment shall occur according to the following timeframes in Section 3.3.3 (the "Effective Date of Disenrollment").

3.3.3 The Effective Date of Disenrollment is as follows:

3.3.3.1 Except as otherwise provided in Appendix F, approved Disenrollment will take effect, if Enrollee requested Disenrollment, as of the first (1st) day of the second month in which the Enrollee requested the disenrollment, or as specified as the Effective Date of Disenrollment recorded by ASES that an Enrollee is no longer eligible.

3.3.3.2 The Contractor is not responsible for providing Covered Services under the Medicare Platino Plan under this Contract after the Effective Date of Disenrollment, unless the Enrollee was incorrectly disenrolled and subsequently re-enrolled in the Contractor's Medicare Platino Plan.

3.3.4 Disenrollment Initiated by the Contractor

3.3.4.1 The Contractor has a limited right to request that an Enrollee be disenrolled without the Enrollee's consent. The Contractor shall notify ASES upon identification of an Enrollee who it knows or believes meets the criteria for Disenrollment.

3.3.4.2 The Contractor shall submit Disenrollment requests to ASES, and the Contractor shall honor all Disenrollment determinations made by ASES. ASES's decision on the matter shall be final, conclusive, and not subject to appeal by the Contractor.

3.3.4.3 The following are acceptable reasons for the Contractor to request Disenrollment:

3.3.4.3.1 The Enrollee's continued Enrollment in the Contractor's Plan seriously impairs the ability to furnish services to either this particular Enrollee or other Enrollees;

3.3.4.3.2 The Enrollee demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness;

3.3.4.3.3 The Enrollee's use of services is fraudulent or abusive (for example, the Enrollee has loaned his or her Enrollee ID Card to other persons to seek services);

3.3.4.3.4 The Enrollee has moved out of the Contractor's Service Regions;

3.3.4.3.5 The Enrollee is placed in a long-term care nursing facility or intermediate care facility for the intellectually disabled;

3.3.4.3.6 The Enrollee's Medicare, Medicaid or CHIP eligibility category changes to a category ineligible for Medicare Platino Program; or

3.3.4.3.7 The Enrollee has died, been incarcerated, or moved out of Puerto Rico, thereby making him or her ineligible for Medicaid or CHIP or otherwise ineligible for the GHP.

3.3.4.4 ASES will approve a Disenrollment request by the Contractor, in ASES's discretion, only if ASES determines:

3.3.4.4.1 That it is impossible for the Contractor to continue to provide services to the Enrollee without endangering the Enrollee or other Medicare Platino Enrollees; and

3.3.4.4.2 That an action short of Disenrollment will not resolve the problem.

3.3.4.5 The Contractor may not request Disenrollment for any discriminatory reason including, but not limited, to the following:

3.3.4.5.1 Adverse changes in an Enrollee's health status;

3.3.4.5.2 Missed appointments;

3.3.4.5.3 Utilization of medical services;

3.3.4.5.4 Diminished mental capacity;

3.3.4.5.5 Pre-existing medical condition;

3.3.4.5.6 The Enrollee's attempt to exercise his or her rights under the Grievance System; or

3.3.4.5.7 Uncooperative or disruptive behavior resulting from the Enrollee's special needs.

3.3.4.6 When requesting Disenrollment of an Enrollee for reasons described in Section 3.3.4.3, the Contractor must make a reasonable effort to identify for the Enrollee, both verbally and in writing, those actions of Enrollee that justify the Disenrollment request. The Contractor must notify the Enrollee of the availability of the Grievance System and of ASES's Administrative Law Hearing process, as provided by Act 72 of September 7, 1993, as amended. The Contractor shall keep ASES informed of decisions related to all complaints filed by an Enrollee as a result of, or subsequent to, the notice of intent to disenroll.

3.3.4.7 The ASES will render a decision within five (5) days of receipt of the fully documented request for Disenrollment. Final written determination will be provided to the Enrollee and the Contractor. Once an Enrollee has been disenrolled at the Contractor's request, the Enrollee will not be re-enrolled with the Contractor's Medicare Platino Plan unless the Contractor first agrees to such re-enrollment.

3.3.5 Disenrollment Initiated by the Enrollee

3.3.5.1 An Enrollee may disenroll from the Contractor's Medicare Platino Plan for any reason. Disenrollments generally shall be effective on the first (1st) of the month following receipt of the written disenrollment request.

3.3.5.2 All Enrollees must be notified at least annually of their disenrollment rights as set forth in Section 3.3 and 42 CFR 438.56. Such notification must clearly explain the process for exercising this disenrollment right, as well as the coverage alternatives available to the Enrollee based on their specific circumstance.

3.3.5.3 An Enrollee wishing to request Disenrollment, or his or her representative, must submit an oral or written request to ASES or to the Contractor. If the request is made to the Contractor, the Contractor shall forward the request to ASES, within five (5) Business Days of receipt of the request, with a recommendation of the action to be taken.

ARTICLE 4 ENROLLEE NOTIFICATION

4.1 General Provisions

4.1.1 The Contractor shall disclose any Information required by federal and state law and regulation, including 42 CFR 438.10, and required by any specific guidance

issued by CMS and ASES, to Potential Enrollees and Enrollees according to the applicable timeframes.

4.1.2 The Contractor shall convey Information to Enrollees and Potential Enrollees via written materials and via telephone, internet, and face-to-face communications, and shall allow Enrollees to submit questions and to receive responses from the Contractor.

4.1.3 The Contractor shall provide Enrollees with at least thirty (30) Calendar Days written notice of any significant change in the Information to be communicated to Potential Enrollees and Enrollees as required in this Article 4.

4.1.4 The Contractor shall use the definitions for managed care terminology set forth by ASES in all of its written and verbal communications with Enrollees, in accordance with 42 CFR 438.10(c)(4)(i).

4.2 Requirements for Written Materials

4.2.1 The Contractor shall make all written materials available through auxiliary aids and services or alternative formats, and in a manner that takes into consideration the Enrollee's or Potential Enrollee's special needs, including Enrollees and Potential Enrollees who are visually impaired or have limited reading proficiency. The Contractor shall notify all Enrollees and Potential Enrollees that Information is available in alternative formats and shall instruct them on how to access those formats. Consistent with Section 1557 of PPACA and 42 CFR 438.10(d)(3), all written materials must also include taglines in the prevalent languages, as well as large print, with a font size of no smaller than 18 point, to explain the availability of written and oral translation to understand the Information provided and the toll-free and TTY/TDD telephone number of the appropriate customer service line. Once an Enrollee has requested a written material in an alternative format or language, the Contractor shall at no cost to the Enrollee or Potential Enrollee (i) make a notation of the Enrollee's preference in the Contractor's system and (ii) provide all subsequent written materials to the Enrollee or Potential enrollee in such format unless the Enrollee or Potential Enrollee requests otherwise.

4.2.2 Except as provided in Section 4.3 and subject to Section 4.2.6, the Contractor shall make all written information available in Spanish, with a language block in English, explaining that (i) Enrollees may access an English translation of the Information if needed, and (ii) the Contractor will provide oral interpretation services into any language other than Spanish or English, if needed. Such translation or interpretation shall be provided by the Contractor at no cost to the Enrollee. The language block and all other content shall comply with 42 CFR 438.10(c)(2) and Section 1557 of PPACA.

4.2.3 If oral interpretation services are required in order to explain the Benefits covered under the Medicare Platino Program to a Potential Enrollee who does

not speak either English or Spanish, the Contractor must, at its own cost, make such services available in a third language, in compliance with 42 CFR 438.10(d)(4).

4.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fourth (4th) grade level.

4.2.5 All written materials must be clearly legible with a minimum font of size twelve (12) point with the exception of Enrollee ID cards and unless otherwise approved in writing by ASES.

4.2.6 Within ninety (90) Calendar Days of a notification from ASES that ASES has identified a Prevalent Non-English Language other than Spanish or English (with "Prevalent Non-English Language" defined as a language that is the primary language of more than five percent (5%) of the population of Puerto Rico), all written materials provided to Enrollees and Potential Enrollees shall be translated into and made available in such language.

4.3 Enrollee Handbook, Provider Directory, and Other Notification Requirements

4.3.1 The Contractor shall provide the following Information in an enrollee handbook, provider directory, and/or other required notices and formats in compliance with 42 CFR 438.10:

4.3.1.1 A Provider Directory with names, provider group affiliations, locations, office hours, telephone numbers, websites, cultural and linguistic capabilities, completion of Cultural Competency training, and accommodations for people with physical disabilities of current Network Providers. The Provider Directory shall also identify all Network Providers that are not accepting new patients.

4.3.1.1.1 This Provider Directory must be made available on the Contractor's website and shall be updated in paper form once a month.

4.3.1.1.2 This Provider Directory must be distributed to all Enrollees at least once per year and additionally upon Enrollee request.

4.3.1.2 Information on the amount, duration and scope of Covered Services available under the Contract, and in sufficient detail to ensure that Enrollees understand the Benefits to which they are entitled;

4.3.1.3 Enrollee Rights and Protections, as set forth in 42 CFR 438.100 and in the Puerto Rico Patient's Bill of Rights Act 194 of August 24, 2000;

4.3.1.4 An explanation of any service limitations or exclusions from coverage, including any restrictions on the Enrollee's freedom of choice among Out-of-Network Providers;

4.3.1.5 Information on where and how Enrollees may access Benefits not available from or not covered by the Contractor's Medicare Platino Plan;

4.3.1.6 A description of all pre-certification, Prior Authorization, or other requirements for treatments and services;

4.3.1.7 Information on the extent to which, and how, after-hours and emergency coverage are provided, including:

4.3.1.7.1 What constitutes an Emergency Medical Condition or Psychiatric Emergency;

4.3.1.7.2 The fact that Prior Authorization is not required for Emergency Services;

4.3.1.7.3 The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent;

4.3.1.7.4 The scope of Post-Stabilization Services offered under the Medicare Platino Plan;

4.3.1.7.5 The locations of emergency rooms and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered under the Medicare Platino Plan; and

4.3.1.7.6 The fact that an Enrollee has a right to use any hospital or other setting for Emergency Services.

4.3.1.8 Information on pharmacy benefits coverage, including which brand name and generic medications are included on the Formulary of Medications Covered ("FMC") and List of Medications by Exception ("LME");

4.3.1.9 An explanation of the cost-sharing responsibilities of Dual Eligible Beneficiaries under the Medicare Platino Plan;

4.3.1.10 Notice of all appropriate mailing addresses and telephone numbers to be utilized by Enrollees seeking Information or authorization, including the Contractor's toll-free telephone line and website address;

4.3.1.11 The policies and procedures for Disenrollment, including when Disenrollment may be requested without Enrollee consent by the Contractor and Information about Enrollee's right to request Disenrollment, and including notice of the fact that the Enrollee will

lose Access to services under the Medicare Platino Program if the Enrollee chooses to disenroll;

4.3.1.12 Information on Advance Directives, including the right of Enrollees to file directly with ASES or with the Puerto Rico Office of the Patient Advocate, Complaints concerning Advance Directive requirements listed in Section 5.4 of this Contract;

4.3.1.13 A statement that additional Information on the structure and operations of the Medicare Platino Plan and Physician Incentive Plans, shall be made available to Enrollees and Potential Enrollees upon request;

4.3.1.14 A description of Utilization Management policies and procedures used by the Contractor.

4.3.1.15 Information on the Contractor's Grievance and Appeal System's policies and procedures, as described in Article 11 of this Contract. This description must include the following:

4.3.1.15.1 The right to file a Grievance and Appeal with the Contractor;

4.3.1.15.2 The requirements and timeframes for filing a Grievance or Appeal with the Contractor;

4.3.1.15.3 The availability of assistance in filing a Grievance or Appeal with the Contractor;

4.3.1.15.4 The toll-free numbers that the Enrollee can use to file a Grievance or an Appeal with the Contractor by phone;

4.3.1.15.5 The right to an Administrative Law Hearing after exhaustion of the Contractor's Grievance and Appeal System, the method for obtaining a hearing, and the rules that govern representation at the hearing;

4.3.1.15.6 Notice that if the Enrollee files an Appeal or a request for an Administrative Law Hearing and requests continuation of services, the Enrollee may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Enrollee;

4.3.1.16 Any Appeal rights that ASES chooses to make available to Providers to challenge the failure of the Contractor to cover a service;

4.3.1.17 Instructions on how an Enrollee can report suspected Fraud, Waste, or Abuse on the part of a Provider, and protections that are available for whistleblowers;

4.3.1.18 Information on non-coverage of counseling or referral services based on Contractor's moral or religious objections, and how to access these services from ASES; and

4.3.1.19 Instructions on how to access oral or written translation services, Information in alternative formats, and auxiliary aids and services, as specified in Sections 4.2 and 4.6.

4.3.2 Any Enrollee Information required under 42 CFR 438.10, including the Enrollee Handbook and Enrollee notices, may not be provided electronically or on the Contractor's website unless such Information (1) is readily accessible, (2) is placed on the Contractor's website in a prominent location, (3) is provided in a form that can be electronically retained and printed, and (4) includes notice to the Enrollee that the Information is available in paper form without charge and can be provided upon request within five (5) Business Days. Enrollee Information provided to Enrollees electronically must also comply with content and language requirements as set forth in 42 C.F.R. § 438.10.

4.3.3 Medicare Platino post-enrollment notices and materials that are also required under this Section 4.3.3 include, but are not limited to, the following:

4.3.3.1 Member ID cards;

4.3.3.2 Notice of the Effective Date of Enrollment;

4.3.3.3 Notice of the Effective Date of Changes to the Medicare Platino Plan;

4.3.3.4 Notice of Termination, and of Service Area and Network Changes; and

4.3.3.5 Summary of Benefits

4.4 Enrollee Rights and Responsibilities

4.4.1 The Contractor shall have written policies and procedures regarding the rights of Enrollees and shall comply with any applicable Federal and Puerto Rico laws and regulations that pertain to Enrollee rights, including those set forth in 42 CFR 438.100, and in the Puerto Rico Patient's Bill of Rights Act 194 of August 25, 2000; the Puerto Rico Mental Health Law Act 408 of October 2, 2000, as amended and implemented; and Law 77 of July 24, 2013 which created the Office of the Patient Advocate. These rights shall be included in the Enrollee Handbook. At a minimum, the policies and procedures shall specify the Enrollee's right to:

4.4.1.1 Receive information pursuant to 42 CFR 438.10;

4.4.1.2 Be treated with respect and with due consideration for the Enrollee's dignity and privacy;

4.4.1.3 Have all records and medical and personal information remain confidential;

4.4.1.4 Receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand;

4.4.1.5 Participate in decisions regarding his or her health care, including the right to refuse treatment;

4.4.1.6 Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation, as specified in 42 CFR 482.13(e) and other Federal regulations on the use of restraints and seclusion;

4.4.1.7 Request and receive a copy of his or her Medical Records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;

4.4.1.8 Choose an Authorized Representative to be involved as appropriate in making care decisions;

4.4.1.9 Provide informed consent;

4.4.1.10 Be furnished with health care services in accordance with 42 CFR 438.206 through 438.210;

4.4.1.11 Freely exercise his or her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the Enrollee is treated;

4.4.1.12 Receive Information about Covered Services and how to access Covered Services and Network Providers;

4.4.1.13 Be free from harassment by the Contractor or its Network Providers with respect to contractual disputes between the Contractor and its Providers;

4.4.1.14 Participate in understanding physical and Behavioral Health problems and developing mutually agreed-upon treatment goals;

4.4.1.15 Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the Covered Services provided to the Enrollee for which ASES does not pay the Contractor; not be held liable for Covered Services provided to the Enrollee for which ASES or the Contractor's Plan does not pay the Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, Referral, or other arrangement to the extent that those

payments are in excess of the amount the Enrollee would owe if the Contractor provided the services directly; and

4.4.1.16 Only be responsible for cost-sharing in accordance with 42 CFR 447.50 through 42 CFR 447.56 and as permitted by the Puerto Rico Medicaid and CHIP State Plans and Puerto Rico law as applicable to the Enrollee.

4.5 Cultural Competency

4.5.1 In accordance with 42 CFR 438.206, the Contractor shall have a comprehensive written Cultural Competency plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Enrollees. The Cultural Competency plan must describe how the Providers, individuals, and systems within the Contractor's Plan will effectively provide services to people of all diverse cultural and ethnic backgrounds, or disabilities, and regardless of gender, sexual orientation, gender identity, or religion in a manner that recognizes values, affirms, and respects the worth of the individual Enrollees and protects and preserves the dignity of each individual.

4.6 Interpreter Services

4.6.1 The Contractor shall provide oral interpreter services to any Enrollee or Potential Enrollee who speaks any language other than English or Spanish as his or her primary language, regardless of whether the Enrollee or Potential Enrollee speaks a language that meets the threshold of a Prevalent Non-English Language. This also includes the use of auxiliary aids such as TTY/TDY and American Sign Language. The Contractor is required to notify its Enrollees of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to an Enrollee or Potential Enrollee for interpreter services.

4.7 Marketing

4.7.1 Prohibited Activities. The Contractor is prohibited from engaging in the following activities:

4.7.1.1 Directly or indirectly engaging in door-to-door, telephone, e-mail, texting, or other Cold-Call Marketing activities aimed at Potential Enrollees;

4.7.1.2 Offering any favors, inducements or gifts, promotions, or other insurance products that are designed to induce Enrollment in the Contractor's Plan;

4.7.1.3 Distributing plans and materials that contain statements that ASES determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or

statement (whether written or oral) that the Contractor's plan is endorsed by the Federal Government or Government of Puerto Rico, or similar entity; and

4.7.1.4 Distributing materials that, according to ASES, mislead or falsely describe the Contractor's Provider Network, the participation or availability of Network Providers, the qualifications and skills of Network Providers (including their bilingual skills); or the hours and location of network services.

4.7.1.5 Seeking to influence Enrollment in conjunction with the sale or offering of any private insurance.

4.7.1.6 Asserting or stating in writing or verbally that the Enrollee or Potential Enrollee must enroll in the Contractor's Plan to obtain or retain Benefits.

4.7.2 Allowable Activities. The Contractor shall be permitted to perform the following Marketing activities:

4.7.2.1 Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);

4.7.2.2 Make telephone calls, mailings and home visits only to Enrollees currently enrolled in the Contractor's Medicare Platino Plan, for the sole purpose of educating them about services offered by or available through the Contractor;

4.7.2.3 Distribute brochures and display posters at Provider offices that inform patients that the Provider is part of the Medicare Platino Plan's Provider Network; and

4.7.2.4 Attend activities that benefit the entire community, such as health fairs or other health education and promotional activities.

4.7.3 If the Contractor performs an allowable activity, the Contractor must conduct that activity in one (1) or all Service Areas covered by this Contract.

4.7.4 All materials shall be in compliance with the informational requirements in 42 CFR 438.10, as well as 42 CFR Part 422, Subpart V, 42 CFR Part 423 Subpart V, and the Medicare Marketing Guidelines, to the extent those requirements apply to the Medicare Platino Plan.

4.7.5 ASES Approval of Marketing Materials

4.7.5.1 The marketing materials the Contractor shall use to market its Medicare Platino products must meet the marketing guidelines specified by ASES. The Contractor shall submit any new Marketing Materials and

changes to previously approved Marketing Materials to ASES, and receive written approval from ASES of the Marketing Materials before distribution. ASES shall review said Marketing Materials within fifteen (15) days of its receipt. If ASES does not provide a written notification to the Contractor within the fifteen (15) days, the materials submitted by the Contractor shall be deemed approved.

4.7.5.2 Approval of marketing materials from ASES is necessary for the Contractor to start its marketing activities. The marketing materials the Contractor intends to distribute must also meet CMS's marketing guidelines and be approved by CMS.

4.7.5.3 In the event that the Contractor failed to follow the marketing guidelines for the Medicare Platino Plan marketing materials, as certified through an investigation or audit from ASES, sanctions and fines may be imposed as permitted by this Contract and/or applicable regulation.

4.7.6 Provider Marketing Materials

4.7.6.1 The Contractor is responsible for ensuring that not only its Marketing activities, but also the Marketing activities of its Subcontractors and Providers, meet the requirements of this Section.

4.7.6.2 The Contractor shall collect from its Providers any Marketing Materials they intend to distribute and submit these to ASES for review and written approval prior to distribution.

4.7.6.3 The Contractor shall provide for equitable distribution of all Marketing Materials without bias toward or against any group.

ARTICLE 5 COVERED SERVICES AND BENEFITS

5.1 CMS Approval. Due to the fact that, at the time of execution of this Contract, ASES will not have yet received the approved Medicare Advantage Plan Benefit Package ("PBP") from CMS, as attached in Appendix C-1, all terms and conditions of this Contract are subject to ASES's determination, in its sole discretion, that the Medicare Platino Plan complies with all the requirements of the Medicare Platino Program as set forth by ASES for this Contract Term. If ASES determines that the Medicare Advantage PBP does not comply with Medicare Platino Program requirements, the Contractor is responsible for requesting and obtaining approval for the necessary changes to the Medicare Advantage PBP from CMS. Until ASES confirms to the Contractor in writing that the Medicare Advantage PBP complies with these requirements, the Contractor shall be prohibited from conducting any Marketing of their Medicare Platino Plan.

5.2 Requirement to Provide Covered Services

5.2.1 The Contractor shall at a minimum provide the services set forth in the following pursuant to the program requirements of the Medicare Platino

Program, and the Puerto Rico Medicaid State Plan and CHIP Plan, and in a manner consistent with professionally recognized standards of health care and access standards required by 42 CFR Section 422.11/438.206 and Law 72 of September 7, 1993, respectively, and as:

5.2.1.1 Appendix C-1. Medicare Advantage PBP submitted to CMS

5.2.1.2 Appendix C-2. Medicaid Wraparound Benefit

5.2.1.3 Appendix C-3. Services not covered by Medicare Platino but provided by the Department of Health, which are hereby made part of this Contract as if set forth fully herein.

5.2.1.4 Appendix C-4. Summary of Benefits Report. The Summary Benefits ("SB") included in Appendix C-4 was submitted by the Contractor and has yet to be approved by ASES Compliance Office. The Parties agree that the inclusion of the SB does not mean that the same have already been approved and that, if necessary, changes could be requested. Therefore, since the SB needs the approval of the ASES, this Section could be amended subject to further ASES review.

5.2.1.5 Appendix C-5. Coordinated Care Model Norms 2016 Certification.

5.2.1.6 Appendix C-6. Co-Payments Certifications

5.2.1.7 Appendix C-7. Benefit Not Covered by Wrap-Around and Value-Added Benefits Certification

5.2.1.8 Appendix N. HIV Drug Certification

5.2.2 The Contractor shall not impose any other exclusions, limitations, or restrictions on any Covered Service, and shall not arbitrarily deny or reduce the amount, duration, or scope of a Covered Service solely because of the diagnosis, type of illness, or condition.

5.2.2.1 In accordance with Section 2702 of the PPACA and 42 CFR 438.3(g), the Contractor must have mechanisms in place to prevent payment for the following Provider preventable conditions and must require all providers to report on such Provider preventable conditions associated with Claims for payment or Enrollee treatments for which payment would otherwise be made. The Contractor must report all identified Provider preventable conditions to ASES as follows:

5.2.2.1.1 All hospital acquired conditions as identified by Medicare other than deep vein thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients for inpatient hospital services; and

5.2.2.1.2 Any incorrect surgical or other invasive procedure performed on a patient; any surgical or other invasive procedure performed on the incorrect body part; or any surgical or other invasive procedure performed on the incorrect patient for inpatient and non-institutional services.

5.2.2.1.3 Any other Provider preventable conditions that meet the criteria set forth in 42 CFR 447.26(b).

5.2.2.2 The Contractor must report all identified Provider preventable conditions to ASES on a quarterly basis. This report shall include, at minimum, a description of each identified instance of a Provider preventable condition, the name of the applicable Provider, and a summary of corrective actions taken by the Contractor or Provider to address any underlying causes of the Provider preventable condition.

5.2.3 The Contractor shall not deny Covered Services based on pre-existing conditions, the individual's genetic Information, or waiting periods.

5.2.4 The Contractor shall not be required to provide a Covered Service to a person who is not an Eligible Person.

5.3 Emergency and Post-Stabilization Services

5.3.1 The Contractor shall cover and pay for Emergency Services where necessary to treat an Emergency Medical Condition or a Psychiatric Emergency. No Prior Authorization will be required for Emergency Services, and the Contractor shall not deny payment for treatment if a representative of the Contractor instructed the Enrollee to seek Emergency Services.

5.3.2 The Contractor shall not deny payment for treatment of an Emergency Medical Condition or a Psychiatric Emergency, including cases in which the absence of immediate medical attention would not have resulted in the outcomes specified in the definition of Emergency Medical Condition or a Psychiatric Emergency in this Contract and in 42 CFR 438.114(a).

5.3.3 Contractor shall abide by 42 CFR 438.114 and may not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms, nor may it refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Enrollees' primary care provider, Contractor or ASES within ten (10) calendar days of presentation for emergency services.

5.3.4 Such emergency services shall consist of whatever is necessary to stabilize the patient's condition, unless the expected medical benefits of a transfer outweigh the risk of not undertaking the transfer, and the transfer conforms with all applicable requirements. Stabilization services include all treatment that may be necessary to assure within reasonable medical probability that no material

deterioration of the patient's condition is likely to result from or occur during discharge of the patient or transfer of patient to another facility.

5.3.4.1 In the event of a disagreement with the provider concerning whether a patient is stable enough in order to be discharged or transferred or whether the medical benefits outweigh the risks of discharge or transfer, the judgment of the attending emergency physician treating the enrollee will prevail and oblige the Contractor.

5.3.5 An Enrollee who has been treated for an Emergency Medical Condition or Psychiatric Emergency shall not be held liable for any subsequent screening or treatment necessary to stabilize or diagnose the specific condition in order to stabilize the Enrollee.

5.3.6 Post-Stabilization Services

5.3.6.1 Pursuant to 42 CFR 438.114(e) and 42 CFR 422.113(c), as applicable, after stabilization of an emergency medical condition, Contractor must ensure that access to services is available and provided in order to maintain the stabilized condition or to improve or resolve the Enrollee's condition.

5.3.6.2 Contractor shall cover Post-Stabilization Services obtained from any Provider that are administered to maintain the Enrollee's stabilized condition for one (1) hour while awaiting response on a Prior Authorization request. The attending Emergency Room physician or other treating Provider shall be responsible for determining whether the Enrollee is sufficiently stabilized for transfer or discharge. That determination will be binding for the Contractor with respect to its responsibility for coverage and payment.

5.3.6.3 Financial Responsibility

5.3.6.3.1 The Contractor shall be financially responsible for Post-Stabilization Services obtained from or Non-Network Providers. These services will be subject to Prior Authorization by a Network Provider or any other Contractor representative.

5.3.6.3.2 The Contractor must limit cost-sharing for Post-Stabilization Services upon inpatient admission to Enrollees to amounts no greater than what the Contractor would charge Enrollee if services were obtained through a Network Provider.

5.3.6.3.3 The Contractor shall be financially responsible for Post-Stabilization Services obtained within or outside the Contractor's Network that are not given Prior Authorization by a Network Provider or other Contractor representative,

but are administered to maintain, improve, or resolve the Enrollee's stabilized condition if:

5.3.6.3.3.1 The Contractor does not respond to a request for Prior Authorization within one (1) hour;

5.3.6.3.3.2 The Contractor cannot be contacted; or

5.3.6.3.3.3 The Contractor and the treating physician cannot reach an agreement concerning the Enrollee's care, and the Network Provider is not available for consultation. In this situation, the Contractor must give the treating physician the opportunity to consult with the Network Provider and the treating physician may continue with care of the patient until the Network Provider is reached or one of the criteria in 42 CFR 422.113(c)(3) is met.

5.3.6.3.4 The Contractor's financial responsibility for Post-Stabilization Services that it has not Prior Authorized ends when:

5.3.6.3.4.1 A Network Provider with privileges at the treating hospital assumes responsibility for the Enrollee's care;

5.3.6.3.4.2 A Network Provider assumes responsibility for the Enrollee's care through transfer;

5.3.6.3.4.3 A Contractor representative and the treating physician reach an agreement concerning the Enrollee's care; or

5.3.6.3.4.4 The Enrollee is discharged.

5.3.6.4 Contractor may conduct post-utilization review of what constitutes an emergency medical condition, as defined herein, in accordance with the Medicaid Managed Care regulations.

5.3.7 Family Planning Services

5.3.7.1 The Contractor shall not restrict the Enrollee's free choice of family planning services and supplies providers.

5.3.7.2 Abortions are covered if the mother suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death

unless an abortion was performed, or in the following instances: (i) life of the mother would be in danger if the fetus is carried to term, as certified by a physician; (ii) when the pregnancy is a result of rape or incest; and (iii) severe and long lasting damage would be caused to the mother if the pregnancy is carried to term, as certified by a physician.

5.3.8 Outpatient / Prescription Drugs

5.3.8.1 Where appropriate, the Contractor shall provide coverage of outpatient prescription drugs as defined in Section 1927(k)(2) of the Act, in accordance with standards for such coverage imposed by Section 1927 of the Social Security Act.

5.3.8.2 The Contractor shall perform drug utilization reviews that meet the standards established by both ASES and Federal authorities, including the operation of a drug utilization review program as required in 42 CFR Part 456, Subpart K.

5.3.8.3 The Contractor shall provide to ASES annually a detailed description of its drug utilization program activities.

5.3.8.4 Consistent with the requirements of Section 1927(d)(5) of the Social Security Act, some or all prescription drugs may be subject to Prior Authorization, which shall be implemented and managed by the Contractor or the Contractor's PBM, in accordance with the drug formularies, policies and procedures established by ASES, and decided upon in consultation with the Contractor when applicable.

5.3.9 Mental Health or Substance Use Disorder Benefits - Parity Requirements

5.3.9.1 The Contractor shall ensure compliance with the requirements for parity in mental health or substance use disorder benefits under 42 CFR part 438, subpart K, including any other applicable guidance. The Contractor shall conduct a medical/surgical and mental health parity analysis to determine compliance with 42 CFR part 438, subpart K and provide the results of the analysis to ASES in the format and timeframes specified by ASES.

5.3.9.2 The Contractor shall ensure that its prior authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits under 42 CFR § 438.910(d).

5.3.9.3 If the Contractor does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits provided to enrollees under this Contract, the Contractor may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

5.3.9.4 If the Contractor includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits provided to enrollees under this Contract, the Contractor must either apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is more restrictive than the aggregate lifetime or annual dollar limit, respectively, on medical/surgical benefits.

5.3.9.5 If the Contractor includes an aggregate lifetime limit or annual dollar amount that applies to one-third or more but less than two-thirds of all medical/surgical benefits provided to enrollees under this Contract, the Contractor must either impose no aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits; or impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no more restrictive than an average limit calculated for medical/surgical benefits in accordance with 42 CFR 438.905(e)(ii).

5.3.9.6 The Contractor must not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification furnished to Enrollees (whether or not the benefits are furnished by the Contractor).

5.3.9.7 If the Enrollee is provided mental health or substance use disorder benefits in any classification of benefits (inpatient, outpatient, emergency care, or prescription drugs), mental health or substance use disorder benefits must be provided by the Contractor to the Enrollee in every classification in which medical/surgical benefits are provided.

5.3.9.8 The Contractor may not apply any cumulative financial requirements for mental health or substance use disorder benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for medical/surgical benefits in the same classification.

5.3.9.9 The Contractor may not impose non-quantitative treatment limitations for mental health or substance use disorder benefits in any classification unless, under the policies and procedures of the Contractor as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the non-quantitative treatment limitations to mental health or substance use disorder benefits in the classification

are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for medical/surgical benefits in the classification.

5.3.9.10 The Contractor shall use processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for mental health or substance use disorder benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to out-of-network providers for medical/surgical benefits in the same classification.

5.3.9.11 The Contractor may cover, in addition to services covered under the state plan, any services necessary for compliance with the requirements for parity in mental health and substance use disorder benefits in 42 CFR part 438, subpart K, based on the types and amount, duration and scope of services consistent with the analysis of parity compliance conducted by either ASES or the Contractor, in accordance with 42 CFR § 438.3(e)(1)(ii).

5.4 Advance Directives

5.4.1 In compliance with 42 CFR 438.3 (j), 42 CFR 422.128(a), 42 CFR 422.128(b), 42 CFR 489.102(a), and Law No. 160 of November 17, 2001, the Contractor shall maintain written policies and procedures for Advance Directives.

5.4.2 Advance Directives shall be included in each Enrollee's Medical Record. The Contractor shall provide Advance Directives policies and procedures written at a fourth (4th) grade reading level in English and Spanish to all eighteen (18) years of age and older and shall advise Enrollees of:

5.4.2.1 Their rights under the laws of Puerto Rico, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives;

5.4.2.2 The Contractor's written policies respecting the implementation of those rights, including a statement of any limitation that incorporates the requirements set forth under 42 CFR 422.128(b)(1)(ii) regarding the implementation of Advance Directives as a matter of conscience; and

5.4.2.3 The Enrollee's right to file Complaints concerning noncompliance with Advance Directive requirements directly with ASES or with the Puerto Rico Office of the Patient Advocate.

5.4.3 Contractor shall include in its contracts with Network Providers acknowledgement of its obligation under Law No. 160 to inform and distribute written information to adult individuals concerning instructions on Advance

Directives, any limitations on implementing Advance Directives due to moral or religious objection, the right to file complaints for non-compliance with these requirements, as well as the continuous duty to provide written information of any changes in laws as it pertains to Advance Directives, not later than ninety (90) days after the effective date of such change.

5.4.4 The Contractor shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Enrollees, and the staff's responsibility to educate Enrollees about this tool and assist them in making use of it.

5.4.5 The Contractor shall educate Enrollees about their ability to direct their care using Advance Directives and shall specifically designate which staff members or Network Providers are responsible for providing this education.

5.5 Moral or Religious Objections

5.5.1 If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, not to reimburse for, or not to provide a Referral or Prior Authorization for a service within the scope of the detailed Covered Services, because of an objection on moral or religious grounds, the Contractor shall notify:

5.5.1.1 ASES within one hundred and twenty (120) Calendar Days before adopting the policy with respect to any service;

5.5.1.2 Enrollees within ninety (90) Calendar Days after adopting the policy with respect to any service; and

5.5.1.3 Enrollees and Potential Enrollees before and during Enrollment.

5.5.2 The Contractor shall furnish information about the services it does not cover based on a moral or religious objection to ASES. The Contractor acknowledges that such objections will be factored into the calculation of rates paid to the Contractor and, when made during the course of the Contract period, may serve as grounds for recalculation of the rates paid to the Contractor.

5.5.3 If the Contractor does not cover counseling or referral services because of moral or religious objections and chooses not to furnish information to enrollees on how and where to obtain such services, ASES must provide that information to the Enrollees.

5.6 Transition of Care

5.6.1 The Contractor must ensure continued access to services during an Enrollee's transition from one Contractor to another by complying with the following:

5.6.1.1 Ensure the Enrollee has access to services consistent with the access they previously had, and is permitted to retain their current Provider for ninety (90) Calendar Days if that Provider is not a Network Provider;

5.6.1.2 Refer Enrollee to appropriate Network Providers;

5.6.1.3 Fully and timely comply with requests for historical utilization data from the new Contractor or other entity in compliance with Federal and State laws;

5.6.1.4 Ensure that the Enrollee's new Provider is able to obtain copies of the Enrollee's medical records, as appropriate;

5.6.1.5 Comply with any other necessary procedures specified by CMS or ASES to ensure continued access to services to prevent serious detriment to the Enrollee's health or reduce the risk of hospitalization or institutionalization.

ARTICLE 6 PROVIDER NETWORK

6.1 General Provisions

6.1.1 The Contractor will establish and maintain a network of Network Providers that complies with 42 CFR 438.206(b)(l) and is otherwise sufficient to provide adequate access to covered services to meet the needs of Enrollees in the Medicare Platino Plan. This network and access must include:

6.1.1.1 A women's health specialist to provide women's routine and preventive health care services. This is in addition to the enrollee's designated source of primary care if that source is not a woman's health specialist.

6.1.1.2 Ability to obtain a second opinion from a qualified health care professional within the network or arrange for the ability of the enrollee to obtain one outside the network, at no cost to the enrollee.

6.1.1.3 Adequate and timely access and coverage for Network Providers as well as out of network services if Contractor is unable to provide such access. Out of network providers shall coordinate with the Contractor with respect to payment. The Contractor must ensure that cost to the enrollee is no greater that it would be if the service were furnished in the network.

6.1.2 The Contractor shall also comply, to the extent applicable and required, with the requirements specified in 42 CFR 438.207 and 438.214 and all applicable Puerto Rico requirements regarding the assurance of adequate capacity and quality. Contractor shall submit to ASES at the beginning of this contract the documentation assuring adequate capacity and services in compliance with 42 CFR 438.207(b) and other applicable regulations governing the ability to

accommodate expected enrollment in accordance with ASES's standards for access and timeliness of care. The Contractor shall also:

6.1.2.1 Establish and maintain a comprehensive network of Providers capable of serving all Enrollees who enroll in the Contractor's Medicare Platino Plan;

6.1.2.2 Pursuant to Section 1932(b)(7) of the Social Security Act, not discriminate against Providers that serve high-risk populations or specialize in conditions that require costly treatment;

6.1.2.3 Not discriminate with respect to participation, reimbursement, or indemnification of any Provider acting within the scope of that Provider's license or certification under applicable Puerto Rico law solely on the basis of the Provider's license or certification;

6.1.2.4 Be allowed to negotiate different reimbursement amounts for different specialties or for different practitioners in the same specialty;

6.1.2.5 Be allowed to establish measures that are designed to maintain quality of services and control of costs and are consistent with its responsibility to Enrollees;

6.1.2.6 Not make payment to any Provider who has been barred from participation based on existing Medicare, Medicaid or CHIP sanctions, except for Emergency Services; and

6.1.2.7 Provide Enrollees with special health care needs direct Access to a specialist, as appropriate for the Enrollee's health care condition, as specified in 42 CFR § 438.208(c)(4).

6.1.2.8 The Contractor's Network Providers must offer hours of operation that are no less than the hours offered to commercial enrollees or are comparable to Medicaid fee-for-service, if the Provider serves only Medicaid Enrollees.

6.1.2.9 Monitor providers regularly to determine compliance with the timely access requirements, and take corrective action if it, or its Providers, fail comply with the timely access requirements.

6.1.3 If the Contractor declines to include individual or groups of Providers in its network, it must give the affected Providers written notice of the reason for its decision. 42 CFR 438.12(a) may not be construed to:

6.1.3.1 Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Enrollees;

6.1.3.2 Preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or

6.1.3.3 Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and is consistent with its responsibilities to Enrollees.

6.1.4 The provider's facilities must comply with Federal and Puerto Rico laws regarding the physical condition of medical facilities, the Provider's facilities and must also comply with ASES's requirements including, but not limited to, accessibility, cleanliness and proper hygiene. ASES reserves the right to evaluate the appropriateness of such facilities to provide the Covered Services. After receiving a written notice from ASES, the Contractor must timely notify the Provider, propose and enforce a corrective plan to be completed within ninety (90) Calendar Days to make the facilities appropriate to provide the Covered Services.

6.1.5 The Contractor shall require that each Provider have a unique National Provider Identifier ("NPI").

6.1.6 The Contractor is responsible for establishing and monitoring Medical Record guidelines which include documentation of all services provided by Network Providers.

6.1.7 Provider Credentialing

6.1.7.1 The Contractor shall ensure that all Network Providers are appropriately credentialed and qualified to provide services under the terms of this Contract, all applicable Federal and Puerto Rico law, and comply with CMS Credentialing requirements included in CMS Chapter 6 of the Medicare Managed Care Manual.

6.1.7.2 Credentialing is required for:

6.1.7.2.1 All physicians who provide services to the Contractor's Enrollees,

6.1.7.2.2 All other types of Providers who provide services to the Contractor's Enrollees, and who are permitted to practice independently under Puerto Rico law including but not limited to: hospitals, X-ray facilities, clinical laboratories, and ambulatory service Providers.

6.1.7.3 Credentialing is not required for:

6.1.7.3.1 Providers who are permitted to furnish services only under the direct supervision of another practitioner;

6.1.7.3.2 Hospital-based Providers who provide services to Enrollees Incident to hospital services, unless those Providers are separately identified in Enrollee literature as available to Enrollees; or

6.1.7.3.3 Students, residents, or fellows.

6.1.7.4 Contractor shall use Standards for Credentialing and Re-Credentialing

6.1.7.4.1 The Contractor shall document the mechanism for Credentialing and Re-Credentialing of Network Providers or Providers it employs to treat Enrollees outside of the inpatient setting and who fall under its scope of authority and action. This documentation shall include, but not be limited to, defining the scope of Providers covered, the criteria and the primary source verification of Information used to meet the criteria, the process used to make decisions that shall not be discriminatory and the extent of delegated Credentialing and Re-Credentialing arrangements. The Contractor shall:

6.1.7.4.1.1 Have written policies and procedures for the Credentialing and Re-Credentialing process. Such process must permit providers to apply for Credentialing and Re-Credentialing online;

6.1.7.4.1.2 Meet Puerto Rico and Federal regulations for Credentialing and Re-Credentialing, including 42 C.F.R. §§ 455.104, 455.105, 455.106 and 1002.3(b);

6.1.7.4.1.3 Use one (1) standard Credentialing form approved by ASES;

6.1.7.4.1.4 Designate a Credentialing committee or other peer review body to make recommendations regarding Credentialing/Re-Credentialing issues;

6.1.7.4.1.5 Complete the Credentialing process within forty-five (45) Calendar Days from receipt of completed application with all required primary source documentation;

6.1.7.4.1.6 Ensure Credentialing/Re-Credentialing forms require ownership and control disclosures, disclosure of business transactions, and criminal conviction information;

6.1.7.4.1.7 Verify that Network Providers maintain a current and valid license to practice. Verification must show that

the license was in effect at the time of the Credentialing decision with a copy of a good standing; or with the Junta de Licenciamiento Médico / Junta de Profesionales de la Salud CD;

6.1.7.4.1.8 Ensure education and training records, including, but not limited to, Internship, Residency, Fellowships, Specialty Boards etc., are validated and current. As per CMS chapter VI, section 60, education verification is required only for the highest level of education or training attained;

6.1.7.4.1.9 Ensure board certification, when applicable, in each clinical specialty area for which the Provider is being credentialed;

6.1.7.4.1.10 Ensure clinical privileges are in good standing at the hospital designated by the Provider, when applicable, as the primary admitting facility. This information may be obtained by contacting the facility, obtaining a copy of the participating facility directory or attestation by the Provider;

6.1.7.4.1.11 Ensure Network Providers maintain current and adequate malpractice insurance. This information may be obtained via the malpractice carrier, a copy of the insurance face sheet or attestation by the Provider;

6.1.7.4.1.12 Obtain Information about sanctions or limitations on licensure from the applicable Puerto Rico licensing agency or board, or from a group such as the Federation of State Medical Boards;

6.1.7.4.1.13 Ensure a valid Drug Enforcement Agency ("DEA") or Controlled Dangerous Substances ("CDS") certificate in effect at the time of the Credentialing. This information can be obtained through confirmation with CDS, entry into the National Technical Information Service ("NTIS") database, or by obtaining a copy of the certificate;

6.1.7.4.1.14 Review Network Provider's history of professional liability claims that resulted in settlements or judgments paid by or on behalf of the Provider: This information can be obtained from the

malpractice carrier or from the National Practitioner Data Bank;

6.1.7.4.1.15 Ensure that Behavioral Health Network Providers (as applicable) are trained and certified by the Substance Abuse and Mental Health Services Administration ("SAMHSA");

6.1.7.4.1.16 Ensure Credentialing of health care facilities shall be governed by, but not limited to, Law 101 of June 26, 1965, as amended, known as "Law of Facilities of Puerto Rico;"

6.1.7.4.1.17 Screen all Providers against the Federal databases specified in 42 CFR 455.436 on a monthly basis to ensure Providers are not employing or contracting with excluded individuals;

6.1.7.4.1.18 Have written policies and procedures, that have been prior approved in writing by ASES, to ensure and verify that providers have appropriate licenses and certifications to perform services outlined in their respective Provider agreements; and

6.1.7.4.1.19 Maintain records that verify its Credentialing and Re-Credentialing activities, including primary source verification and compliance with Credentialing/Re-Credentialing requirements.

6.1.7.4.2 The Contractor shall perform the following functions:

6.1.7.4.2.1 Credential any Provider who contracts with the Contractor and maintaining complete Credentialing information for these Providers;

6.1.7.4.2.2 Identify potential and actual Network Providers who are enrolled with ASES as Medicaid or Medicare Providers;

6.1.7.4.2.3 Require any Network Provider to be enrolled with the GHP and/or Medicare Platino as a managed care Provider;

6.1.7.4.2.4 Perform site visits. The Contractor's site visit policy will be reviewed pursuant to CMS' monitoring protocol. At minimum, the Contractor should consider requiring initial Credentialing site visits of the offices of Primary Care practitioners,

obstetrician-gynecologists, or other high-volume Providers, as defined by the Contractor;

6.1.7.4.2.5 Re-Credential Network Providers every three (3) years;

6.1.7.4.2.6 Ensure all required documents and licenses are current at the time of initial Credentialing or Re-Credentialing;

6.1.7.4.2.7 Maintain a Provider file for all Network Providers. The Provider file shall be updated annually and consist of, at a minimum, the following documents: annual Puerto Rico review, DEA license, malpractice insurance and ASSMCA license.

6.1.7.4.2.8 The Contractor shall ensure and be able to demonstrate at the request of ASES, that: (i) Out-of-Network Providers have been credentialed by an authoritative entity and that (ii) the Contractor's internal Credentialing and Re-Credentialing processes are in accordance with 42 CFR 438.214.

6.1.7.4.2.9 If the Contractor determines, through the Credentialing or Re-Credentialing process, or otherwise, that a Provider could be excluded pursuant to 42 CFR 1001.1001, or if the Contractor determines that the Provider has failed to make full and accurate disclosures as required in Section 10.5.11 below, the Contractor shall deny the Provider's request to participate in the Provider Network, or, for a current Network Provider, as provided in Section 7.3, terminate the Provider Contract. The Contractor shall notify ASES of such a decision and shall provide documentation of the bar on the Provider's Network participation, within twenty (20) Business Days of communicating the decision to the Provider. The Contractor shall screen its employees, Network Providers, and Subcontractors initially and on an ongoing monthly basis to determine whether any of them have been excluded from participation in Medicare, Medicaid, CHIP, or any other Federal health care program (as defined in Section 1128B(f) of the Social Security Act). ASES or the Puerto Rico Medicaid Program shall, upon receiving notification from a Contractor that the Contractor has denied Credentialing, notify

the HHS Office of the Inspector General of the denial with twenty (20) Business Days of the date it receives the Information, in conformance with 42 CFR 1002.4.

6.1.7.4.2.10 The Contractor shall report to ASES upon request the Credentialing and Re-Credentialing status of Providers.

ARTICLE 7 PROVIDER CONTRACTING

7.1 Provider Guidelines

7.1.1 The Contractor shall prepare Provider Guidelines, to be distributed to all Network Providers. The Provider Guidelines shall, in accordance with 42 CFR 438.236, (i) be based on valid and reliable clinical evidence or a consensus of Providers in the particular field; (ii) consider the needs of the Contractor's Enrollees; (iii) be adopted in consultation with Providers; and (iv) be reviewed and updated periodically, as appropriate.

7.1.2 The Provider Guidelines shall describe the procedures to be used to comply with the Provider's duties and obligations pursuant to this Contract, and under the Provider Contract.

7.1.3 The Contractor shall submit the Provider Guidelines to ASES for review and prior written approval according to the timeframe set forth in Appendix L to this Contract.

7.1.4 The content of the Provider Guidelines will include, without being limited to, the following topics: the duty to verify eligibility; selection of Providers by the Enrollee; Covered Services; procedures for Access to and provision of services; Preferential Turns, as applicable; coordination of Access to Behavioral Health Services; required service schedule; Medically Necessary Services available twenty-four (24) hours ; report requirements; Utilization Management policies and procedures; Medical Record maintenance requirements; Complaint, Grievance, and Appeal procedures (see Article 11); Co-Payments; HIPAA requirements; the prohibition on denial of Medically Necessary Services; Electronic Health Records and sanctions or fines applicable in cases of non-compliance; and Fraud, Waste and Abuse compliance.

7.1.5 The Provider Guidelines shall be delivered to each Network Provider as part of the Provider contracting process, and shall be made available to Enrollees and to Potential Enrollees upon request. The selected Contractor shall maintain evidence of having delivered the Provider Guidelines to all of its Network Providers within fifteen (15) Calendar Days of award of the Provider Contract. The evidence of receipt shall include the legible name of the Network Provider, NPI, date of delivery, and signature of the Network Provider and shall be made available to ASES Immediately upon request.

7.1.6 The Contractor shall have policies and procedures to inform its Provider Network, in a timely manner, of programmatic changes such as changes to drug formularies, Covered Services, and protocols.

7.2 Required Provisions in Provider Contracts

7.2.1 All Provider Contracts shall be labeled with the Provider's NPI, if applicable. In general, the Contractor's Provider Contracts shall:

7.2.1.1 Include a section summarizing the Contractor's obligations under this Contract, as they affect the delivery of health care services under the Medicare Platino Program, and describing Covered Services and populations (or, include the Provider Guidelines as an attachment);

7.2.1.2 Include a signature page that contains the Contractor and Provider names which are typed or legibly written, Provider company with titles, and dated signatures of all appropriate parties;

7.2.1.3 Specify the effective dates of the Provider Contract;

7.2.1.4 Require that the Provider work to advance the integrated model of physical and Behavioral Health Services;

7.2.1.5 Require that the Provider comply with the applicable Federal and Puerto Rico laws, and with all CMS requirements;

7.2.1.6 Require that the Provider verify the Enrollee's Eligibility before providing services or making a Referral;

7.2.1.7 Prohibit any unreasonable denial, delay, or rationing of Covered Services to Enrollees; and violation of this prohibition shall be subject to the provisions of Article VI, Section 4 of Act 72 and of 42 CFR Part 438, Subpart I (Sanctions);

7.2.1.8 Prohibit the Provider from making claims for any unallowed administrative expenses;

7.2.1.9 Prohibit the unauthorized sharing or transfer of ASES Data, as defined in Section 24.1;

7.2.1.10 Notify the Provider that the terms of the contract for services under Medicare Platino are subject to subsequent changes in legal requirements that are outside of the control of ASES;

7.2.1.11 Require the Provider to comply with all reporting requirements contained in Article 15 of this Contract, as applicable, and particularly with the requirements to submit Encounter Data for all services

provided, and to report all instances of suspected Fraud, Waste, or Abuse;

7.2.1.12 Require the Provider to acknowledge that ASES Data (as defined in Section 24.1) belongs exclusively to ASES, and that the Provider may not give access to, assign, or sell such Data to Third Parties, without Prior Authorization from ASES. The Contractor shall include penalty clauses in its Provider Contracts to prohibit this practice, and require that the fines be determined by and payable to ASES;

7.2.1.13 Prohibit the Provider from seeking payment from the Enrollee for any Covered Services provided to the Enrollee within the terms of the Contract, and require the Provider to look solely to the Contractor for compensation for services rendered to Enrollees, with the exception of any nominal cost-sharing, as provided in Section 4.4.1.16;

7.2.1.14 Require the Provider to cooperate with the Contractor's quality improvement and Utilization Management activities;

7.2.1.15 Not prohibit a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of an Enrollee for the Enrollee's health status, medical care, or treatment or non-treatment options per 42 CFR 438.102(a)(1);

7.2.1.16 Not prohibit a Provider from advocating on behalf of the Enrollee in any Grievance and Appeal System or Utilization Management process, or individual authorization process to obtain necessary health care services;

7.2.1.17 Require Providers to meet the timeframes for Access to services pursuant to Section 6.1.2 of this Contract;

7.2.1.18 Provide for continuity of treatment in the event that a Provider's participation in the Contractor's Network terminates during the course of an Enrollee's treatment by that Provider;

7.2.1.19 Require Providers to monitor and as necessary and appropriate register Enrollee patients to determine whether they have a medical condition that suggests Care Management or Disease Management services are warranted;

7.2.1.20 Prohibit Provider discrimination against high-risk populations or Enrollees requiring costly treatments;

7.2.1.21 Prohibit Providers who do not have a pharmacy license from directly dispensing medications, as required by the Puerto Rico Pharmacy Act;

7.2.1.22 Specify that ASES, the Secretary, the DHHS, CMS, the Office of the Inspector General, the Comptroller General, the Medicaid Fraud Control Unit, and their designees shall have the right at any time to inspect, evaluate, and audit any pertinent records or documents, and may inspect the premises, physical facilities, and equipment where activities or work related to the Medicare Platino program is conducted. Upon request, the Provider shall assist in such reviews, including the provision of complete copies of medical records. The right to audit exists for ten (10) years from the final date of the contract period or from the date of completion of any audit, whichever is later;

7.2.1.23 Include the definition and standards for Medically Necessary Services;

7.2.1.24 Require that the Provider attend promptly to requests for Prior Authorizations, when Medically Necessary, in compliance with the timeframes set forth in Section 8.4.1 and in 42 CFR 438.210 and the Puerto Rico Patient's Bill of Rights;

7.2.1.25 Prohibit the Provider from establishing specific days for the delivery of Referrals or requests for Prior Authorization;

7.2.1.26 Notify the Provider that, in order to participate in the Medicare Platino Program, the Provider must accept Medicare Platino Enrollees;

7.2.1.27 Specify rates of payment, as detailed in Section 7.4, and require that Providers accept such payment as payment in full for Covered Services provided to Enrollees, less any applicable Enrollee Co-Payments pursuant to Section 4.4.1.16 of this Contract;

7.2.1.28 Specify acceptable billing and coding requirements including ICD-10;

7.2.1.29 Require that the Provider comply with the Contractor's Cultural Competency plan;

7.2.1.30 Require that any Marketing Materials developed and distributed by the Provider be submitted to the Contractor for submission to ASES for prior written approval according to the timeframe set forth in Appendix L to this Contract;

7.2.1.31 Specify that the Contractor shall be responsible for any payment owed to Providers for services rendered after the Effective Date of Enrollment, as provided in Section 3.2.3;

7.2.1.32 Require Providers to collect Enrollee Co-Payments as specified in Appendix C-6;

7.2.1.33 Require that Providers not employ or subcontract with individuals on the Puerto Rico or Federal LEIE, or with any entity that could be excluded from the Medicaid program under 42 CFR 1001.1001 (ownership or control in sanctioned entities) and 1001.1051 (entities owned or controlled by a sanctioned person);

7.2.1.34 Require that Medically Necessary Services shall be available twenty-four (24) hours per day, seven (7) days per Week, to the extent feasible;

7.2.1.35 Prohibit the Provider from operating on a different schedule for Medicare Platino Enrollees than for other patients, and from in any other way discriminating in an adverse manner between Medicare Platino Enrollees and other patients;

7.2.1.36 Not require that Providers sign exclusive Provider Contracts with the Contractor if the Provider is an FQHC or RHC;

7.2.1.37 Provide notice that the Contractor's negotiated rates with Providers shall be adjusted in the event that the Executive Director of ASES directs the Contractor to make such adjustments in order to reflect budgetary changes to the Medical Assistance program;

7.2.1.38 Impose fees or penalties if the Provider breaches the contract or violates Federal or Puerto Rico laws or regulations;

7.2.1.39 Require that the Provider make every effort to cost-avoid claims and identify and communicate to the Contractor available Third-Party resources, as required in Section 20.2 of this Contract, and require that the Contractor cover no health care services that are the responsibility of the Medicare Program;

7.2.1.40 Provide that the Contractor shall not pay Claims for services covered under the Medicare Program, and that the Provider may not bill both the GHP and the Medicare Program for a single service to a Dual Eligible Beneficiary;

7.2.1.41 Require the Provider to sign a release giving ASES access to the Provider's Medicare billing Data, provided that such access is authorized by CMS and compliant with all HIPAA requirements;

7.2.1.42 Set forth the Provider's obligations under the Physician Incentive Programs outlined in Section 20.4 of this Contract;

7.2.1.43 Require the Provider to notify the Contractor Immediately if or whether the Provider is under investigation for, accused of, convicted of, or sentenced to imprisonment, in Puerto Rico, the other USA jurisdictions, or any other jurisdiction, for any crime involving