CONTRACT BETWEEN

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES)

and

MMM HEALTHCARE, LLC.

for

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

Contract No.: 2027-000002

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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") and **MMM Healthcare, LLC.** ("the Contractor"), a Medicare Advantage Organization duly organized and authorized to do business under the laws of Puerto Rico.

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 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 supersede 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; GENERAL PROVISIONS

Definitions

Whenever mentioned 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 meet the needs of Enrollees, guaranteed through a provider network that is sufficient, accessible, and compliant with the federal standards established by CMS. Access requires that Enrollees obtain all covered services without undue delay, within the time, distance, clinical availability, and continuity-of-care parameters.

Adverse Benefit Determination: The denial or limited authorization of a Service Authorization Request, 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 and Appeal System and Complaint Process.

Administrative Functions: The contractual obligations of the Contractor under this Contract, other than providing Covered Services; these functions 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 Law 160-2001, 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 filed 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 their authorized Agents.

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.

Risk Based Contract: 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 26-2017, as amended, known as "Fiscal Plan Compliance Act", 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 on the same site as primary care services.

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.

Continuity of Care: The obligation of the Contractor to ensure that Medicare Platino Enrollees continue to receive all covered services without interruption, even when a provider leaves the network, in accordance with the requirements established by CMS and the provisions of 42 CFR 422.112 and 42 CFR 422.116. This obligation includes ensuring orderly transitions, access to adequate alternative providers, timely notification to the Enrollee, and the preservation of clinical continuity during any transition, network change or disruption that may affect access to medically necessary treatments, therapies and authorized services.

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 (also referred to as "VITAL") 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. The VITAL and Medicare Platino programs are under the GHP and available as alternatives to receive Medicaid coverage in Puerto Rico. The VITAL program is available for all Medicaid beneficiaries, while the Medicare

Platino program is an integrated Medicare-Medicaid program available to dual eligible beneficiaries with Medicare Parts A&B.

Geographic Accessibility: The Contractor has the obligation to ensure that Medicare Platino Enrollees have access to covered providers and services within the time-and-distance standards established by CMS for Medicare Advantage, in accordance with 42 CFR 422.112 and 42 CFR 422.116. This obligation requires the Contractor to maintain a provider network that is sufficient and geographically accessible to meet the clinical needs of the dual-eligible population, ensuring adequate provider availability and uninterrupted access to medically necessary services during any network change.

Grievance: An expression of dissatisfaction about any matter other than an Adverse Benefit Determination. Pursuant to 42 CFR 422.561, this term shall mean "any complaint or dispute, other than one that constitutes an organization determination, expressing dissatisfaction with any aspect of an MA organization's or provider's operations, activities, or behavior, regardless of whether remedial action is requested".

Grievance and Appeal System: The overall system that includes Complaints, Grievances, Service Authorization Requests, 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 specialist, 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. To the extent applicable, this term will also include services that ensure LTSS enrollees have access to community living, can achieve person-centered goals, and can live and work in the setting of their choice, consistent with 42 CFR 438.210(a)(5)(ii)(D). Under this contract, this term shall in no manner be more restrictive than the State Medicaid Program, including compliance with all applicable Quantitative and Non-Quantitative Treatment Limits (QTL and NQTL), QTL and NQTL requirements established in state law, the Medicaid State Plan, and State policies, consistent with 42 CFR 438.210(a)(5)(i).

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 Adequacy Standards: Contractor's obligation to maintain a provider network that meets sufficiency, availability, time and distance, and specialty capacity standards established under 42 CFR 422.116, ensuring that the network includes the number, type, and distribution of providers necessary to guarantee reasonable access to medically necessary services for Enrollees. These standards include the Provider to Enrollee Ratios, the Provider per Municipality requirements, the Required Network Provider requirements, in accordance with 42 CFR 438.68, ensuring continuous provider availability, preventing fluctuations that may affect access, monitoring provider terminations, and ensuring that the network preserves its capacity to deliver medically necessary services without interruption.

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 or in excess of the amounts specified in this Contract. 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.

Bill of Rights and Responsibilities of the Patient: Law No. 194-2000, as amended, 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.

Provider Enrollment Portal (PEP): The Provider Enrollment Portal (PEP) is a platform managed by the Puerto Rico Department of Health that facilitates the registration, certification, and oversight of healthcare providers in the Puerto Rico Medicaid Program (PRMP). Its primary function is to ensure that providers comply with the requirements established in the 42 CFR 431.107 and 455.410, and Part 422 subparts B and E, as well as any applicable Department of Health Administrative regulations, promoting transparency and quality in the delivery of healthcare services. Through the PEP, providers can submit enrollment applications, update their information, and comply with the certification standards required by the program. This system is essential to ensuring that Medicaid beneficiaries

receive appropriate medical care from duly qualified providers, reducing the risk of fraud and improving program efficiency.

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.

Prior Authorization: A type of Service Authorization Request that is submitted before a Covered Service provided in order to determine if such Service will be covered or reimbursed by Contractor; also known as "pre-certification."

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.

Service Authorization Request: A request submitted by Enrollee or on the Enrollee's behalf to approve coverage or reimbursement by the Contractor for a Covered Service, where such Covered Service is subject to Prior Authorization or other Utilization Management requirement.

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.

1.1 General Provisions

1.1.1 The Contractor shall maintain the staff, organizational, and administrative capacity necessary to carry out all duties and responsibilities under this Contract, in accordance with 42 CFR Part 422 and consistent with the "Medicare Advantage Program".

1.1.2 The Contractor shall not make any changes of services under the Medicare Advantage Program without explicit prior written approval from the Executive Director of ASES or his or her designee.

1.1.3 The Contractor shall notify ASES within five (5) Business Days of any change in its corporate officers or executive employees, or any change to its Federal Employer Identification Number (FEIN) or Federal Tax Identification Number, as such changes may affect the Contractor's legal identity. The Contractor shall notify any changes in solvency, as a result of a non-operational event,

1.1.4. **Immediate Notification Requirements.** Unless otherwise specified, the Contractor shall immediately notify ASES and/or the Puerto Rico Medicaid Program of any applicable provisions or events requiring disclosure under Title 42 CFR Part 422, including but not limited to:

1.1.4.1 Compliance events involving actual or potential non-compliance with Federal requirements under 42 CFR Part 422, CMS sub-regulatory guidance, or ASES contractual standards, including failures related to beneficiary protections, coverage determinations, appeals, grievances, marketing, or operational performance;

1.1.4.2 Program integrity - Any matter requiring disclosure under 42 CFR 422.503(b)(4)(vi) or 42 CFR 422.504(a), including suspected or confirmed fraud, waste, abuse, misconduct, data falsification, improper payments, or violations of CMS program integrity rules; officers or executive employees; or

1.1.4.3 Financial solvency - Any event affecting the Contractor's financial condition that may impair its ability to meet obligations under this Contract or under 42 CFR 422.504(b)(14), including reductions in reserves, adverse audit findings, material losses, or actions by insurance regulators.

1.1.4.4 Network adequacy - Any change or event that may cause the Contractor to fall below CMS network adequacy standards under 42 CFR 422.116, including provider terminations, loss of essential specialists, facility closures, or inability to meet time-and-distance or appointment-wait-time requirements, and;

1.1.4.5 Administrative capacity requirements - Any circumstance that may compromise the Contractor's administrative or operational capacity as required under 42 CFR 422.504(b)(4), including failures in claims processing, utilization management, prior authorization systems, grievance and appeal operations, data submission systems, or beneficiary service functions.

1.1.5. Unless otherwise specified herein, all documentation, including policies and procedures that the Contractor is required to maintain, shall receive prior written approval from ASES. All documentation, including the Deliverables listed in Attachment L to this Contract, must be submitted to ASES in English.

1.1.6. Unless otherwise specified, the Contractor shall immediately notify ASES and/or the Puerto Rico Medicaid Program of any changes in any applicable provisions to this Contract.

1.1.7. Pursuant to 42 CFR 422.503(b)(2) and 42 CFR 400.200, the Contractor shall maintain all administrative and operational functions within the United States. The Contractor shall also ensure that all Medicare Platino data, systems, records, and operational platforms remain fully accessible to CMS and ASES at all times, including during audits, monitoring activities, program integrity reviews, and any other oversight functions, as may be amended from time to time.

1.1.8 **Administrative Functions Location Requirements**. All Administrative Functions of the Contractor must be located within the United States. The following Administrative Functions must be located in Puerto Rico, consistent with 42 CFR Part 422 and CMS operational requirements:

1.1.8.1 Care Management, including coordination of care, transitions of care, and case management activities;

1.1.8.2 Marketing and beneficiary communications, including all beneficiary-facing materials, outreach, and required notices;

1.1.8.3 Utilization Management determinations, including Prior Authorization, clinical review, timeliness compliance, and adherence to Medicare coverage criteria.

1.1.8.4 Management of Enrollee and Provider Grievances and Appeals, including intake, adjudication, notifications, and redeterminations;

1.1.8.5 Decision-making authority related to related to Enrollee Services, including benefit administration and service authorization decisions;

1.1.8.6 Decision-making authority related to Provider Services, including claims dispute resolution, including payment integrity oversight and provider issue resolution; and

1.1.8.7 Network management activities including contracting, credentialing, monitoring, and adequacy compliance;

1.1.8.8 Coverage Determinations and Redeterminations Operations, including Medicare coverage decisions, redeterminations, and compliance with CMS timeliness standards.

1.1.8.9 Prior Authorization Clinical Review Staff, including clinicians responsible for medical necessity determinations under Medicare rules.

1.1.8.10 Star Ratings, Quality, and Performance Operations, including HEDIS, CAHPS, Part C & D reporting, and quality improvement activities.

1.1.8.11 Compliance Program Operation, including monitoring, auditing, investigations, and oversight required under 42 CFR 422.503(b)(4)(vi).

1.1.8.12 Program Integrity and Fraud, Waste, and Abuse (FWA) Oversight, including detection, reporting, and coordination with CMS, OIG and state agencies.

1.1.8.13 Claims Processing Oversight and Payment Integrity, including adjudication oversight, error correction, and provider payment dispute resolution.

1.1.9 The Contractor acknowledges that all Medicare Platino regulations, as well as Medicaid regulations related to Wraparound services, shall apply to this Contract. In the event of any irreconcilable conflict between Medicare Platino and Medicaid operational requirements, such conflict shall not be interpreted or applied in a manner that limits, reduces, or otherwise adversely affects Enrollee rights or covered services under Medicare Platino. Notwithstanding the foregoing, ASES retains its legal authority to establish and enforce state requirements to the extent permitted under applicable federal and local laws and regulations.

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 set forth fully herein, is the specific geographic area within which Eligible Persons shall enroll in the Contractor's Medicare Platino Plan. The Contractor shall only have a Medicare Advantage contract for the service area that aligns with this Contract.

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 Medicaid wrap around services in 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 Parts A and B;

3.1.2.2 Must have Medicaid 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 a resident of a long-term care nursing facility or intermediate care facility for the intellectually disabled;

3.1.3.2 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;

3.1.2.3 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

3.1.2.4 The individual is incarcerated.

3.1.4 Any individual who is a Dual Eligible, but is not eligible for Medicare Platino, may choose to enroll in another Medicare Advantage plan benefit package that is not integrated with the Medicaid wrap-around services covered under this contract.

3.1.5 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. The Enrollment and Disenrollment data must be submitted electronically through the FTPs.

3.1.5.1 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 be enrolled in Medicare Part A and Part B and 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 Default Enrollment Option for Newly Medicare Eligible Individuals as set forth in Section 40.1.4 of 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.

Enrollees will always have a choice of all Medicare service delivery options in their service area.

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.

3.2.2.5 ASES, ASES's enrollment broker or the Contractor must identify persons with special health care needs as defined by ASES.

3.2.2.6 The Contractor shall ensure that any limitation on the enrollee's ability to change Primary Care Providers (PCP) under the rural resident exception is no more restrictive than the limitations on disenrollment permitted under 42 CFR 438.56(c).

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 following month during which the Enrollee is enrolled in the Contractor's Medicare Platino Plan and according to the Prepaid Premium Plan Roster, as specified on 42 CFR 406.22.

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 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 of their disenrollment rights using integrated Medicare and Medicaid materials that meets requirements set forth in Section 3.3 and meets the requirements of 42 CFR 422 Subpart B and 42 CFR 438.56. Such notification must clearly explain the process for exercising their disenrollment rights, 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 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.

3.2.5 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 will have an enrollment period to be enrolled back in the Contractor's Medicare Platino Plan.

3.2.6 The Contractor shall accept eligible Enrollees in the order in which they apply without restriction, up to the limits set under this Contract. 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 The Contractor shall ensure that enrollees retain the right to disenroll for cause at any time, and without cause during the 90-day periods, and annual windows for disenrollment without cause, as required under 42 CFR 438.3(q)(5), 42 CFR 438.56(c)(1), and 42 CFR (c)(2)(iv).

3.3.3 The Contractor shall allow enrollees to disenroll without cause when the State imposes intermediate sanctions on the Contractor.

3.3.4 The Contractor shall allow disenrollment when related services must be performed together and cannot be provided within the network, and when separate delivery would pose unnecessary risk. The Enrollee's Primary Care Provider (PCP) or another provider must determine that receiving the services separately would subject the Enrollee to unnecessary risk.

3.3.5 The Contractor shall allow Enrollees who use Managed Long-Term Services and Supports (MLTSS), to the extent applicable, to request disenrollment when a provider's network status change would disrupt residential, institutional, or employment supports for Enrollees.

3.3.6 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.

3.3.7 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 ten (10) Business Days of a final Disenrollment decision, as provided in Section 3.3.7.

3.3.8 Each notice of Disenrollment shall include information concerning:

3.3.8.1 The Effective Date of Disenrollment;

3.3.8.2 The reason for the Disenrollment;

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

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

3.3.8.5 Disenrollment shall occur according to the following timeframes in Section 3.3.9 (the "Effective Date of Disenrollment").

3.3.9 The Effective Date of Disenrollment is as follows:

3.3.9.1 Except as otherwise provided in this Section, Disenrollment will take effect as of the Effective Date of Disenrollment specified in ASES's notice to the Contractor that an Enrollee is no longer eligible.

3.3.9.2 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.

3.3.9.3 If ASES or its representative fails to make a Disenrollment determination within the required timeframes, the Effective Date of Disenrollment shall be what would have been established had ASES made a determination in the required timeframe.

3.3.10 Disenrollment Initiated by the Contractor

3.3.10.1 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.

3.3.10.2 The Contractor shall submit Disenrollment requests to ASES's Compliance Office, 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.

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

3.3.10.3.1 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;

3.3.10.3.2 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;

3.3.10.3.3 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);

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

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

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

3.3.10.3.7 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.

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

3.3.10.4.1 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

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

3.3.10.5 All Disenrollment requests will be notified to ASES's Compliance and Client Service Offices.

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

3.3.10.6.1 Adverse changes in an Enrollee's health status;

3.3.10.6.2 Missed appointments;

3.3.10.6.3 Utilization of medical services;

3.3.10.6.4 Diminished mental capacity;

3.3.10.6.5 Pre-existing medical condition;

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

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

3.3.10.6 When requesting Disenrollment of an Enrollee for reasons described in Section 3.3.10.3, 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 and Appeal System and of ASES's Administrative Law Hearing process, as provided by Law 72-1993, 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.

3.3.10.7 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.

3.3.11 Disenrollment Initiated by the Enrollee

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

3.3.11.2 All Enrollees must be notified of their disenrollment rights using integrated Medicare and Medicaid materials that meets requirements set forth in Section 3.3 and meets the requirements of 42 CFR 422 Subpart B 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.

3.3.11.3 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.

3.3.12 Disenrollment Allowed due to Contract Termination

3.3.12.1 After the Contractor is notified that ASES intends to terminate this Contract, ASES will be permitted to notify Enrollees of its intent to terminate this Contract and to allow Enrollees to disenroll immediately without cause.

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 the requirements set forth in 42 CFR 438.10, as well as any specific guidance issued by CMS and ASES. Such disclosures shall be made to

Potential Enrollees and Enrollees within the applicable regulatory timeframes and through the use of integrated Medicare and Medicaid materials, as mandated by governing federal and territorial authorities.

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 established by ASES in all of its written and verbal communications with Enrollees, in accordance with 42 CFR 438.10(c)(4)(i), which requires managed care plans to use standardized terminology and definitions determined by the State agency in all communications directed to enrollees. This requirement likewise applies under the Medicare program, pursuant to 42 CFR 422.111, which mandates that Medicare Advantage organizations provide information to enrollees using clear, consistent, and CMS-approved terminology.

4.1.5 Each Medicare Platino Enrollee, as a dual eligible, must receive the Summary of Benefits (SB) within the timeframe established by the applicable federal regulation, including 42 CFR 422.111 – Disclosure Requirements for Medicare Advantage Organizations, as well as the guidance issued by CMS. The SB serves as the compendium the Enrollee uses to review the benefits and coverage of the selected product. The Evidence of Coverage (EOC) must be made available to the Enrollee upon request, in the format the Enrollee chooses, whether through a printed copy mailed to the Enrollee's postal address, by e-mail if the Enrollee has consented to receive it electronically, through digital access on the Contractor's website with notice to the Enrollee regarding its availability and location, or by any other method reasonably expected to ensure receipt of such information. This obligation likewise applies under the disclosure requirements governing Medicaid Managed Care, including 42 CFR 438.10 – Information Requirements, as applicable to the dual-eligible population.

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. This requirement likewise applies under the Medicare program, pursuant to 42 CFR 422.2267(e), which mandates that Medicare Advantage Organizations provide all required materials in accessible formats, including large print, Braille, audio, and electronic formats, and ensure that Enrollees are informed of the availability of such formats and how to request them.

4.2.2 The Contractor shall provide electronic and paper information identifying all covered generic and brand-name medications, including the tier placement of each drug. The Contractor shall also maintain its complete formulary drug list on its public website in a machine-readable file and format as required under 42 CFR 438.10(i).

4.2.3 Except as provided in Section 4.3 and subject to Section 4.2.7, 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), 42 CFR 422.2267(e) and Section 1557 of PPACA.

4.2.4 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). This requirement likewise applies under the Medicare program, pursuant to 42 CFR 422.2267(a)(2), which requires Medicare Advantage Organizations to provide oral interpretation services in any language, free of charge, to ensure that Potential Enrollees and Enrollees can understand the information provided to them.

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

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

4.2.7 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 the Evidence of Coverage (EOC), the Summary of Benefits (SB), and/or in other notices and formats, in compliance with 42 CFR 438.10. This obligation also applies under Medicare pursuant to 42 CFR 422.111 and 42 CFR 422.2267, which require Medicare Advantage Organizations to furnish clear, accessible, and CMS-compliant materials, including the EOC, the SB, and all other mandatory documents. All such requirements shall be implemented as developed or approved by ASES.

4.3.1.1 A Provider Directory with the names of physicians, including specialists, hospitals, pharmacies, and behavioral health providers, covered under this Contract, along with their 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 and, in electronic form, no later than thirty (30) days after receipt of updated Provider information.

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

4.3.1.1.3 The Provider Directory must include information on Provider participation in the Medicare and Medicaid networks.

4.3.1.1.4 The Provider Directory must include information on the amount, duration and scope of Covered Services available under the Contract, and how and where to access such Covered Services, all explained in sufficient detail to ensure that Enrollees understand the Benefits to which they are entitled and how to effectively use them.

4.3.1.2 The Provider Directory must also include:

4.3.1.2.1 Enrollee Rights and Protections, as set forth in 42 CFR 438.100 and in the Puerto Rico Patient's Bill of Rights, Act No. 194-2000, as amended;

4.3.1.2.2 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;

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

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

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

4.3.1.2.5.1 What constitutes an Emergency Medical Condition or Psychiatric Emergency;

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

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

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

4.3.1.2.5.5 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

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

4.3.1.2.6 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") and the tier each medication is on;

4.3.1.3 The Contractor shall provide a clear, complete, and updated explanation of the cost-sharing responsibilities applicable to Dual Eligible Beneficiaries under the Medicare Platino Plan. This explanation shall include:

4.3.1.3.1 The cost-sharing obligations applicable to services covered under Medicare.

4.3.1.3.2 The financial responsibilities of the enrollee when benefits are carved out of the Medicare Platino Plan and provided directly by ASES or the Government of Puerto Rico.

4.3.1.3.3 The coordination of benefits between Medicare, Medicaid, and ASES, in accordance with the requirements of 42 CFR 422.100 and 42 CFR 422.108.

4.3.1.4 The Contractor shall ensure that Enrollees receive accurate information regarding their financial responsibility and that providers receive appropriate guidance for correct billing, including:

4.3.1.4.1 A description of the cost-sharing out-of-pocket maximums under Medicare coverage, and the notice to Enrollees and their providers within the Contractor's provider network when the maximum is reached, in accordance with 42 CFR 422.100(f) and 42 CFR 422.101(d). These provisions require Medicare Advantage organizations to establish an annual limit on beneficiary out-of-pocket expenditures for Medicare covered services and to ensure that Enrollees and providers are informed once such limit has been met. The notice shall include, at a minimum:

4.3.1.4.1.1 Confirmation that the Enrollee has reached the out-of-pocket maximum;

4.3.1.4.1.2 The date on which the maximum was reached;

4.3.1.4.1.3 A statement indicating that the Enrollee is no longer responsible for additional cost-sharing for Medicare-covered services for the remainder of the contract year;

4.3.1.4.1.4 Instructions to providers regarding billing and claims adjudication after the maximum has been reached.

4.3.1.4.1.5 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;

4.3.1.4.1.6 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;

4.3.1.4.1.7 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;

4.3.1.4.1.7 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;

4.3.1.4.1.8 A description of Utilization Management policies and procedures used by the Contractor, and upon Enrollee's or Potential Enrollee's request, any actual practice guidelines.

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

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

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

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

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

4.3.1.4.1.13 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;

4.3.1.4.1.14 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;

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

4.3.1.4.1.16 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;

4.3.1.4.1.17 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 Evidence of Coverage (EOC), the Summary of Benefits (SB), notices, and any other regulatory material, may not be provided electronically or on the Contractor's website unless it is easily accessible, prominently located, electronically retainable and printable, and includes a notice of availability in printed format at no cost within five (5) Business Days. All electronic information must comply with the content and language requirements of 42 CFR 438.10. Likewise, because these are dual Members, the Contractor must also comply with 42 CFR 422.111 and 42 CFR 422.2267, which require Medicare Advantage Organizations to provide the EOC, the SB, and other regulatory materials in a clear, accessible manner, in accordance with CMS standards, and available in printed format at no cost when requested.

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;

4.3.3.5 Summary of Benefits;

4.3.3.6 Evidence of Coverage (EOC);

4.3.3.7 Annual Notice of Changes (ANOC);

4.3.3.8 Letters; and

4.3.3.9 Marketing materials.

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 No. 77-2013 which created the Office of the Patient Advocate. These rights shall be included in the Evidence of Coverage (EOC) and Summary of Benefits (SB), whenever possible. 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 and the applicable Medicare Advantage standards under 42 CFR 422.111 and 42 CFR 422.2267;

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 choose his or her Network Provider to the extent possible and appropriate, the right to refuse treatment, and the right to express preferences about future treatment decisions;

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 Enrollees shall only be responsible for cost-sharing in accordance with 42 CFR Part 447, Subpart A, specifically 42 CFR 447.50 through 42 CFR 447.56, and as permitted by the Puerto Rico Medicaid and CHIP State Plans and applicable Puerto Rico law. Any cost-sharing imposed on Medicare benefits beyond the amounts permitted under this section shall be the

responsibility of the Contractor, whether through Medicare supplemental benefits or Medicaid wrap-around benefits. Consistent with the CMS Final Rule for Contract Year 2027, the Contractor must ensure that Enrollees are protected from any cost-sharing obligations that exceed State-authorized limits, including those arising from Medicare-covered services. The 2027 Final Rule reinforces that Medicaid managed care enrollees may not be billed for covered services beyond the approved cost-sharing amounts and requires managed care plans to implement and enforce these protections as a condition of federal compliance.

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. Any cost sharing imposed on Medicare benefits beyond those permitted in this section shall be the responsibility of the Contractor either through Medicare supplemental benefits or Medicaid wrap-around benefits.

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. Contractor will participate in ASES's efforts to promote culturally competent delivery of services to all Enrollees.

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, texting, or other Cold-Call Marketing activities aimed at Potential Enrollees. E-mail is permitted if Contractor includes in each communication a process to allow a recipient to opt-out from receiving future e-mails;

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 are not first approved by ASES or 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, provided that such materials constitute informational communications and not directed marketing, in accordance with the applicable Medicare Advantage standards under 42 CFR 422.2260 through 42 CFR 422.2267; 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. Any marketing materials distributed by the Contractor must be distributed to its entire Service Area.

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 changes to previously approved Marketing Materials and receive written approval from ASES of the changes before distribution.

4.7.5.2 ASES Approval of marketing materials is required before the Contractor may initiate any marketing activities, as mandated by Title 42 of the CFR, specifically 42 CFR 438.104. Marketing materials include, but are not limited to, the Summary of Benefits (SB), Evidence of Coverage (EOC), Annual Notice of Change (ANOC), the Enrollee Identification Card (ID Card), and any other enrollee-facing documents describing benefits, coverage, rights, obligations, or plan rules. All such materials must comply with the CMS Medicare Communications and Marketing Guidelines, Title 42 CFR Part 422, Subpart V, and the strengthened communication and beneficiary-protection standards established under the Medicare Advantage and Part D Final Rule (CMS-4201-F).

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.

4.7.6.1.2 The Contractor shall collect from its Providers any Marketing Materials they intend to distribute. Although prior approval of Provider Marketing Materials is not required, in the event such materials are found to be in violation of this Agreement, they are subject to cease-and-desist orders and/or other applicable sanctions by ASES.

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.

5.1.1 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, including CMS approval, 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. The medically necessary services to be provided by the Contractor shall in no manner be more restrictive than the State Medicaid Program, including compliance with all applicable Quantitative and Non-Quantitative Treatment Limits (QTL and NQTL), QTL and NQTL requirements established in state law, the Medicaid State Plan, and State policies, consistent with 42 CFR 438.210(a)(5)(i). Also, Covered Services will be rendered 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 72-1993, respectively, and as:

Appendix C-1. Medicare Advantage Plan Benefit Package (PBP) submitted to CMS

Appendix C-2. Medicaid Wraparound Benefits

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.

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 the ASES Compliance Office. The Parties agree that the inclusion of the SB does not mean that it has already been approved and that, if necessary, changes could be requested. Therefore, since the SB needs the approval of ASES and this Section could be amended subject to further ASES review.

Appendix C-5. Coordinated Care Model Norms 2027 Certification.

Appendix C-6. Co-Payments Certifications

Appendix C-7. Part C Supplementary Benefits Certification

Appendix C-8. Value Added Benefits Certification Medicare Platino

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 hospitals 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.

5.2.5 The Contractor shall ensure that the initial and annual Health Risk Assessment includes a structured evaluation of the enrollee's caregiving needs, together with all

mandatory assessment components required under 42 CFR 422.101(f). The assessment must capture medical, functional, psychosocial, and long-term services and supports needs to support care coordination and compliance with Medicare Advantage standards. The Contractor shall make best efforts to conduct the initial screening of each enrollee's needs within 90 days of enrollment and shall make subsequent attempts if initial contact is unsuccessful, consistent with 42 CFR 438.208(b)(3).

5.2.6 The Contractor shall share results of enrollee needs identification and assessments with the State and other MCOs, PIHPs, or PAHPs serving the enrollee to prevent duplication of activities, consistent with 42 CFR 438.208(b)(4).

5.2.7 The Contractor shall implement mechanisms to comprehensively assess each enrollee identified as having special health care needs to determine any ongoing conditions requiring a course of treatment or regular care monitoring, consistent with 42 CFR 438.208(c)(2). When required by the State, the Contractor shall produce a treatment or service plan for enrollees with special health care needs who require a course of treatment or regular care monitoring, consistent with 42 CFR 438.208(c)(3).

5.2.8 The Contractor shall ensure that treatment or service plans for enrollees with special health care needs are approved in a timely manner, comply with State Quality Assurance and Utilization Review standards, and are reviewed and revised at least annually or when the enrollee's needs or circumstances change significantly, or at the request of the enrollee, consistent with 42 CFR 438.208(c)(3) and 42 CFR 441.301(c)(3).

5.2.9 If the State elects to offer and arrange for an external medical review consistent with 42 CFR 438.402(c)(1)(i)(B), the Contractor shall comply with all requirements of the State-defined external medical review process, including submission of all necessary documentation and adherence to determinations issued through such review.

5.2.10 If the ASES enters into a Coordination of Benefits Agreement (COBA) with Medicare for fee-for-service claims, the Contractor shall comply with the State-defined methodology to ensure that all applicable Medicare crossover claims for which the Contractor is responsible are accurately routed, received, and processed, consistent with 42 CFR 438.3(t).

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 422.113 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:

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

5.3.6.3.1.2 The Contractor cannot be contacted; or

5.3.6.3.1.3 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

5.3.6.3.5 The Enrollee is discharged.

5.3.7 The Contractor may conduct post-utilization reviews to determine whether a service met the definition of an emergency medical condition, as defined herein, in accordance with applicable Medicaid Managed Care regulations. For dual-eligible enrollees under the Medicare Platino product, such reviews shall also comply with Medicare Advantage requirements, including federal standards governing emergency and post-stabilization services under 42 CFR 422.113. These reviews must adhere to the strengthened beneficiary protections, prudent

layperson standards, and utilization management limitations established in the CY 2027 Medicare Advantage and Part D Final Rule, which prohibit the application of criteria more restrictive than Medicare Fee-for-Service and require timely authorization, coordination, and documentation of post-stabilization care.

5.3.8 Family Planning Services

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

5.3.8.2 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.

5.3.9 Outpatient / Prescription Drugs

5.3.9.1 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.

5.3.9.2 The Contractor shall perform drug utilization reviews that meet the standards established by ASES and Federal authorities, including the operation of a Drug Utilization Review (DUR) program as required under 42 CFR Part 456, Subpart K, which includes prospective and retrospective drug use review, educational interventions, DUR Board functions, and annual reporting requirements. For dual-eligible enrollees under the Medicare Platino product, the Contractor shall also comply with Medicare Advantage and Part D drug management, quality assurance, and utilization review requirements under 42 CFR Part 423, including medication therapy management, drug safety edits, and utilization management safeguards. These obligations shall be carried out in alignment with the strengthened drug safety, utilization management, and reporting requirements established in the CY 2027 Medicare Advantage and Part D Final Rule.

5.3.9.3 The Contractor shall provide to ASES an annual report of its drug utilization review (DUR) activities. The report shall be submitted to the Clinical Operations Office no later than thirty (30) calendar days following the end of each contract year and shall be included as part of Appendix L, Deliverables. The report shall include, at minimum: (1) a description of the Contractor's DUR program structure and operations; (2) findings from prospective and retrospective DUR activities; (3) identification of patterns of inappropriate or unsafe prescribing or utilization; (4) educational or corrective interventions implemented; (5) DUR Board recommendations and actions;

and (6) data summaries and trend analyses consistent with federal and ASES requirements.

5.3.9.4 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 PBM or the Contractor, according to policies and procedures established by ASES's (or its designee's) Pharmacy and Therapeutic ("P&T") Committee and decided upon in consultation with the Contractor when applicable.

5.3.10 Mental Health or Substance Use Disorder Benefits - Parity Requirements

5.3.10.1 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.

5.3.10.2 For dual-eligible enrollees under the Medicare Platino product, the Contractor shall also comply with Medicare Advantage requirements governing MH/SUD parity, including nondiscrimination, benefit design, and behavioral health management standards under 42 CFR Part 422 and prescription drug benefit requirements under 42 CFR Part 423. These obligations shall be carried out in alignment with the strengthened behavioral health access, utilization management, and parity enforcement provisions established in the CY 2027 Medicare Advantage and Part D Final Rule.

5.3.10.3 The Contractor shall provide to ASES an annual MH/SUD Parity Compliance Report containing the results of the parity analysis. The report shall be submitted to the Clinical Operations Office no later than thirty (30) calendar days following the end of each contract year and shall be included as part of Appendix L, "Deliverables."

5.3.10.4 The report shall include, at minimum, a description of the Contractor's benefit design across all classifications; an analysis of quantitative treatment limitations (QTLs); an analysis of non-quantitative treatment limitations (NQTLs), including utilization management, prior authorization, step therapy, network standards, and evidentiary factors; a comparison of processes, evidentiary standards, and methodologies applied to MH/SUD versus medical/surgical benefits; identification of any parity compliance gaps; corrective actions implemented or planned; and data summaries and trend analyses consistent with federal and ASES requirements.

5.3.10.5 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).

5.3.10.6 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.

5.3.10.7 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.

5.3.10.8 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).

5.3.10.9 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 the benefits are furnished by the Contractor).

5.3.10.10 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.

5.3.10.11 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.

5.3.10.12 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.

5.3.10.13 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.

5.3.10.14 The Contractor may offer services or settings "in lieu of" State Plan services that are a medically appropriate substitute under the State Plan, when the substitute or alternative services is cost-effective, optional for the enrollee, and expressly authorized and identified in the contract, consistent with 42 CFR 438.3(e)(2). Also, 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 Puerto Rico Act No. 160-2001, the Contractor shall maintain written policies and procedures for Advance Directives. For dual-eligible enrollees under the Medicare Platino product, the Contractor shall also comply with all Medicare Advantage requirements governing Advance Directives, including nondiscrimination, beneficiary rights, and implementation standards under 42 CFR Part 422. These obligations shall be carried out in alignment with the strengthened beneficiary rights, communication standards, and compliance expectations established in the CY 2027 Medicare Advantage and Part D Final Rule.

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 (4^{th}) 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 The Contractor shall include in its contracts with Network Providers an acknowledgement of its obligations under Puerto Rico Act No. 160-2001 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, and the continuous duty to provide written information of any changes in laws pertaining to Advance Directives no later than ninety (90) days after the effective date of such change. Under the Medicare Platino product, the Contractor shall also ensure that Network Provider agreements comply with the Advance Directives requirements under 42 CFR 422.128 and in the applicable guidance.

5.4.4 The Contractor shall implement procedures to coordinate the services it furnishes to the enrollee with services the enrollee receives from any other MCO, PIHP, or PAHP, consistent with 42 CFR 438.208(b)(2)(ii).

5.4.5 The Contractor shall implement procedures to ensure that each enrollee has an ongoing source of care appropriate to their needs and shall formally designate a person or entity as primarily responsible for coordinating all services accessed by the enrollee, consistent with 42 CFR 438.208(b)(1). The Contractor shall also provide each enrollee with clear information on how to contact their designated care coordinator, consistent with 42 CFR 438.208(b)(1).

5.4.6 The Contractor shall implement procedures to coordinate services across all care settings, including implementing appropriate discharge planning for both short-term and long-term hospital and institutional stays, consistent with 42 CFR 438.208(b)(2)(i).

5.4.7 The Contractor shall educate its staff regarding its policies and procedures on Advance Directives, situations in which Advance Directives may benefit Enrollees, and the staff's responsibility to educate and assist Enrollees in the use of this tool. Staff education shall comply with the requirements under 42 CFR 438.3(j) and 42 CFR 422.128(a), (b), as reinforced by the CY 2027 Medicare Advantage and Part D Final Rule.

5.4.8 The Contractor shall educate Enrollees about their ability to direct their care through Advance Directives and shall designate the staff members or Network Providers responsible for providing such education. This obligation includes compliance with 42 CFR 422.128 for Medicare Advantage dual-eligible enrollees, including the enhanced communication and beneficiary rights standards established in the CY 2027 Medicare Advantage and Part D Final Rule.

5.4.9 The Contractor shall monitor and verify compliance with Advance Directives requirements through periodic reviews of Enrollee Medical Records and internal operational audits. The Contractor shall confirm: (1) the distribution of Advance Directives information; (2) the documentation of Advance Directives in Medical Records; and (3) the implementation of staff and provider responsibilities. The Contractor shall submit to ASES, through the Operations Clinical Office, an annual Advance Directives Compliance Report summarizing monitoring results, deficiencies,

and corrective actions, no later than thirty (30) calendar days following the end of each contract year (Appendix L " Deliverables"). This requirement aligns with the strengthened beneficiary rights, communication, and documentation standards established in the CY 2027 Medicare Advantage and Part D Final Rule.

5.4.10 The Contractor shall implement procedures to coordinate the services it furnishes to the enrollee with services the enrollee receives under the State's applicable fee-for-service Medicaid program, consistent with 42 CFR 438.208(b)(2)(iii).

5.4.11 The Contractor shall implement procedures to coordinate services it furnishes to enrollees with services provided by community and social support organizations, consistent with 42 CFR 438.208(b)(2)(iv).

5.5 Moral or Religious Objections

5.5.1 If, during the course of the Contract period, pursuant to 42 CFR 438.102 or 422.206(b), 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 of Enrollee 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 The Contractor shall fully and timely comply with requests for historical utilization data from the new Contractor or any other authorized entity, in compliance with Federal and State laws, including 42 CFR 438.62 Continuity and Coordination of Care, which requires outgoing contractors to provide all necessary information to ensure continuity of care during transitions. Likewise, because the Medicare Platino population is dual eligible, the Contractor shall also comply with the applicable Medicare Advantage requirements, including 42 CFR 422.504(a)(13), as strengthened by the CY 2027 Medicare Advantage and Part D Final Rule, which reinforces the obligation of Medicare Advantage organizations to provide timely, accurate, and complete data, records, and information necessary for coordination of care, regulatory oversight, and transition to a successor organization;

5.6.1.4 The Contractor shall ensure that the Enrollee's new Provider is able to obtain copies of the Enrollee's medical records, as appropriate, in compliance with 42 CFR 438.62 and 42 CFR 422.504(a)(13) for Medicare Advantage dual-eligible Enrollees, and Puerto Rico Act No. 194-2000, which guarantees the patient's right to access and transfer their medical information;

5.6.1.5 Implement a transition of care policy that complies with federal requirements and meets or exceeds the State-defined transition of care standards, consistent with 42 CFR 438.62(b)(1)–(2).

5.6.1.6 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.

5.7 Payments for Wrap-Around Benefits

5.7.1 Any anticipated or future increases in Medicaid Wrap-Around Benefit payments are subject to the Contractor's complete compliance with all applicable state, federal, and local laws, rules, regulations, and Medicaid public policy.

5.7.2 Increases in Medicaid Wrap-Around Benefit payments, whether anticipated or not, will only be used to enhance dual-eligible individual's access to essential medical services, cover any gaps in coverage or costs that Medicare might not cover, and for payments to the healthcare providers.

5.7.3 The Contractor agrees that it will use this increase exclusively for payment of services provided to dual-eligible individuals that are covered under Appendix C-2 Wrap-Around Benefit, this Contract, or any applicable law, regulation, or under Medicaid public policy.

5.7.4 If the Contractor fails to comply with this section, ASES reserves the right to suspend or reverse any applicable payment increase.

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), "Availability of Services", and is otherwise sufficient to provide adequate access to covered services to meet the needs of Enrollees in the Medicare Platino Plan. Because the Medicare Platino population is dual eligible, the Contractor shall also comply with the Medicare Advantage network adequacy requirements under 42 CFR 422.116, "Network Adequacy Standards", including the strengthened access, time-and-distance, and appointment availability standards established in the Contract Year 2027 Medicare Advantage and Part D Final Rule. The Contractor's network must ensure timely access to primary care, specialty care, behavioral health services, emergency and urgent care, inpatient and hospital services, pharmacy services, and continuity of care during transitions, consistent with applicable Federal and Puerto Rico requirements. 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 with the requirements specified in 42 CFR 438.207, "Assurances of Adequate Capacity and Services", and 438.214, "Provider Selection", as well as all applicable Puerto Rico requirements governing the selection of Network Providers and the assurance of adequate capacity and quality. Because the Medicare Platino population is dual eligible, the Contractor shall also comply with the Medicare Advantage network adequacy standards under 42 CFR 422.116, "Network Adequacy Standards", including the strengthened access and oversight provisions established in the Contract Year 2027 Medicare Advantage and Part D Final Rule.

6.1.3 At the beginning of this Contract, the Contractor shall submit to ASES, through the Clinical Operations Office, the documentation required as part of the deliverables under Appendix L, demonstrating adequate capacity to accommodate expected enrollment in accordance with ASES's access and timeliness standards. Such documentation shall, at a minimum, include evidence of an adequate network through the CMS Medicare Advantage application process and/or the results of any Medicare or other accreditation body audits related to network capacity or adequacy. The submitted documentation must demonstrate that it offers an adequate range of

preventive, primary care, specialty services, and LTSS, to the extent applicable, sufficient for the anticipated number of enrollees in each service area, consistent with 42 CFR 438.207(b)(1).

6.1.4 The Contractor shall also:

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

6.1.4.2 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;

6.1.4.3 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;

6.1.5 Upon declining to include a Provider or group of Providers that have requested inclusion in the Contractor's General Network, the Contractor shall provide the affected Provider(s) with a written notice that clearly states the basis for its determination. The notice shall include a detailed and factual explanation of the criteria applied, the specific grounds for the denial, the data or documentation relied upon, and any information relevant to the Contractor's evaluation process. The Contractor shall ensure that its decision-making process is objective, transparent, consistently applied across all Providers, and free from any discriminatory, arbitrary, or non-evidence-based factors. Consistent with the current Medicaid Managed Care guidance, including 42 CFR 438.12, 42 CFR 438.68, 42 CFR 438.206, 42 CFR 438.207, and 42 CFR 438.10, the Contractor shall:

6.1.5.1 Apply publicly available, objective, measurable, and consistently enforced network admission standards;

6.1.5.2 Demonstrate that its determination does not result in inappropriate network narrowing, reduced access, or disruption of continuity of care;

6.1.5.3 Maintain complete and reviewable documentation of the evaluation and determination, subject to State oversight, audit, and compliance review;

6.1.5.4 Ensure that all network decisions are traceable, reviewable, and supported by verifiable evidence; and

6.1.5.5 Issue the written notice within a strictly defined and reasonable timeframe, in a manner that enables the affected Provider(s) to fully understand the rationale for the determination and, when applicable, pursue any available reconsideration, corrective action, or appeal process.

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

6.1.5.7 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;

6.1.5.8 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

6.1.6 The Contractor shall provide Enrollees with special health care needs direct access to a to an appropriate specialist for the Enrollee's health care condition and identified needs, in full compliance with 42 CFR 438.208(c)(4).

6.1.7 The Contractor shall ensure that such direct access is provided without delays, prior authorization barriers, referral restrictions, or other administrative processes that could impede timely access to medically necessary specialty services.

6.1.8 The Contractor shall further ensure that:

6.1.8.1 Direct access supports continuity of care and prevents treatment interruptions;

6.1.8.2 Specialists with the appropriate training and expertise are available within the network;

6.1.8.3 Any denial, limitation, or modification of direct access is fully documented, based on clinical criteria, and subject to State review and audit;

6.1.8.4 Enrollees are informed of their right to direct access and the process to exercise it, consistent with federal information and communication requirements;

6.1.8.5 Ensure Network Providers 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.

6.1.8.6 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.

6.1.8.7 Ensure Network Providers provide physical access, reasonable accommodations and accessible equipment for Enrollees with physical or mental disabilities.

6.1.8.8 Implement written policies and procedures for the selection and retention of Network Providers evidencing compliance with all requirements set forth in this Section 6.1.2.

6.1.8.9 Comply with the State's uniform credentialing and recredentialing policy for all acute, primary care, behavioral health, substance use disorder, and LTSS providers (to the extent applicable), consistent with 42 CFR 438.12(a)(2) and 438.214(b)(1).

6.1.9 The Contractor shall adhere to all State-established quantitative network adequacy standards for LTSS provider types, to the extent applicable, consistent with 42 CFR 438.68(b)(2)(i).

6.1.10 The Contractor shall meet all State quantitative network adequacy standards for LTSS in every geographic area in which it operates, when applicable, consistent with 42 CFR 438.68(b)(3).

6.1.11 As set forth in 42 CFR 422.116, the Contractor shall meet the applicable time and distance standards and all other CMS network adequacy requirements for each provider type covered under this Contract. Because the Medicare Platino population is dual eligible, the Contractor shall also comply with 42 CFR 422.504(a)(13), including the strengthened oversight provisions established in the CY 2027 Medicare Advantage and Part D Final Rule. If the Contractor cannot meet such network requirements, or the requirements set forth in Section 6,1 the Contractor must request an exception from ASES and obtain written approval prior to implementation. The exception request shall be formally submitted to the ASES Executive Director and the Operations Clinical Office, who shall evaluate the request promptly. The request must include documentation demonstrating that CMS has granted the Contractor an exception to the applicable standard, detailed justification for forth in 42 CFR 422.116, Contractor shall meet time and distance standards and other network adequacy standards set forth by CMS for all provider types covered under the Contract. In the event the Contractor cannot meet such network requirements, an exception must be requested and approved in writing by ASES using documentation that demonstrates the Contractor has received an exception from CMS from the standard. The request must provide detailed information justifying the need for an exception and actions underway to meet compliance. The standard by which ASES will evaluate the exception request will be based, at a minimum, on the number of network providers in that specialty practicing in Puerto Rico.

6.1.12 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. Pursuant to 42 CFR 438.12(a), this provision may not be construed to require the Contractor to contract with any Provider who does not meet the Contractor's quality, credentialing, performance, or efficiency standards, or who fails to comply with applicable Federal, State, or Puerto Rico requirements. Because the Medicare Platino population is dual eligible, the Contractor shall also comply with 42 CFR 422.504(a)(13) and 42 CFR 422.116, including the strengthened provider-selection,

oversight, and access provisions established in the CY 2027 Medicare Advantage and Part D Final Rule. In such case, the following will apply:

6.1.12.1 Contract with Providers beyond the number necessary to meet the needs of its Enrollees, consistent with 42 CFR 438.12(a) and the Medicare Advantage network adequacy framework under 42 CFR 422.116;

6.1.12.2 Contractor will be precluded from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, provided such methodologies comply with 42 CFR 438.12(a) and with applicable Medicare Advantage payment and contracting requirements under 42 CFR 422.504(a)(13); or

6.1.12.3 The Contractor will be precluded from establishing measures designed to maintain quality of services and control costs, consistent with its responsibilities to Enrollees and in alignment with 42 CFR 438.12(a), 42 CFR 422.504(a)(13), and the enhanced quality-oversight provisions of the CY 2027 Medicare Advantage and Part D Final Rule.

6.1.13 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.

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

6.1.15 The Contractor is responsible for establishing and monitoring Medical Record guidelines which include documentation of all services provided by Network Providers. The Contractor shall also ensure that all providers maintain and appropriately share enrollee health records in accordance with applicable professional standards, consistent with 42 CFR 438.208(b)(5).

6.2 Provider Credentialing

6.2.1 The Contractor shall ensure that all Network Providers are enrolled as Medicaid providers and are otherwise appropriately credentialed and qualified to provide services under the terms of this Contract and all applicable Federal and Puerto Rico law. In accordance with 42 CFR 438.214, the Contractor must maintain a credentialing and recredentialing process that complies with Federal Medicaid requirements for primary source verification, quality standards, and nondiscrimination. Because the Medicare Platino population is dual eligible, the Contractor shall also comply with 42 CFR 422.204 and 42 CFR 422.504(a)(13), which require Medicare Advantage organizations to maintain accurate, timely, and complete credentialing information and to ensure

compliance with CMS oversight requirements, including those set forth in Chapter 6 of the Medicare Managed Care Manual. The Contractor shall further comply with the CY 2027 Medicare Advantage and Part D Final Rule, which strengthens provider-credentialing oversight, including enhanced requirements for credentialing timeliness, transparency of credentialing status, and accuracy of provider information used for network adequacy and access determination.

6.2.2 Credentialing is required for:

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

6.2.2.2 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.

6.2.3 Credentialing is not required for:

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

6.2.3.2. 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

6.2.3.3 Students, residents, or fellows.

6.2.4 Contractor Standards for Credentialing and Re-Credentialing.

6.2.4.1 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.

6.2.4.2 The Contractor shall have written policies and procedures for the Credentialing and Re-Credentialing process. Such process must allow Providers to apply for Credentialing and Re-Credentialing online. The Contractor shall submit these written policies and procedures to the ASES Compliance Office for approval and as part of the deliverables required under Appendix L. These policies and procedures must fully describe the Contractor's Credentialing and Re-Credentialing workflow, including verification activities, timelines, decision-making standards, documentation requirements, and compliance with 42 CFR 455.436 and all other applicable Federal and Commonwealth regulations.

6.2.4.3 The Contractor shall:

6.2.4.3.1 Ensure all Network Providers are enrolled as Providers with Puerto Rico Medicaid through its Provider Enrollment Portal (PEP) and prohibit payments to any unenrolled Providers unless authorized under federal law, e.g. for Emergency Services.

6.2.4.3.2 Ensure potential and actual Network Providers are credentialed and enrolled as Providers through its PEP system;

6.2.4.3.3 Meet Puerto Rico and Federal regulations for Credentialing and Re-Credentialing, including the requirements of 42 CFR 455.104, 42 CFR 455.105, 42 CFR 455.106, and 42 CFR 1002.3(b) State-Initiated Exclusions. Because the Medicare Platino population is dual eligible, the Contractor shall also comply with Medicare Advantage credentialing requirements under 42 CFR 422.204 and 42 CFR 422.504(a)(13);

6.2.4.3.4 Use one (1) standard Credentialing form approved by ASES for all Credentialing and Re-Credentialing activities, and shall submit this standard form to the ASES Compliance Office for review and approval as part of the deliverables required under Appendix L.

6.2.4.3.5 Include in the Credentialing form, at a minimum, the following information: Provider demographic information; NPI; active licenses and certifications; DEA and CDS registrations (if applicable); education and training history; work history; board certification status; malpractice claims history; sanctions, exclusions, or disciplinary actions; ownership and control disclosures required under 42 CFR 455.104; criminal conviction disclosures required under 42 CFR 455.106; and screening attestations consistent with 42 CFR 455.436.

6.2.4.3.5.1 The form shall also include an attestation signed by the Provider confirming the accuracy and completeness of the information provided and authorizing primary source verification.

6.2.4.3.5.2 The content and use of this form shall include provisions related to transparency, uniformity of the credentialing process, exclusion verification, and compliance with Medicaid provider screening and disclosure requirements.

6.2.4.3.6 Designate a Credentialing and Re-credentialing processes committee or other peer review body to make recommendations regarding Credentialing/Re-Credentialing issues;

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

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

6.2.4.3.9 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;

6.2.4.3.10 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;

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

6.2.4.3.12 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;

6.2.4.3.13 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;

6.2.4.3.14 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;

6.2.4.3.15 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;

6.2.4.3.16 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;

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

6.2.4.3.18 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;"

6.2.4.3.19 As part of the credentialing and re credentialing processes, the Contractor shall verify on a monthly basis all Providers and any other individuals subject to the credential validation process against the Federal databases specified in 42 CFR 455.436, to ensure that no excluded individuals or entities are employed or contracted. The Contractor shall submit the results of such monthly screenings to the ASES Compliance Office as part of the deliverables required under Appendix L. The monthly report shall include, at a minimum, the name, NPI, specialty, provider type, date of the screening, screening result, and the databases consulted; the identification of any match or alert, including the action taken, the date of the action, and the current status; and a description of any corrective actions implemented. The report shall include a certification signed by the Contractor's Compliance Officer attesting that the information contained therein is complete, accurate, and prepared in compliance with 42 CFR 455.436.

6.2.4.3.20 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

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

6.2.5 Contractor Functions

The Contractor shall perform the following functions:

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

6.2.5.2 The Contractor shall prepare a monthly Credentialing and Re Credentialing Status Report for all Providers subject to credentialing requirements, in accordance with the applicable provisions of 42 CFR 455.104, 42 CFR 455.106, 42 CFR 455.436, and any applicable regulation. The details of this report are described in the section 15.2.1.15 of this contract. 6.2.5.3 The

Contractor shall maintain all documentation necessary to support the accuracy and completeness of the status information reported;

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

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

6.2.5.6 The Contractor shall perform site visits as part of its Credentialing and Re Credentialing activities. The Contractor's site visit policy shall be reviewed pursuant to CMS's monitoring protocol and shall comply with the applicable requirements of 42 CFR 438.358 and 42 CFR 438.602. At a minimum, the Contractor shall require initial Credentialing site visits for the offices of Primary Care practitioners, obstetrician gynecologists, and other high volume Providers, as defined by the Contractor, consistent with CMS oversight.

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

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

6.2.5.9 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.

6.2.5.10 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.

6.2.6 Determination to Exclude Providers

6.2.6.1 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.

6.2.6.2 Contractors shall ensure that all Network Providers, when initially contracted and as periodically revalidated thereafter, are Medicaid-enrolled Providers consistent with the Provider disclosure, screening and enrollment requirement of 42 CFR part 455, subparts B and E as incorporated in 42 CFR 438.608(b).

6.2.6.3 Contractors may execute temporary Provider Contracts pending the outcome of the Medicaid provider enrollment process of up to one hundred twenty (120) Calendar Days but must terminate a Network Provider Immediately upon notification from ASES that the Network Provider cannot be enrolled, or the expiration of the one hundred twenty (120) Calendar Day period without enrollment of the Provider, and notify affected Enrollees.

6.2.6.4 The Contractor shall assist ASES in facilitating the Medicaid Provider enrollment process, in the manner requested by ASES, including but not limited to the production, transmission, or certification of Provider Credentialing records; the distribution of ASES Provider agreements; and all other verbal and written communications related to the Medicaid Provider enrollment process. Such assistance shall be performed in compliance with the applicable requirements of 42 CFR 455.410, 42 CFR 455.432, 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 455.436.

6.3 Training and Education.

6.3.1 The Contractor's education process for Providers shall include:

6.3.1.1 The importance of preventive care of special conditions like: Diabetes, Hypertension, Alzheimer's, Asthma, Dementia, Heart Conditions, Kidney Conditions, Depression, Special Conditions.

6.3.1.2 The coverage under Medicare Platino Plan and copayments including available Supplemental benefits under Medicare;

6.3.1.3 Immunization services;

6.3.1.4 Dental and hearing coverage;

6.3.1. 5 Training about medication and overdose;

6.3.2 The Contractor shall ensure that such training includes requirements related to Provider screening, enrollment, program integrity, transparency, and uniform application of credentialing standards; and

6.3.3 The Contractor shall use various forms of delivery when providing Providers' training sessions, including a combination of written and oral (web-based sessions, group workshops, face-to-face individualized education, newsletters, communications, and office visits.) methods.

6.3.4 The Contractor shall make the dates and locations of sessions available to Providers, as soon as possible, but no later than five (5) Business Days prior to the event.

6.3.5 The Contractor shall maintain a record of its training and technical assistance activities, which it shall make available to ASES upon request.

6.3.6 The Contractor shall submit a quarterly Provider Training and Educational Evaluation Report to assess the effectiveness of the training initiatives described in this section and to present findings and lessons learned. The report shall specify, at a minimum: the training topic(s), the targeted Providers, the content of the training, the training schedule (including dates, times, and locations), the training methods used, and the number and types of attendees. The Contractor shall deliver this quarterly report in accordance with the submission requirements set forth in Section 15.2.1.27.

6.4 Contractor Participation on the Government Health Care Facilities Advisory Committee.

6.4.1 ASES intends to establish a committee, the Government Health Care Facilities Advisory Committee, for the purpose of providing recommendations and ongoing input to ASES regarding the financial and operational concerns and challenges of the Government Health Care Facilities.

6.4.2 This Committee will consist of at least one (1) representative from each Government Health Care Facility, as well as one (1) representative from each of the MAO, including the Contractor.

6.4.3 The Contractor agrees to engage at least one (1) member of its staff to collaborate in good faith in the discussions aimed at identifying and remedying the challenges faced by the Government Health Care Facilities, if applicable.

6.4.4 The Committee will convene at least once every three (3) months or at any time if requested by the ASES.

6.5 Contractor Documentation of Adequate Capacity and Services

6.5.1 Within thirty (30) days of the Effective Date of this Contract, the Contractor shall provide documentation demonstrating compliance with the requirements of this Section as part of Attachment L "Deliverables". The Contractor shall submit such documentation to ASES's Clinical Operations Office. The documentation shall demonstrate that the Contractor:

6.5.1.1 Offers an adequate range of assessment and treatment services, preventive services, Primary Care, Medicare-covered services, and specialty services sufficient for the anticipated number of Enrollees, and complies with

both ASES Network Adequacy Standards and applicable CMS Medicare Advantage network requirements; and

6.5.1.2 Maintains a Provider Network that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of Enrollees, including the dually eligible population, and complies with ASES Network Adequacy Standards and CMS network adequacy rules.

6.5.2 The Contractor shall provide the documentation of the Network Adequacy Standards established in this Section on an annual basis, and shall submit the report required in accordance with Section 15.2.1.28 to ASES's Clinical Operations Division, and Immediately whenever a significant change occurs in the Contractor's operations that may affect adequate capacity and the provision of services. Significant changes include, but are not limited to:

6.5.2.1 Changes in Benefits, in the composition of Network Providers, or in payments to such Providers, whether under the Medicaid or Medicare components of the Plan; and

6.5.2.2 The enrollment of a new eligibility group in the Contractor's Plan, or any material change affecting the dually eligible population.

6.6 Network Adequacy Standards

6.6.1 The Contractor must maintain an Island-wide provider network that complies with the Network Adequacy Standards specified in this Section and with the minimum federal requirements applicable to Medicare Advantage and D-SNP plans under 42 CFR 422.116. The Contractor must use Geographical-access and thermal mapping to demonstrate that the contracted network is distributed across Puerto Rico in a manner that ensures adequate access for Platino Enrollees. The Contractor shall ensure that Enrollees have adequate and timely Access to all covered services at all times, consistent with ASES standards and CMS network adequacy requirements.

6.6.2 If the Contractor cannot meet a Network Adequacy Standard in Section 6.4 or the applicable CMS time and distance standards, an exception request must be submitted and approved in writing by ASES. The request must include:

6.6.2.1 Detailed justification for the exception.

6.6.2.2 Documentation of efforts underway to achieve compliance.

6.6.2.3 Corrective actions and timelines consistent with CMS and ASES expectations.

6.6.3 The approval of an exception does not relieve the Contractor from the obligation to remedy non-compliance within a reasonable timeframe or from complying with a Corrective Action Plan established in collaboration with ASES.

6.6.4 All approved exceptions must be reported in the annual Provider Network Development and Management described in Section 15.2.1.29, and must align with CMS requirements for Exception Requests under 42 CFR 422.116(d).

6.6.5 The Contractor agrees to fully cooperate with ASES in all activities necessary to comply with the Network Adequacy and Access reporting requirements mandated by the Centers for Medicare & Medicaid Services (CMS) and any other applicable regulatory authority. This cooperation includes, without limitation, all obligations established under 42 CFR 422.116, which are necessary for ASES to complete the annual submission of the CMS Medicare Advantage Network Adequacy and Access Report (NAAR).

6.6.5.1 The Contractor shall provide ASES, upon request and within the timeframe established by ASES, all data, documentation, analyses, and supporting materials necessary to demonstrate compliance with federal and local network adequacy standards. This includes all information required for ASES to prepare, validate, or timely file the NAAR or any other related reports required by CMS or ASES.

6.6.5.2 The Contractor shall ensure that all information provided is complete, accurate, current, and sufficient to enable ASES to meet its regulatory obligations, including the timely submission of the NAAR and any other network adequacy reports required by CMS or ASES.

ARTICLE 7 PROVIDER CONTRACTING

7.1 Provider Guidelines

The Contractor shall prepare Provider Guidelines to be distributed to all Network Providers. The Provider Guidelines shall comply with the requirements of 42 CFR 438.236 and with the following:

7.1.1 The Provider Guidelines shall consider the needs of the Contractor's Enrollees, including clinical appropriateness, cultural considerations, and population health needs.

7.1.2 The Provider Guidelines shall be developed in consultation with Providers, ensuring that subject-matter experts participate in the review and development process.

7.1.3 The Provider Guidelines shall be reviewed and updated periodically, and whenever changes in clinical evidence, regulatory requirements, or standards of care warrant revision.

7.1.4 The development, adoption, and dissemination of the Provider Guidelines shall include requirements related to transparency, clinical appropriateness, quality improvement, and uniform application of practice guidelines across the Contractor's Network.

7.1.5 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.

7.1.6 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.

7.1.7 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.

7.1.8 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. Contractor shall maintain evidence of having delivered the Provider Guidelines to its Network Providers within fifteen (15) Calendar Days of an 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 submitted to ASES in the Appendix L. After the initial provision of the Provider Guidelines upon an award of the Provider Contract, Contractor may allow changes and updates to the Provider Guidelines to be shared with Network Providers electronically or through the Contractor's website or portal. Contractor must provide a copy of an update to the Provider Guidelines by mail upon Network Provider's request.

7.2 Required Provisions in Provider Contracts

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

7.2.1 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);

7.2.2 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;

7.2.3 Specify the effective dates of the Provider Contract;

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

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

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

7.2.7 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);

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

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

7.2.10 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;

7.2.11 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;

7.2.12 Collect and maintain complete enrollee encounter data identifying the rendering provider and submit encounter data to the State at the frequency and level of detail required by the State and CMS, including allowed and paid amounts required under 42 CFR 438.818. All encounter data shall be submitted in standardized ASC X12N 837, NCPDP, and ASC X12N 835 formats, as applicable, consistent with 42 CFR 438.242(c);

7.2.13 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;

7.2.14 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;

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

7.2.16 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, including any alternative treatment that may be self-administered. Pursuant to 42 CFR 438.102(a)(1), a Provider cannot be prohibited from providing Information Enrollee needs to decide on a treatment option, including the risks, benefits and consequences of available options;

7.2.17 Inform Provider about Contractor's Grievance and Appeal System, including information about applicable procedures, timeframes, and the Enrollee's right to file Grievances and Appeals, including the availability of assistance in filing Grievances and Appeals and the right to request continuation of benefits during a pending proceeding. Contractor shall 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;

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

7.2.19 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;

7.2.20 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;

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

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

7.2.23 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;

7.2.24 Include the definition and standards for Medically Necessary Services;

7.2.25 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;

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

7.2.27 Notify the Provider that, in order to participate in the Medicare Platino Program, the Provider must accept Medicare Platino Enrollees for both Medicare and Medicaid Wrap-Around services;

7.2.28 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;

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

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

7.2.31 Require that any Marketing Materials developed and distributed by the Provider be submitted to the Contractor and complies with Section 4.7.6;

7.2.32 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;

7.2.33 Require Providers to collect Enrollee Co-Payments as specified in Appendix C-6. Contractor shall provide a description of cost-sharing out of pocket maximums under the Medicare coverage and notice to Enrollees and their providers within Contractor's provider network when the maximum is reached;

7.2.33 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);

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

7.2.35 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;

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

7.2.37 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;

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

7.2.39 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;

7.2.40 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 and services must first be billed to the Medicare Program for any Medicare covered services including Supplemental Benefits for a Dual Eligible Beneficiary;

7.2.41 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;

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

7.2.43 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 corruption, fraud, embezzlement, or unlawful appropriation of public funds, pursuant to Act No. 2-2018 or has been excluded from the Medicare, Medicaid, or Title XX Services Programs;

7.2.44 Include a penalty clause to require the return of public funds paid to a Provider that falls within the prohibitions stated in Section 7.2.1.43 above;

7.2.45 Require that all reports submitted by the Provider to the Contractor be labeled with the Provider's NPI, if applicable;

7.2.46 Include Provider dispute process as described in Section 11.1.18

7.2.47 Require the Provider to disclose information on ownership and control as specified in Section 48.2; and

7.2.48 Require the Provider to disclose information as listed in Section 15.2.1.9.

7.2.49 The Contractor shall submit its Provider Contract model to the ASES Office of Legal Affairs, as part of the deliverables required under Appendix L, for the purpose

of confirming that the Provider Contract model aligns with, and fully incorporates, the duties and obligations established in the Provider Guidelines and the applicable provisions of 42 CFR 438.236.

7.2.50 The Provider Contract model shall include all Required Provisions in Provider Contracts established under this Contract, including but not limited to Provider duties and obligations, performance standards, reporting requirements, compliance responsibilities, quality expectations, and any other contractual or operational requirements applicable to Network Providers.

7.2.51 The development, adoption, and dissemination of both the Provider Guidelines and the Provider Contract model shall include requirements related to transparency, clinical appropriateness, quality improvement, and the uniform and consistent application of practice guidelines across the Contractor's Network.

7.3 Termination of Provider Contracts

The Contractor shall comply with all Puerto Rico and Federal laws regarding Provider termination. If such laws conflict, applicable federal laws and regulations shall take precedence over Puerto Rico laws and regulations. The Provider Contracts shall:

7.3.1 Contain provisions allowing immediate termination of the Provider Contract by the Contractor "for cause." Termination of the Provider Contract without cause must be with at least sixty (60) days written notice to each other before terminating contract as established on 42 CFR 422.202(d)(4), related to requirements for provider contract termination. Cause for termination includes, but is not limited to, gross negligence in complying with contractual requirements or obligations; a pattern of noncompliance with contractual requirements or obligations that the Provider fails to correct after being notified of such noncompliance by the Contractor; insufficiency of funds of ASES or the Contractor, which prevents them from continuing to pay for their obligations; changes in Federal or State law, among others. The Contractor shall not terminate a Provider Contract in retaliation for the Provider exercising his or her Appeal rights, advocating on behalf of the Provider, or for advocating on behalf of an Enrollee.

7.3.2 Specify that in addition to any other right to terminate the Provider Contract, and notwithstanding any other provision of this Contract, ASES may demand Provider termination Immediately, or the Contractor may Immediately terminate on its own, a Provider's participation under the Provider Contract if:

7.3.2.1 The Provider fails to abide by the terms and conditions of the Provider Contract, as determined by ASES, or, in the sole discretion of ASES, if the Provider fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from the Contractor specifying such failure and requesting such Provider to abide by the terms and conditions hereof; or

7.3.2.2 The Contractor or ASES learns that the Provider:

7.3.2.2.1 Falls within the prohibition stated in Section 7.2.1.43;

7.3.2.1.2 Has been or could be excluded from participation in the Medicare, Medicaid, or CHIP Programs;

7.3.2.1.3 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); and/or

7.3.2.1.4 Fails to comply with the Provider Credentialing process and requirements.

7.3.3 Specify that any Provider whose participation is terminated under the Provider Contract for any reason shall utilize the applicable Appeals procedures outlined in the Provider Contract. No additional or separate right of Appeal to ASES or the Contractor is created as a result of the Contractor's act of terminating, or decision to terminate any Provider under this Contract. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, this Contract shall remain in full force and effect with respect to all other Providers.

7.3.4 The Contractor shall notify ASES at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network. If the termination is "for cause," the Contractor shall provide ASES with the reasons for termination immediately.

7.3.5 The Contractor shall submit this information as a monthly report, to Compliance Office which shall include, at a minimum, the following data elements: Provider name; specialty; address; national Provider Identifier (NPI); date of contract; termination effective date; Reason for cancellation; Number of affected enrollees; Date notification was provided to enrollees; Confirmation that transition of care was implemented with the new provider

7.3.6 This monthly report shall be submitted by each MAO in Excel format, and the detailed reporting structure and additional specifications are further described in Section 15.2.1.17 of this Agreement.

7.3.7 The Contractor shall, unless otherwise specified by ASES, provide written notice of a Provider's termination to all Enrollees who received their Primary Care from, or were seen on a regular basis by, the terminated Provider. This notice shall be issued within fifteen (15) Calendar Days after the Contractor receives or issues the termination notice. This obligation shall be carried out in accordance with 42 CFR 438.10, which requires timely, accurate, and accessible communication to Enrollees regarding changes in the availability of Network Providers.

7.3.7.1 The Contractor shall comply with the requirements of 42 CFR 438.62, to ensure that Enrollees continue to receive medically necessary services without undue interruption following the termination of a Provider. The Contractor shall take all necessary steps to prevent gaps in care, including honoring ongoing treatment plans, facilitating access to alternative Providers,

and ensuring that medically necessary services remain available during the transition period.

7.3.7.2 In accordance with 42 CFR 438.206 the Contractor shall maintain adequate access to Network Providers at all times, including when a Provider is terminated. The Contractor must ensure that Enrollees retain access to Providers who meet time, distance, and appointment availability standards.

7.3.7.3 The Contractor shall comply with 42 CFR 438.208 and shall actively assist Enrollees in transitioning to a new Provider. Such assistance shall include, as applicable:

7.3.7.3.1 Helping the Enrollee identify and select a new Provider

7.3.7.3.2 Coordinating the transfer of medical records

7.3.7.3.3 Assisting with scheduling appointments

7.3.7.3.4 Providing any additional support necessary to ensure a smooth transition.

7.3.7.3.5 For purposes of validating compliance with this Section, the Contractor shall submit, as part of Appendix L, a monthly Attestation certifying that:

7.3.7.3.5.1 The enrollee notification was issued within the required fifteen (15) Calendar Days; and

7.3.7.3.5.2 The Enrollee received appropriate assistance in identifying and transitioning to a new Provider, including continuity-of-care measures when applicable.

7.3.7.3.5.3 If during any reporting month the Contractor has no cases requiring enrollee notification or transition of care under this Section, the Contractor shall attest to the absence of applicable cases in the Appendix L submission.

7.3.7.3.5.4 Upon request from ASES at any time, the Contractor shall provide verifiable documentation supporting the Attestation submitted under this Section.

7.4 Provider Payment

7.4.1 General Provisions

7.4.1.1 The Contractor guarantees payment for all Medically Necessary Services rendered by Providers on a person's Effective Date of Enrollment.

7.4.1.2 The Contractor shall require, as a condition of payment, that the Provider accept the amount paid by the Contractor or appropriate denial made by the Contractor (or, if applicable, payment by the Contractor that is supplementary to the Enrollee's Third-Party payer) plus any applicable amount of Co-Payment responsibilities due from the Enrollee as payment in full for the service.

7.4.1.3 The Contractor shall ensure that Enrollees are not held responsible by the Provider for the costs of Medically Necessary Services, except for the applicable co-payment amounts described in Section 4.4.1.1.6 and Appendix C-6 of this Contract. Providers shall not bill, charge, request payment from, or attempt to recover from an Enrollee any amount that exceeds the allowable cost-sharing. This requirement is established in accordance with 42 CFR 438.3(h), which prohibits balance billing in Medicaid managed care arrangements.

7.4.1.4 Likewise, compliance with the CMS Final Rule for Contract Year 2027 is required, specifically as it relates to Enrollee Financial Protections, which reaffirms that Medicaid managed care enrollees may not be billed by in-network or out-of-network providers for covered services beyond the State-authorized cost-sharing amount. The 2027 Final Rule also requires managed care plans to implement and enforce these protections as a condition of federal compliance.

7.4.1.5 The insolvency, liquidation, bankruptcy, or breach of contract of any Provider will not release the Contractor from its obligation to pay for all services rendered as authorized under this Contract.

7.4.1.6 The Contractor shall negotiate rates with Providers, and such rates shall be specified in the Provider Contract. Payment arrangements may take any form allowed under Federal law and the laws of Puerto Rico, including Capitation payments, Fee-for-Service payment, and salary, if any.

7.4.1.7 Any Capitation payment made by the Contractor to Providers shall be based on sound actuarial methods in accordance with 42 CFR 438.4. The Contractor shall submit data supporting the actuarial soundness of Capitation Payments to ASES, including the base data generated by the Contractor. All Provider payments by the Contractor shall be reasonable, and the amount paid shall not jeopardize or infringe upon the quality of the services provided.

7.4.1.8 Even if the Contractor does not enter into a capitated payment arrangement with a Provider, the Provider shall nonetheless be required to submit detailed Encounter Data to the Contractor. This requirement is consistent with 42 CFR 438.242, which mandates that Medicaid managed care plans collect, maintain, and report complete and accurate Encounter Data for all services furnished to Enrollees, regardless of the payment methodology used. Likewise, the CMS Final Rule for Contract Year 2027 reinforces that the Contractor must ensure that Encounter Data submitted by Providers is timely,

accurate, complete, and sufficient to support federal oversight, rate setting, quality measurement, and program integrity requirements. The 2027 Final Rule further establishes that Encounter Data obligations apply uniformly to all contracted Providers, including those reimbursed under non-capitated, capitated, or alternative payment arrangements, and requires managed care plans to implement processes to validate, monitor, and enforce Provider compliance with Encounter Data reporting standards (see Section 13.8 of this Contract).

7.4.1.9 The Contractor shall be responsible for issuing to the forms required by the Department of the Treasury, in accordance with all Puerto Rico laws, regulations, and guidelines.

7.4.1.10 The Contractor shall make timely payments to Providers in accordance with the timeliness standards outlined in Section 13.10 of this Contract.

7.4.1.11 Payments to FQHCs and RHCs. When the Contractor negotiates a contract with an FQHC and/or an RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act, the Contractor shall pay to the FQHC or RHC rates that are not less than the rates paid to other similar Providers providing similar services. The Contractor shall cooperate with ASES and the Department of Health in ensuring that payments to FQHCs and RHCs are consistent with Sections 1902(a)(15) and 1902(bb)(5) of the Social Security Act.

7.4.1.12 Requirement to Verify Eligibility. The Contractor warrants that all of its Network Providers shall verify the eligibility of Enrollees before the Provider provides Covered Services. This verification of eligibility is a condition of receiving payment from the Contractor for Covered Services.

7.4.1.13 Payments to Providers Owing Funds to ASES. Upon receipt of notice from ASES that ASES is owed funds by a Provider due to an Overpayment or other reasons, the Contractor shall reduce payment to the Provider for all Claims submitted by that Provider by one hundred percent (100%), or such other amount as ASES may elect, until the amount owed to ASES is recovered. The Contractor shall promptly remit any such funds recovered to ASES in the manner specified by ASES. To that end, the Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to ASES.

7.4.1.14 Payment Rates Subject to Change. If applicable, the Contractor shall adjust its negotiated rates with Providers to reflect budgetary changes, as directed by the Executive Director of ASES, to the extent that such adjustments can be made within funds appropriated to ASES and available for payment to the Contractor. The Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's

execution of the Provider Contract shall constitute agreement with the Contractor's obligation to ASES.

ARTICLE 8 UTILIZATION MANAGEMENT

8.1 General

8.1.1 The Contractor shall comply with Puerto Rico and Federal requirements for Utilization Management ("UM") including but not limited to 42 CFR Part 456.

8.1.2 The Contractor shall ensure the involvement of appropriate, knowledgeable, currently practicing Providers in the development of UM procedures.

8.1.3 The Contractor shall manage the use of a limited set of resources and maximize the effectiveness of care by evaluating clinical appropriateness and authorizing the type and volume of services through fair, consistent, and Culturally Competent decision-making processes while ensuring equitable Access to care and a successful link between care and outcomes.

8.1.4 The Contractor shall submit to ASES, on an annual basis and as part of the required contractual reports pursuant to Section 15.2.1.18, a complete inventory of all Utilization Management ("UM") edits embedded in the Contractor's claims processing system that control utilization and prevent improper payment. This inventory shall include, at a minimum, edits designed to identify duplicate claims, unbundled services, services included within another payable code, mutually exclusive procedures, and any other UM edits used to prevent inappropriate billing or payment.

8.1.5 The Contractor shall ensure that all UM edits comply with applicable Puerto Rico and Federal requirements, including 42 CFR Part 456 and 42 CFR 438.210. For dual-eligible Enrollees under the Medicare Platino Program, the Contractor shall also ensure compliance with CMS Utilization Management requirements for Medicare Advantage and D-SNP pursuant to 42 CFR Part 422. The Contractor shall maintain all supporting documentation related to the design, application, and effectiveness of these UM edits and shall make such documentation available to ASES upon request.

8.1.6 The Contractor may apply appropriate UM limits, provided that services for enrollees with chronic or ongoing conditions, or those requiring LTSS (to the extent applicable), are authorized in a manner that reflects the Enrollee's ongoing need for such services and supports, consistent with 42 CFR 438.210(a)(4)(ii)(B).

8.1.7 The Contractor shall submit a monthly Utilization Management (UM) report to the Office of Clinical Operations, in accordance with the reporting elements and Attestation requirements established in Section 15.2.1.18.1.

8.1.8 ASES reserves the right require the Contractor to submit any Utilization Management report.

8.2 Utilization Management Policies and Procedures

8.2.1 The Contractor shall provide assistance to Enrollees and Providers to ensure the appropriate Utilization of resources. The Contractor and its Subcontractors, as applicable, shall have written Utilization Management policies and procedures included in the Provider Guidelines (see Section 7.1) that:

8.2.2 Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over, under, and inappropriate Utilization. Such protocols and criteria shall comply with Federal and Puerto Rico laws and regulations.

8.2.3 Address which services require PCP Referral, which services require a Service Authorization Request or Prior Authorization, and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective, or prospective review.

8.2.4 Describe mechanisms in place that ensure consistent application of review criteria for Service Authorization Requests and consult with the requesting Provider when appropriate.

8.2.5 Require that all Medical Necessity determinations be made in accordance with ASES's Medical Necessity definition. Divergence from standards set forth in clinical protocols and guidelines cannot be the sole reason for denying a Covered Service if the divergence is documented by the treating physician and supported by clinical evidence and generally accepted medical norms; appropriate in type, frequency, grade, setting and duration; and not solely for the convenience of the Enrollee, treating or other Provider, or the Contractor.

8.2.6 Facilitate the delivery of high quality, low cost, efficient, and effective care.

8.2.7 Ensure that services are based on the history of the problem or illness, its context, and desired outcomes.

8.2.8 Emphasize relapse and crisis prevention, not just crisis intervention.

8.2.9 Detect over, under, and inappropriate Utilization of services to assess quality and appropriateness of services and to assess quality and appropriateness of care furnished to Enrollees with special health care needs.

8.2.10 Ensure that any decision to deny a Service Authorization Request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a Provider who has appropriate clinical expertise to understand the treatment of the Enrollee's condition or disease, such as the Contractor's medical director.

8.2.11 Utilization Guidelines to be used for clinical audit must be approved by ASES and must be prepared by nationally recognized companies. The Contractor submitted as part of the information requested, the licenses for use and certification of personnel training that will be using. These Guidelines should be sent to the Executive Office within thirty (30) days of signed contract.

8.2.12 The Contractor's Utilization Management policies and procedures shall define when a conflict of interest for a Provider involved in Utilization Management activities may exist and shall describe the remedy for such conflict.

8.2.13 The Contractor, and any delegated Utilization Management agent, shall not permit or provide compensation or anything of value to its employees, Agents, or contractors based on:

8.2.13.1 Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or

8.2.13.2 Any other method that encourages a decision to deny, limit, or discontinue a Medically Necessary Covered Service to any Enrollee, as set forth by 42 CFR 438.210(e).

8.3 Utilization Management Guidance to Enrollees.

8.3.1 As provided in Section 4.3.1.14, the Contractor shall provide clear guidance to Enrollees on its Utilization Management policies. Upon request, the Contractor shall provide Utilization Management decision criteria to Providers, Enrollees, their families, and the public. The Contractor shall notify all Utilization Management guidelines and decision criteria to ASES's Clinical Operations Office, in accordance with the deliverable requirements and timeframes established in Appendix L to this Contract.

8.4 Timeliness of Prior Authorization Requests

8.4.1 For services that require Prior Authorization by the Contractor, the Service Authorization Request shall be submitted promptly by the Provider for the Contractor's approval, so that Prior Authorization may be provided within required timeframes set forth in Section 11.4.7.

8.5 Prohibited Actions

8.5.1 Any denial, unreasonable delay, or rationing of Medically Necessary Services to Enrollees is expressly prohibited. The Contractor shall ensure compliance with this prohibition by Network Providers and any other entity involved in the provision of Behavioral Health services to Medicare Platino Enrollees. Should the Contractor violate this prohibition, the Contractor shall be subject to the provisions of Article VI, Section 6 of Act 72 and 42 CFR Part 438, Subpart I – Sanctions. Furthermore, the CMS Final Rule for Contract Year 2027 reinforces federal protections requiring that managed care plans ensure timely access to Medically Necessary Services and prohibits

practices that result in inappropriate service denials, delays, or rationing. The 2027 Final Rule strengthens enforcement mechanisms under Subpart I by clarifying that states must impose sanctions when plans fail to provide required services, engage in patterns of inappropriate denials, or otherwise restrict access to covered benefits. In the context of this Contract, PRHIA (ASES), as the State entity responsible for program administration and oversight, reaffirms its authority to impose the sanctions established under Subpart I, as well as any other sanctions or remedies permitted by law or by this Agreement, in response to any Contractor non-compliance.

8.6 Emergency Services

8.6.1 Prior Authorization shall not be required for any Emergency Service, regardless of whether it is ultimately determined that the condition for which the Enrollee sought treatment from an Emergency Services Provider did not constitute an Emergency Medical Condition or a Psychiatric Emergency. This requirement is established pursuant to 42 CFR 438.114, which prohibits Medicaid managed care plans from requiring prior authorization for Emergency Services under the prudent layperson standard. Equally, the CMS Final Rule for Contract Year 2027 further requires states to ensure that managed care plans do not impose prior authorization requirements, delays, or retrospective determinations that restrict access to Emergency Services. In the context of this Contract, PHIA (ASES), as the State entity responsible for Program oversight, and the Contractor agree that compliance with this prohibition is mandatory. ASES reaffirms its authority to impose sanctions under 42 CFR Part 438, Subpart I, as well as any other remedy permitted by law or by this Agreement, in the event of Contractor non-compliance.

ARTICLE 9 QUALITY IMPROVEMENT AND PERFORMANCE PROGRAM

9.1 General Provisions

9.1.1 The Contractor shall provide for the delivery of quality care to all Enrollees with the primary goal of improving health status or, in instances where the Enrollee's health is not amenable to improvement, maintaining the Enrollee's current health status by implementing measures to prevent any further deterioration of his or her health status.

9.1.2 The Contractor shall seek input from, and work with, Enrollees, Providers, community resources, and agencies to actively improve the quality of care provided to Enrollees.

9.1.3 The Contractor shall ensure that its Quality Assessment and Performance Improvement Program effectively monitors the program elements listed in 42 CFR 438.66.

9.1.4 ASES, in strict compliance with 42 CFR 438.340 and other applicable Federal and Puerto Rico regulations, including the requirements reinforced under the CMS Final Rule for Contract Year 2027, shall evaluate the delivery of health care by the Contractor. Such quality monitoring shall include, at a minimum, the review and reporting of the following measures to CMS and ASES, as required:

9.1.4.1 Health Plan and Employer Data Information Set (HEDIS)

9.1.4.2 Consumer Assessment of Health Plan Satisfaction (CAHPS)

9.1.4.3 Health Outcomes Survey (HOS)

9.1.4.4 Medicaid & CHIP Program Annual Report (MCPAR)

9.1.4.5 Network Adequacy and Access

9.1.4.6 Analysis Report (NAAAR)

9.1.4.7 Medical Loss Ratio (MLR) Reporting

9.1.4.8 Pursuant to 42 CFR Part 438, including but not limited to Subpart D (Quality), Subpart H (MLR), and Subpart I (Sanctions), and as reinforced by the 2027 Final Rule, the Contractor shall, at a minimum, fully cooperate with ASES in the collection, validation, submission, and verification of all data required for these reports. The Contractor shall provide timely, accurate, and complete information, and shall support ASES in meeting all Federal reporting obligations. Failure to comply may result in sanctions under 42 CFR Part 438, Subpart I and any other remedies permitted by law or this Agreement.

9.1.5 The Contractor shall cooperate with any monitoring by Puerto Rico or the Federal Government of its performance under this Contract, as required by 42 CFR Part 438, which may include, among others, external quality reviews, operational reviews, performance audits, financial audits, and evaluations. Such monitoring may also include audits or monitoring of care coordination, case management, accessibility compliance, network adequacy, data integrity, claims processing, external quality reviews, information systems and data security, oversight of delegated entities, and activities related to fraud, waste, and abuse (FWA). These monitoring activities may be used to determine the accuracy, truthfulness, and completeness of the information, data, and reports submitted by the Contractor.

9.1.5.1 In accordance with 42 CFR 422.503, 42 CFR 422.504, and 42 CFR 422.107, as reinforced by the CMS Final Rule for Contract Year 2027, Medicare Advantage Organizations operating a D-SNP are required to provide federal and state oversight entities with full access to audit results, compliance findings, financial audits, and Corrective Action Plans. By virtue of these requirements, ASES is authorized to require the submission of such information, and the Parties expressly agree to this obligation.

9.1.5.2 The Contractor shall submit to the ASES Compliance Office the results of all audits conducted on the Medicare Platino product under the Medicare Advantage product operating within the Medicaid Platino program during the past five years, no later than January 31, 2027. The Contractor shall also submit any responses provided and any corrective action plans developed based on the findings, including their final determination.

9.1.5.3 Audits and oversight reviews may include, among others, reviews of quality, access, timeliness of services to Enrollees, claims, encounters, policies and procedures, program integrity, financial reporting, or any other results issued by an accrediting body. Any new report received shall be submitted to the ASES Compliance Office within 30 calendar days of its receipt from CMS or another oversight entity.

9.1.6 The Contractor shall identify, collect and provide any Data, Medical Records or other Information requested by ASES or its authorized representative or the Federal agency or its authorized representative in the format specified by ASES/Federal agency or its authorized representative. The Contractor shall ensure that the requested Data, Medical Records, and other Information is provided at no charge to ASES, all Federal agencies, or their authorized representative.

9.1.7 If requested, the Contractor shall provide workspace at the Contractor's local offices for ASES, any Federal agencies, or their authorized representative to review requested Data, Medical Records, or other Information.

9.2 Quality Assessment Performance Improvement ("QAPI") Program

9.2.1 The Contractor shall comply with Puerto Rico and Federal standards for Quality Management/Quality Improvement ("QM/QI").

9.2.1.1 The Contractor shall establish QAPI that specifies the Contractor's quality measurement and performance improvement activities using clinically sound, nationally developed and accepted criteria.

9.2.1.2 The Contractor's QAPI program must include mechanisms to detect both underutilization and overutilization of Covered Services, assess the quality and appropriateness of care furnished to Enrollees with special health care needs, and be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction.

9.2.2 The QAPI program shall comply with Federal requirements specified at 42 CFR 438, Subpart E.

9.2.3 The Contractor agrees to implement a Chronic Care Improvement Program (CCIP) applicable to its Enrollees in accordance with Section 1852 of the Social Security Act and the requirements set forth in 42 CFR 422.152, including all standards governing chronic care improvement initiatives for Medicare Advantage Organizations. The CCIP shall be developed, executed, and evaluated consistent with CMS guidance and the obligations applicable to Dual Eligible Special Needs Plans (D-SNPs).

9.2.4 The Contractor shall submit the annual CCIP report, as required by CMS, to both CMS and ASES as part of the deliverables identified in Appendix L. The report shall be submitted to ASES through its Clinical Operations Division.

9.2.5 The submission shall include all required components established by CMS for the applicable contract year, including performance metrics, evaluation of interventions, population health outcomes, and any updates or modifications to the CCIP.

9.2.6 The Contractor's annual QAPI program shall be submitted to ASES for review and prior written approval according to the timeframe set forth in Appendix L to this Contract and subject to the annual reporting requirements outlined in Section 15.2.1.5.

9.2.7 The Contractor shall submit any changes to its Quality Assessment and Performance Improvement (QAPI) Program to ASES for review and prior written approval at least sixty (60) Calendar Days before the proposed implementation date. Each submission shall include a certification attesting to the accuracy, completeness, and effective incorporation of the changes made to the QAPI Program, as well as a description of the specific modifications implemented. All submissions shall be provided to ASES through its Clinical Operations Division.

9.2.8 Upon the request of ASES, the Contractor shall provide any Information and documents related to the implementation of the QAPI program.

9.2.9 At the ASES's option, the Contractor exclusively serving dual-eligible enrollees may substitute a Medicare Advantage quality-improvement project for one or more Performance Improvement Projects (PIPs) otherwise required under this contract, consistent with 42 CFR 438.330(d)(4) and 42 CFR 422.152(d).

9.2.10 At the ASES's option, the Contractor shall develop and maintain a formal process to evaluate the impact and effectiveness of its Quality Assessment and Performance Improvement (QAPI) program, consistent with 42 CFR 438.330(e)(2) and 42 CFR 438.310(c)(2).

9.3 External Quality Review ("EQR")

9.3.1 In accordance with 42 CFR 438.350 ("External Quality Review"), the Contractor shall undergo an annual external and independent review of the quality, timeliness, and access to the Covered Services provided under this Contract. This requirement shall apply unless the Contractor meets the conditions to qualify for an exemption from External Quality Review (EQR) pursuant to 42 CFR 438.362 ("Exemptions from External Quality Review").

9.3.2 The EQR process shall comply with the updated quality evaluation standards, uniform measurement methodologies, transparency requirements, and state and federal reporting obligations applicable to managed care organizations, as reinforced by the CMS Final Rule for Medicaid Managed Care 2027. The Contractor shall fully cooperate with the EQR process and provide all information, documentation, and access required by the external review entity, CMS, and ASES.

9.4 Accreditation

9.4.1 In accordance with 42 CFR § 438.32(b)(1)–(3) ("Accreditation Requirements"), the Contractor shall inform ASES whether it has been accredited by a private,

independent accrediting entity and shall authorize such accrediting entity to transmit directly to ASES a copy of its most recent accreditation review. This document shall be considered a required deliverable under Appendix L. The Contractor shall coordinate with the accrediting entity to ensure the direct submission of this copy to the Clinical Operations Office on or before fifteen (15) days from the date the accreditation is issued or updated. If the accrediting entity does not submit the document, the Contractor shall be responsible for submitting the copy on its own within the same timeframe.

ARTICLE 10 FRAUD, WASTE, AND ABUSE

10.1 General Provisions

10.1.1 The Contractor shall have and implement a comprehensive internal administrative and management controls, policies, and procedures in place designed to prevent, detect, report, investigate, correct, and resolve potential or confirmed cases of Fraud, Waste, and Abuse in the administration and delivery of services detailed in this Contract.

10.1.2 The Contractor's internal controls, policies, and procedures shall comply with all Federal requirements regarding Fraud, Waste, and Abuse and program integrity, including but not limited to Sections 1128, 1128A, 1156, 1842(j)(2), 1902(a)(68), and 1903(i)(2)(C) of the Social Security Act, 42 CFR 438.608, the CMS Medicaid Integrity program, and the Deficit Reduction Act of 2005. The Contractor shall exercise diligent efforts to ensure that no payments are made to any person or entity that has been excluded from participation in Federal health care programs. (See State Medicaid Director Letter #09-001, January 16, 2009.)

10.1.3 For these purposes, the Contractor shall comply with all Federal exclusion requirements, including monthly screening of the HHS-OIG List of Excluded Individuals/Entities (LEIE), ensuring that no payments or contractual or employment relationships exist with excluded individuals or entities, reviewing additional Federal exclusion databases such as SAM.gov and OFAC, reporting any exclusion findings to ASES and/or CMS, and implementing internal controls that ensure compliance pursuant to 42 U.S.C. § 1320a-7, 42 CFR 1001.1901, 42 CFR 422.503(b)(4)(vi)(F), 42 CFR 438.610, and the Medicare Managed Care Manual, Chapter 21.

10.1.4 The Contractor shall maintain and implement comprehensive surveillance and Utilization control programs, consistent with 42 CFR 456.3, 42 CFR 456.4, and 42 CFR 456.23, to prevent under-utilization, unnecessary or inappropriate use of Covered Services, and excess payments. These programs shall include prospective, concurrent, and retrospective Utilization review; monitoring of service patterns and encounter data; identification of aberrant Utilization trends; and the implementation of Corrective Action Plans when irregularities are detected.

10.1.5 The Contractor shall have adequate staffing and resources to identify and investigate unusual incidents and develop and implement Corrective Action plans to assist the Contractor in preventing and detecting potential Fraud, Waste, and Abuse.

10.1.6 The Contractor shall establish effective lines of communication between the Contractor's compliance officer and the Contractor's employees to facilitate the oversight of systems that monitor service Utilization and Encounters for Fraud, Waste, and Abuse.

10.1.7 The Contractor shall submit its Fraud, Waste, and Abuse policies and procedures, its proposed compliance plan, and its program integrity plan to ASES for prior written approval according to the timeframe set forth in Appendix L to this Contract.

10.1.8 Any changes to the Contractor's Fraud, Waste, and Abuse policies and procedures must be submitted to ASES for approval within fifteen (15) Calendar Days of the date the Contractor plans to implement the changes and the changes shall not go into effect until ASES provides prior written approval.

10.1.9 The Contractor shall comply with all Program Integrity provisions established under the Patient Protection and Affordable Care Act (PPACA) and applicable Federal regulations, including but not limited to:

10.1.9.1 Section 6401 of the PPACA "Enhanced Provider Screening and Enrollment";

10.1.9.2 Section 6501 of the PPACA "Termination of Provider Participation";

10.1.9.3 Section 6401(a) "Disclosure of Current or Previous Affiliation with Excluded Providers";

10.1.9.4 Provider screening and enrollment, 42 CFR Part 455, Subpart E;

10.1.9.5 42 CFR Part 455, Subpart B – Provider Disclosure Requirements;

10.1.9.6 42 CFR 455.23 "Mandatory Payment Suspension Based on Credible Allegations of Fraud";

10.1.9.7 42 CFR 438.608 "Program Integrity Requirements for Managed Care Organizations"; and

10.1.9.8 Medicare Advantage Compliance Program Requirements for D-SNP Contractors" 42 CFR 422.503(b)(4)(vi).

10.1.10 The Contractor shall implement and maintain an effective compliance and program integrity program, including internal controls, auditing and monitoring systems, fraud prevention safeguards, verification of provider licensure and enrollment, exclusion screening, ownership and control disclosures, reporting of suspected fraud, waste, or abuse, and timely cooperation with State and Federal oversight entities. The Contractor shall also ensure that all subcontractors and network Providers comply with these requirements.

10.1.11 Contractor shall inform ASES's Compliance Office in writing, within twenty-four (24) hours of becoming aware of any compliance breach with a significant suspicion of fraud or cybersecurity event involving the Contractor and/or any Network Provider. Such notification shall include, at a minimum:

10.1.11.1 the nature and scope of the breach;

10.1.11.2 the date the breach was identified;

10.1.11.3 the individuals, providers, subcontractors, or entities involved;

10.1.11.4 the actual or potential impact on Members, program operations, or Medicaid funds;

10.1.11.5 corrective actions taken or proposed; and

10.1.11.6 any other information relevant to enable ASES to assess and respond to the breach.

10.1.12 This requirement shall be carried out in accordance with the timely reporting standards established under 42 CFR 438.608 "Program Integrity Requirements for Medicaid Managed Care Organizations", 42 CFR Part 455, Subpart B "Provider Disclosure Requirements", 42 CFR Part 455, Subpart E " Provider Screening and Enrollment", and 42 CFR 422.503(b)(4)(vi) " Medicare Advantage Compliance Program Requirements" applicable to Dual Eligible Special Needs Plans (D-SNPs). The Contractor shall maintain all necessary supporting documentation, cooperate fully with ASES, and ensure that all subcontractors and Network Providers comply with these reporting obligations.

10.1.13 The Contractor shall inform the Medicaid Fraud Control Unit and ASES of any meetings it holds with any other Medicare Platino or GHP MCOs related to compliance and program integrity issues at least forty-eight (48) hours prior to the meeting. The Contractor shall provide a copy of the meeting minutes as well as the results of any follow-up investigations to ASES in writing Immediately.

10.1.14 The Contractor shall develop, implement, and maintain policies and procedures, and shall submit such policies and procedures as part of Appendix L to ASES for prior written approval, to address:

10.1.15 Immediately notifying ASES of pending Network Provider investigations, suspensions, terminations, or debarments; and

10.1.16 Transitioning Enrollees from suspended, terminated, or debarred Network Providers.

10.1.17 These policies and procedures shall, at a minimum, include:

10.1.17.1 Procedures to detect, prevent, and report fraud, waste, and abuse, including monitoring of subcontractors and Network Providers, consistent with 42 CFR 438.608 "Program Integrity Requirements for Medicaid Managed Care Organizations".

10.1.17.2 Requirements for immediate reporting of credible allegations of fraud and compliance with 42 CFR 455.23.

10.1.17.3 Administrative arrangements designed to prevent fraud, waste, and abuse, as required under 42 CFR 438.608(a).

10.1.17.4 Procedures for timely transition of Enrollees to ensure continuity of care when Network Providers are suspended, terminated, or debarred, consistent with 42 CFR 438.62 "Continuity and Coordination of Care", 42 CFR 438.206(b)(4) "Availability of Services", and the administrative requirements to prevent fraud, waste, and abuse under 42 CFR 438.608(a) "Administrative Requirements to Prevent Fraud, Waste, and Abuse", as implemented through the Medicaid Managed Care Final Rule (CMS-2390-F).

10.1.18 The Contractor shall ensure that all subcontractors and Network Providers comply with these policies and procedures and shall maintain documentation demonstrating adherence to these requirements.

10.2 Compliance Plan

10.2.1 The Contractor shall maintain a written Fraud, Waste, and Abuse (FWA) Compliance Plan that includes clearly defined program goals and objectives, program scope, and a methodology to evaluate program performance. The Compliance Plan shall comply with the requirements established under 42 C.F.R. § 422.503(b)(4)(vi), "Compliance program requirements" and 42 C.F.R. § 423.504(b)(4)(vi), "Compliance program requirements", which mandate that Medicare Advantage Organizations and Part D Sponsors implement and maintain an effective compliance program, including measures to detect, correct, and prevent fraud, waste, and abuse.

10.2.2 A paper and electronic copy of the Compliance Plan shall be submitted to ASES annually for prior written approval, in accordance with the timeframe set forth in Appendix L to this Contract. ASES shall provide written notice of approval, denial, or required modifications within thirty (30) Calendar Days of receipt. The Contractor shall implement any changes required by ASES within an additional thirty (30) Calendar Days of the request.

10.2.3 The Compliance Plan shall also incorporate all applicable provisions of the CMS Final Rule related to program integrity and compliance oversight, including the requirements codified at 42 C.F.R. 422.503(b)(4)(vi), "Compliance program requirements" and 42 C.F.R. 423.504(b)(4)(vi), "Compliance program requirements". The Contractor shall ensure:

10.2.3.1 Strengthened oversight of delegated entities, including documented monitoring, auditing, and verification that delegated functions are performed in full compliance with Medicare and Medicaid program requirements.

10.2.3.2 Documented methodologies and auditable evidence demonstrating the effectiveness of the compliance program, including monitoring activities, internal audits, corrective actions, and follow-up validation.

10.2.3.3 Formal documentation and timely reporting of all FWA investigations, including case intake, triage, investigative steps, findings, and disposition, consistent with CMS program integrity expectations, ASES, and other State regulatory Agencies.

10.2.3.4 Timely implementation of Corrective Action Plans (CAPs), including written CAPs, deadlines, responsible parties, and documented closure with evidence of sustained remediation.

10.2.3.5 Maintenance of complete, accurate, and auditable records for all compliance activities for a minimum period required by CMS, and in a manner that allows ASES, other State agencies and CMS to verify compliance at any time.

10.2.3.6 Immediate escalation and reporting of potential non-compliance or misconduct in accordance with CMS and ASES program integrity rules and the contractor's internal reporting mechanisms.

10.2.3.7 Annual review, update, and Board-level approval of the Compliance Plan, ensuring alignment with the most current CMS regulatory updates and Final Rule requirements

10.2.4 At a minimum, the Contractor's Fraud, Waste, and Abuse (FWA) Compliance Plan shall comply with the requirements established under 42 C.F.R. 438.608, *Program Integrity Requirements*, and shall incorporate all applicable provisions of the CMS Final Rule related to Medicaid managed care program integrity:

10.2.4.1 Ensure that all of its officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud, Waste, and Abuse compliance plan;

10.2.4.2 Require the designation of a compliance officer and a compliance committee that are accountable to the Contractor's senior management. The compliance officer shall have express authority to provide unfiltered reports directly to the Contractor's most senior leader and governing body;

10.2.4.3 Ensure and describe effective training and education for the compliance officer and the Contractor's employees on CMS and ASES standards and requirements under this Contract;

10.2.4.4 Ensure that Providers and Enrollees are educated about Fraud, Waste, and Abuse identification and reporting in the materials provided to them;

10.2.4.5 Ensure effective lines of communication between the Contractor's compliance officer and the Contractor's employees to ensure that employees understand and comply with the Contractor's Fraud, Waste, and Abuse program;

10.2.4.6 Ensure enforcement of standards of conduct through well-publicized disciplinary guidelines;

10.2.4.7 Ensure internal monitoring and auditing with provisions for prompt response to potential offenses, along with the prompt referral of any such offenses to MFCU, and for the development of corrective action initiatives relating to the Contractor's Fraud, Waste, and Abuse efforts;

10.2.4.8 Include policies and procedures that describe standards of conduct that articulate the Contractor's commitment to comply with all applicable Puerto Rico and Federal requirements and standards;

10.2.4.9 Ensure that no individual who reports Provider violations or suspected cases of Fraud, Waste, and Abuse is retaliated against; and

10.2.5 The Contractor shall include a monitoring program designed to prevent and detect potential or suspected Fraud, Waste, and Abuse (FWA), consistent with the requirements of 42 CFR 422.503(b)(4)(vi) (Medicare Advantage Compliance Program Requirements) and 42 CFR 438.608(a) (Program Integrity Requirements). This monitoring program shall include, but not be limited to:

10.2.5.1 Monitoring the billings of its Providers to ensure Enrollees receive the services for which the Contractor is billed, including the use of data analytics, risk-based monitoring, and identification of aberrant billing patterns, as required under 42 CFR 422.503(b)(4)(vi)(F) and 42 CFR 438.608(a)(1)(iii);

10.2.5.2 Requiring the investigation of all reports of suspected cases of Fraud, Waste, Abuse, and over-billing, including timely referrals to ASES, PIU, CMS, OIG, MFCU, or other authorities, as required under 42 CFR 422.503(b)(4)(vi)(G) and 42 CFR 438.608(a)(7);

10.2.5.3 Reviewing Providers for over-utilization, under-utilization, and inappropriate utilization of services, supported by comparative analytics, benchmarking, and periodic audits, consistent with 42 CFR 422.152(f) (Utilization Management Requirements) and 42 CFR 438.210(e);

10.2.5.4 Verifying with Enrollees the delivery of services as claimed, including at a minimum the confirmation of service dates, provider identity, and the nature of the services rendered, through outbound calls, surveys, or other validated methods such as targeted document reviews, structured interviews, electronic verifications, claim-discrepancy analyses, and any other mechanism that reliably corroborates that the billed services were in fact delivered. These activities shall comply with the obligations established under 42 CFR 422.504(a)(13) (accuracy and verification of data submitted to CMS) and 42 CFR 438.608(a)(1)(iii) (verification of services actually

rendered), and incorporate risk-based monitoring, data analytics, and coordination with the Contractor's Compliance Program and Special Investigations Unit (SIU) to identify potential indicators of fraud, waste, or abuse; and

10.2.5.5 Reviewing and trending Enrollee Complaints regarding Providers to identify patterns or indicators of potential Fraud, Waste, or Abuse, including the categorization, analysis, and follow-up of complaint data to detect anomalies or repeated concerns. These activities shall comply with the program integrity obligations under 42 CFR 422.504(a)(13) (accuracy and verification of data submitted to CMS) and 42 CFR 438.608(a)(1)(iii) (verification of services actually furnished), as well as the requirements reinforced in the Medicare Advantage and Part D Final Rule (CMS-4201-F), which emphasizes enhanced oversight of provider behavior, complaint tracking, and timely escalation of issues. This process shall incorporate risk-based monitoring, data analytics, and coordination with the Contractor's Compliance Program and Special Investigations Unit (SIU) to ensure early detection and appropriate handling of potential fraud, waste, or abuse.

10.2.5.6 Implement and maintain arrangements or procedures for prompt reporting of all Overpayments identified or recovered, specifying any Overpayments due to potential Fraud, to ASES. Overpayment reporting should specify if the overpayment was on a Medicaid-only covered service or if the overpayment was for a cross-over claim.

10.2.6 The Contractor and any Subcontractors delegated the responsibility by the Contractor for coverage of services and payment of claims under this Contract, shall include in all employee handbooks a specific discussion of Fraud, Waste, and Abuse laws (including the False Claims Act), corresponding policies and procedures, the rights of whistleblowers to be protected, and the Contractor's and Subcontractor's procedures for detecting and preventing Fraud, Waste, and Abuse.

10.2.7 The Contractor shall include in the Evidence of Coverage (EOC) instructions on how to report Fraud, Waste, and Abuse and the protections for whistleblowers.

10.3 Program Integrity Plan

10.3.1 The Contractor shall develop a program integrity plan that at a minimum:

10.3.1.1 Defines Fraud, Waste, and Abuse;

10.3.1.2 Specifies methods to detect Fraud, Waste, and Abuse;

10.3.1.3 Describes a process to perform investigations on each suspected case of Fraud, Waste, and Abuse;

10.3.1.4 Describes the Contractor's staff responsible for conducting the investigations and reporting of potential Fraud, Waste, or Abuse, including an organizational chart documenting roles and responsibilities;

10.3.1.5 Includes a variety of methods for identifying, investigating, and referring suspected cases to appropriate entities;

10.3.1.6 Includes a systematic approach to Data analysis;

10.3.1.7 Defines mechanisms to monitor frequency of Encounters and services rendered to Enrollees billed by Providers;

10.3.1.8 Identifies requirements to complete the preliminary investigation of Providers and Enrollees;

10.3.1.9 Include provisions regarding prompt terminations of inactive Providers due to inactivity in the past twelve (12) months;

10.3.1.10 Include a risk assessment of the Contractor's various Fraud, Waste, and Abuse processes. The risk assessment shall include a listing of the Contractor's top three (3) vulnerable areas and outline action plans to mitigate risks;

10.3.1.11 Include procedures for the confidential reporting of potential Fraud, Waste, and Abuse, including potential Contractor violations, to the appropriate agency, including the prompt referral of potential Fraud, Waste, and Abuse to MFCU; and

10.3.1.12 Include procedures to ensure that there is no retaliation against an individual who reports Contractor violations or other potential Fraud, Waste, or Abuse to the Contractor or an external entity.

10.3.2 The Contractor's program integrity plan shall comply in all respects with ASES's guidelines for the development of a program integrity plan. Upon review of the Contractor's Program Integrity Plan, ASES will promptly (within twenty (20) Business Days) notify the Contractor of any needed revisions in order for the program integrity plan to comply with the guidelines and with Federal law. The Contractor, in turn, shall promptly (within twenty (20) Business Days of receipt of the ASES comments) re-submit its Plan for ASES review and prior written approval.

10.3.3 The Contractor shall notify ASES within two (2) Business Days of any initiated investigation of a suspected case of Fraud, Waste, or Abuse, and shall otherwise comply with the requirements set forth in Section 10.5.2. The Contractor shall subsequently report preliminary results of such investigations activities to ASES and other appropriate Puerto Rico and Federal entities. ASES will provide the Contractor with guidance during the pendency of the investigation and will refer the matter to the US Department of Justice.

10.4 Prohibited Affiliations with Individuals Debarred by Federal Agencies

10.4.1 The Contractor shall not knowingly have a relationship with the following:

10.4.1.1 Any person or entity that has been, or whose affiliated subsidiary companies, or any of its shareholders, partners, officers, principals, managing employees,

subsidiaries, parent companies, officers, directors, board members, or ruling bodies have been, 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 corruption, fraud, embezzlement, or unlawful appropriation of public funds, pursuant to Act No. 2-2018, as amended.

10.4.1.2 An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under Executive Order No. 12549 or under any guidelines implementing the Executive Order.

10.4.1.3 An individual who is an Affiliate, as defined in the Federal Acquisition Regulation, of a person described in Section 10.4.1.2. The relationship is defined as follows:

10.4.1.3.1 director, officer, or partner of the Contractor;

10.4.1.3.2 A person with beneficial ownership of five percent (5%) or more of the Contractor's equity; or

10.4.1.3.3 Any Subcontractor, or other person with an employment, consulting, or other arrangement with the Contractor for the provision of items or services that are significant and material the Contractor's obligations under this Contract.

10.4.1.3.4 A Network Provider or person with an employment, consulting or other arrangement with the Contractor for the provision of items and services that are significant and material to the Contractor's obligations under the Contract.

10.4.2 The Contractor shall not have a relationship with an individual or entity that is excluded from participation in any Federal health care program under Section 1129 or 1128A of the Social Security Act, or with an individual or entity convicted of crimes described in Section 1128(b)(8)(B) of the Social Security Act. This Section shall also apply to any subcontracted relationships.

10.4.3 The Contractor must provide written disclosure of any individuals or entities described in this Section 10.4. If ASES learns that a Contractor has a prohibited relationship with an individual or entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or if the Contractor has relationship with an individual who is an Affiliate of such an individual, this Contract may continue unless the Secretary directs otherwise. However, this Contract may not be renewed or otherwise extended in duration unless the Secretary provides to ASES and to Congress a written statement describing compelling reasons that exist for renewing or extending this Contract despite the prohibited affiliations.

10.5 Reporting and Investigations

10.5.1 The Contractor shall cooperate with all duly authorized Federal and Puerto Rico agencies and representatives in reporting, investigating and prosecuting Fraud, Waste, and Abuse.

10.5.2 The Contractor shall have methods for identifying, investigating, and referring suspected Fraud, Waste, and Abuse pursuant to 42 CFR 455.1, 42 CFR 455.13, 42 CFR 455.14 and 42 CFR 455.21 and Immediately notifying ASES. All suspected or confirmed instances of Provider Fraud and Enrollee abuse and neglect shall be referred Immediately by the Contractor to ASES, the Puerto Rico Medicaid Program, and the Medicaid Fraud Control Unit.

10.5.3 The Contractor shall Immediately report to ASES the identity of any Provider or other person who is debarred, suspended, or otherwise prohibited from participating in procurement activities. ASES shall promptly notify the Secretary of Health and Human Services of the noncompliance, as required by 42 CFR 438.610(d).

10.5.4 The Contractor shall notify ASES within two (2) Business Days of any initiated investigation of a suspected case of Fraud, Waste, or Abuse. The Contractor shall conclude its preliminary investigation within ten (10) Business Days of identifying the potential Fraud, Waste, or Abuse and shall provide the findings of its preliminary investigation in writing to ASES within two (2) Business Days of completing the preliminary investigation.

10.5.5 The Contractor shall subsequently report preliminary results of such investigation activities to ASES and to any other appropriate State or Federal entities. ASES will provide the Contractor with guidance during the pendency of the investigation and will refer the matter to the U.S. Department of Justice and the Medicaid Fraud Control Unit (MFCU), as appropriate. If directed by ASES and/or the Medicaid Fraud Control Unit, the Contractor shall conduct a full investigation. In addition, any communication, notice, directive, request for information, or correspondence issued to the Contractor by the Medicaid Integrity Unit, the Medicaid Fraud Control Unit, the U.S. Department of Justice, or any other regulatory or investigative entity regarding the case shall be promptly logged, preserved, and deposited by the Contractor into the case file created for ASES. Such documentation shall form part of the official case record and shall be maintained for reference, audit, oversight, and future determinations.

10.5.6 The Contractor shall provide the results of its full investigations in writing to ASES within two (2) Business Days of completing the investigation. The Contractor shall consult with ASES, who shall notify the Medicaid Fraud Control Unit, prior to taking any proposed action regarding an instance of suspected or confirmed fraud or Enrollee abuse.

10.5.7 The Contractor and all Subcontractors shall cooperate fully with Federal and State agencies, including the Medicaid Fraud Control Unit, in Fraud, Waste, and Abuse investigations and subsequent legal actions, whether administrative, civil, or criminal.

Such cooperation shall include actively participating in meetings, providing requested Information, access to records, and access to interviews with employees and consultants, including but not limited to those with expertise in the administration of the program and/or medical or pharmaceutical matters or in any matter related to an investigation or prosecution. Such cooperation shall also include providing personnel to testify at any hearings, trials, or other legal proceedings on an as-needed basis.

10.5.8 In accordance with Section 1903(i)(2)(C) of the Social Security Act and 42 CFR 455.23, the Contractor shall have a mechanism in place to suspend payments to any Provider or other Subcontractor when there is a pending investigation of a Credible Allegation of Fraud under the Medicaid program. In addition, for any cases related to Provider Fraud, which ASES must refer to the Medicaid Fraud Control Unit, the Contractor shall refrain from, or suspend any attempt to, recoup amounts related to the reported instance of Provider Fraud from the referred Provider for a period of thirty (30) Calendar Days while the Medicaid Fraud Control Unit conducts its preliminary evaluation. The Contractor may resume recoupment efforts subsequent to the thirty (30) Calendar Days unless otherwise instructed by the Medicaid Fraud Control Unit or ASES. A determination by the Medicaid Fraud Control Unit not to pursue further action on a referred case of Provider Fraud shall in no way be interpreted to restrict attempts by the Contractor to continue to recoup outstanding amount from the Provider, or to pursue further correction action or penalty otherwise permitted by law or under the Provider Contract.

10.5.9 If a Provider is suspended or terminated from participation in the Puerto Rico Medicaid Program by ASES, the Contractor shall also suspend or terminate the Provider.

10.5.10 If a Provider is terminated from Medicare or another state's Medicaid or State Children's Health Insurance Program, the Contractor shall terminate its Provider participation agreement with that Provider (see Section 1902(a)(39) of the Social Security Act and 42 CFR 455.416) and notify ASES Immediately.

10.5.11 The Contractor shall notify ASES in writing no fewer than two (2) Business Days prior to taking any action against a Provider for program integrity reasons, including, but not limited to, the denial of a Provider's Credentialing or Re-Credentialing application, the imposition of corrective action, or any action that limits, restricts, suspends, or terminates the Provider's ability to participate in the program. Such notification shall be complete, detailed, and supported by documentation, and shall include, at a minimum:

10.5.11.1 Identification of the Provider;

10.5.11.2 A precise description of the action to be taken;

10.5.11.3 The specific program integrity basis for the action, including applicable regulatory citations; and

10.5.11.4 All evidence, records, and materials supporting the determination.

10.5.12 The Contractor shall provide any additional Information requested by ASES within a minimum of twenty-four (24) hours from receipt of the request. All notifications and supporting documentation shall be prepared and submitted in accordance with 42 CFR Part 455 ("Program Integrity: Medicaid") and 42 CFR 438.608 ("Program Integrity Requirements").

10.5.13 The Contractor shall submit a risk assessment on an "as needed" basis and Immediately after a program integrity-related action against a Provider. The Contractor shall inform ASES of such action and provide details of such financial action.

10.5.14 The Contractor shall Immediately disclose to ASES any and all criminal convictions of its managing employees

10.5.12 Regarding Provider disclosures, the Contractor shall:

10.5.12.1 Not make payment to a Provider unless the Provider has submitted completed disclosures required by Federal law either to ASES or the Contractor. This includes but is not limited to disclosure regarding ownership and control, business transactions, and criminal convictions (see 42 CFR Part 455, Subpart B).

10.5.12.2 Track information received from ASES identifying Providers from whom ASES has received completed disclosures.

10.5.12.3 For Network Providers for whom ASES has not received completed disclosures, as reported to the Contractor, collect and retain completed Provider disclosures as part of initial Credentialing and then annually, using a disclosure form prior approved by ASES in writing.

10.5.12.4 In accordance with 42 CFR 455.106, Immediately report any criminal conviction disclosures to ASES and explain what action it will take (e.g., terminate the Provider).

10.5.12.5 In accordance with Section 1866(j)(5) of the Social Security Act and implementing regulations, notify ASES if Contractor is informed of or discovers Out-of-Network Providers who (i) have any current or previous affiliations with a Provider or supplier that has uncollected debt, (ii) have been or are subject to a payment suspension under a Federal health care program (as defined in Section 1128B(f)), (iii) have been excluded from participation under Medicare, Medicaid or CHIP, or (iv) have had their billing privileges denied or revoked.

10.6 Service Verification with Enrollees

10.6.1 In accordance with 42 CFR 438.608(a)(5), the Contractor shall implement a process for verifying with Enrollees whether services billed by Providers were received.

10.6.2 The Contractor must employ a methodology and sampling process prior approved by ASES to verify with its Enrollees on a monthly whether services billed to

the Contractor by Providers were actually received. The methodology and sampling process must include criteria for identifying "high-risk" services and Provider types.

10.7 Stark Law Compliance.

The Contractor shall have mechanisms in place to ensure that payments are not made in violation of Section 1903(s) of the Social Security Act with respect to certain physician Referrals as defined in Section 1877 of the Social Security Act. The Contractor shall ensure that disclosing Parties provide a financial analysis that includes the total amount actually or potentially due and owed as a result of the disclosed violation, a description of the methodology used to determine the amount due and owing, the total amount of remuneration involved physicians (or an immediate family member of such physicians) received as a result of an actual or potential violation, and a summary of audit activity and documents used in the audit. In accordance with Section 6409 of the PPACA, the Contractor will encourage provider use of the self-referral disclosure protocols, under which providers of services and suppliers may self-disclose actual or potential violations of the physicians' self-referral statute (Section 1877 of the Social Security Act).

ARTICLE 11 GRIEVANCE AND APPEAL SYSTEM

11.1 General Requirements

11.1.1 In accordance with 42 CFR Part 438, Subpart F and 42 CFR Part 422, Subpart M, the Contractor shall establish an internal, integrated Grievance and Appeal System under which Enrollees, or Providers acting on their behalf, may express dissatisfaction with the Contractor or challenge the denial of coverage of, or payment for, Covered Services.

11.1.2 The Contractor's Grievance and Appeal System shall include (i) a Complaint process, (ii) a Grievance process, (iii) a Service Authorization Request process, (iv) an Appeal process, and (v) access to the Administrative Law Hearing process. The Contractor agrees to comply with all procedures and requirements in (i) 42 CFR 422.560, 422.561, 422.562, 422.566, and 422.592 through 422.626, unless otherwise provided in 422.629 to 422.634, (ii) 42 CFR 422.629 through 422.634, (iii) 42 CFR 438.210, 438.400 and 438.402, (iv) Parts C and D Enrollee Grievance, Organization/Coverage Determinations and Appeals Guidance and (v) Act No. 72-1993, all as amended and as applicable. Any appeals or grievances that are Medicaid only shall meet all 438 requirements and shall be tracked and reported to ASES separate from integrated appeals and grievances.

11.1.3 The Contractor shall designate, in writing, an officer who shall have primary responsibility for ensuring that Complaints, Grievances, Service Authorization Requests, and Appeals are resolved pursuant to this Contract and for signing all Notices of Adverse Benefit Determination. For such purposes, an officer shall mean a president, vice president, secretary, treasurer, chairperson of the board of directors of the Contractor's organization, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

11.1.4 The Contractor shall develop a Grievance and Appeal System and written policies and procedures that detail the operation of the Grievance and Appeal System. The Grievance and Appeal System policies and procedures shall be submitted to ASES for review and prior written approval according to the timeframe specified in Appendix L to this Contract.

11.1.5 At a minimum, the Contractor's Grievance and Appeal System policies and procedures shall include the following, consistent with the requirements of Title 42 of the Code of Federal Regulations (CFR), including 42 CFR Part 438 (Subpart F – Grievance and Appeal System) and 42 CFR Part 422 (Subpart M – Grievances, Organization Determinations, and Appeals), as well as the strengthened communication, disclosure, accessibility, and beneficiary-protection standards established under the Medicare Advantage and Part D Final Rule (CMS-4201-F):

11.1.5.1 Filing processes. A clear and accessible process for filing a Complaint, Grievance, Service Authorization Request, or Appeal, or for seeking an Administrative Law Hearing, including all required steps, timeframes, and available assistance, consistent with 42 CFR 438.402, 438.406, 422.562, and 422.564;

11.1.5.2 Intake, Tracking & Resolution. A process for receiving, documenting, tracking, reviewing, reporting, and resolving Grievances, Service Authorization Requests, and Appeals filed verbally, in writing, or in person, as permitted. This must comply with the recordkeeping and handling requirements under 42 CFR §§ 438.406, 438.416, 422.562, and 422.566;

11.1.5.3 Process Representative & Provider Filings. A process and timeframe for an Enrollee's Authorized Representative or Provider to file a standard or expedited Complaint, Grievance, Service Authorization Request, or Appeal on behalf of an Enrollee, consistent with 42 CFR 438.402, 438.406, 422.562, 422.570, and 422.572;

11.1.5.4 Process Patient Advocate Office Notice. A process for notifying Enrollees of their right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office and clear instructions on how to contact the Patient Advocate Office, consistent with federal disclosure and meaningful-access requirements

11.1.5.5 Information Exchange Procedures. Procedures for the timely and accurate exchange of Information with Enrollees, Authorized Representatives, Providers, and ASES regarding Complaints, Grievances, Service Authorization Requests, and Appeals, consistent with 42 CFR §§ 438.406, 438.408, 422.562, and 422.568.

11.1.5.6 Written Notice Requirements. A process and timeframes for notifying Enrollees in writing regarding the receipt, review, resolution, and any other action related to Complaints, Grievances, Service Authorization Requests, and Appeals. This includes:

requirements governing delays and extensions,

requirements for denials of expedited review,

compliance with notice standards under 42 CFR 438.404, 438.408, 422.568, 422.572,

and adherence to the strengthened communication and beneficiary-protection standards under CMS-4201-F.

11.1.6 The Contractor's Grievance and Appeal System shall fully comply with the Puerto Rico's Patient's Bill of Rights Act, to the extent that such provisions do not conflict with or pose an obstacle to Federal regulations.

11.1.7 The Contractor shall process each Complaint, Grievance, Service Authorization Request or Appeal in accordance with applicable Puerto Rico and Federal statutory and regulatory requirements, this Contract, and the Contractor's written policies and procedures. Pertinent facts from all Parties shall be collected during the process.

11.1.8 The Contractor shall include in the Evidence of Coverage (EOC) clear, complete, and accessible educational information regarding the Contractor's Grievance and Appeal System, in accordance with the applicable federal standards set forth in 42 CFR 438.10 (Information Requirements), 42 CFR 438.406 (Handling of Grievances and Appeals), 42 CFR 438.408 (Resolution and Notification), 42 CFR 422.111 (Disclosure Requirements for MA Organizations), 42 CFR 422.564 (Grievance Procedures), 42 CFR 422.566 (Organization Determinations), 42 CFR 422.568 (Notice of Denial), 42 CFR 422.570 (Expedited Determinations), and 42 CFR 422.572 (Standard Timeframes), as well as the requirements established under the Medicare Advantage and Part D Final Rule (CMS-4201-F), which strengthens federal standards for beneficiary communications, disclosures, accessibility, transparency, and beneficiary protections.

11.1.9 At a minimum, the EOC shall include:

11.1.9.1 A clear and comprehensive description of the structure, processes, levels of review, and beneficiary rights associated with the Contractor's Grievance and Appeal System, consistent with federal communication and disclosure standards;

11.1.9.2 Instructions clear for the Enrollee on how to file Complaints, Grievances, Service Authorization Requests, and Appeals shall provide comprehensive and accessible guidance describing the processes available for submitting such requests, including the applicable filing timeframes, any restrictions or conditions for submission, the permitted methods for filing (oral, written, or electronic), the Enrollee's rights throughout the review process, and the timeliness standards governing the Contractor's obligations when responding. These instructions shall reflect the strengthened communication, disclosure, and transparency requirements established under CMS-4201-F;

11.1.9.3 The Contractor's toll-free telephone number and the office hours for Medical Management, as well as for any other unit that provides services directly to Enrollees, shall be clearly disclosed in a manner that ensures accessibility, visibility, and ease of use for all Enrollees. Such disclosure shall enable Enrollees to readily identify how and

when to contact the Contractor for assistance, support, or service-related inquiries, consistent with federal beneficiary communication standards;

11.1.9.4 Information regarding an Enrollee's right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office and how to file a Complaint, Grievance, or Appeal with the Patient Advocate Office;

11.1.9.5 Information describing the Administrative Law Hearing process and the governing rules, including the requirement that the Enrollee must first exhaust the Contractor's Grievance and Appeal System before accessing the Administrative Law Hearing process, shall be provided in accordance with the applicable federal requirements set forth in 42 CFR Part 438 and 42 CFR Part 422, ensuring that Enrollees receive clear, accurate, and accessible guidance regarding their rights, procedural steps, and the conditions under which they may seek further administrative review.

11.1.10 The following individuals or entities may request a Grievance, Service Authorization Request or Appeal, and are parties to the case:

11.1.10.1 The Enrollee or the Enrollee's Authorized Representative. When the term "Enrollee" is used within this Article 11, it includes Authorized Representatives and Providers that file a request pursuant to this Section, unless otherwise specified;

11.1.10.2 An assignee of the Enrollee, that is, a Provider who has furnished or intends to furnish a service to the Enrollee and formally agrees to waive any right to payment from the Enrollee for that service, or any other Provider or entity who has an appealable interest in the proceeding;

11.1.10.3 The legal representative of a deceased Enrollee's estate; or

11.1.11 Any Provider that furnishes, or intends to furnish, services to the Enrollee, provided, however, that if the Provider requests that benefits continue while the Appeal is pending, pursuant to 42 CFR 422.632 and consistent with Puerto Rico law, the Provider must obtain the written consent of the Enrollee to request the Appeal on behalf of the Enrollee. A Provider who is providing treatment to the Enrollee may, upon providing notice to the Enrollee, request a standard or expedited pre-service Appeal on behalf of an Enrollee.

11.1.12 In addition to the requirements set forth in 42 CFR 422.562(a)(5) (Standard for Providing Assistance to Enrollees), the Contractor shall provide Enrollees with reasonable assistance in completing forms and taking any procedural steps necessary for the submission of Complaints, Grievances, Service Authorization Requests, and Appeals. Such assistance shall include, but not be limited to, the provision of interpreter services, auxiliary aids, and toll-free telephone numbers equipped with adequate TDD/TTY and interpreter capability, ensuring that all Enrollees regardless of language, disability, or communication needs are able to effectively exercise their rights throughout the Contractor's Grievance and Appeal System. These requirements shall be implemented consistent with the strengthened communication, disclosure,

accessibility, and beneficiary-protection standards established under the Medicare Advantage and Part D Final Rule (CMS-4201-F).

11.1.13 The Contractor shall include comprehensive, accurate, and accessible information regarding the Grievance and Appeal System in the Provider Guidelines and shall ensure that such information is provided to all Providers and Subcontractors upon joining the Contractor's Network. The Contractor shall also ensure that all Providers and Subcontractors, as applicable, receive training and education regarding the Contractor's Grievance and Appeal System, consistent with the requirements of 42 CFR Part 438 and 42 CFR Part 422, as well as the strengthened communication, disclosure, and beneficiary-protection standards established under the Medicare Advantage and Part D Final Rule (CMS-4201-F). Training shall include, but not be limited to, the following elements:

11.1.13.1 The Enrollee's right to file Complaints, Grievances, Service Authorization Requests, and Appeals, including the applicable requirements, procedural steps, and federal and local timeframes for filing;

11.1.13.2 The Enrollee's right to file a Complaint, Grievance, or Appeal with the Patient Advocate Office, including how to access and contact the Patient Advocate Office;

11.1.13.3 The Enrollee's right to an Administrative Law Hearing, the process for requesting such a hearing, the requirement to first exhaust the Contractor's Grievance and Appeal System, and the rules governing representation during the Administrative Law Hearing process;

11.1.13.4 The availability of assistance in filing a Complaint, Grievance, Service Authorization Request, or Appeal, including reasonable assistance requirements under 42 CFR 422.562(a)(5), interpreter services, auxiliary aids, and toll-free numbers with adequate TDD/TTY and interpreter capability;

11.1.13.5 The toll-free numbers available for filing oral Complaints, Grievances, Service Authorization Requests, and Appeals, including hours of operation and accessibility requirements.;

11.1.13.6 The Enrollee's right to request continuation of Benefits pending an Appeal or Administrative Law Hearing, including applicable timeframes, conditions, and potential liability if the decision is upheld; and

11.1.13.7 Any Puerto Rico determined Provider Appeal rights to challenge the Contractor's failure to cover a service, including procedural steps and timelines.

11.1.14 The Contractor shall have procedures in place to notify all Enrollees, in their primary language, of all Complaint, Grievance, Service Authorization Request, and Appeal dispositions. Such notifications shall comply with the language access, accessibility, and meaningful-communication standards required under 42 CFR Part 438 and 42 CFR Part 422, including the provision of translated materials, auxiliary

aids, and interpreter services as necessary to ensure full comprehension. Notifications shall also reflect the strengthened communication, disclosure, and beneficiary-protection requirements established under the Medicare Advantage and Part D Final Rule (CMS-4201-F).

11.1.15 The Contractor shall develop Grievance and Appeal System forms to be submitted for prior written approval by ASES according to the timeframe specified in Appendix L to this Contract. The approved forms shall be made available to all Enrollees, shall meet all requirements listed in Sections 4.2 and 4.3 for written materials, and shall, at a minimum:

11.1.15.1 Instruct the Enrollee or Enrollee's Authorized Representative that documentary evidence should be included, if available; and

11.1.15.2 Include instructions for completion and submission.

11.1.15.3 All ASES prior approved Complaints, Grievances, Service Authorization Requests and Appeals files and forms shall be made available to ASES for auditing. All Complaint, Grievance, Service Authorization Requests and Appeal documents and related information shall be considered as containing protected health information and shall be treated in accordance with HIPAA regulations and other applicable laws of Puerto Rico.

11.1.16 The Contractor shall ensure that the individuals who make decisions on Grievances, Service Authorization Requests, and Appeals are individuals:

11.1.16.1 Who were neither involved in any previous level of review or decision-making nor subordinates of any such individual; and

11.1.16.2 Who, if deciding any of the following, are Providers who have the appropriate clinical expertise, as determined by ASES, in treating the Enrollee's condition or disease if deciding any of the following:

11.1.16.2.1 An Appeal of a denial that is based on lack of Medical Necessity;

11.1.16.2.2 A Grievance regarding denial of expedited resolution of an Appeal; and

11.1.16.2.3 Any Grievance, Service Authorization Request or Appeal that involves clinical issues; and

11.1.16.3 Who take into account all comments, documents, records and other information submitted by Enrollee or their Authorized Representative without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination.

11.1.16.4 Who, for Service Authorization Requests for dental services, are licensed dentists authorized to make such decisions.

11.1.17 The Contractor shall ensure that punitive action is not taken against a Provider who requests a Grievance, Appeal, Service Authorization Request or an Administrative Law Hearing for expedited resolution, or supports an Enrollee's Grievance, Appeal, Service Authorization Request or Administrative Law Hearing.

11.1.18 The Contractor and Subcontractors, as applicable, shall have a system in place to collect, maintain, analyze, and integrate Data regarding Complaints, Grievances, Service Authorization Requests and Appeals. At a minimum, the record of each case shall be accurate, accessible to ASES and available upon request to CMS, and include the following information:

11.1.18.1 Date the Complaint, Grievance, Service Authorization Request or Appeal was received;

11.1.18.2 Enrollee's name;

11.1.18.3 Enrollee's Medicaid ID number, if applicable;

11.1.18.4 Name of the individual filing the Complaint, Grievance, Service Authorization Request or Appeal on behalf of the Enrollee;

11.1.18.5 Date of acknowledgement that receipt of the Grievance or Appeal was mailed to the Enrollee;

11.1.18.6 A general description of the reasons for the Complaint, Grievance, Service Authorization Request or Appeal;

11.1.18.7 Date of each review or, if applicable, review meeting, with, if applicable, the resolution at each level of the Grievance, Service Authorization Request or Appeal and applicable date of resolution;

11.1.18.8 Date Notice of Disposition or Notice of Adverse Benefit Determination was mailed to the Enrollee; and

11.1.18.9 A description if the Complaint, Grievance, Service Authorization Request or Appeal was on a Medicaid only covered service.

11.1.19 Contractor shall have sufficient staffing to timely address Complaints, Grievances, Service Authorization Requests, Appeals, Provider disputes and to provide attorney representation or the attendance of other required personnel at administrative hearings, when applicable.

11.1.20 If an Enrollee to exhaust the Contractor's grievance system before ASES acts on a disenrollment request, the Contractor shall complete its grievance review in time to ensure that disenrollment becomes effective no later than the first day of the second month following the month in which the enrollee requests disenrollment or the Contractor refers the request to the State, consistent with 42 CFR 438.56(d)(5)(ii), 438.56(e)(1), and 438.228(a). In case of a Dual Elegible, the process should be

consistent with: 42 CFR 438.56(d)(5)(ii); 42 CFR 438.56(e)(1); and 42 CFR 438.228(a).

11.2 Complaint

11.2.1 The Complaint process is the procedure for addressing Enrollee Complaints, defined as expressions of dissatisfaction about any matter other than an Adverse Benefit Determination that are resolved at the point of contact rather than through filing a formal Grievance.

11.2.2 An Enrollee or Enrollee's Authorized Representative may file a Complaint either orally or in writing. The Enrollee or Enrollee's Authorized Representative may follow-up an oral request with a written request. However, the timeframe for resolution begins with the date the Contractor receives the oral request.

11.2.3 An Enrollee or Enrollee's Authorized Representative shall file a Complaint within fifteen (15) Calendar Days after the date of occurrence that initiated the Complaint. If the Enrollee or Enrollee's Authorized Representative attempts to file a Complaint beyond the fifteen (15) Calendar Days, the Contractor shall instruct the Enrollee or Enrollee's Authorized Representative to file a Grievance.

11.2.4 The Contractor shall have procedures in place to provide Notice of Dispositions of Complaints to all Enrollees in their primary language.

11.2.5 The Contractor shall resolve each Complaint within seventy-two (72) hours of the time the Contractor received the initial Complaint, whether orally or in writing. If the Complaint is not resolved within this timeframe, the Complaint shall be treated as a Grievance. The Contractor cannot require the Enrollee to file a separate Grievance before proceeding to Appeal.

11.2.6 The Notice of Disposition shall include the results and date of the resolution of the Complaint and shall include notice of the right to file a Grievance or Appeal and information necessary to allow the Enrollee to request an Administrative Law Hearing, if appropriate, including contact information necessary to pursue an Administrative Law Hearing.

11.3 Grievance Process

11.3.1 An Enrollee may file a Grievance with the Contractor or with the Office of the Patient's Advocate of Puerto Rico either orally or in writing.

11.3.2 An Enrollee may file a Grievance at any time.

11.3.3 The Contractor shall acknowledge receipt of each Grievance in writing to the Enrollee (and the Provider, if the Provider filed the Grievance on the Enrollee's behalf) within ten (10) Business Days of receipt.

11.3.4 Enrollee must be provided a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor

shall inform the Enrollee of the limited time available to provide evidence sufficiently in advance of the resolution timeframe for expedited review.

11.3.5 The Contractor shall provide written notice of the disposition of the Grievance as expeditiously as the Enrollee's health condition requires, but no later than thirty (30) Calendar Days from the date the Contractor receives the Grievance. If the Grievance involves the Contractor's decision to invoke an extension relating to a Service Authorization Request or Appeal, or the Contractor's refusal to grant an Enrollee's request for an expedited organization determination or Appeal, the Contractor must respond within twenty-four (24) hours of the Grievance. If the Grievance originated from a Complaint that was not resolved within the seventy-two (72) hour timeframe set forth in Section 11.2.5, the time already spent by the Contractor to resolve the original Complaint must be deducted from this thirty (30) Calendar Day timeframe.

11.3.6 All Grievances submitted in writing must be responded to in writing, consistent with the requirements of 42 CFR 438.406(b)(1), which obligates the Contractor to follow State-established procedures and provide timely, compliant responses.

11.3.7 Grievances submitted orally may be responded to orally or in writing, unless the Enrollee requests a written response, in which case a written Notice is required.

11.3.8 Any Grievance related to quality of care must be responded to in writing, regardless of how the Grievance was filed, consistent with 42 CFR 438.406(b)(2), which requires a formal Notice of Disposition for grievances involving clinical or quality-related matters.

11.3.9 The Notice of Disposition shall include, at a minimum, the following elements, presented in clear, accessible, and Enrollee-appropriate language:

11.3.9.1 A description of the resolution of the Grievance,

11.3.9.2 A clear explanation of the factual, clinical, contractual, or regulatory basis supporting the resolution, and

11.3.9.3 The date on which the resolution was finalized.

11.3.9.4 The Notice shall comply with the communication, disclosure, and meaningful-access requirements under 42 CFR Part 438 and 42 CFR Part 422, as well as the strengthened beneficiary-protection standards established under the Medicare Advantage and Part D Final Rule (CMS-4201-F).

11.3.10 The Contractor may extend the timeframe to provide a written Notice of Disposition of a Grievance for up to fourteen (14) Calendar Days if the Enrollee requests the extension or if the Contractor demonstrates (to the satisfaction of ASES, upon its request) that additional Information is required and that the delay is in the Enrollee's best interest. Any such extension shall be implemented in accordance with the communication, disclosure, and meaningful-access standards established under 42 CFR Part 438 and 42 CFR Part 422, as well as the strengthened beneficiary-protection

requirements under the Medicare Advantage and Part D Final Rule (CMS-4201-F). For any extension not requested by the Enrollee, the Contractor shall:

11.3.10.1 Make reasonable and documented efforts to promptly notify the Enrollee of the specific reasons for the delay, including any outstanding Information required to complete the review. Such notification shall be provided in clear, accessible, and Enrollee-appropriate language consistent with federal communication and meaningful-access standards;

11.3.10.2 Send the Enrollee a written notice explaining the reason for the extension immediately, but no later than within two (2) Calendar Days of making the decision to extend the timeframe. The written notice shall comply with all applicable federal disclosure and accessibility requirements under Title 42 CFR Parts 438 and 422 and shall clearly describe how the extension serves the Enrollee's interest; and

11.3.10.3 Inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with the decision to extend the timeframe, including instructions on how to file the Grievance, available assistance, and applicable timeframes, consistent with the strengthened communication and beneficiary-protection standards under CMS-4201-F.

11.4 Service Authorization Request Process

11.4.1 Contractor must adopt and implement a process for Enrollees to submit a Service Authorization Request. The process to make a Service Authorization Request must be the same for all covered benefits.

11.4.2 The Enrollee may submit a Service Authorization Request orally or in writing, except for requests for payment, which must be in writing unless the Contractor has implemented a voluntary policy of accepting payment requests orally.

11.4.3 The Enrollee may submit an expedited Service Authorization Request orally or in writing. The Contractor must complete an expedited Service Authorization Request when the Contractor determines, or the Provider indicates, that taking the time for a standard resolution could seriously jeopardize the Enrollee's life, physical or mental health, or ability to attain, maintain or regain maximum function.

11.4.4 If Contractor denies the request for expediting the Service Authorization Request, Contractor must:

11.4.4.1 Automatically transfer a request to the standard timeframe and make the determination within the timeframe set forth in Section 11.4.5.2. Those timeframes begin with the day the Contractor received the request for an expedited Service Authorization Request.

11.4.4.2 Give Enrollee prompt oral notice of the denial and transfer and deliver, within three (3) calendar days, a written letter that:

11.4.4.2.1 Contractor will process the request using the fourteen (14) day timeframe set forth for standard Service Authorization Requests.

11.4.4.2.2 Informs the Enrollee of the right to file an expedited Grievance if he or she disagrees with Contractor's decision not to expedite;

11.4.4.2.3 Informs the Enrollee of the right to resubmit an expedited Service Authorization Request with any physician's support; and

11.4.4.2.4 Provide instructions about the Grievance process and its timeframes.

11.4.5 If Contractor expects to issue a partial or full Adverse Benefit Determination based on medical necessity following the initial review of the request, the case must be reviewed by a Provider with sufficient medical and other expertise, including knowledge of Medicare and Medicaid coverage criteria, before the Adverse Benefit Determination is issued. Such Provider must have a current and unrestricted license to practice within the scope of his or her profession.

11.4.6 Pursuant to 42 CFR 422.631(d), the Contractor shall provide a written notice of the Adverse Benefit Determination to the Enrollee within required timeframes of any decision by the Contractor to deny a Service Authorization Request, or to authorize a service in an amount, duration, or scope that is less than requested.

11.4.6.1 In cases where a previously approved service is being reduced, suspended or terminated, Contractor must send notice of its Adverse Benefit Determination at least ten (10) days before the date the reduction, suspension or termination becomes effective, except where an exception is permitted under 42 CFR 431.213 and 431.214.

11.4.6.2 In all other cases that are not expedited Service Authorization Requests, Contractor must send notice of its determination as expeditiously as the Enrollee's health condition requires, but no later than fourteen (14) Calendar Days from receipt of the Service Authorization Request.

11.4.6.3 If a determination is not reached within the timeframes set forth in this section, that will constitute an Adverse Benefit Determination and Contractor must send notice of its determination on the date that the timeframes expire. Such notice must describe all applicable Medicare and Medicaid Appeal rights and conform with the requirements set forth in Section 11.4.6.

11.4.7 The Contractor's notice to Enrollees of its determination on a Service Authorization Request must meet the language and format requirements in Section 4.2 and 4.3, must be sent in accordance with the timeframes described in Section 11.4.5, and must contain the following.

11.4.7.1 The Contractor's determination on the Service Authorization Request;

11.4.7.2 The date the determination was made and the date the determination will take effect;

11.4.7.3 Reasons for the determination,

11.4.7.4 The Enrollee's right to file an Appeal through the Contractor's internal Grievance and Appeal System, the ability for someone else to file an Appeal on the Enrollee's behalf, and the procedure for filing an Appeal;

11.4.7.5 The circumstances under which expedited review is available and how to request it; and

11.4.7.6 If applicable, the Enrollee's right to have Benefits continue pending resolution of the Appeal with the Contractor, in accordance with 42 CFR 422.632.

11.4.8 The Contractor shall send notice of its determination on a Service Authorization Request within the following timeframes:

11.4.8.1 For termination, suspension, or reduction of previously authorized Covered Services, at least ten (10) Calendar Days before the date of the Adverse Benefit Determination, except where one or more of the following exceptions apply, in which case the notice may be sent no later than the date of the Adverse Benefit Determination:

11.4.8.1.1 The Contractor has factual Information confirming the death of an Enrollee.

11.4.8.1.2 The Enrollee's whereabouts are unknown, and the post office returns the Contractor's mail directed to the Enrollee indicating no forwarding address (refer to 42 CFR 431.231(d) for procedures if the Enrollee's whereabouts become known).

11.4.8.1.3 The Contractor receives a clear written statement signed by the Enrollee that he or she no longer wishes to receive services or gives Information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that Information.

11.4.8.1.4 The Enrollee has been admitted to an institution where he or she is ineligible for further services.

11.4.8.1.5 The Enrollee's Provider prescribes a change in the level of medical care.

11.4.8.1.6 The notice involves an Adverse Benefit Determination with regard to the preadmission screening requirements set forth in Section 1919(e)(7) of the Social Security Act.

11.4.8.1.7 The date of the Adverse Benefit Determination will occur in less than ten (10) Calendar Days, due to a transfer or discharge from a long-term facility under the circumstances set forth under 42 CFR 483.15(c)(4)(ii) and (c)(8), or because Contractor has facts indicating that Adverse Benefit Determination should be taken because of probable Enrollee Fraud and the facts have been verified, if possible, through secondary sources

11.4.8.1.8 The Enrollee is accepted for Medicaid services by another local jurisdiction, state, territory or commonwealth.

11.4.8.1.9 The date of the Adverse Benefit Determination will occur in less than five (5) Calendar Days, because Contractor has facts indicating that Adverse Benefit Determination should be taken

because of probable Enrollee Fraud and the facts have been verified, if possible, through secondary sources.

11.4.9 For expedited Service Request Authorizations, as expeditiously as the Enrollee's health condition requires, but not later than seventy-two (72) hours after receipt of the request

11.4.10 For all other determinations, as expeditiously as the Enrollee's health condition requires, but no later than fourteen (14) Calendar Days from the receipt of the Service Authorization Request.

11.4.11 Contractor may extend the timeframe for a standard or expedited Service Authorization Request by up to fourteen (14) Calendar Days if the Enrollee or Provider requests the extension or the Contractor demonstrates (to the satisfaction of ASES, upon its request) that the delay is in the Enrollee's interest and there is need for additional information and a reasonable likelihood that receipt of such information would lead to approval of the request. If the Contractor extends the timeframe, it shall, for any extension not requested by the Enrollee:

11.4.11.1 Give the Enrollee written notice of the reason for the delay as expeditiously as the Enrollee's health condition requires but no later than upon expiration of the extension;

11.4.11.2 Inform the Enrollee of the right to file a Grievance if the Enrollee disagrees with the decision to extend the timeframe; and

11.4.11.3 Resolve the Service Authorization Request as expeditiously as the Enrollee's health condition requires, and no later than the date the extension expires.

11.4.11.4 For authorization decisions not reached within the timeframes required for either standard or expedited authorizations, the Notice of Adverse Benefit Determination shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus an Adverse Benefit Determination. Such notice must describe all applicable Medicare and Medicaid Appeal rights and conform with the requirements set forth in Section 11.4.6.

11.4.12 Failure of Contractor to adhere to notice and timing requirements for Service Authorization Requests constitutes an Adverse Benefit Determination for the Enrollee, so that Enrollee may request an Appeal.

11.5 Appeal Process

11.5.1 The Enrollee may file an Appeal either orally or in writing.

11.5.2 Oral inquiries seeking to appeal an Adverse Benefit Determination are treated as Appeals (to establish the earliest possible filing date for the Appeal).

11.5.3 Upon Enrollee's request, Contractor must provide the Enrollee or Authorized Representative with the Enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by Contractor or at Contractor's direction in connection with the Appeal. This information must be provided free of charge and sufficiently in advance of the resolution timeframe for the Appeal.

11.5.4 Only one (1) level of Appeal is permitted before proceeding to an Administrative Law Hearing.

11.5.5 The Enrollee may file an Appeal to the Contractor within sixty (60) Calendar Days from the date on the Contractor's notice of the Adverse Benefit Determination.

11.5.6 The timeframe for filing an Appeal request may be extended for good cause. If the timeframe in which to file an Appeal request has expired, a party to the Service Authorization Request determination or a physician acting on behalf of an Enrollee may file a written Appeal request with the Contractor. This request must state why the Appeal request was not filed on time.

11.5.7 Appeals shall be filed directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Appeal committee, but the delegation shall be in writing.

11.5.8 The Contractor shall acknowledge receipt of each Appeal in writing to the Enrollee (and the Provider, if the Provider filed the Appeal on the Enrollee's behalf) within ten (10) Business Days of receipt.

11.5.9 The Appeals process shall provide the Enrollee a reasonable opportunity, in person and in writing, to present evidence and testimony and make legal and factual arguments. The Contractor shall inform the Enrollee of the limited time available to provide evidence sufficiently in advance of the resolution timeframe for expedited review.

11.5.10 If deciding an Appeal of a denial that is based on a lack of medical necessity, before the Notice of Disposition is issued, the individual making the Appeal determination must be a Provider who has the appropriate clinical expertise in treating the Enrollee's condition or disease, and knowledge of Medicare and Medicaid coverage criteria.

11.5.11 The Contractor shall establish and maintain an expedited review process for Appeals, subject to prior written approval by ASES, when the Contractor determines (for a request from the Enrollee) or the Provider indicates (in making the request on the Enrollee's behalf or supporting the Enrollee's request) that taking the time for a standard resolution could seriously jeopardize the Enrollee's life or health or ability to attain, maintain, or regain maximum function. The Enrollee may file an expedited Appeal either orally or in writing.

11.5.12 If Contractor denies the request for expediting the Appeal request, Contractor must:

11.5.12.1 Automatically transfer a request to the standard timeframe and make the determination within the timeframe set forth in Section 11.5.10.1. Those timeframes begin with the day the Contractor received the request for an expedited Appeal.

11.5.12.2 Give Enrollee prompt oral notice of the denial and transfer and deliver, within two (2) Calendar Days, a written letter that:

11.5.12.2.1 Includes the reason for the denial;

11.5.12.2.2 Informs the Enrollee of the right to file an expedited Grievance if he or she disagrees with Contractor's decision not to expedite;

11.5.12.2.3 Informs the Enrollee of the right to file an expedited Grievance if he or she disagrees with Contractor's decision not to expedite;

11.5.12.2.4 Informs the Enrollee of the right to resubmit an expedited Appeal with any physician's support; and

11.5.12.2.5 Provide instructions about the Grievance process and its timeframes.

11.5.13 If Contractor must receive medical information from non-Contracted Providers, the Contractor must request the necessary information within twenty-four (24) hours of the initial request for an expedited Appeal. Non-Contract Providers must make reasonable and diligent efforts to expeditiously gather and forward all necessary information to assist Contractor in meeting the required timeframe. Contractor is responsible for meeting timeframe and notice requirements for Appeals regardless of whether information must be requested from non-Contract Providers.

11.5.14 The Contractor shall resolve each Appeal and provide written Notice of the Disposition of the Appeal as expeditiously as the Enrollee's health condition requires but no more than:

11.5.14.1 For standard Appeals, thirty (30) Calendar Days from the date the Contractor receives the Appeal.

11.5.14.2 For expedited Appeals, seventy-two (72) hours after the Contractor receives the Appeal. In addition to required written notice, Contractor must make reasonable efforts to provide prompt oral notice of the expedited resolution to the Enrollee.

11.5.15 The Contractor may extend the timeframe for standard or expedited resolution of the Appeal by up to fourteen (14) Calendar Days if the Enrollee or Provider requests the extension or the Contractor demonstrates (to the satisfaction of ASES, upon its request) that the delay is in the Enrollee's interest and there is need for additional information and a reasonable likelihood that receipt of such information would lead to approval of the request. If the Contractor extends the timeframe, it shall, for any extension not requested by the Enrollee:

11.5.15.1 Make reasonable efforts to provide Enrollee prompt oral notice of the delay;

11.5.15.2 Give the Enrollee written notice of the reason for the delay within two (2) Calendar Days of making the decision to extend the timeframe to resolve the Appeal; and

11.5.12.3 Inform the Enrollee of the right to file an expedited Grievance if the Enrollee disagrees with the decision to extend the timeframe.

11.5.16 The Contractor shall provide written Notice of Disposition of an Appeal to the Enrollee. The written notice of Disposition shall be in a format and language that, at a minimum, meets applicable notification standards and include:

11.5.16.1 The resolution of and basis for the Appeal determination and the date it was completed; and

11.5.16.2 For decisions not wholly in the Enrollee's favor:

11.5.16.2.1 An explanation of the Administrative Law Hearing process and Medicare Appeals process as the next level of appeal available;

11.5.16.2.2 How to request an Administrative Law Hearing;

11.5.16.2.3 How the Enrollee can obtain assistance in pursuing an Administrative Law Hearing; and

11.5.16.2.4 The right to request and receive Medicaid-covered Benefits pending an Administrative Law Hearing.

11.5.17 The Contractor shall also provide a copy of the written Notice of Disposition to ASES within two (2) Business Days of the resolution.

11.5.18 Failure of Contractor to adhere to notice and timing requirements for Appeals constitutes an adverse determination for the Enrollee, so that Enrollee may request an Administrative Law Hearing, and, for Medicare benefits, the Contractor must forward the case to the independent review entity.

11.5.19 The Appeal determination of the Contractor is binding on all parties unless it is appealed to the next applicable level. In the event the Enrollee pursues the next level

of appeal in multiple forums and receives conflicting decisions, the Contractor is bound by, and must act in accordance with, decisions favorable to the Enrollee.

11.6 Administrative Law Hearing

11.6.1 The Contractor is responsible for explaining the Enrollee's right to and the procedures for an Administrative Law Hearing, including that the Enrollee must exhaust the Contractor's Complaints, Grievance, Service Authorization Request and Appeals process before requesting an Administrative Law Hearing. However, if the Contractor fails to adhere to all notice and timing requirements set forth in 42 CFR 438.408, the Enrollee is deemed to have exhausted the Contractor's Appeals process and may proceed with initiating an Administrative Law Hearing.

11.6.2 The parties to the Administrative Law Hearing include the Contractor as well as the Enrollee or his or her Authorized Representative, or the representative of a deceased Enrollee's estate.

11.6.3 If the Contractor makes an Adverse Benefit Determination, the Enrollee appeals the Adverse Benefit Determination and the resolution of the Appeal is not in the Enrollee's favor, and the Enrollee requests an Administrative Law Hearing, ASES shall grant the Enrollee such hearing. The right to such Administrative Law Hearing, how to obtain it, and the rules concerning who may represent the Enrollee at such hearing shall be explained to the Enrollee and by the Contractor.

11.6.4 ASES shall permit the Enrollee to request an Administrative Law Hearing within one hundred and twenty (120) Calendar Days of the Notice of Disposition of the Appeal.

11.6.5 Before the Administrative Law Hearing, the Enrollee and the Enrollee's Authorized Representative, if applicable, can ask to look at and copy the documents and records the Contractor will use at the Administrative Law Hearing or that the Enrollee may otherwise need to prepare his/her case for the hearing. The Contractor shall provide such documents and records at no charge to the Enrollee.

11.6.6 The Administrative Law Hearing resolution shall be:

11.6.6.1 For standard resolution: within ninety (90) Calendar Days of the date the Enrollee filed the appeal with the Contractor (excluding the days the Enrollee took to subsequently file for an Administrative Law Hearing).

11.6.6.2 For an expedited resolution: within three (3) Business Days from agency receipt of an Administrative Law Hearing request for a denial of a service.

11.6.7 The Contractor shall comply with all determinations rendered as a result of Administrative Law Hearings. Nothing in this Section 11.6 shall limit the remedies available to ASES or the Federal government relating to any non-compliance by the

Contractor with an Administrative Law Hearing determination or by the Contractor's refusal to provide disputed services.

11.6.8 The decision issued as a result of the Administrative Law Hearing is subject to review before the Court of Appeals of Puerto Rico.

11.6.9 The Contractor shall comply with all determinations rendered as a result of Administrative Law Hearings. Nothing in this Section 11.6 shall limit the remedies available to the Puerto Rico or the Federal government relating to any non-compliance by the Contractor with an Administrative Law Hearing determination or by the Contractor's refusal to provide disputed services.

11.7 Continuation of Benefits while the Appeal and Administrative Law Hearing are Pending

11.7.1 As used in this Section, "timely" filing means filing on or before the later of the following:

11.7.1.1 Within ten (10) Calendar Days of the Contractor sending notice of the Adverse Benefit Determination or Notice of Disposition of Appeal, as applicable; or

11.7.1.2 The intended effective date of the Contractor's proposed adverse determination.

11.7.2 The Contractor shall continue the Enrollee's Benefits if the Enrollee timely files the Appeal in accordance with Section 11.5.4; the Appeal involves the termination, suspension, or reduction of a previously authorized services; the services were ordered by an authorized Provider; the period covered by the original authorization has not expired; and the Enrollee timely files for continuation of the Benefits.

11.7.3 If, at the Enrollee's request, the Contractor continues or reinstates the Enrollee's Benefits while the Appeal or Administrative Law Hearing is pending, the Benefits shall be continued until one of the following occurs:

11.7.3.1 The Enrollee withdraws the Appeal or request for the Administrative Law Hearing;

11.7.3.2 The Enrollee receives a determination on Appeal or at the Administrative Law Hearing that is unfavorable to the Enrollee related to the continued benefit;

11.7.3.3 The Enrollee does not request an Administrative Law Hearing with continuation of Benefits within ten (10) Calendar Days from the date the Contractor sends the Notice of Adverse Benefit Determination or Notice of Disposition of an Appeal, as applicable

11.7.3.4 The time period or service limits of a previously authorized service has been met.

11.7.4 Neither Contractor nor ASES may recover from the Enrollee the cost of the services furnished to the Enrollee while the Appeal or Administrative Law Hearing was pending, to the extent that such services were furnished solely because of the requirements of this Section. If an Enrollee requests continuation of Medicaid benefits after a final level of appeal, Puerto Rico's rules governing recovery of costs apply for costs incurred for services furnished pending appeal subsequent to the date of the Appeal or Administrative Law Hearing decision.

11.7.5 If at the Appeal or Administrative Law hearing stage, a decision to deny, limit, or delay services that were not furnished while the Appeal or Administrative Law Hearing was pending were reversed, the Contractor shall authorize or provide the disputed services promptly and as expeditiously as the Enrollee's health condition requires, but no later than seventy-two (72) hours from the date the Contractor receives notice reversing the determination.

11.7.6 If at the Appeal or Administrative Law hearing stage a decision to deny authorization of services, and the Enrollee received the disputed services while the Appeal or Administrative Law Hearing was pending were reversed, the Contractor shall pay for those services. The Contractor shall submit to ASES evidence of compliance.

11.8 Reporting Requirements

11.8.1 The Contractor shall log and track all Complaints, Grievances, Notices of Adverse Benefit Determination, Appeals, including extensions of time granted by the Contractor for these items, as well as Administrative Law Hearing requests.

11.8.2 ASES may publicly disclose summary Information regarding the nature of Complaints, Grievances, Appeals and related dispositions or resolutions in consumer Information materials.

11.8.3 The Contractor shall submit quarterly Grievance and Appeal System reports to ASES using the format prescribed by ASES and shall incorporate the findings of such reports into its Quality Strategy. The reports shall identify whether any of the services corresponded to Medicaid-only covered services. Using the description and requirements set forth in Section 15.2.1.4, the quarterly report shall also comply with all applicable Federal requirements governing Grievance and Appeal Systems under Medicaid Managed Care, including the obligation to maintain complete, accurate, and timely documentation of all grievances, appeals, notices, resolutions, timeframes, and outcomes for reporting and oversight purposes, in accordance with the standards established in 42 CFR 438.400 ("Grievance and Appeal System"), 42 CFR 438.402 ("Grievances and Appeals"), 42 CFR 438.404 ("Notice of Adverse Benefit Determination"), 42 CFR 438.406 ("Handling of Grievances and Appeals"), 42 CFR 438.408 ("Resolution and Notification").

11.9 Remedy for Contractor Non-Compliance with Advance Directive Requirements. In addition to the Complaint, Grievance, and Appeal rights described in this Article, an Enrollee

may lodge with ASES a Complaint concerning the Contractor's non-compliance with the Advance Directive requirements stated in Section 5.4 of this Contract.

ARTICLE 12 ADMINISTRATION AND MANAGEMENT

12.1 General Provisions

12.1.1 The Contractor shall be responsible for the administration and management of all requirements of this Contract, and consistent with the Medicaid Managed Care regulations of 42 CFR Part 438.

12.1.2 All costs and expenses related to the administration and management of this Contract shall be the responsibility of the Contractor.

12.2 Data Certification

12.2.1 The Contractor shall submit all data required under 42 CFR 438.604 and shall certify concurrently the submission all such Data pursuant to 42 CFR 438.606. The Data that must be certified include, but are not limited to, Enrollment Information, Encounter Data, and other Information required by ASES and contained in Contracts, the Contractor's Proposal, and related documents. The Data must be certified by one of the following: the Contractor's Chief Executive Officer ("CEO"), the Contractor's Chief Financial Officer ("CFO"), or an individual who has delegated authority to sign for, and who reports directly to the Contractor's CEO or CFO. The certification must attest, based on best knowledge, Information, and belief, as follows:

12.2.1.1 To the accuracy, completeness and truthfulness of the Data; and

12.2.1.2 To the accuracy, completeness, and truthfulness of the documents specified by ASES.

12.2.2 Contractor shall submit an attestation simultaneously with the certified data. This shall also apply to all reports contemplated in Article 15, Appendix L which include data, as well as to other requirements not contractually contemplated and required by ASES as part of the management of Medicare Platino Plan.

ARTICLE 13 PROVIDER PAYMENT MANAGEMENT

13.1 General Provisions

13.1.1 The Contractor shall administer an effective, accurate and efficient Provider payment management function that (i) under this Contract's risk arrangement adjudicates and settles Provider Claims for Covered Services that are filed within the timeframes specified by this Article 13 and in compliance with all applicable Puerto Rico and Federal laws, rules, and regulations; (ii) processes PMPM Payments to applicable Providers within the timeframes specified by this Article; and (iii) performs

Claims payment administrative functions for all Providers as specified by this Article 13.

13.1.2 The Contractor shall maintain a Claims management system that can accurately identify the date of receipt (the date the Contractor receives the Claim as indicated by the date-stamp), real-time-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, appealed, etc.), and the date of payment (the date of the check or other form of payment).

13.1.3 To the extent feasible, the Contractor shall implement an Automated Clearinghouse ("ACH") mechanism that allows Providers to request and receive Electronic Funds Transfer ("EFT") of Claims payments. The Contractor shall encourage its Providers, as an alternative to the filing of paper-based Claims, to submit and receive Claims Information through Electronic Data Interchange ("EDI"), i.e., electronic Claims. Electronic Claims must be processed in adherence to Information exchange and Data management requirements specified in Article 14. As part of this electronic Claims management ("ECM") function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status Information.

13.1.4 If the Contractor does not receive Claims through an EDI system, the Contractor shall either provide a central address to which Providers must submit Claims; or provide to each Network Provider a complete list, including names, addresses, electronic mail and phone number, of entities to which the Providers must submit Claims.

13.1.5 The Contractor shall notify Network Providers in writing of any changes in the policies and procedures for filing Claims at least thirty (30) Calendar Days before the effective date of the change. If the Contractor is unable to provide thirty (30) Calendar Days of notice, it must give Providers a thirty (30) Calendar Day extension on their Claims filing deadline to ensure Claims are routed to the correct processing center.

13.1.6 Network Providers may not receive payment other than by the Contractor for Covered Services, except when such payments are specifically required to be made by ASES under Title XIX of the Social Security Act, or its implementing regulations, or when ASES makes direct payments to Network Providers for graduate medical education costs approved under the Medicaid State Plan.

13.2 To be processed, all Claims submitted for payment shall comply with the Clean Claim standards as established by Federal regulation (42 CFR 447.46), and with the standards described in Section 13.10.2 of this Contract.

13.3 The Contractor shall generate explanations of benefits and remittance advices in accordance with ASES standards for formatting, content, and timeliness.

13.4 The Contractor shall not pay any Claim submitted by a Provider during the period of time when such Provider is excluded or suspended from the Medicare, Medicaid, CHIP or Title V Maternal and Child Health Services Block Grant programs for Fraud, Waste, or Abuse or otherwise included on the Department of Health and Human Services Office of the Inspector

General exclusions list, or employs someone on this list, and when the Contractor knew, or had reason to know, of that exclusion, after a reasonable time period after reasonable notice has been furnished to the Contractor. The Contractor shall not pay any Claim submitted by a Provider that is on Payment Hold.

13.5 The Contractor is prohibited from paying for an item or service (other than an emergency item or service, not including items or services furnished in an emergency room of a hospital):

13.5.1 Furnished under the plan by any individual or entity during any period when the individual or entity is excluded from participation under title V, XVIII, or XX or under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) of the Act;

13.5.2 Furnished at the medical direction or on the prescription of a physician, during the period when such physician is excluded from participation under title V, XVIII, or XX under this title pursuant to sections 1128, 1128A, 1156, or 1842(j)(2) or the Act and when the person furnishing such item or service knew, or had reason to know, of the exclusion (after a reasonable time period after reasonable notice has been furnished to the person);

13.5.3 Furnished by an individual or entity to whom the state has failed to suspend payments during any period when there is a pending investigation of a credible allegation of fraud against the individual or entity, unless the state determines there is good cause not to suspend such payments;

13.5.4 With respect to any amount expended for which funds may not be used under the Assisted Suicide Funding Restriction Act of 1997.

13.5.5 With respect to any amount expended for roads, bridges, stadiums, or any other item or service not covered under

13.6 Payment Schedule

13.6.1 At a minimum, the Contractor shall run one (1) Provider payment cycle per Week, on the same day each Week, as determined by the Contractor. The Contractor shall develop a payment schedule to be submitted to ASES for review and its prior written approval according to the timeframe specified in Appendix L to this Contract.

13.6.2 Other than for cause explicitly stated in the Provider Contract, payment to Providers made in the form of a Capitation payment shall be issued not later than the fifteenth (15th) Calendar Day of the month. Any Provider Capitation payment retained by the Contractor past the 15th Calendar Day of each month shall accrue interest at the prevailing highest legal interest rate for personal loans as such rate is determined by the Board of the Office of the Commissioner of Financial Institutions, and interest shall be paid along with the Capitation payment to the Provider for that month. The Contractor shall make such payment regardless of receiving the PMPM Payment.

13.7 Required Claims Processing Reports

13.7.1 The Contractor shall submit to ASES a monthly report not later than the fifteenth (15th) Calendar Day after the last day of the month listing all paid, pending, and denied

Claims during that month. The report shall be made available in an electronic format and shall detail all paid, pending, and denied Claims for all Providers.

13.7.2 The report shall list, by Provider, Claims paid from the preceding month, and those that are pending payment and the reason for the payment delay or the reason for the Contractor's decision to deny the Claim.

13.7.3 In the event that Providers associated with a PMG consent to the disbursement of payment directly to the PMG, the Contractor shall so specify in its report.

13.8 Submission of Encounter Data

13.8.1 Providers shall furnish Encounter Data to the Contractor on a monthly basis. The Data shall be submitted regardless of the payment arrangement, capitated or otherwise, agreed upon between the Contractor and the Provider. The Contractor must verify the accuracy and timeliness of Data reported by Providers, and must screen Data received from Providers for completeness, logic, and consistency. Encounter Data for all items and services provided by Network Providers, even if the Network Provider is reimbursed on a Capitated basis, must be submitted with the paid field indicating the allowed amount, even if the amount is zero (0) dollars. Encounter Data must be sufficiently collected and maintained by the Contractor so as to identify the Provider who delivers any item or service to Enrollees. The Contractor shall submit all Encounter Data that ASES is required to report to CMS.

13.9 Relationship with Pharmacy Benefit Manager (PBM)

13.9.1 The Contractor shall work with their PBM to facilitate the processing of pharmacy services Claims submitted by the PBM, as provided in Section 5.3.8.

13.9.2 To facilitate Claims processing, the Contractor shall send to the PBM, on a Daily Basis, the Enrollee Data described in Section 5.3.8.

13.10 Timely Payment of Claims

13.10.1 The Contractor shall comply with the timely processing of Claims standards contained in Section 1902(a)(37) of the Social Security Act and Federal regulations at 42 CFR 447.46. Provider Contracts shall include the following provisions for timely payment of Clean Claims.

13.10.1.1 A Clean Claim under 42 CFR 447.46(b), as defined in 42 CFR 447.45(b), is 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 for Medical Necessity.

13.10.1.2 Provider Contracts shall provide that ninety-five percent (95%) of all Clean Claims must be paid by the Contractor not later than thirty (30) Calendar

Days from the date of receipt of the Claim (including Claims billed by paper and electronically), and one hundred percent (100%) of all Clean Claims must be paid by the Contractor not later than fifty (50) Calendar Days from the date of receipt of the Claim.

13.10.1.3 Any Clean Claims not paid within thirty (30) Calendar Days shall bear interest in favor of the Provider on the total unpaid amount of such Claim, according to the prevailing highest legal interest rate fixed by the Puerto Rico Commissioner of Financial Institutions. Such interest shall be considered payable on the day following the terms of this Section 13.10, and interest shall be paid together with the claim.

13.10.2 An Unclean Claim is any Claim that falls outside the definition of Clean Claim in Section 13.10.1.1. The Contractor shall include the following provisions in its Provider Contracts for timely resolution of Unclean Claims:

13.10.2.1 Ninety percent (90%) of Unclean Claims must be resolved and processed with payment by the Contractor, if applicable, not later than ninety (90) Calendar Days from the date of initial receipt of the Claim. This includes Claims billed on paper or electronically.

13.10.2.2 Of the remaining ten percent (10%) of total Unclean Claims that may remain outstanding after ninety (90) Calendar Days,

13.10.2.2.1 Nine percent (9%) of the Unclean Claims must be resolved and processed with payment by the Contractor, if applicable, not later than six (6) calendar months from the date of initial receipt (including Claims billed on paper and those billed electronically); and

13.10.2.2.2 One percent (1%) of the Unclean Claims must be resolved and processed with payment by the Contractor, if applicable, not later than one year (twelve (12) months) from the date of initial receipt of the Claim (including Claims billed on paper and those billed electronically).

13.10.3 The Contractor shall not establish any administrative procedures, such as administrative audits, authorization number, or other formalities under the control of the Contractor, which could prevent the Provider from submitting a Clean Claim.

13.10.4 The foregoing timely payment standards are more stringent than those required in the Federal regulations, at 42 CFR 447.46. The Contractor shall include the foregoing standards in each Provider Contract and, per 42 CFR 447.46(c).

13.10.5 The Contractor shall deliver to Providers, within fifteen (15) Calendar Days of award of the Provider Contract (along with the Provider Guidelines described in Section 7.1), Claims coding and processing guidelines for the applicable Provider type, and the definition of a Clean Claim, as requested in this Article 13, to be applied.

13.10.6 The Contractor shall give Providers ninety (90) Calendar Days' notice in advance of the effective date of any change in Claims coding and processing deadlines.

13.11 Contractor Recovery from Providers

13.11.1 When the Contractor determines after the fact that it has paid a Claim incorrectly, the Contractor may request applicable reimbursement from the Provider through written notice, stating the basis for the request. The notice shall list the Claims and the amounts to be recovered.

13.11.2 The Provider will have a period of sixty (60) Calendar Days to make the requested payment, to agree to Contractor retention of said payment, or to dispute the recovery action.

13.12 ASES Review of Contractor, Subcontractor, and Provider Use of Puerto Rico and Federal Funds

13.12.1 The Contractor shall cooperate fully and diligently with ASES and/or its auditors in their review of the use of Puerto Rico and Federal funds provided to the Contractor under the Medicare Platino Program. The Contractor, its Subcontractors, and Network Providers shall, upon request, make available to ASES and/or its auditors any and all administrative, financial, and Medical Records relating to the administration of and the delivery of items or services for which Puerto Rico and Federal monies are expended. In addition, the Contractor and its Subcontractors including Network Providers shall provide ASES and/or its auditors with access during normal business hours to its respective place of business and records.

13.13 ASES Recovery from Contractor

13.13.1 ASES and the Contractor shall diligently work in good faith together to resolve any audit findings identified through audits by ASES. All audit findings shall be resolved, or a Corrective Action Plan shall be implemented within ninety (90) Calendar Days of issuance of a final audit report. Any Overpayment remittance due to ASES from the Contractor will be offset from future payments to the Contractor or invoiced by ASES to the Contractor.

ARTICLE 14 INFORMATION MANAGEMENT AND SYSTEMS

14.1 General Provisions

14.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet Medicare Platino and GHP requirements, ASES and Federal reporting requirements, all other Contract requirements, and any other applicable Puerto Rico and Federal laws, rules and regulations including but not limited to the standards and operating rules in Section 1104 of the PPACA and associated regulations, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Health Information Technology for Economic and Clinical Health Act (HITECH) and associated regulations and 42 CFR 438.242.

14.1.2 The Contractor shall file a statement of certification with the U.S. Department of Health and Human Services (HHS) no later than start of this Contract, certifying that the Contractor's Data and Systems are in compliance with the standards and operating rules for EFT, eligibility, Claim status and health care payment/remittance advice

transactions, in accordance with Section 1104 of the PPACA and associated regulations.

14.1.3 The Contractor's Systems shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible, so they can be adapted as needed, within negotiated timeframes, in response to program or Enrollment changes.

14.1.4 The Contractor's Systems shall have the capability of adapting to any future changes necessary as a result of modifications to the service delivery system and its requirements, including Data collection, records and reporting based upon unique Enrollee and Provider identifiers to track services and expenditures across funding streams. The Systems shall be scalable and flexible, so they can be adapted as needed, within negotiated timeframes, in response to changes in Contract requirements, increases in Enrollment estimates, etc. The System architecture shall facilitate rapid application of the more common changes that can occur in the Contractor's operation, including but not limited to:

14.1.4.1 Changes in pricing methodology;

14.1.4.2 Rate changes;

14.1.4.3 Eligibility criteria changes;

14.1.4.4 Changes in Utilization Management criteria;

14.1.4.5 Additions and deletions of Provider types; and

14.1.4.6 Additions and deletions of procedure, diagnosis and other service codes.

14.1.4.7 Changes in the Enrollment methodology.

14.1.5 The Contractor shall provide secure, online access to select system functionality to at least three (3) ASES personnel to facilitate resolution of Enrollee inquiries and to research Enrollee-related issues as needed.

14.1.6 The Contractor shall participate in systems work groups organized by ASES. The Systems work groups will meet on a designated schedule as agreed to by ASES and the Medicare Platino MAOs.

14.1.7 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with ASES. This system shall be:

14.1.7.1 Available from the workstations of the designated Contractor contacts; and

14.1.7.2 Capable of attaching and sending documents created using software products other than Contractor systems, including the Government's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

14.2 Global System Architecture and Design Requirements

14.2.1 The Contractor shall comply with Federal and Puerto Rico policies, standards and regulations in the design, development and/or modification of the Systems it will employ to meet the aforementioned requirements and in the management of information contained in those Systems. Additionally, the Contractor shall adhere to ASES and Puerto Rico-specific system and Data architecture standards and/or guidelines.

14.2.2 The Contractor's Systems shall meet Federal and industry standards of architecture, including but not limited to the following requirements:

14.2.2.1 Conform to HIPAA standards for Data and document management;

14.2.2.2 Contain controls to maintain information integrity. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly by and mutually agreed upon by the Contractor and ASES; and

14.2.2.3 Partner with ASES in the development of transaction/event code set, Data exchange and reporting standards not specific to HIPAA or other Federal efforts and will conform to such standards as stipulated in the plan to implement the standards.

14.2.3 Where web services are used in the engineering of applications, the Contractor's Systems shall conform to World Wide Web Consortium (W3C) standards such as XML, UDDI, WSDL and SOAP so as to facilitate integration of these Systems with ASES and other Government systems that adhere to a service-oriented architecture.

14.2.4 Audit trails shall be incorporated into all Systems to allow information on source Data files and documents to be traced through the processing stages to the point where the information is finally recorded. The audit trails shall:

14.2.4.1 Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;

14.2.4.2 Have the date and identification "stamp" displayed on any on-line inquiry;

14.2.4.3 Have the ability to trace Data from the final place of recording back to its source Data file and/or document shall also exist;

14.2.4.4 Be supported by listings, transaction reports, update reports, transaction logs, or error logs;

14.2.4.5 Facilitate auditing of individual Claim records as well as batch audits; and

14.2.4.6 Be maintained for ten (10) years in either live and/or archival systems. The duration of the retention period may be extended at the discretion of and as indicated to the Contractor by ASES as needed for ongoing audits or other purposes.

14.2.5 The Contractor shall house indexed images of documents used by Enrollees and Providers to transact with the Contractor in the appropriate database(s) and document management systems so as to maintain the logical relationships between certain documents and certain Data. The Contractor shall follow all applicable requirements for the management of Data in the management of documents.

14.2.6 The Contractor shall institute processes to insure the validity and completeness of the Data it submits to ASES. At its discretion, ASES will conduct general Data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Enrollee ID, date of service, Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of Claim processing, and date of Claim payment.

14.2.7 Where a System is herein required to, or otherwise supports, the applicable batch or on-line transaction type, the system shall comply with HIPAA-standard transaction code sets.

14.2.8 The Contractor shall assure that all Contractor staff is trained in all HIPAA requirements, as applicable.

14.2.9 The layout and other applicable characteristics of the pages of Contractor websites shall be compliant with Federal "Section 508 standards" and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.

14.3 System and Data Integration Requirements

14.3.1 The Contractor's applications shall be able to interface with ASES's systems for purposes of Data exchange and will conform to standards and specifications set by ASES. These standards and specifications are subject to change. Current standards and specifications are detailed in Appendix K to this Contract.

14.3.2 The Contractor shall implement and maintain an Application Programming Interface (API) compliant with 42 CFR 431.60 that provides: (1) adjudicated claims data within one business day of processing; (2) encounter data within one business day of receipt from providers or subcontractors; (3) clinical data, including laboratory results, within one business day of receipt by the State; and (4) information about

covered outpatient drug information and updates within one business day of their effective date.

14.3.3 The Contractor shall implement and maintain a publicly accessible, standards-based API consistent with 42 CFR 431.70, including all provider directory elements required under 42 CFR 438.10(h)(1)–(2), and shall ensure continuous accuracy and availability of such information.

14.3.4 The Contractor's System(s) shall be able to transmit and receive transaction Data to and from ASES's systems as required for the appropriate processing of Claims.

14.3.4.1 The Contractor will be required to perform any necessary changes to update interfaces to ASES's systems, including those required by the expected implementation of Medicaid Management Information System (MMIS) as well as new Eligibility and Enrollment processes. This interface changes may require changes in the Contractors' core systems.

14.3.5 Each month the Contractor shall generate Encounter Data files from its Claims management system(s) and/or other sources. Such files must be submitted in standardized Accredited Standards Committee (ASC) X12N 837 and National Council for Prescription Drug Programs (NCPDP) formats, and the ASC X12N 835 format as appropriate. The files will contain settled Claims and Claim adjustments and Encounter Data from Providers for the most recent month for which all such transactions were completed. The Contractor shall provide these files electronically to ASES and/or its Agent at a frequency and level of detail to be specified by CMS and ASES based on program administration, oversight, and program integrity needs, and in adherence to the procedure, content standards and format indicated in Appendix K to this Contract. The Contractor shall make changes or corrections to any systems, processes or Data transmission formats as needed to comply with Encounter Data quality standards as originally defined or subsequently amended.

14.3.6 The Contractor's System(s) shall be capable of generating files in the prescribed formats for upload into ASES Systems used specifically for program integrity and compliance purposes.

14.3.7 The Contractor's System(s) shall possess mailing address standardization functionality in accordance with USA Postal Service conventions.

14.3.8 To comply with MAGI requirements, the Contractor must update its Information Systems in accordance with the procedures and timelines set forth in Appendix K to this Contract and any other subsequent guidance issued by ASES.

14.4 System Access Management and Information Accessibility Requirements

14.4.1 The Contractor's System shall employ an access management function that restricts access to varying hierarchical levels of system functionality and Information. The access management function shall:

14.4.1.1 Restrict access to information on a "need-to-know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;

14.4.1.2 Restrict access to specific System functions and Information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by ASES and the Contractor; and

14.4.1.3 Restrict attempts to access system functions to three (3), with a system function that automatically prevents further access attempts and records these occurrences.

14.4.2 The Contractor shall make System information available to duly Authorized Representatives of ASES and other Puerto Rico and Federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

14.4.3 The Contractor shall have procedures to provide for prompt transfer of System Information upon request to other Network or Out-of-Network Providers for the medical management of the Enrollee in adherence to HIPAA and other applicable requirements.

14.4.4 All Information, whether Data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract, are owned by ASES. The Contractor is expressly prohibited from sharing or publishing ASES Information and reports without the prior written consent of ASES. In the event of a dispute regarding the sharing or publishing of Information and reports, ASES's decision on this matter shall be final and not subject to appeal.

14.5 Systems Availability and Performance Requirements

14.5.1 The Contractor shall ensure that critical systems, including but not limited to the Enrollee and Provider portal and/or phone-based functions and information, such as confirmation of Contractor Enrollment ("CCE") and electronic Claims management (ECM), Enrollee services and Provider services, are available to the applicable System users twenty-four (24) hours a day, seven (7) Calendar Days a Week, except during periods of scheduled System Unavailability agreed upon by ASES and the Contractor. Unavailability caused by events outside of a Contractor's Span of Control is outside of the scope of this requirement.

14.5.2 The Contractor shall ensure that at a minimum all non-critical system functions and information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. Monday through Friday (Atlantic Time).

14.5.3 The Contractor shall develop an automated method of monitoring critical systems on at least thirty (30) minute basis twenty-four (24) hours a day, seven (7) days per Week.

14.5.4 Upon discovery of any problem within its Span of Control that may jeopardize System availability and performance as defined in this Section of the Contract, the Contractor shall notify the applicable ASES staff in person, via phone, and/or electronic mail. The Contractor shall deliver notification as soon as possible but no later than 7:00 pm (Atlantic Time) if the problem occurs during the Business Day and no later than 9:00 am (Atlantic Time) the following Business Day if the problem occurs after 7:00 pm (Atlantic Time).

14.5.5 Where the operational problem results in delays in report distribution or problems in on-line access during the Business Day, the Contractor shall notify the applicable ASES staff within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on System Unavailability protocols.

14.5.6 The Contractor shall provide to appropriate ASES staff information on System Unavailability events, as well as status updates on problem resolution. These up-dates shall be provided on an hourly basis and made available via electronic mail, telephone and, if applicable, the Contractor's website.

14.5.7 The Contractor shall submit a monthly Systems Incident Report. The report shall provide information on any Incidents or suspicion that involve unauthorized access to the Contractor's systems, databases or servers. This report shall be provided at least annually, but the Contractor shall provide the report at least 24 hours after the incident occurred. The report shall include, at a minimum, the date it was reported to ASES, the nature and scope of the incident, the Contractor's response, and any mitigation measures taken to prevent similar incidents in the future. Port scans or other failed queries to the Contractor's Information System shall not be considered a privacy/security incident for the purposes of this report. This report shall be submitted annually, along with all incidents reported as part of Appendix L.

14.5.8 The following rules govern unscheduled System Unavailability:

14.5.8.1 CCE Functions

14.5.8.1.1 Unscheduled System Unavailability of CCE functions caused by the failure of systems and telecommunications technologies within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the official declaration of System Unavailability.

14.5.8.1.2 Throughout the Contract Term, the Contractor shall have in place a method to validate eligibility manually twenty-four (24) hours per day, seven (7) days a Week as a contingency to any unscheduled Systems Unavailability for CCE functions.

14.5.8.2 ECM Functions. Unscheduled System Unavailability of ECM functions caused by the failure of systems and technologies within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within sixty (60) minutes of the official declaration of System Unavailability, if unavailability occurs during normal business hours; or within

sixty (60) minutes of the start of the next Business Day, if unavailability occurs outside business hours.

14.5.8.3 All Other Contractor System Functions. Unscheduled System Unavailability of all other Contractor System functions caused by systems and telecommunications technologies within the Contractor's Span of Control shall be resolved, and the restoration of services implemented:

14.5.8.3.1 Within four (4) hours of the official declaration of Unscheduled System Unavailability, when unavailability occurs during business hours, and

14.5.8.3.2 Within two (2) hours of the start of the next Business Day, when unavailability occurs during non-business hours.

14.5.9 Cumulative System Unavailability caused by systems and telecommunications technologies within the Contractor's Span of Control shall not exceed one (1) hour during any continuous five (5) Calendar Day period for functions that affect Enrollees and services. For functions that do not affect Enrollees, cumulative System Unavailability caused by systems and telecommunications technologies within the Contractor's Span of Control shall not exceed four (4) hours during any continuous five (5) Business Day periods.

14.5.10 The Contractor shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Contractor's Span of Control.

14.5.11 For any System outage that is not corrected within the required time limits, the Contractor shall provide full written documentation that includes a Corrective Action Plan, describing how the problem will be prevented from occurring again, within five (5) Business Days of the problem's occurrence.

14.5.12 Regardless of the architecture of its Systems, the Contractor shall develop and be continually ready to invoke a Business Continuity and Disaster Recovery ("BC-DR") plan that at a minimum addresses the following scenarios: (i) the central computer installation and resident software are destroyed or damaged; (ii) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage; (iii) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of Data maintained in a live or archival system; and (iv) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or Data maintained in a live or archival system but does prevent access to the System, i.e. causes unscheduled System Unavailability. This BC-DR plan must be prior approved by ASES.

14.5.13 The Contractor shall on an annual basis test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to ASES that it can restore System functions per the standards outlined elsewhere in this Section 14.5 of the

Contract. The results of these tests shall be reported to ASES within thirty (30) Calendar Days of completion of said tests.

14.5.14 In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall be required to submit to ASES a Corrective Action Plan that describes how the failure will be resolved. The Corrective Action Plan will be delivered within five (5) Business Days of the conclusion of the test.

14.6 System Testing and Change Management Requirements

14.6.1 The Contractor shall absorb the cost of routine maintenance, inclusive of defect correction, System changes required to effect changes in Puerto Rico and Federal statute and regulations, and production control activities, of all Systems within its Span of Control.

14.6.2 The Contractor shall respond to ASES reports of System problems not resulting in System Unavailability according to the following timeframes:

14.6.2.1 Within five (5) Calendar Days of receipt, the Contractor shall respond in writing to notices of System problems.

14.6.2.2 Within fifteen (15) Calendar Days, the correction will be made, or a requirements analysis and specifications document will be due.

14.6.3 The Contractor shall correct the deficiency by an effective date to be determined by ASES.

14.6.4 The Contractor's Systems will have a system-inherent mechanism for recording any change to a software module or subsystem.

14.6.5 The Contractor shall put in place procedures and measures for safeguarding ASES from unauthorized modifications to the Contractor's Systems.

14.6.6 Unless otherwise agreed to in advance by ASES, scheduled System Unavailability to perform System maintenance, repair and/or upgrade activities to Contractor's CCE systems shall take place between 11 p.m. on a Saturday and 6 a.m. on the following Sunday (Atlantic Time).

14.6.7 The Contractor shall work with ASES pertaining to any testing initiative as required by ASES.

14.6.8 The Contractor shall provide sufficient System access to allow verification of System functionality, availability and performance by ASES during the times required by ASES during the implementation and duration of the Contract Term.

14.7 Security and Information Confidentiality and Privacy Requirements

14.7.1 The Contractor shall provide for the physical safeguarding of its Data processing facilities and the Systems and Information housed therein. The Contractor shall provide ASES with access to Data facilities upon ASES's request. The physical security provisions shall be in effect for the life of this Contract.

14.7.2 The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

14.7.3 The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire-retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

14.7.4 The Contractor shall ensure that the operation of all of its Systems is performed in accordance with Puerto Rico and Federal regulations and guidelines related to security and confidentiality of the protected information managed by the Contractor and shall strictly comply with HIPAA Privacy and Security Rules, as amended, and with the Breach Notification Rules under the HITECH Act.

14.7.5 The Contractor will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the Data communications network inside of a Contractor's Span of Control.

14.7.6 The Contractor shall ensure compliance with:

14.7.6.1 42 CFR Part 431 Subpart F (confidentiality of information concerning applicants and enrollees of public medical assistance programs);

14.7.6.2 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and

14.7.6.3 Special confidentiality provisions in Puerto Rico or Federal law related to people with HIV/AIDS and mental illness.

14.7.7 The Contractor shall provide its Enrollees with its HIPAA Notice of Privacy Practices that conforms to all applicable Federal and State laws. The Contractor shall provide ASES with a copy of this Notice.

14.8 Information Management Process and Information Systems Documentation Requirements

14.8.1 The Contractor shall ensure that the written System Process and Procedure Manuals clearly document and describe all manual and automated procedures related to its information management processes and Information Systems. These Manuals shall comply with the administrative, operational, data submission, and recordkeeping

requirements established under 42 CFR § 422.504, § 422.516, and § 422.310. The Contractor shall submit these Manuals to ASES Information System Office in accordance with the Deliverables requirements set forth in Attachment L, for review, approval, validation, and reference prior to implementation or modification. The ASES Office of Information Systems shall issue its approval within thirty (30) days of receipt of the Manuals.

14.8.2 The System User Manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system Data.

14.8.3 When a System change that would alter the conditions and services agreed upon in this Contract is subject to ASES sign off, the Contractor shall draft revisions to the appropriate manuals prior to ASES sign off of the change.

14.8.4 Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) Business Days of the update taking effect.

14.8.5 ASES reserves the right to audit the Contractor's policies and procedures manuals and protocols compliance related to its Information Systems.

14.9 Reporting Functionality Requirements

14.9.1 The Contractor's Systems shall have the capability of producing a wide variety of reports that support program management, policymaking, quality improvement, program evaluation, analysis of fund sources and uses, funding decisions and assessment of compliance with Federal and Puerto Rico requirements.

14.9.2 The Contractor shall support a mechanism for obtaining service and expenditure reports by funding source, Provider, Provider type or other characteristic; and Enrollee, Enrollee group/category or other characteristic.

14.9.3 The Contractor shall extend access to this mechanism to select ASES personnel in a secure manner to access Data, including program and fiscal information regarding Enrollees served, services rendered, etc. and the ability for said personnel to develop and/or retrieve reports. This requirement could be met by the provision of access to a decision support system/Data warehouse. The Contractor shall provide training in and documentation on the use of this mechanism.

14.9.4 Within five (5) Calendar Days upon ASES's request, the Contractor will deliver a copy of the then current ASES's System information to ASES in a mutually acceptable form and format.

14.10 Disaster Recovery, Disaster Declaration, Data Content Delivery to ASES

14.10.1 The Contractor shall maintain an effective Disaster Recovery Plan and Business Continuity Plan throughout the term of the Contract. These Plans shall comply with the administrative, operational, data protection, systems availability, and

recordkeeping requirements established under 42 CFR 422.504(a), 422.504(b)(4), 422.504(b)(13), 422.516(a), and 422.310.

14.10.2 The Contractor shall maintain safeguards to prevent the destruction, loss, intrusion, or unauthorized alteration of data and printed materials in its possession. At a minimum, the Contractor shall perform:

14.10.2.1 incremental daily backups,

14.10.2.2 weekly full backups, and

14.10.2.3 any additional backups necessary to ensure data integrity and operational continuity.

14.10.3 The Disaster Recovery and Business Continuity Plans shall include defined Recovery Time Objectives (RTO) and Recovery Point Objectives (RPO) for all critical systems, redundancy and failover capabilities, and documented procedures for restoring operations.

14.10.4 The Contractor shall conduct periodic testing of these Plans, including at least one annual disaster recovery test and any additional tests necessary to validate system restoration and operational readiness. The Contractor shall submit the results of each test to the ASES Office of Information Systems within five (5) calendar days of completion for acknowledgment and validation of the information.

14.10.5 The Contractor shall notify ASES of any event that materially affects system availability, data integrity, or the Contractor's ability to meet CMS or ASES operational requirements. Such notification shall be made in writing in less than twenty-four (24) hours to the ASES Chief Information Officer and the ASES Executive Director. The Contractor shall ensure that all third-party vendors supporting critical systems maintain disaster recovery and business continuity capabilities consistent with this Section.

14.10.6 The Disaster Recovery and Business Continuity Plans shall be submitted to the ASES Office of Information Systems as part of the Deliverables required under Attachment L for review, approval, validation, and reference. The ASES Office of Information Systems shall issue its approval within thirty (30) days of receipt of the Plans.

Both Parties recognize that a failure by the Contractor's Network may adversely impact ASES business and operations, as the responsible party for the Medicare Platino Program. Therefore, in the event that the Contractor's Network designed to deliver the services herein contemplated becomes unable, or is anticipated to become unable, to deliver such services on a timely basis, Contractor shall Immediately notify ASES by telephone, and shall work closely with ASES to fix the problem. In the event that Contractor fails to provide such required notice to ASES and such delay in the notification has a material and adverse effect upon ASES and/or Enrollees, ASES may terminate this Contract for cause as provided in Article 30 of this Contract.

Within five (5) calendar days of ASES's request, the Contractor shall deliver to ASES a copy of the then-current ASES Data Content in a mutually acceptable form and format that is usable, readable, and understandable by ASES. The Contractor shall ensure that the delivery of such Data Content complies with the administrative, operational, data submission, and recordkeeping requirements established under 42 CFR 422.504, 422.516, and 422.310, including applicable CMS standards for data integrity, accuracy, and secure transmission.

14.11 Health Information Organization (HIO) and Health Information Exchange (HIE) Requirements

14.11.1 The Contractor shall initiate the active participation in any Health Information Organization (HIO) that offers Health Information Exchange services, in order to integrate the Enrollees' Personal Health Information, facilitate access to and retrieval of their clinical Data to provide safer and more timely, efficient, effective, and equitable patient-centered care. The HIO participation is also required to support the analysis of the health of the population. As required by ASES, the Contractor shall be active in a HIO and cooperate with this effort.

ASES shall retain the right to request from the Contractor the active participation in the Puerto Rico Health Information Exchange Corporation (PRHIEC), the Puerto Rico HIO State Designated Entity, in order to achieve the effective alignment of activities across Medicaid and Government public health programs, to avoid duplicate efforts and to ensure integration and support of a unified approach to information exchange for the Medicare Platino Program.

14.11.2 The Contractor shall verify that the HIO complies with all Information System standards and requirements for interoperability and security capabilities dictated by ONCHIT, and other Federal and Puerto Rico regulations.

14.11.3 The Contractor shall work with Network Providers and staff to encourage-an active participation in an HIO.

ARTICLE 15 REPORTING

15.1 General Requirements

15.1.1 ASES may, at its discretion, require the Contractor to submit additional Ad Hoc or recurring reports. If ASES requests revisions to any reports already submitted, the Contractor shall make the required changes and re-submit the revised reports within the time period and in the format specified by ASES. To the extent applicable, the Contractor shall ensure that all reporting clearly identifies any Medicaid-only covered services or requirements separately when such distinctions are not explicitly noted below. All reporting under this Section shall comply with the administrative, operational, data submission, and recordkeeping requirements established under 42 CFR § 422.504, § 422.516, and § 422.310, including applicable CMS standards for data accuracy, completeness, integrity, and secure transmission.

15.1.2 The Contractor shall timely and accurately submit all reports to ASES in the manner and format prescribed by ASES. The submission of late, inaccurate, or otherwise incomplete reports constitutes failure to report. "Timely submission" shall mean that the report was submitted on or before the date it was due. "Accurately" shall mean the report was prepared according to the specific written guidance, including report template, provided by ASES to the Contractor. All elements must be met for each required report submission.

15.1.3 All reports, including reports containing Data submitted to the Contractor by Providers, must be verified for accuracy, completeness, integrity, and timeliness. The Contractor shall review, as part of its continuous improvement activities, the timeliness and accuracy of all reports submitted to ASES to identify instances and patterns of non-compliance. The Contractor shall perform an analysis identifying any recurring issues, trends, or deficiencies and shall implement quality improvement activities to improve overall reporting performance and compliance. All activities under this Section shall comply with the administrative, operational, data submission, and recordkeeping requirements established under 42 CFR 422.504, 422.516, and 422.310, as well as the monitoring, oversight, and data integrity standards reinforced in the Medicare Advantage and Part D Final Rule (CMS-4201-F).

15.1.4 Extensions to report submission deadlines will be considered by ASES only after the Contractor has contacted, via email, the ASES designated point of contact (POC) in the office responsible for the report, as well as the Contractor's Compliance Officer, at least twenty-four (24) hours in advance of the report due date. Extensions shall be granted solely under rare and unusual circumstances. If ASES grants an extension and the Contractor submits the report on or before the extended deadline, the report shall be considered timely and not subject to timeliness penalties. Failure to request an extension at least twenty-four (24) hours prior to the report due date shall constitute a failure to report timely. All extension requests and determinations under this Section shall align with the Contractor's reporting obligations under 42 CFR 422.504, 42 CFR 422.516, and the monitoring and compliance standards reinforced in the Medicare Advantage and Part D Final Rule (CMS-4201-F).

15.1.5 Anytime a report is rejected for any reason, the Contractor shall resubmit the corrected report within five (5) Business Days from the notification of the rejection or within the timeframe otherwise directed by ASES. The Contractor shall ensure that all corrections address the deficiencies identified by ASES and that the revised submission meets all requirements for accuracy, completeness, integrity, format, and timeliness. Re-submitted reports shall comply with the Contractor's reporting obligations under 42 CFR 422.504, 422.516, and 422.310, as well as the monitoring, oversight, and data integrity standards reinforced in the Medicare Advantage and Part D Final Rule (CMS-4201-F). Failure to resubmit a corrected report within the required timeframe shall constitute a failure to report.

15.1.6 The Contractor shall submit all reports electronically to ASES's FTP site unless directed otherwise by ASES. ASES shall provide the Contractor with access to the FTP site. The email generated by the FTP upload will serve as the official time stamp for

the submission of the report(s). In addition, the Contractor shall notify, via email, the ASES designated point of contact (POC) in the office responsible for the report, as well as the Contractor's Compliance Officer, confirming that the information has been submitted through the FTP site.

15.1.7 All reports in the reporting templates provided to the Contract require Contractor certification. The Authorized Certifier or an equivalent position as delegated by the Contractor and approved by ASES, shall review the accuracy of language, analysis, and Data in each report prior to submitting the report to ASES. The Authorized Certifier shall include a signed attestation each time the report is submitted. The attestation must include a certification, based on best knowledge, information, and belief, as to the accuracy, completeness and truthfulness of the Data in the report. Reports will be deemed incomplete if an attestation is not included.

15.1.8 The Contractor Data transfers shall occur in standard format as prescribed by ASES and will be compliant with HIPAA and Federal regulations. The Contractor shall submit in formats as prescribed by ASES so long as ASES's direction does not conflict with any Federal law.

15.1.9 The Contractor shall submit all reports to ASES in the manner and format prescribed by ASES and as specified in the applicable reporting guide. All report submissions shall comply with the administrative, operational, data submission, and recordkeeping requirements established under 42 CFR 422.504, 422.516, and 422.310, as well as the monitoring, oversight, and data integrity standards reinforced in the Medicare Advantage and Part D Final Rule (CMS-4201-F).

15.1.10 Unless otherwise specified in the Reporting Guide issued by ASES or this Contract, the Contractor shall submit all reports to ASES, according to the schedule below:

DELIVERABLES	DUE DATE
Weekly Reports	Friday of the following Week
Monthly Reports	Fifteenth (15th) Calendar Day of the following month
Quarterly Reports	Thirtieth (30th) Calendar Day of the following month
Semi-Annual Reports	March 31 and September 30 of the Contract year
Annual Reports	Ninety (90) Calendar Days after the end of Puerto Rico's Fiscal Year

15.1.11 If a report due date falls on a weekend or a Puerto Rico holiday, receipt of the report the next Business Day is acceptable.

15.1.12 ASES shall provide feedback, as necessary, to the Contractor regarding format and timeliness of reports within forty-five (45) Calendar Days from the due date of the report.

15.2 Specific Requirements

15.2.1 The following section provides an overview and description of all reports required by this Contract. The details and requirements of the reports are subject to change at the discretion of ASES.

15.2.1.1 The Contractor shall submit a Quarterly Fraud, Waste, and Abuse Report that provides information regarding suspicious activity, Fraud, Waste, and Abuse cases, recoupments, Cost Avoidance, Referrals, and other information as directed by ASES. In the event of, or upon the suspicion of, a possible pattern of conduct, the Contractor shall include such information in the report. The report shall comply with the program integrity, documentation, monitoring, and reporting requirements established under 42 CFR Part 422 and reinforced in the Contract Year 2025 Medicare Advantage and Part D Final Rule (CMS-4205-F), as well as any applicable provisions of subsequent CMS Final Rules, including the Contract Year 2027 Final Rule (CMS-4208-F3 / CMS-4212-F), to the extent such rules apply to program integrity and reporting obligations. At a minimum, the report shall include: (i) Enrollee name and ID number; (ii) Provider name, Provider type, and NPI; (iii) source and date of the Complaint; (iv) nature of the Complaint (including the alleged persons or entities involved, category of services, factual explanation of the allegation, and dates of contact); (v) all communications between the Contractor and the Provider regarding the Complaint; (vi) approximate dollars involved or amount paid to the Provider during the past three (3) years (whichever is greater); (vii) disciplinary measures imposed, if any; (viii) legal disposition of the case. The Contractor shall also include, as a qualitative analysis, information regarding investigative activities, corrective actions, prevention efforts, and the results of such prevention efforts.

15.2.1.2 The Contractor shall submit *Encounter Data* in a standardized format as specified by ASES and be transmitted electronically to ASES on a monthly basis. The Contractor shall provide any information and/or Data requested in a format to be specified by ASES as required to support the validation, testing or auditing of the completeness and accuracy of Encounter Data submitted by the Contractor.

15.2.1.3 The Contractor shall submit within thirty (30) Business Days of the close of the quarter a *National Provider List (NPL) Report* that provides information on Network Providers of Medicare Platino Covered Services who have executed a provider agreement with the Contractor to serve Medicare Platino Enrollees.

15.2.1.4The Contractor shall submit a quarterly *Grievances and Appeals Repo rt* within thirty (30) calendar Days after the close of each quarter. Relevant information includes all Provider and Enrollee Grievances (informal and formal), Appeals, Notices of Actions and Administrative Law Hearings utilizing the ASES-provided reporting templates and codes. The report will also

capture Enrollee comments and inquiries made through the Contractor's website.

15.2.1.5 The Contractor shall submit an annual *QAPI Program Report* that shall include information on all quality assessment and performance improvement projects, including a program overview, methodology, performance measures and analysis of the respective programs.

15.2.1.6 The Contractor shall submit a quarterly *Unaudited Financial Statement Report* no later than thirty (30) Calendar Days after the close of each quarter. The Contractor shall submit (i) a separate accounting of activities relating to each Service Region, and (ii) a consolidated section accounting for all Medicare Platino Program activities. ASES may grant a 15-day extension of the reporting deadline upon good cause shown by the Contractor.

15.2.1.7 The Contractor shall submit annual Audited Financial Statements. The Contractor shall provide ASES with copies of its audited financial statements, prepared in accordance with Generally Accepted Accounting Principles ("GAAP") and generally accepted auditing standards in the United States, at its own cost and expense, for the duration of the Contract and as of the end of each fiscal year during the Contract Term, regarding the financial operations related to the Medicare Platino Program. The financial statements shall include:

15.2.1.7.1 A separate accounting of activities relating to each Service Region; and

15.2.1.7.2 A consolidated section accounting for all Medicare Platino Program activities.

15.2.1.7.3 These reports shall be submitted to ASES no later than June 1st of each year, with respect to the operational year ended December 31 of the previous year. ASES may grant an extension of the reporting deadline upon good cause shown by the Contractor. Equally, the Contractor shall also comply with the applicable requirements established under 42 CFR Part 422, including the obligation under 42 CFR 422.504(d) to maintain all financial and administrative records for a minimum of ten (10) years; the obligation under 42 CFR 422.504(e)(2) to provide CMS, HHS, OIG, and GAO access to financial statements, books, and records; the obligation under 42 CFR 422.310 to ensure that all financial information submitted is complete, accurate, and timely; and the obligation under 42 CFR 422.503(b)(6) to demonstrate adequate financial solvency to operate the Program.

15.2.1.8 The Contractor shall submit an annual *Disclosure of Information on Annual Business Transactions*, which shall include information on any loans, business transactions, and other special arrangements between the Contractor and any Network Provider, Subcontractor, or other Party in Interest, as defined by Section 1318(b) of the Public Health Service Act and as required by that law and by Section 1903(m)(4)(A) of the Social Security Act. This report may be made available to Enrollees upon reasonable request.

15.2.1.9 The Contractor shall submit an annual *Report to the Puerto Rico Insurance Commissioner's Office* in the format agreed upon by the National Association of Insurance Commissioners (NAIC).

15.2.1.10 The Contractor shall submit an annual *Physician Incentive Plan Report* that provides adequate information about the Contractor's monitoring activities for the Physician Incentive Plan as described in Section 20.4. The Contractor shall submit, at a minimum: (i) description of the Physician Incentive Plan; (ii) description of incentive arrangements; (iii) description and Data on percentage of Withhold or bonus attached to the plan; and (iv) the number of Providers participating in the plan and the number of Enrollees affected.

15.2.1.11 The Contractor shall submit an annual *PMPM Utilization Report* in a format to be determined by ASES.

15.2.1.12 On a quarterly basis the Contractor must report all *identified Provider preventable conditions* to ASES as specified by Section 5.2.2.2.

15.2.1.13 The Contractor shall provide to ASES annually a detailed description of its *drug utilization program activities* as established on Section 5.3.8.3.

15.2.1.14 The Contractor shall provide to the ASES Clinical Operations Office the results of the medical/surgical and mental health parity analysis annually, as required under Section 5.3.9.1. The Contractor shall also ensure that the submission includes, at a minimum, the elements necessary for ASES to evaluate compliance with 42 CFR Part 438, Subpart K and to meet CMS regulatory expectations, including:

15.2.1.14.1 A description of the benefit design, including medical/surgical and MH/SUD benefits, network structure, and covered populations.

15.2.1.14.2 Identification of all six federally required classifications.

15.2.1.14.3 A comparative analysis of cost-sharing, visit limits, day limits, and other numerical limitations applied to MH/SUD versus medical/surgical benefits.

15.2.1.14.4 A detailed evaluation of prior authorization processes, utilization management, network standards, reimbursement methodologies, clinical criteria, and other NQTLs, including the factors, evidentiary standards, and comparative processes used.

15.2.1.14.5 A description of the data sources, analytical methods, actuarial or statistical models, and review procedures used to conduct the parity analysis.

15.2.1.14.6 A summary of compliance determinations for each classification and each QTL/NQTL reviewed, including identification of any deficiencies.

15.2.1.14.7 If applicable, a detailed plan addressing any identified non-compliance, including timelines, responsible parties, and evidence of implementation.

15.2.1.14.8 A signed attestation by an authorized officer certifying that the analysis is complete, accurate, and compliant with federal parity requirements.

15.2.1.14.9 All policies, procedures, clinical criteria, utilization management guidelines, and other materials necessary for ASES to validate compliance.

15.2.1.14.10 In addition to the annual submission, the Contractor shall update and resubmit the parity analysis whenever there are material changes to benefits, utilization management processes, clinical criteria, network standards, reimbursement methodologies, or any other element that may affect parity compliance. The Contractor shall also maintain the analysis and all supporting documentation in a manner that allows ASES to provide it to CMS upon request at any time, including during audits, readiness reviews, or compliance monitoring.

15.2.1.15 The Contractor shall report to ASES on a monthly basis the Credentialing and Re-Credentialing status of Providers. The monthly Credentialing and Re-Credentialing Status Report shall be submitted to the ASES Compliance Office and shall include, at a minimum:

15.2.1.15.1 Provider Name; NPI; Provider Type and Specialty; Credential Status (Yes / No / NA), indicating whether the Provider is fully credentialed, pending credentialing or re-credentialing, or not subject to credentialing requirements Credential Effective Date (or "NA" if not applicable) Re-Credential Due Date (or "NA" if not applicable); verification and screening results required under 42 CFR 455.104, 42 CFR 455.106, and 42 CFR 455.436, including ownership and control disclosures, criminal conviction disclosures, and exclusion screening results; identification of any match or alert found during screening (Yes/No/N/A), including the action taken (Y/N or N/A if noy applicable), the date of the action(Y/N or N/A if noy applicable) , and the current status (Y/N or N/A if noy applicable) with any corrective actions implemented and their status ((Y/N or N/A if noy applicable)

15.2.1.15.2 The report shall be certified by the Contractor's Compliance Officer as complete, accurate, and prepared in compliance with all applicable Federal and Commonwealth requirements.

15.2.1.16 Within fifteen (15) Calendar Days of the award of the Provider Contract, the Contractor shall deliver the Provider Guidelines to all Network Providers and shall maintain verifiable evidence of such delivery. The Contractor shall submit to ASES, specifically to the ASES Beneficiary Service Office, a complete copy of the Provider Guidelines together with all documentation substantiating the delivery to its Network Providers, including but not limited to delivery logs, provider portal access reports, certified mail receipts, or written acknowledgments from the Network Providers. The Provider Guidelines delivered to Network Providers shall include, at a minimum, all operational, administrative, clinical, compliance, quality, and reporting requirements applicable to Network Providers under this Contract, as well as any additional requirements established by ASES. The Contractor shall retain all evidence of delivery for the duration of the Contract and shall make such evidence available to ASES upon request, including during audits, monitoring activities, compliance reviews, or any CMS-directed oversight. Any revision, amendment, or update to the Provider Guidelines shall likewise be delivered to all Network Providers, and the Contractor shall submit the updated version and all supporting documentation of delivery to the ASES Beneficiary Service Office. The Contractor shall maintain verifiable evidence of each such updated delivery in the same manner described above.

15.2.1.17 The Contractor shall notify ASES at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network, as required in Section 7.3.2. The Contractor shall also prepare and submit to ASES, through the Compliance Office, a monthly Provider Suspension, Termination or Withdrawal Report that includes all Providers terminated during the reporting period. For each terminated Provider, the report shall include, at a minimum, the following elements:

15.2.1.17.1 Provider Name; Provider Specialty; NPI; Effective Date of Termination; List of Impacted Enrollees (including Member ID and PCP attribution status); Date of Transition to New Provider for each impacted Enrollee; Copy of the Enrollee Notification Letter; Date the Notification Letter Was Issued; Description of Transition Assistance Provided;

15.2.1.17.2 Attestation of Compliance with 42 CFR 438.10; 42 CFR 438.62; 42 CFR 438.206; and 42 CFR 438.208 requirements regarding network changes and enrollee protections

15.2.1.17.3 If no Provider terminations occurred during the reporting period, the Contractor shall submit a written attestation to the Compliance Office confirming that no Provider Suspension, Termination or Withdrawal Report applies for that month.

15.2.1.17.4 The Contractor shall maintain all supporting documentation and shall ensure that the information submitted is complete, accurate, and sufficient to allow ASES to verify compliance with federal and contractual requirements.

15.2.1.17 The Contractor shall submit to ASES on an annual basis existing *Utilization Management edits* in the Contractor's Claims processing system that control Utilization and prevent payment for Claims that are duplicates, unbundled when they should be bundled, already covered under another charge, etc. Section 8.1.4.

15.2.1.18 The Contractor shall submit a monthly Utilization Management (UM) report to the Office of Clinical Operations, in accordance with 42 CFR Part 422 – Medicare Advantage and D SNP Requirements, 42 CFR Part 456 "Utilization Control", 42 CFR 438.210 "Coverage and Authorization of Services, and 42 CFR 438.236 "Practice Guidelines". Each UM report shall include as minimum:

15.2.1.18.1 a description of the UM activity or edit;

15.2.1.18.2 the applicable clinical criteria or policy;

15.2.1.18.3 the volume of affected claims or services;

15.2.1.18.4 the number of approvals, denials, and modifications; timeliness of UM determinations;

15.2.1.18.5 any identified compliance issues and corrective actions; and

15.2.1.18.6 An Attestation certifying that:

UM decisions were made in accordance with Federal and contractual requirements;

Clinical criteria were applied consistently; and

No inappropriate barriers to medically necessary care were created.

15.2.1.19 Pursuant to the Data required under 42 CFR 438.606 the Contractor shall submit the certification concurrently with the *certified data* required under 42 CFR 438.604. See Section 12.2 for more details.

15.2.1.20 As required in Section 13.7.1, the Contractor shall submit to ASES a monthly report not later than the fifth (5th) Calendar Day after the last day of the month listing all *paid, pending, and denied Claims* during that month. The report shall be made available in an electronic format and shall detail all paid, pending, and denied Claims for all Providers.

15.2.1.21 On a monthly basis, pursuant to Section 13.8.1 Providers shall furnish Encounter Data to the Contractor. Encounter Data must be sufficiently collected and maintained by the Contractor to identify the Provider who delivers any item or service to Enrollees. The Contractor shall submit all Encounter Data that ASES is required to report to CMS.

15.2.1.22 As established in Section 20.1.6 the Contractor shall provide to ASES a copy of the *annual corporate report of its parent company* at the close of the calendar year.

15.2.1.23 The Contractor shall report an annually all *Overpayment recoveries*, as follows:

15.2.1.23.1 The Contractor shall submit a Monthly Overpayment Recoveries Report to the Office of Finance no later than fifteen (15) calendar days following the end of each reporting month. The report shall summarize all Overpayments recovered during the reporting month and demonstrate compliance with 42 CFR 422.326 "Reporting and Returning of Overpayments." The Monthly Overpayment Recoveries Report shall include, at a minimum: the Overpayment amount; the date identified; the date returned the provider involved; the provider's physical location; the service region, if applicable; the reason for the Overpayment, supporting documentation demonstrating compliance with 42 CFR 422.326, including evidence of timely return within the required 60-day period. Each Monthly Overpayment Recovery Report shall be attested by the Contractor's Chief Compliance Officer (CCO) and Chief Financial Officer (CFO), certifying its accuracy, completeness, and compliance.

15.2.1.23.2 The Contractor shall report annually all Overpayment recoveries to the Office of Finance. All Overpayments shall be identified, documented, reported, and returned in accordance with 42 CFR 422.326 "Reporting and Returning of Overpayments", which requires return of any Overpayment no later than sixty (60) days after identification or by the date of the applicable reconciliation, whichever is later. The Contractor shall maintain complete documentation of each Overpayment as required under 42 CFR 422.504(d) "Record Maintenance Requirements." The Annual Overpayment Recoveries Report shall be submitted to the Office of Finance within ninety (90) calendar days following the close of the contract year ending on December 31 and shall consist of a comprehensive compilation of all Monthly Overpayment Recoveries Reports submitted during the contract year. The annual report shall include, at a minimum: the Overpayment amount; the date identified; the date returned; the provider involved; the provider's location; the service region, if applicable; the reason

for the Overpayment; supporting documentation demonstrating compliance with 42 CFR 422.326, including evidence of timely return within the required 60-day period. The Annual Overpayment Recoveries Report shall be formally attested by the Contractor's Chief Compliance Officer (CCO) and Chief Financial Officer (CFO), certifying its accuracy, completeness, and compliance.

15.2.1.23.3 As part of its Program Integrity obligations, the Contractor shall implement effective processes for the detection, investigation, correction, and prevention of Overpayments. The Contractor shall submit a Monthly Integrity Overpayment Recoveries Report to the Compliance Office no later than fifteen (15) calendar days following the end of each reporting month. The report shall identify recoveries Overpayment types; patterns or trends; systemic causes; provider-level or system-level recurrence; corrective actions implemented; monitoring results any Overpayments associated with FWA activity; others. This report is required under 42 CFR 422.326 and 42 CFR 422.504(d) and is separate from the Monthly Overpayment Recovery Report to Finance Office. Each Monthly Overpayment Recoveries Report shall be attested by the Contractor's Chief Compliance Officer (CCO), certifying its accuracy, completeness, and compliance with applicable federal requirements.

15.2.1.23.4 The Contractor shall submit each report required under this Section even when there are no cases to report for the applicable reporting period. In such instances, the Contractor shall submit the report indicating that no Overpayments were identified. Each report with no cases to report shall be attested by the Contractor's Chief Compliance Officer (CCO), certifying that no Overpayments were identified during the reporting period, that no required information was omitted, and that the submission complies with the accuracy, completeness, and compliance requirements established under applicable federal regulations, including 42 CFR 422.326 and 42 CFR 422.504(d).

15.2.1.24 On a quarterly basis, the Contractor shall report all *Cost Avoidance values* to ASES in accordance with Federal guidelines and as provided for in Section 20.2. For more information see Section 20.2.5.

15.2.1.25 The Contractor shall submit a monthly *Privacy and Confidentiality Report,* per required on Section 29.3.4, to the Compliance Office no later than fifteen (15) calendar days following the end of each reporting month. The report shall document all privacy and confidentiality related events, incidents, and suspected incidents, including those that, after evaluation, did not result in an unauthorized use or disclosure of Protected Health Information (PHI) or Personally Identifiable Information (PII). All reporting shall comply with the applicable requirements of 45 CFR 164.502 "Uses and Disclosures of Protected Health Information" and 45 CFR 164.530 "Administrative Requirements", including any amendments or updates in effect at the time of reporting.

15.2.1.26 The Contractor shall submit a monthly *Systems Incident Report.* As established on Section 14.5.7.

15.2.1.27 The Contractor shall submit a quarterly Provider Training and Educational Evaluating Report no later than thirty (30) Calendar Days after the close of each quarter. The report will be according with the requirement established in the 6.1.10.1.10 of the contract.

15.2.1.28 The Contractor shall submit the Network Adequacy Report required under Section 6.1.5 quarterly. The report shall include, at minimum, the elements required under 42 CFR 422.116, including: provider name, specialty, address, and contracting status; time and distance compliance with CMS standards; reference to access to Primary and Specialty Care; evidence that the network can serve anticipated enrollment; confirmation of active provider contracts; and Exception Requests, when applicable, pursuant to 42 CFR 422.116(d).

15.2.1.29 The Contractor shall submit an annual Provider Network Development and Management Plan to Operation Clinic Office setting forth how the Contractor shall comply with timely access requirements under 42 CFR 438.206(c)(1)(i)–(vi) and the Medicare Advantage and D-SNP network adequacy requirements under 42 C.F.R. 422.116, taking into account the urgency of the need for services. The Plan shall include, at a minimum:

15.2.1.29.1 Summary of Network Providers by type, CMS-defined specialty category, and geographic location in Puerto Rico.

15.2.1.29.2 Monitoring activities to ensure that access standards are met and Enrollees have timely access to services, consistent with ASES and CMS requirements.

15.2.1.29.3 Network capacity analysis by service and municipality, including remediation actions, quality management/quality improvement activities, and targeted and actual completion dates.

15.2.1.29.4 Network deficiencies by service and geographic area, and interventions to address such deficiencies.

15.2.1.29.5 Provider network development and expansion activities considering provider capacity, network deficiencies, service delivery issues, and future needs.

15.2.1.29.6 Exception Request updates, including recruitment initiatives, when an exception has been granted under 42 C.F.R. 422.116(d).

15.2.1.29.7 Time and distance compliance for all CMS-required provider types.

15.2.1.29.8 Access to primary and specialty care for Platino Enrollees.

15.2.1.29.9 Confirmation of active provider contracts for all listed providers.

15.2.1.30 The Contractor acknowledges and agrees that, regardless of whether the requested report does not have a format established by ASES, they must submit the required information to the Compliance Office to ensure compliance with the signed agreement. Additionally, any information that is not part of a report or the deliverables of Appendix L must be provided as previously stated and in compliance with current contractual provisions.

ARTICLE 16 ENFORCEMENT – INTERMEDIATE SANCTIONS

16.1 General Provisions

16.1.1 In monitoring Contractor's compliance with the terms of the Contract, ASES may impose intermediate sanctions, and/or liquidated damages, and/or fines pursuant to Puerto Rico Act No. 134 of 2013, for Contractor's failure to comply with the terms and conditions of this Contract.

16.1.2 In the event the Contractor incurs any proscribed conduct or otherwise is in default as to any applicable term, condition, or requirement of this Contract, and in accordance with any applicable provision of 42 CFR 438.700 and Section 4707 of the Balanced Budget Act of 1997, at any time following the Effective Date of the Contract, the Contractor agrees that, in addition to the terms of Section 30.1.1 of this Contract, ASES may impose intermediate sanctions against the Contractor for any such default in accordance with this Article 16. ASES may impose intermediate sanctions against the Contractor for any such default in accordance with this Article 16. ASES may impose both intermediate sanctions and fines pursuant to Puerto Rico Act No. 72-1993 and ASES Regulation 8446. The assessment or non-assessment of intermediate sanctions under this Contract cannot and will not limit the power or authority of ASES to impose any other fines, civil money penalties, sanctions, or other remedies recognized by Puerto Rico or Federal laws or regulations, including, but not limited to, Puerto Rico Act No. 72-1993 and ASES Regulation No. 8446.

16.1.3 Notwithstanding any intermediate sanctions imposed upon the Contractor under this Article 16, other than Contract termination, the Contractor shall continue to provide all Covered Services and other Benefits under this Contract.

16.1.4 ASES shall have the right to impose the following intermediate sanctions:

16.1.4.1 Civil Money Penalty – ASES may impose a civil money penalty for the following categories of events.

16.1.4.1.1 Category 1 - A civil money penalty in accordance with any applicable provision of 42 CFR 438.700 up to one-hundred thousand dollars ($100,000) per determination shall be imposed for this category. The following constitute Category 1 events:

16.1.4.1.1.1 Acts that discriminate among Enrollees on the basis of their health status or need for health care services. This includes termination of Enrollment or refusal to reenroll a Potential Enrollee, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage Enrollment by beneficiaries whose medical or

Behavioral Health condition or history indicates probable need for substantial future medical or Behavioral Health Services. Notwithstanding the foregoing, ASES may impose a civil money penalty in the amount of fifteen thousand dollars ($15,000) per each (i) Potential Enrollee that was not enrolled because of discriminatory practices as described above and/or (ii) discriminatory practices imposed on Enrollees, subject to the overall limit of one-hundred thousand dollars ($100,000) per each determination.

16.1.4.1.1.2 The misrepresentation or falsification of information submitted to ASES and/or CMS.

16.1.4.1.2 Category 2 - A civil money penalty in accordance with any applicable provision of 42 CFR 438.700 up to twenty-five thousand dollars ($25,000) per determination shall be imposed for this category. The following constitute Category 2 events:

16.1.4.1.2.1 Failure by the Contractor to substantially provide Medically Necessary Services that the Contractor is required to provide, under applicable law or under this Contract, to an Enrollee under this Contract.

16.1.4.1.2.2 Misrepresentation or falsification by the Contractor of information that it furnishes to an Enrollee, Potential Enrollee, or Provider.

16.1.4.1.2.3 Failure by the Contractor to comply with the requirements for Physician Incentive Plans, as set forth in 42 CFR 422.208 and 422.210.

16.1.4.1.2.4 The distribution by the Contractor, directly or indirectly through any Agent or independent contractor, of Marketing Materials that have not been prior approved by ASES or that contain false or materially misleading information.

16.1.4.1.3 Category 3 – Pursuant to 42 CFR 438.704 (c), ASES may impose a civil money penalty for the Contractor's imposition of premiums or charges in excess of the amounts permitted under the Medicaid program. The maximum amount of the penalty is the greater of twenty-five thousand dollars ($25,000) or double the amount of the excess charges. ASES will deduct from the penalty the amount of overcharge and return it to the affected Enrollees.

16.1.4.2 Temporary Management. ASES may appoint temporary management for the Contractor's Medicare Platino operations, as provided in 42 C.F.R. 438.702 and 42 C.F.R. 438.706 as a result of Contractor's:

16.1.4.2.1 Continued egregious behavior, including but not limited to behavior described in Categories 1 through 3 of this Article 16;

16.1.4.2.2 Behavior that is contrary to, or is non-compliant with, Sections 1903(m) or 1932 of the Social Security Act, as amended, found at 42 U.S.C. §§ 1396b (m) and 1396u-2;

16.1.4.2.3 Actions which have caused substantial risk to an Enrollee's health; and/or

16.1.4.2.4 Behavior that has led ASES to determine that temporary management is necessary to ensure the health of Contractor's Enrollees while improvements to remedy Category 1 through 3 violations are being made, or until the Contractor's orderly termination or reorganization.

16.1.4.2.5 If temporary management is appointed for any reason specified in Sections 16.1.4.2 above, such temporary management will cease once ASES has, in its discretion, determined that the sanctioned behavior will not re-occur.

16.1.4.3 Enrollment Termination. ASES may grant Enrollees the right to terminate Enrollment without cause, and notify the affected Enrollees of their right to disenroll when:

16.1.4.3.1 The Contractor has engaged in continued egregious behavior, including but not limited to behavior described in Categories 1 through 3 of this Article 16;

16.1.4.3.2 The Contractor has engaged in behavior that is contrary to, or is non-compliant with, Sections 1903(m) or 1932 of the Social Security Act, as amended, found at 42 U.S.C. §§ 1396b (m) and 1396u-2;

16.1.4.3.3 The Contractor has taken actions that have caused substantial risk to Enrollees' health;

16.1.4.3.4 ASES determines that temporary management is necessary or convenient to ensure the health of the Contractor's Enrollees; or

16.1.4.3.5ASES determines that such Enrollment termination is necessary or appropriate to remedy Category 1 through 3 violations.

16.1.4.4 Enrollment Suspension. ASES may suspend all new Enrollments, including default Enrollment, after the effective date of the intermediate sanction and until the intermediate sanction is no longer in effect.

16.1.4.5 Payment Suspension. ASES may suspend payment of the PMPM Payment for Enrollees enrolled after the effective date of the intermediate sanction and until CMS or ASES is satisfied that the reason for imposition of the intermediate sanction no longer exists and is not likely to re-occur or upon the Termination Date of the Contract.

16.1.4.6 Mandatory Imposition of Certain Intermediate Sanctions. ASES shall impose the temporary management and Enrollment

suspension intermediate sanctions described in Sections 16.1.4.2 and 16.1.4.3 above, if ASES finds that the Contractor has repeatedly failed to meet substantive requirements in Sections 1903(m) or 1932 of the Social Security Act, as amended, found at 42 U.S.C. §§ 1396b (m) and 1396u-2.

16.1.4.7 Subject to Article 30 of this Contract, in lieu of imposing a sanction allowed under this Article 16, ASES may terminate this Contract, and place Enrollees with a different Contractor or provide Medicare Platino benefits through another state plan authority, without any liability whatsoever (but subject to making any payments due under this Contract through any such date of termination), if the terms of a Corrective Action Plan implemented pursuant to this Article 16 to address a failure specified in Category 1 or Category 2 of this Article 16 are not implemented to ASES's approval or if such failure continues or is not corrected, to ASES's satisfaction.

16.2 Notice of Administrative Inquiry

16.2.1 ASES may issue the Contractor a notice of imposition of sanctions in lieu of a notice of administrative inquiry if ASES determines, in its sole discretion, that the Contractor's non-compliance will not be cured with a Corrective Action Plan. In all other cases, ASES shall issue a notice of administrative inquiry informing Contractor about ASES's compliance, monitoring, and auditing activities regarding potential non-compliance as described in this Article 16. This notice of administrative inquiry shall include the following:

16.2.1.1 A brief description of the facts;

16.2.1.2 Citations to Puerto Rico and Federal laws and regulations, or Contract provisions that the Contractor has breached;

16.2.1.3 The Contractor's non-compliance with Puerto Rico and Federal laws and regulations or Contract provisions as referenced in the Contract;

16.2.1.4 The Contractor's breach of applicable intermediate sanction Contract provisions;

16.2.1.5 ASES's authority to determine and impose intermediate sanctions under this Article 16;

16.2.1.6 The amount of potential, or Contractor's exposure to intermediate sanctions, when they will be imposed and how they were computed; and

16.2.1.7 If applicable, a statement requiring the Contractor to submit a Corrective Action Plan within fifteen (15) Calendar Days of

receipt of the notice of administrative inquiry under this Article 16.

16.2.2 The Contractor shall submit a Corrective Action Plan within fifteen (15) Calendar Days of receipt of the notice of administrative inquiry. However, the submission of a Corrective Action Plan shall not limit ASES's power and authority to impose intermediate sanctions, fines, liquidated damages, or any other remedy allowed under this Contract or under Federal or Puerto Rico laws and regulations.

16.2.3 A notice of administrative inquiry shall not be deemed to constitute and is not ASES's final or partial determination of intermediate sanctions. Thus, any administrative inquiries issued by ASES are not subject to administrative review under Section 16.4, and would be considered premature rendering any administrative examiner without jurisdiction to review the matter.

16.2.4 If the Contractor fails to comply with any material provision under a Corrective Action Plan submitted to ASES pursuant to Section 16.2.2 above, ASES may impose:

16.2.4.1 A daily $5,000 civil money penalty, up to a maximum total of $100,000, for Contractor's ongoing failure to comply with any material provision of the Corrective Action Plan; or

16.2.4.2 The applicable intermediate sanction for any or all behavior that resulted in the Contractor's submission of the Corrective Action Plan pursuant to Section 16.2.2 above.

16.3 Notice of Imposition of Intermediate Sanctions

16.3.1 Prior to the imposition of intermediate sanctions, ASES will issue a notification, delivered thorough US Postal Service Certified Mail, to the Contractor that includes the following:

16.3.1.1 A brief description of the facts;

16.3.1.2 Citations to Puerto Rico and Federal laws and regulations, or Contract provision(s) that the Contractor has breached;

16.3.1.3 ASES's determination to impose intermediate sanctions;

16.3.1.4 Intermediate sanctions imposed and their effective date;

16.3.1.5 Methodology for the civil money penalty calculation or determination of the intermediate sanctions; and

16.3.1.6 A statement that the Contractor has a right to object and request an administrative review of the imposition of intermediate sanctions pursuant to the procedures in ASES Regulation 8446.

16.3.2 ASES shall notify CMS in writing of the imposition of intermediate sanctions within thirty (30) Calendar Days of imposing sanctions and concurrently provide the Contractor with a copy of such notice

16.4 Administrative Review. Contractor has the right to object and seek administrative review of the imposition of intermediate sanctions, including but not limited to civil money penalties, by ASES, pursuant to the procedures in ASES Regulation No. 8446.

16.4.1 The Contractor has the right within fifteen (15) Calendar Days following receipt of the notice of imposition of intermediate sanctions to seek administrative review in writing of ASES's determination and any such immediate sanctions, pursuant to Act 72 or under any other applicable law or regulation. This time period can be extended for an additional fifteen (15) Calendar Days if the Contractor submits a written request that includes a credible explanation of why it needs additional time, the request is receipted by ASES before the end of the initial period, and ASES has determined that the Contractor's conduct does not pose a threat to an Enrollee's health or safety.

16.4.2 As part of the administrative review, the Parties shall cooperate with the examining officer and follow all applicable procedures for the administrative review.

16.4.3 Upon completion of the administrative review, the examining officer may recommend:

16.4.3.1 Confirm the intermediate sanctions;

16.4.3.2 Modify or amend the intermediate sanctions pursuant to applicable law or regulation; or

16.4.3.3 Eliminate the imposed intermediate sanctions.

16.4.4 Once the sanction becomes final ASES shall deduct the amount of the sanction from payments owed to the Contractor.

16.4.5 In addition to the actions described under Section 16.4.3, the examining officer may recommend the delivery and implementation of a Corrective Action Plan with respect to the Contractor's failure to comply with the terms of this Contract as set forth in ASES' notice of intermediate sanctions.

16.4.6 ASES shall notify CMS in writing of any modification in the imposition of intermediate sanctions through the administrative review process within thirty (30) Calendar Days of receipt of the examining officer's determination, and concurrently provide the Contractor with a copy of such notice.

16.5 Judicial Review. To the extent administrative review is sought by the Contractor pursuant to Section 16.4, the Contractor has the right to seek judicial review of ASES's Actions by the

Puerto Rico Court of Appeals, San Juan Panel, within thirty (30) Calendar Days of the notice of final determination issued by ASES.

16.6 Federal Sanctions. Payments provided for under this Contract will be denied for new Enrollees when, and for so long as, payment for those Enrollees is denied by CMS in accordance with the requirements in 42 C.F.R. 438.730.

ARTICLE 17 ENFORCEMENT - LIQUIDATED DAMAGES AND OTHER REMEDIES

17.1 General Provisions

17.1.1 ASES may impose intermediate sanctions, liquidated damages, and/or fines pursuant to Puerto Rico Act No. 72-1993 and ASES Regulation No. 8446.

17.1.2 In the event the Contractor is in default as to any applicable term, condition, or requirement of this Contract, and in accordance with any applicable provision of 42 CFR 438.700 and Section 4707 of the Balanced Budget Act of 1997, at any time following the Effective Date of this Contract, the Contractor agrees that, in addition to the terms of Section 30.1.1 of this Contract, ASES may assess liquidated damages against the Contractor for any such default, in accordance with this Article 17. ASES may not impose liquidated damages with respect to a specific event of default of Contractor for which intermediate sanctions, including but not limited to civil monetary penalties, sought to be imposed or are imposed against the Contractor under Article 16. The Parties further acknowledge and agree that the specified liquidated damages are reasonable and the result of a good faith effort by the Parties to estimate the anticipated or actual harm caused by the Contractor's breach and are in lieu of any other financial remedies to which ASES may otherwise have been entitled. The assessment of liquidated damages under the Contract cannot and will not limit the power or authority of ASES to impose fines, civil money penalties, sanctions, or other remedies under Article 17 of this Contract or otherwise under by The Government of Puerto Rico or Federal laws or regulations, including fines pursuant to Puerto Rico Act No. 134.

17.1.3 Notwithstanding any sanction, including liquidated damages, imposed upon the Contractor, other than Contract termination, the Contractor shall continue to provide all Covered Services and other Benefits under this Contract.

17.1.4 The Contractor's breach or failure to comply with the terms and conditions of this Contract for which liquidated damages may be assessed under this Article 17 shall be divided into four (4) categories of events. ASES retains the discretion to impose liquidated damages or other sanctions for Contractor's non-compliance with an obligation of the Contractor under this Contract or Puerto Rico Law that is not specified under the categories in Sections 17.2, 17.3, 17.4 or 17.5.

17.2 Category 1

17.2.1 Liquidated damages in accordance with any applicable provision of this Contract of up to one-hundred thousand dollars ($100,000) per violation, Incident or occurrence may be imposed for Category 1 events. The following constitute Category 1 events:

17.2.1.1 Material non-compliance with an ASES or CMS directive, determination or notice to cease and desist not otherwise described in Article 16 or other provision of this Article 17, provided that the Contractor has received prior written notice with respect to such specific material non-compliance, and afforded an opportunity to cure within a reasonable period to be determined by ASES in its sole discretion.

17.3 Category 2

17.3.1 Liquidated damages in accordance with any applicable provision of this Contract of up to twenty-five thousand dollars ($25,000) per violation, Incident, or occurrence may be imposed for Category 2 events. The following constitute Category 2 events:

17.3.1.1 Subject to ASES compliance with its obligations under Article 22 of this Contract, repeated noncompliance by the Contractor with any material obligation that adversely affects the services that the Contractor is required to provide under Article 5 of this Contract;

17.3.1.2 Failure of the Contractor to assume its duties and obligations under this Contract in accordance with the transition timeframes specified herein;

17.3.1.3 Failure of the Contractor to terminate a Provider that imposes Co-Payments or other cost-sharing on Enrollees that are in excess of the fees permitted by ASES (ASES will deduct the amount of the overcharge and return it to the affected Enrollees);

17.3.1.4 Failure of the Contractor to address Enrollees' Complaints, Appeals, and Grievances, and Provider disputes, within the timeframes specified in this Contract;

17.3.1.5 Failure of the Contractor to comply with the confidentiality provisions in accordance with 45 CFR 160 and 164; and

17.3.1.6 Failure of the Contractor to comply with a subcontracting requirement in the Contract.

17.4 Category 3

17.4.1 Liquidated damages in accordance with any applicable provision this Contract of five-thousand dollars ($5,000) per day may be imposed for Category 3 events. The following constitute Category 3 events:

17.4.1.1 Failure to submit required reports in the timeframes prescribed in Article 15;

17.4.1.2 Submission of incorrect or deficient Deliverables as set forth in Appendix L to this Contract or reports in accordance with Article 15 of this Contract;

17.4.1.3 Failure to comply with the Claims processing standards as follows:

17.4.1.3.1 Failure to process and finalize to a paid or denied status ninety-five percent (95%) of all Clean Claims within thirty (30) Calendar Days of receipt;

17.4.1.3.2 Failure to process and finalize to a paid or denied status one hundred percent (100%) of all Clean Claims within fifty (50) Calendar Days of receipt; and

17.4.1.3.3 Failure to process Unclean Claims as specified in Section 13.10.3 of this Contract;

17.4.1.4 Failure to pay Providers interest at the rate identified in and otherwise in accordance with Section 13.10.2.3 of this Contract when a Clean Claim is not adjudicated within the Claims processing deadlines;

17.4.1.5 Failure to seek, collect and/or report Third Party Liability information as provided in Section 20.2 of this Contract; and

17.4.1.6 Failure of Contractor to issue written notice to Enrollees upon Provider's termination of a Provider as described in Section 73 of this Contract.

17.5 Category 4

17.5.1 Liquidated damages as specified below may be imposed for Category 4 events. The following constitute Category 4 events:

17.5.1.1 Failure to implement the BC-DR plan as follows:

17.5.1.1.1 Implementation of the (BC-DR) plan exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2;

17.5.1.1.2 Implementation of the (BC-DR) plan exceeds the proposed time by more than two (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per each day beginning with day 3 and up to day 5;

17.5.1.1.3 Implementation of the (BC-DR) plan exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days, twenty-five thousand dollars ($25,000) per day beginning with day 6 and up to day 10;

17.5.1.1.4 Implementation of the (BC-DR) plan exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per each day beginning with day 11;

17.5.1.2 Unscheduled System Unavailability in violation of Article 14, in ASES's discretion, two hundred fifty dollars ($250) for each thirty (30) minute period or portions thereof;

17.5.1.3 Failure to make available to ASES or its Agent, valid extracts of Encounter Information for a specific month within fifteen (15) Calendar Days of the close of the month: five hundred dollars ($500) per day. After thirty (30) Calendar Days of the close of the month: two thousand dollars ($2,000) per Calendar Day;

17.5.1.4 Failure to correct a system problem not resulting in System Unavailability within the allowed timeframe, where failure to complete was not due to the action or inaction on the part of ASES as documented in writing by the Contractor:

17.5.1.4.1 One (1) to fifteen (15) Calendar Days late: two hundred and fifty dollars ($250) per Calendar Day for days 1 through 15;

17.5.1.4.2 Sixteen (16) to thirty (30) Calendar Days late: five hundred dollars ($500) per Calendar Day for days 16 through 30; and

17.5.1.4.3 More than thirty (30) Calendar Days late: one thousand dollars ($1,000) per Calendar Day for days 31 and beyond; and

17.6 Other Remedies

17.6.1 Subject to Article 30 of this Contract, in lieu of imposing a Remedy allowed under this Article 17, ASES may elect to terminate this Contract, without any liability whatsoever (but subject to making any payments due, if any, under this Contract through any such date of termination), if the terms of a Corrective Action Plan implemented pursuant to this Article 17 to address a failure specified in Category 1 or Category 2 of this Article 17 are not implemented to ASES's satisfaction or if such failure continues or is not corrected, to ASES's sole satisfaction.

17.6.1 In the event of non-compliance by the Contractor with Article 15 of this Contract, ASES shall have the right to Withhold, with respect to Article 15, a sum not to exceed ten percent (10%) of the Per Member Per Month Payment for the following month and for continuous consecutive months thereafter until such noncompliance is cured and corrected to ASES's satisfaction in lieu of imposing any liquidated damages, penalties or sanctions against the Contractor hereunder. ASES shall release the Withhold of the PMPM Payment to the Contractor within two (2) Business Days after the corresponding event of noncompliance is cured to ASES's sole satisfaction.

17.7 Notice of Administrative Inquiry regarding Liquidated Damages and/or Other Article 17 Remedies

17.7.1 Administrative Inquiry. ASES may issue the Contractor a notice of imposition of liquidated damages and/or other Article 17 remedies in lieu of a notice of administrative inquiry regarding liquidated damages and/or other Article 17 remedies if ASES determines, in its sole discretion, that the Contractor's non-compliance will not be cured with a Corrective Action Plan. In all other cases, ASES shall issue a notice

of administrative inquiry informing the Contractor about ASES's compliance, monitoring, and auditing activities regarding potential non-compliance as described in this Article 17. This notice of administrative inquiry shall include the following:

17.7.1.1 A brief description of the facts;

17.7.1.2 Citations to Puerto Rico and Federal laws and regulations, or Contract provision(s) the Contractor has breached;

17.7.1.3 The Contractor's non-compliance with Puerto Rico and Federal laws and regulations or Contract provisions;

17.7.1.4 The Contractor's breach of applicable Contract provisions and event categories that could result in remedies or liquidated damages pursuant to this Article 17;

17.7.1.5 ASES's authority to determine and seek liquidated damages or other remedies against the Contractor under this Article 17;

17.7.1.6 The amount of potential, or Contractor's exposure to liquidated damages, or other Article 17 remedies, and how they were computed; and

17.7.1.7 A statement describing the Contractor's right to submit a Corrective Action Plan within fifteen (15) Calendar Days of receipt of the notice of administrative inquiry under this Article 17.

17.7.2 The Contractor shall submit a Corrective Action Plan within fifteen (15) Calendar Days of receipt of the notice of administrative inquiry issued pursuant to this Article 17.

17.7.3 A notice of administrative inquiry shall not constitute ASES's final or partial determination of liquidated damages. Thus, any administrative inquiries made are not subject to administrative review under Section 17.8.3 and would be construed to be premature rendering any administrative examiner without jurisdiction to review the matter.

17.7.4 If the Contractor fails to comply with any material provision under a Corrective Action Plan submitted to ASES pursuant to Section 17.7.2 above, ASES may impose:

17.7.4.1 A daily amount of $5,000 in liquidated damages, up to a maximum total amount of $100,000, for the Contractor's failure to comply with any material provision part or condition of the Corrective Action Plan; and/or

17.7.4.2 The applicable Article 17 Remedy for any or all behavior that resulted in the submission of Corrective Action Plan pursuant to Section 17.7.2 above.

17.8 Notice of Imposition of Liquidated Damages and/or Other Remedies

17.8.1 Prior to the imposition of liquidated damages and/or any other remedies under this Article 17, ASES will issue a notification, delivered thorough US Postal Service Certified Mail, to the Contractor that includes the following:

17.8.1.1 A brief description of the facts;

17.8.1.2 Citations to Puerto Rico and Federal laws and regulations, or Contract provision(s) the Contractor has breached;

17.8.1.3 ASES's determination to assess and impose liquidated damages and/or any other Article 17 Remedy;

17.8.1.4 Liquidated damages and/or any other Article 17 Remedy imposed and their effective date;

17.8.1.5 Methodology for the liquidated damages and/or any other Article 17 Remedy calculation; and

17.8.1.6 A statement that the Contractor has a right to object and request an administrative review of the imposition of liquidated damages and other Article 17 remedies pursuant to the procedures in ASES Regulation 8446 and Puerto Rico Act No. 38-2017, as amended.

17.8.2 The Contractor shall submit a Corrective Action Plan to ASES within thirty (30) Calendar Days of receipt of a notice of liquidated damages or other remedies pursuant to this Article 17.

17.8.3 Administrative Review. The Contractor has the right to object and seek administrative review of the imposition of liquidated damages and/or any other Remedy under this Article 17, pursuant to the procedures in ASES Regulation No. 8446.

17.8.3.1 As part of the administrative review, the Parties shall cooperate with the examining officer and follow all applicable procedures for the administrative review.

17.8.3.2 Once the sanction becomes final ASES shall deduct the amount of the sanction from the PMPM Payment or the Retention Fund.

17.9 Judicial Review. The Contractor has the right to seek reconsideration and judicial review of ASES's determination pursuant to the procedures in ASES Regulation No. 8446 and Puerto Rico Act No. 389-2017, as amended.

ARTICLE 18 CONTRACT TERM

18.1 Subject to and upon the terms and conditions herein, this Contract shall be in full force and effect on January 1, 2027, and shall terminate on December 31, 2027. The foregoing notwithstanding, ASES, subject to Article 30 reserves the right, prior written notice of ninety (90) Calendar Days, to amend or partially terminate the Contract at any time to implement a demonstrative plan to incorporate the new public health policies and/or strategies of the Government of Puerto Rico in any Service Region or portion thereof.

18.2 The Contract shall expire at the close of the Contract Term unless earlier terminated under Article 30 or extended by written amendment with the agreement of the Parties. This Contract shall not be automatically renewed.

18.3 To the extent that, due to the number of products offered by the Contractor, this Contract is projected to surpass the monetary minimum established by the Financial Oversight and Management Board (FOMB) to require FOMB approval, it must be approved by the FOMB. In the event the FOMB does not approve this Contract prior to September 30, 2026, or denies approval, it shall be considered immediately terminated on September 30, 2026.

ARTICLE 19 PAYMENT FOR SERVICES

19.1 General Provisions

19.1.1 Compensation to the Contractor shall consist of a monthly, PMPM Payment which will be equal to the number of Enrollees as of the last day of the month preceding the month in which payment is made, multiplied by the negotiated PMPM Payment agreed to between the Contractor and ASES for each Service Region covered by the Contract. The applicable rate for compensation is specified in Appendix B and shall be effective for the entire Contract Term. The Contractor shall not, at any time, increase the rate agreed in the Contract, nor reduce the Covered Services or other benefits agreed to.

19.1.1.1 PMPM Payment to Contractor will be disbursed from the Finance Department Control Account Number 246-5377-5381-P01-P02-2027.

19.1.1.2 PMPM Payments to Contractor will be conducted through an Automated Clearinghouse System (ACH). Prior to the execution of this Contract, the Contractor must have duly signed the proper ACH transfer authorization form.

19.1.1.3 The PMPM Payment made based upon the number of Enrollees as of the last day of the preceding month will be reconciled to the actual number of Enrollees for that month when that information is available and appropriate PMPM Payment adjustments will be made.

19.1.2 ASES shall only make monthly capitation payments for enrollees aged 21–64 receiving inpatient treatment in an Institution for Mental Diseases (IMD), as defined in 42 CFR 435.1010, so long as the IMD is a hospital or sub-acute psychiatric or substance abuse disorder inpatient care or a sub-acute facility providing psychiatric or substance use disorder crisis residential services, and length of stay in the IMD is for a short term stay under federal IMD payment limits, consistent with 42 CFR 438.6(e).

19.1.3 If CMS denies payment on the basis of Section 1903(m)(5)(B)(ii) of the Social Security Act, or such other applicable federal statute or regulation, ASES will deny PMPM Payment to the Contractor for Enrollees enrolled after the date that CMS has notified the Contractor of their denial and until CMS is satisfied that the basis for such determination has been corrected and is not likely to recur.

19.1.4 ASES will have the discretion to recoup payments made to the Contractor for ineligible Enrollees, including, but not limited to, the following:

19.1.4.1 Enrollees incorrectly enrolled with more than one Contractor;

19.1.4.2 Enrollees who die prior to the Enrollment month for which the payment was made;

19.1.4.3 Enrollees whom ASES later determines were not eligible for Medicaid during the Enrollment month for which payment was made;

19.1.4.4 Enrollees whom were not domiciled in Puerto Rico at the time the service was rendered for which payment was made; or

19.1.4.5 Enrollees whom were incarcerated during the Enrollment month for which payment was made.

19.1.5 Any such payments due to ASES from the Contractor will be offset from future payments to the Contractor.

19.1.6 The Contractor shall have the right to recoup from Providers or other persons to whom the Contractor has made payment for any payments made for which ASES has recouped the PMPM Payment.

19.1.7 The PMPM Payment for Enrollees not enrolled for the full month shall be determined on a pro rata basis by dividing the monthly Capitation amount by the number of days in the month and multiplying the result by the number of days including and following the Effective Date of Enrollment or the number of days prior to and including the Effective Date of Disenrollment, as applicable. The Contractor is entitled to a PMPM Payment for each Enrollee as of the Effective Date of Enrollment, including the period referred to in Section 3.2.3. The Contractor is entitled to a PMPM Payment for each Enrollee up to the Effective Date of Disenrollment, including the period referred to in Section 3.3.

19.1.8 The Contractor acknowledges that the capitated payments agreed to under the terms of this Contract in addition to any applicable cost-sharing as provided in Appendix C-6 to this Contract constitute full and complete payment for Covered Services and Benefits under the Medicare Platino Program. ASES will have no responsibility for payment for Covered Services and Benefits beyond that amount unless the Contractor has obtained prior written approval, in the form of a Contract amendment, authorizing an increase in the total payment. The Contractor further agrees that such capitated payments may be made only by ASES and retained by Contractor for Dual-Eligible Enrollees.

19.1.9 The Contractor and any Network or Out-of-Network Provider shall be prohibited from holding any Enrollee liable for the payment of any fees that are the legal obligation of Contractor. Balance billing is expressly prohibited. Any cost sharing imposed on Enrollees shall be in accordance with 42 CFR 447.50 through 42 CFR 447.60.

19.1.10 To comply with 42 CFR 438.608(d), "Program Integrity Requirements", the Contractor shall report and return to ASES any Overpayment within sixty (60) calendar days after the date on which the Overpayment was Identified. The Contractor shall specify its retention policies governing the treatment of all Overpayment recoveries made to a Provider, including the specific treatment of Overpayments resulting from Fraud, Waste, or Abuse (FWA). The Contractor shall also maintain and require the use of a mechanism through which a Network Provider may report an Overpayment to the Contractor and return such Overpayment together with a written explanation of the reason for the Overpayment, in accordance with this Section. All Overpayment reporting and recovery activities shall comply with the requirements established in Section 15.2.1.23, related to "Overpayment Recoveries Reporting".

ARTICLE 20 FINANCIAL MANAGEMENT

20.1 General Provisions

20.1.1 The Contractor shall be responsible for the sound financial management of Puerto Rico and Federal funds provided to the Contractor under the Medicare Platino Program.

20.1.2 The Contractor shall notify ASES's Executive and Legal Director in writing of any proposed loan or other special financial arrangement between the Contractor and any Provider no less than sixty (60) days prior to its execution. The notification shall include all documentation necessary to demonstrate compliance with applicable federal and Puerto Rico laws and regulations governing such transactions, including the Federal Anti-Kickback Statute, the Safe Harbor Regulations at 42 CFR 1001.952, the False Claims Act, 42 CFR Part 455 (Program Integrity Requirements), and any other federal or Puerto Rico statutes related to fraud, abuse, improper remuneration, or prohibited financial inducements. This requirement includes compliance with any amendments, updates, or applicable Final Rules issued by HHS or CMS that are in effect at the time the transaction is reviewed or implemented.

20.1.3 The Contractor shall provide ASES with copies of its audited financial statements following Generally Accepted Accounting Principles ("GAAP") in the US, at its own cost and expenses, for the duration of the Contract, and as of the end of each fiscal year during the Contract Term, regarding the financial operations related to the Medicare Platino Program. The statements shall provide (1) a separate accounting of activities relating to each Service Area, and (2) a consolidated section accounting for all Medicare Platino Program activities. These reports shall be submitted to ASES no later than every June 1st of each year with respect to the operation year ended December 31 of the previous year. ASES may grant an extension of the reporting deadline upon good cause shown by the Contractor.

20.1.4 The Contractor shall provide to ASES a copy of its Annual Report required to be filed with the Puerto Rico Office of the Insurance Commissioner (OIC Report), as applicable, in the format agreed upon by the National Association of Insurance Commissioners (NAIC), for the year ended on December 31, 2019, and subsequently thereafter, during the Contract Term, not later than March 31 of each year. The Contractor shall submit to ASES a reconciliation of the OIC Report with its annual audited financial statements filed pursuant to Section 20.1.3.

20.1.5 The Contractor shall provide to ASES unaudited financial statements for each quarter during the Contract Term, not later thirty (30) Calendar Days after the close of each quarter. The Contractor shall submit (1) a separate accounting of activities relating to each Service Area, and (2) a consolidated section accounting for all Medicare Platino Plan activities. ASES may grant a 15-day extension of the reporting deadline upon good cause shown by the Contractor.

20.1.6 The Contractor shall provide to ASES a copy of the annual corporate report of its parent company at the close of the calendar year.

20.1.7 Section 20.1.6 of the Contract states that the Contractor shall provide ASES with a copy of the annual corporate report of its parent company within thirty (30) days following the issuance or filing of that report (including, where applicable, its Form 10-K), and in no event later than one hundred twenty (120) days after the close of each calendar year. While 42 CFR Part 422 does not prescribe the specific content of a parent company's annual corporate report, the Contractor shall ensure that the report reflects industry-standard corporate reporting practices for health insurance and managed care organizations, including consolidated audited financial statements, corporate governance information, organizational structure, disclosure of material changes, and any other information customarily included in such reports. Where the parent company is a publicly traded entity, its most recent Form 10-K (or equivalent regulatory filing) shall satisfy this requirement. For private (non-publicly traded) parent companies, consolidated audited financial statements shall satisfy this requirement. This contractual obligation is independent of, and supplementary to, the Contractor's own obligations under 42 CFR Part 422, which continue to apply, including: the maintenance of books, records, and documents for a minimum of ten (10) years (42 CFR 422.504(d)); the right of HHS, the Comptroller General, and their designees (including CMS and the HHS Office of Inspector General) to audit, evaluate, and

inspect the Contractor's books, contracts, and records, which right extends through ten (10) years (42 CFR 422.504(e)(2) and (e)(4)); the certification of the accuracy, completeness, and truthfulness of data submitted to CMS (42 CFR 422.504(l)); and the maintenance of a fiscally sound operation reflected in a positive net worth (42 CFR 422.504(a)(14)). ASES reserves the right to request supplemental financial or corporate information reasonably necessary to verify the financial condition and contractual compliance of the Contractor and its parent company.

20.1.8 The Contractor shall maintain adequate procedures and internal controls to ensure that all payments made pursuant to this Contract are properly authorized and disbursed. In establishing and maintaining such procedures, the Contractor shall ensure a clear separation between the functions of certification and disbursement. The Contractor shall comply with applicable federal and Puerto Rico requirements governing financial management and program integrity, including 42 CFR 438.3(h), 42 CFR 438.608,42 CFR §438.608(c); 42 CFR 438.66(e), and 42 CFR Part 455 "Fraud, Waste, and Abuse Controls", as amended by any applicable Final Rules issued by HHS or CMS. The Contractor shall submit to ASES a Monthly Overpayment Recovery Report and an Annual Overpayment Recovery Report, in accordance with Section 15.2.1.23 of this Contract.

20.1.9 The Contractor acknowledges, and shall incorporate in contracts with Subcontractors, that the Medicare Platino Program is a government-funded program. As such, the administrative costs that are deemed allowable shall be in accordance with cost principles permissible, and with Federal and Puerto Rico applicable guidelines, including Office of Management and Budget Circulars, primarily recognizing that: (1) a cost shall be reasonable if it is of the type generally recognized as ordinary and necessary, and if in its nature and amount, and taking into consideration the purpose for which it was disbursed, it does not exceed that which would be incurred by a prudent person in the ordinary course of business under the circumstances prevailing at the time the decision was made to incur the cost; and (2) a cost shall be reasonable if it is allocable to or related to the cost objective that compels cost association..

20.1.10 The Contractor shall maintain an accounting system for Medicare Platino separate from the rest of its commercial activities. This system shall include only ASES Data, which must be segregated by Service Area. The Contractor shall ensure that the accounting system complies with the applicable federal requirements, including 42 CFR 438.3(h); 42 CFR 438.608(a)(2); 42 CFR 438.608(a)(7); 42 CFR 438.608(c); 42 CFR 455.18; and 42 CFR 438.66(e). The accounting system shall also allow for the segregation, tracking, and independent verification of all funds and transactions related to Medicare Platino and ASES.

20.1.11 The Contractor shall provide, throughout the Contract Term, any additional information that ASES deems necessary to evaluate the Contractor's financial capacity and stability. Such information shall be submitted in accordance with applicable federal requirements, including the financial reporting, monitoring, and program integrity obligations established under 42 CFR 438.3(h), 42 CFR 438.66(e), and 42 CFR 438.608. All information submitted shall support ASES's oversight responsibilities and

demonstrate ASES's continued compliance with CMS monitoring, oversight, and accountability requirements.

20.2 Third Party Liability and Cost Avoidance

20.2.1 General Provisions

20.2.1.1 The Contractor shall exercise full assignment rights as applicable and shall be responsible for making every reasonable effort to determine the legal liability of Third Parties to pay for services rendered to Enrollees under this Contract and to cost avoid or recover any such liability from the Third Party. "Third Party," for purposes of this Section, shall mean any person or entity that is or may be liable to pay for the care and services rendered to an Enrollee. Examples of a Third Party include, but are not limited to, an Enrollee's health insurer, casualty insurer, a managed care organization, and original Medicare.

20.2.1.2 The Contractor, and by extension its Providers and Subcontractors, hereby agree to utilize for Claims Cost Avoidance purposes, within thirty (30) Calendar Days of learning of such sources, other available public or private sources of payment for services rendered to Enrollees in the Contractor's Medicare Platino Plan. If Third Party Liability (TPL) exists for part or all of the services provided directly by the Contractor to an Enrollee, the Contractor shall make reasonable efforts to recover from TPL sources the value of services rendered. If TPL exists for part or all of the services provided to an Enrollee by a Subcontractor or a Provider, and the Third Party will make payment within a reasonable time, the Contractor may pay the Subcontractor or Provider only the amount, if any, by which the Subcontractor's or Provider's allowable Claim exceeds the amount of TPL.

20.2.1.3 The Contractor shall deny payment on a Claim that has been denied by a Third-Party payer when the reason for denial is the Provider's failure to follow prescribed procedures, including, but not limited to, failure to obtain Prior Authorization, failure to file Claims timely, etc.

20.2.1.4 The Contractor shall, within five (5) Business Days of issuing a denial of any Claim based on TPL, provide TPL Data to the Provider.

20.2.1.5 The Contractor shall treat funds recovered from Third Parties as offsets to Claims payments. The Contractor shall report all Cost Avoidance values to ASES in accordance with Federal guidelines and as provided for in this Section.

20.2.1.6 The Contractor shall post all Third-Party payments or recoveries to Claim-level detail by Enrollee.

20.2.1.7 If the Contractor operates or administers a non-Medicare Platino program or other lines of business, the Contractor shall access the resources of those entities to assist ASES with the identification of Enrollees with access to other insurance or sources of payment.

20.2.1.8 The Contractor shall demonstrate, upon request, to ASES that reasonable effort has been made to seek, including through collaboration with Providers, to collect and report Third Party recoveries. ASES shall have the sole responsibility for determining whether or not reasonable efforts have been demonstrated. Said determination shall take into account reasonable industry standards and practices.

20.2.1.9 The Contractor shall comply with 42 CFR 433 Subpart D – Third Party Liability and 42 CFR 447.20 Provider Restrictions: State Plan Requirements and work cooperatively with ASES to assure compliance with the requirements therein, as it relates to the Medicaid and CHIP populations served by the Contractor's plan and its Third Party Liability and Cost Avoidance responsibilities.

20.2.2 Legal Causes of Action for Damages. ASES or its designee will have the sole and exclusive right to pursue and collect payments made by the Contractor when a legal cause of action for damages is instituted on behalf of an Enrollee against a Third Party, or when ASES receives notices that legal counsel has been retained by or on behalf of any Enrollee. The Contractor shall cooperate with ASES in all collection efforts and shall also direct its Providers to cooperate with ASES in these efforts.

20.2.3 Estate Recoveries. ASES (or another agency of the Government of Puerto Rico) will have the sole and exclusive right to pursue and recover correctly paid benefits from the estate of a deceased Enrollee in accordance with Federal and Puerto Rico law. Such recoveries will be retained by ASES.

20.2.4 Subrogation

20.2.4.1 Third Party resources shall include subrogation recoveries. The Contractor shall be required to seek subrogation amounts regardless of the amount believed to be available as required by Federal Medicare or Medicaid guidelines and Puerto Rico law.

20.2.4.2 The amount of any subrogation recoveries collected by the Contractor outside of the Claims processing system shall be treated by the Contractor as offsets to medical expenses for the purposes of reporting.

20.2.4.3 The Contractor shall conduct diagnosis and trauma code editing to identify potential subrogation Claims. This editing should, at minimum, identify Claims with a diagnosis of 900.00 through 999.99 (excluding 994.6) or Claims submitted with an accident trauma indicator of 'Y.'

20.2.5 Cost Avoidance

20.2.5.1 In compliance with the federal requirements for coordination of benefits and third-party liability established under 42 CFR 433.139, which require Medicaid and its contracted entities to act as the payer of last resort, the Contractor shall avoid payment when it is aware of existing health or casualty

insurance coverage prior to paying for a Covered Service. To meet this obligation, the Contractor shall promptly reject the Provider's Claim (within fifteen (15) Business Days of receipt) and direct the Provider to first submit the Claim to the appropriate Third Party.

20.2.5.2 The Contractor shall, in strict compliance with the federal requirements governing coordination of benefits and third-party liability including the exceptions authorized under 42 CFR 433.139(b)(3) apply the pay-and-chase method in the circumstances described in this Section. These exceptions permit Medicaid and its contracted entities to pay first and subsequently pursue recovery from the liable Third Party when continuity of care or the protection of vulnerable populations requires it. Accordingly, the Contractor shall pay its Providers first and then coordinate with the liable Third Party, unless prior approval from ASES is obtained to proceed otherwise, in the following situations.

20.2.5.2.1 The coverage is derived from a parent whose obligation to pay support is being enforced by a government agency.

20.2.5.2.2 The Claim is for maternal and prenatal services to a pregnant woman or for EPSDT services that are covered by the Medicaid program.

20.2.5.2.3 The Claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with an inpatient stay.

20.2.5.2.4 The Claim is for a child who is in the custody of ADFAN.

20.2.5.2.5 The Claim involves coverage or services mentioned in this Section in combination with another service.

20.2.5.3 If the Contractor has actual knowledge that the Third Party will not pay for or provide the Covered Service, and the service is Medically Necessary, the Contractor shall not deny payment for the service, delay authorization, or require the Provider or Enrollee to obtain a written denial from the Third Party. In such circumstances, the Contractor remains fully responsible for ensuring timely access to the Medically Necessary Covered Service. If the Contractor does not know whether a particular service is covered by the Third Party, and the service is Medically Necessary, the Contractor shall promptly (within ten (10) Business Days of receipt of the Claim) contact the Third Party and determine whether or not such service is covered rather than requiring the Enrollee to do so. Further, the Contractor shall require the Provider to bill the Third Party if coverage is available.

20.3 Medicaid as Secondary Payer to Medicare

20.3.1 If a Covered Service is covered in whole or part by both Medicare and Medicaid, assuming no other Third Parties liable for payment exist, the Contractor shall determine liability as a secondary payer as follows:

20.3.1.1 If the total amount of Medicare's established liability for the services (Medicare paid amount) is equal to or greater than the negotiated contract rate between the Contractor and the Provider for the services, minus any Medicaid cost-sharing requirements, then the Provider is not entitled to, and the Contractor shall not pay, any additional amounts for the services.

20.3.1.2 If the total amount of Medicare's established liability (Medicare paid amount) is less than the negotiated contract rate between the Contractor and the Provider for the services, minus any Medicaid cost-sharing requirements, the Provider is entitled to, and the Contractor shall pay, the lesser of:

20.3.1.2.1 The Medicaid cost-sharing (Deductibles and coinsurance) payment amount for which the Dual Eligible Beneficiary is responsible under Medicare, and

20.3.1.2.2 An amount which represents the difference between (1) the negotiated contract rate between the Contractor and the Provider for the service minus any Medicaid cost-sharing requirements, and (2) the established Medicare liability for the services.

20.3.2 Protections for Medicare Platino Enrollees

20.3.2.1 In accordance with the protections established under federal Medicaid law—including the coordination of benefits and third-party liability requirements set forth in 42 CFR 447.15 (prohibition on beneficiary billing) and 42 CFR 433.139 (third-party liability rules) as well as applicable provisions of Puerto Rico Medicaid law, Covered Services may not be denied to an Enrollee due to the potential liability of a Third Party to pay for such services. The Contractor shall also ensure that its Cost Avoidance efforts do not interfere with, delay, or otherwise impede an Enrollee's access to Medically Necessary Services while the responsibility of the Third Party is being determined.

20.4 Physician Incentive Plans

20.4.1 If Contractor elects to operate a Physician Incentive Plan, Contractor agrees that no specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an Enrollee. Contractor agrees to submit to ASES annual reports containing the information on its physician incentive plan in accordance with 42 CFR 422.208. The contents of such reports shall comply with the requirements of 42 CFR 422.208 and 210 and be in a format to be provided by ASES.

20.4.2 The Contractor must ensure that any agreements for contracted services covered by this Agreement, such as agreements between the Contractor and other entities or between the Contractor's subcontracted entities and their Contractors, at all levels including the physician level, included language requiring that the physician incentive plan information be provided by the Subcontractor in an accurate and timely manner to the Contractor, in the format requested by ASES.

20.4.3 In the event that the incentive arrangements place the physician or physician group at risk for services beyond those provided directly by the physician or physician group for an amount beyond the risk threshold of 25% of potential payments for covered services (substantial financial risk), the Contractor must comply with all additional requirements listed in regulation, such as: conduct enrollee/disenrollee satisfaction surveys; disclose the requirements for the physician incentive plans to its beneficiaries upon request; and ensure that all physicians and physician groups at substantial financial risk have adequate stop loss protection. Any of these additional requirements that are passed on to the sub-Contractors must be clearly stated in their Agreement.

20.4.4 The Contractor shall ensure that all incentive arrangements are established for a fixed period of time, consistent with 42 CFR 438.6(b)(2)(i).

20.4.5 The Contractor shall ensure that performance under any incentive arrangement is measured during the rating period of the contract to which the incentive applies, pursuant to 42 CFR 438.6(b)(2)(i).

20.4.6 The Contractor shall ensure that incentive arrangements are not automatically renewed, are offered to public and private contractors under identical performance terms, and do not require participation in or adherence to intergovernmental transfer agreements, consistent with 42 CFR 438.6(b)(2)(ii)-(iv).

20.4.7 The Contractor shall ensure that all incentive arrangements are necessary to support the activities, targets, performance measures, or quality-based outcomes identified in the State's quality strategy, consistent with 42 CFR 438.6(b)(2)(v).

20.4.6 The Contractor shall ensure that all withhold arrangements: (1) are established for a fixed period of time; (2) measure performance during the contract rating period in which the withhold applies; (3) are not automatically renewed; (4) are offered to public and private contractors under identical performance terms; (5) do not require participation in or adherence to intergovernmental transfer agreements; and (6) are necessary to support the activities, targets, performance measures, or quality-based outcomes identified in the State's quality strategy, consistent with 42 CFR 438.6(b)(3) and 42 CFR 438.340.

20.5 Medical Loss Ratio

20.5.1 The Contractor shall report a Medical Loss Ratio (MLR) and related data as required under 42 CFR 438.8(k) "Medical Loss Ratio (MLR) standards", for each rating period, using the official CMS MLR Reporting Template (Excel format), including all twelve (12) regulatory elements specified thereunder. Such reporting shall be provided to the Financial Department no later than ninety (90) calendar days following the close of the contract year. The Contractor acknowledges that ASES is required to submit an annual summary of MLR reports received from each MAO to CMS pursuant to 42 CFR 438.74(a) "Medical Loss Ratio (MLR) reporting requirements". Any failure by the Contractor to submit its MLR report within the

deadlines established herein will be evaluated by ASES on a case-by-case basis to determine if a cure period, corrective actions, immediate enforcement or any other administrative action is appropriate.

20.5.2 In addition to the unaudited financial statements required under Section 20.1.4, the Contactor shall submit to the ASES Financial Department a quarterly interim Medical Loss Ratio (MLR) report with forty-five (45) calendar days of each quarter's close. The quarterly interim MLR report shall include, at a minimum:

20.5.2.1 The year today (YTD) accumulated Medical Loss Ratio (MLR);

20.5.2.2 An actuarially certified incurred but not reported (IBNR) reserves consistent with the assumptions established by ASES's Actuary;

20.5.2.3 A Quality Improvement Activity (QIA) documentation with evidence of measurable clinical outcomes;

20.5.2.4 A Medicare/Medicaid encounter data cross-reference report comparing T-MSIS Medicaid encounter data against Medicare Parts A and B claims data for the same dual-eligible population; and

20.5.3 The Contractor shall ensure that all data required for MCPAR indicators D1.X.9c (MLR%); D1.X.9d (remittance amount); D1.E.1 (actuarial certification); and D1. G.1+ (Program Integrity / FWA) included in the annual MLR Report in a format compatible with ASES's MCPAR reporting obligations to CMS, as required by 42 CFR 438.66(e) State monitoring requirements (CMS MCPAR Requirements).

20.5.4 The annual MLR report shall include a Certification signed by both the Chief Executive Officer (CEO) and the Chief Financial Officer (CFO) of the contractor, attesting under penalty of law to: the accuracy and completeness of all information reported; compliance with applicable CMS and ASES regulations; consistency of the reported data with the Contractor's books, record, and financial systems; the absence of any known material omissions; that the MLR numerator includes Exclusively Medicaid Wraparound Services and that no Medicare Covered Services (Part A, B and D) have been included therein; and the No Cost-Shifting certification, affirming that no costs attributable to Medicare-covered services have been allocated to the Medicaid MLR numerator or denominators.

20.5.5 The Contractor shall calculate its Medical Loss Ratio and related data based on the methodology set forth in 42 CFR 438.8 using only Medicaid revenues and expenditures and any other instructions issued by CMS or ASES. The Contractor is expected to achieve a target medical loss ratio standard, as calculated under 42 CFR 438.8, of at least eighty-five percent (85%) for the contract year, and if required by ASES, must provide a remittance to ASES if this standard is not met.

ARTICLE 21 RELATIONSHIP OF PARTIES

21.1 Neither Party is an Agent, employee, or servant of the other. It is expressly agreed that the Contractor and any Subcontractors and Agents, officers, and employees of the Contractor or any Subcontractor in the performance of this Contract shall act as independent contractors and not as officers or employees of ASES. The Parties acknowledge, and agree, that the Contractor, its Agent, employees, and servants shall in no way hold themselves out as Agent, employees, or servants of ASES. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any Subcontractor and ASES.

ARTICLE 22 INSPECTION OF WORK

22.1 ASES, the Puerto Rico Medicaid Program, other agencies of the Government of Puerto Rico, the Secretary, the US Department of Health and Human Services, CMS, the General Accounting Office, the US Comptroller General, the Comptroller General of the Government of Puerto Rico, if applicable, or their Authorized Representatives, shall have the right to enter into the premises of the Contractor or all Subcontractors, or such other places where duties under this Contract are being performed for ASES, to inspect, monitor or otherwise evaluate the services or any work performed pursuant to this Contract. All inspections and evaluations of work being performed shall be conducted with prior notice and during normal business hours. All inspections and evaluations shall be performed in such a manner that will not unduly delay work.

22.2 This responsibility is consistent with federal program integrity and oversight requirements under 42 CFR 455.300–455.304, which require contractors to safeguard government assets, ensure proper stewardship of federally funded resources, and maintain full accountability for equipment, records, and materials used in the administration of Medicaid-related functions. In addition, 42 CFR 438.66 authorizes the State to monitor contractor performance, including the use, protection, and management of government-owned property.

22.3 The Contractor acknowledges that failure to safeguard ASES property, or failure to maintain proper custody and accountability, constitutes a material breach of this Contract and may result in corrective actions, sanctions, or other remedies permitted under federal and state law, including those set forth in 42 CFR 438.700 regarding sanctions for noncompliance.

ARTICLE 23 GOVERNMENT PROPERTY

23.1 The Contractor agrees that all documents, materials, data, records, reports, photographs, videos, or other work products that are produced of that result, directly or indirectly, from, under, or in connection with the performance of services under this Contract shall be the property of ASES upon their creation, for any use that ASES deems appropriate. The Contractor further agrees to prepare, maintain, and deliver all necessary documents, including the

Deliverables listed in Appendix L to this Contract, as well as any reports, analyses, records, operational evidence, or supplemental documentation required by ASES, and to take any additional actions necessary to fully and effectively comply with this provision. IF the work product includes photographs, video recordings, or other media involving individuals, the Contractor shall obtain all required consents and authorizations permitting ASES to use such photographs, videos, images, likenesses, and names.

23.2 The Contractor shall also obtain the necessary releases that discharge ASES from any claims or demands arising from the use of such material. This obligation includes the preparation, retention, and availability of all information generated in the course of performing services, in accordance with the access, availability, and record retention requirements set forth in 42 CFR 422.504(d)–(e) and 42 CFR 438.3(u), which require contractors and subcontractors of federally funded programs to maintain complete, accurate, verifiable, and accessible records for a minimum period of ten (10) years, or longer if required by an audit, investigation, enforcement action, or litigation. The Contractor acknowledges that failure to prepare, deliver, retain, or make such documents available constitutes a material breach of its contractual obligations.

23.3 The Contractor shall be responsible for the proper custody and care of any ASES-owned property furnished for the Contractor's use in connection with the performance of this Contract. The Contractor will reimburse ASES for its loss or damage, normal wear and tear excepted, while such property is in the Contractor's custody or use.

ARTICLE 24 OWNERSHIP AND USE OF DATA AND SOFTWARE

24.1 Ownership and Use of Data

24.1.1 All Information created from Data, documents, messages (verbal or electronic), reports, analyses, work product, or meetings involving, arising out of, or in connection with this Contract is and shall remain the exclusive property of ASES ("ASES Data and Information"). The Contractor shall make all ASES Data and Information available to ASES upon request, and ASES may provide such Data to CMS or any other pertinent governmental agency or authority as required or permitted by law, consistent with the requirements of 42 CFR 438.3(h) "Enrollee Information and Confidentiality" *and* 42 CFR Part 431 Subpart F "Safeguarding of Information". The Contractor is strictly prohibited from sharing, distributing, disseminating, transferring, selling, licensing, or publishing ASES Data and Information, or permitting access to such Data by any unauthorized individual or entity, without the express prior written consent of ASES. This prohibition includes the use of ASES Data and Information for marketing, commercial analytics, or any purpose not expressly authorized under this Contract. CMS expressly prohibits the use of Medicaid data for marketing or commercial purposes and requires that such data be used solely for program administration, oversight, and compliance functions, consistent with federal confidentiality and

data-use standards. In the event of any dispute regarding what constitutes ASES Data and Information, ASES's determination shall be final, binding, and not subject to appeal;

24.1.2 ASES acknowledges that, prior to the execution of this Contract and in contemplation of it, the Contractor developed certain proprietary programs, systems, standard operating procedures, business plans, and policies ("Contractor Proprietary Systems"), which remain the exclusive property of the Contractor. However, in the event of Contractor default, ASES is authorized to use such systems, to the extent permitted by applicable software and hardware licensing, for a period of one hundred and twenty (120) Calendar Days solely to ensure continuity of operations and effect an orderly transition to a new Contractor or service provider, consistent with the continuity-of-operations requirements established in 42 CFR 438.207 (Availability of Services) and the delegation and oversight standards set forth in 42 CFR 438.230 (Subcontractual Relationships and Delegation).

24.1.3 In any cases where the use of such systems from an operational perspective would also impact other lines of the Contractor's business or where licensing restrictions cannot be remedied, the Contractor shall operate such systems on behalf of ASES. Such operation by the Contractor on behalf of ASES can occur at ASES's discretion under the full supervision of their employees or appointed third party personnel. Under such a scenario, ASES's access to Data will be restricted through the most efficient means possible to the Contractor's Data segment. If the Contractor fails to operate such systems on ASES's behalf in a timely manner per normal previous operating schedule, ASES may use such systems and operate them for its own purposes. In this case, ASES will issue a written notice to the Contractor within a reasonable period prior to such use.

24.1.4 The Contractor shall not deny, delay, restrict, or condition ASES's access to ASES Data and Information under any circumstances. The Contractor shall not retain, withhold, or condition the release of ASES Data and Information during any dispute, controversy, or litigation between the Parties. This obligation is consistent with the requirements of 42 CFR 438.3(h)(1)(iii) "Enrollee Information and Confidentiality", which require Medicaid managed care entities to provide State Medicaid agencies with immediate access to all records, data, and information necessary for program oversight and administration.

24.1.5 For the dual-eligible Medicare Platino population, the Contractor shall also comply with the access-to-records requirements established in 42 CFR 422.504(d) "Access to Records and Facilities", which require Medicare Advantage Organizations to provide CMS, its designees, and State agencies with full, timely, and unrestricted access to all books, contracts, records, systems, data, and information necessary for oversight, audits, evaluations, program integrity, and compliance monitoring.

24.1.6 The Contractor shall further comply with CMS audit-access requirements, which mandate immediate and unrestricted access to all operational systems, data universes, claims, appeals, grievances, provider records, subcontractor records, and any

other information required for CMS program audits, financial reviews, and performance evaluations. Such access must be provided without delay and without regard to the existence of contractual disputes, consistent with CMS program integrity standards and federal oversight authority.

24.1.7 ASES reserves the right to modify, expand, or delete the requirements contained in Article 24 with respect to the Data that Contractor is required to submit to ASES, or to issue new requirements, subject to consultation with Contractor and to cost negotiation, if necessary. Unless otherwise stipulated in the Contract or mutually agreed upon by the Parties, the Contractor shall have ninety (90) Calendar Days from the day on which ASES issues notice of a required modification, addition, or deletion, to comply with the modification, addition, or deletion. Any payment made by ASES that is based on data submitted by the Contractor is contingent upon the Contractor's compliance with the Certification requirements contained in 42 CFR 438.606.

24.2 Responsibility for Information Technology Investments. The Parties understand and agree that the cost of any newly acquired or developed software programs or upgrades or enhancements to existing software programs, hardware, or other related information technology equipment or infrastructure component, made in order to comply with the requirements of this Contract shall be borne in its entirety by the Contractor.

ARTICLE 25 SUBCONTRACTS

25.1 Use of Subcontractors

25.1.1 In carrying out the terms of this Contract, the Contractor may enter into written Subcontract(s) with other entities for the provision of administrative services or a combination of Covered Services and administrative services, under terms and conditions acceptable to CMS.

25.1.2 These subcontracts and/or agreements will be notified to ASES within thirty (30) calendar days after their execution.

25.1.3 The cancelation or termination of the agreement with the subcontractor will be notified to ASES within five (5) Business Days of a change. The Contractor shall assume sole responsibility for all functions performed by a Subcontractor(s), as well as any payments to a Subcontractor(s) for services related to this Contract.

25.1.5 All contracts between the Contractor and Subcontractors must be in writing and must specify the activities and responsibilities delegated to the Subcontractor containing terms and conditions consistent with this Contract. The contracts must also include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate. The Contractor and the Subcontractors must also make reference to a business associates agreement between the Parties.

25.1.6 ASES shall have the right, at any time and without limitation, to audit, inspect, or review any Subcontractor, its records, systems, facilities, or operations related to the

delegated functions, to verify compliance with this Contract and all applicable federal and Commonwealth requirements. The Contractor shall ensure that all Subcontracts expressly grant ASES this audit and inspection authority.

25.1.7 The Contractor shall provide ASES with prior written notice of any proposed change, amendment, renewal, termination, or replacement of a Subcontract involving delegated functions, within the timeframe established by ASES. No such change shall take effect without ASES's review and, when required, approval.

ARTICLE 26 REQUIREMENT OF INSURANCE LICENSE AND CERTIFICATE OF SOLVENCY

26.1 In order for this Contract to take effect, the Contractor must be licensed to underwrite health insurance by the Puerto Rico Insurance Commissioner. The Contractor must submit a copy of its Insurance License and Certificate of Solvency, both issued by the Office of the Puerto Rico Insurance Commissioner.

26.2 The Contractor shall renew the license as required and shall submit evidence of the renewal to ASES within thirty (30) Calendar Days of the expiration date of the license.

ARTICLE 27 CERTIFICATIONS

27.1 The Contractor shall provide to ASES within fifteen (15) Calendar Days of the Effective Date of this Contract the certifications and other documents set forth below, according to the timeframe specified below. If any certification, document, acknowledgment, or other representation or assurance on the Contractor's part under this Article, or elsewhere in this Contract, is determined to be false or misleading, ASES shall have cause for termination of this Contract. In the event that the Contract is terminated based upon this Article, the Contractor shall reimburse ASES all sums of monies received under the Contract; provided, however, that the amount reimbursed shall not exceed the amount of outstanding debt, less any payments made by the Contractor in satisfaction of such debt.

27.2 The Contractor shall submit the following certifications:

27.2.1 Certification of Eligibility from de Professional Services Providers Registry (RUP by its Spanish acronym) issued by the Puerto Rico General Services Administration (ASG by its Spanish acronym). It is expressly acknowledged that this certification is an essential condition of this Agreement and certifies that the Contractor had submitted to ASG the following certifications:

27.2.2 A sworn statement certifying that it has no debt with the government of the Government of Puerto Rico, or with any state agencies, corporations or instrumentalities that provide or are related to the provision of health services; and

27.2.3 Certification from the Puerto Rico Administration of Medical Services ("ASEM", its Spanish acronym) certifying that there is no outstanding debt or, if a debt

exists, that such debt is subject to a payment plan or pending administrative review under applicable law or regulations.

27.2.4 Contractor Certification Requirement as requested by the Financial Oversight and Management Board of Puerto Rico. Any incorrect, incomplete or false statement made by the contractor's representative as part of this certification shall cause the nullity of the proposed contract and the contractor must reimburse immediately to the Commonwealth any amounts, payments or benefits received from the Commonwealth under the contract.

27.2.5 Evidence of active registry at the System for Award Management (SAM).

27.3 If the Contractor fails to meet the obligations of this Section within the required timeframe, ASES shall cease payment to the Contractor until the documents have been delivered to the ASES's satisfaction, or adequate evidence is provided to ASES that reasonable efforts have been made to obtain the documents.

ARTICLE 28 RECORDS REQUIREMENTS

28.1 General Provisions

28.1.1 The Contractor and its Subcontractors, if any, shall preserve and make available all of its records pertaining to the performance under this Contract for inspection or audit, as provided below, throughout the Contract Term, for a period of ten (10) years from the date of final payment under this Contract, and for such period, if any, as is required by applicable statute or by any other section of this Contract. If the Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of ten (10) years from the Termination Date of the Contract or of any resulting final settlement. The Contractor is responsible to preserve all records pertaining to its performance under this Contract, and to have them available and accessible in a timely manner, and in a reasonable format that assures their integrity. These records include, but are not limited to, enrollee grievance and appeal records in 42 CFR 438.416, base data in 42 CFR 438.5(c), medical loss ratio reports in 42 CFR 438.8(k), and the data, information, and documentation specified in 42 CFR 438.604, 438.606, 438.608, and 438.610. Records that relate to Appeals, litigation, or the settlements of Claims arising out of the performance of this Contract, or costs and expenses of any such agreements as to which exception has been taken by the Contractor or any of its duly Authorized Representatives, shall be retained by Contractor until such Appeals, litigation, Claims or exceptions have been disposed of.

28.2 Records Retention and Audit Requirements

28.2.1 Since funds from the Puerto Rico Plans under Title XIX and Title XXI of the Social Security Act Medical Assistance Programs (Medicaid and CHIP) are used to finance this project in part, the Contractor shall agree to comply with the requirements and conditions of the Centers for Medicare and Medicaid Services (CMS), the USA Comptroller General, the Comptroller of Puerto Rico and ASES, as to the maintenance of records related to this Contract.

28.2.2 Puerto Rico and Federal standards for audits of ASES Agents, contractors, and programs are applicable to this Section and are incorporated by reference into this Contract as though fully set out herein.

28.2.3 Pursuant to the requirements of 42 CFR 434.6(a)(5) and 42 CFR 434.38, ASES, the Secretary, DHHS, CMS, the Office of the Inspector General, the Comptroller General, and their respective designees shall have the right at any time to inspect, evaluate, and audit any pertinent records or documents of the Contractor or Subcontractor, and may inspect the premises, physical facilities, and equipment where activities or work related to the Medicare Platino program is conducted. 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. Any records requested hereunder shall be produced Immediately for on-site review or sent to the requesting authority by mail within fourteen (14) Calendar Days following a request. All records shall be provided at the sole cost and expense of the Contractor or Subcontractor. ASES shall have unlimited rights to use, disclose, and duplicate all Information and Data in any way relating to this Contract in accordance with applicable Puerto Rico and Federal laws and regulations.

28.2.4 In certain circumstances, as follows, the authorities listed in Section 28.2.3 shall have the right to inspect and audit records in a timeframe that exceeds the timeframe set forth in Section 28.1.1.

28.2.4.1 ASES determines that there is a special need to retain a particular record or group of records for a longer period and notifies the Contractor at least thirty (30) Calendar Days before the expiration of the timeframe set forth in Section 28.1.1.

28.2.4.2 There has been a Contract termination, dispute, fraud, or similar fault by the Contractor, resulting in a final judgment or settlement against the Contractor, in which case the retention may be extended to three (3) years from the date of the final judgment or settlement.

28.2.4.3 ASES determines that there is a reasonable possibility of Fraud, and gives the Contractor notice, before the expiration of the timeframe set forth in Section 28.1.1, that it wishes to extend the time period for retention of records.

28.2.4.4 There has been, during the time period set forth in Section 28.1.1, an audit initiated by CMS, the Comptroller of Puerto Rico, the US Comptroller General, and/or ASES, in which case the timeframe for retention of records shall extend until the conclusion of the audit and publication of the final report.

28.2.5 All records retention requirements set forth in this Article or in any other Article shall be subject at all times and to the extent mandated by law and regulation, to the HIPAA regulations described elsewhere in this Contract.

28.3 Medical Record Requests

28.3.1 The Contractor shall ensure that a copy of each Enrollee's Medical Record is made available, without charge, upon the written request of the Enrollee or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request.

28.3.2 The Contractor shall ensure that Medical Records are furnished at no cost to a Provider, upon the Enrollee's request, no later than fourteen (14) Calendar Days following the written request.

ARTICLE 29 CONFIDENTIALITY

29.1 General Confidentiality Requirements

29.1.1 The Contractor shall protect all information, records, and Data collected in connection with the Contract from unauthorized disclosures. In addition, the Contractor shall agree to guard the confidentiality of Enrollee information. Access to all individually identifiable information relating to Medicaid Enrollees that is obtained by the Contractor shall be limited by the Contractor to Subcontractors, consultants, advisors or agencies that require the information in order to perform their duties in accordance with this Contract, and to such others as may be authorized by ASES in accordance with applicable law.

29.1.2 The Contractor is responsible for understanding the degree to which information obtained through the performance of this Contract is confidential under Puerto Rico and Federal law, rules, and regulations.

29.1.3 Any other party shall be granted access to confidential Information only after complying with the requirements of Puerto Rico and Federal law pertaining to such access. ASES shall have absolute authority to determine if and when any other party has properly obtained the right to have access to this confidential information. Nothing herein shall prohibit the disclosure of information in summary, statistical, or other form that does not identify particular individuals. The Contractor shall retain the right to use information for its quality and Utilization Management and research purposes subject to the Data ownership and publicity requirements defined within the Contract.

29.1.4 The Contractor, its employees, Agents, Subcontractors, consultants or advisors must treat all information that is obtained through Providers' performance of the services under this Contract, including, but not limited to, information relating to Enrollees, Potential Enrollees, as confidential Information to the extent that confidential treatment is provided under Puerto Rico and Federal law, rules, and regulations.

29.1.5 Any disclosure or transfer of confidential information by the Contractor, including information required by ASES, will be in accordance with applicable law. If the Contractor receives a request for information deemed confidential under this Contract, the Contractor will Immediately notify ASES of such request, and will make reasonable efforts to protect the information from public disclosure.

29.1.6 In accordance with the timeframes outlined in Appendix L to the Contract, the Contractor shall develop and provide to ASES for review and approval written policies and procedures for the protection of all records and all other documents deemed confidential under this Contract including Medical Records/Enrollee information and adolescent/sexually transmitted disease appointment records. All Enrollee information, Medical Records, Data and Data elements collected, maintained, or used in the administration of this Contract shall be protected by the Contractor from unauthorized disclosure per the HIPAA Privacy and Security standards codified at 45 CFR Part 160 and 45 CFR Part 164, Subparts A, C and E. The Contractor must provide safeguards that restrict the use or disclosure of protected health information (PHI) concerning Enrollees to purposes directly connected with the administration of this Contract. The Contractor shall use and disclose individually identifiable health information only in accordance with the confidentiality requirements of 45 CFR Parts 160 and 164, consistent with 42 CFR 438.208(b)(6) and 438.224.

29.1.7 Assurance of Confidentiality

29.1.7.1 The Contractor shall take reasonable steps to ensure the physical security of Data under its control, including, but not limited to: fire protection; protection against smoke and water damage; alarm systems; locked files, guards, or other devices reasonably expected to prevent loss or unauthorized removal of manually held Data; passwords, access logs, badges, or other methods reasonably expected to prevent loss or unauthorized access to electronically or mechanically held Data; limited terminal access; limited access to input documents and output documents; and design provisions to limit use of Enrollee names.

29.1.7.2 The Contractor shall inform and provide quarterly trainings to each of its employees having any involvement with personal Data or other confidential information, whether with regard to design, development, operation, or maintenance, of the Puerto Rico and Federal law relating to confidentiality.

29.1.8 Return of Confidential Data

29.1.8.1 The Contractor shall return all Personal Health Information Data furnished pursuant to this Contract promptly at the request of ASES in whatever form it is maintained by the Contractor. Upon the termination or completion of the Contract, the Contractor may not use any such Data or any material derived from the Data for any purpose not permitted by Puerto Rico or Federal law or regulation and where so instructed by ASES shall destroy such Data or material if permitted and required by Puerto Rico or Federal law or regulation.

29.1.9 Publicizing Safeguarding Requirements

29.1.9.1 The Contractor shall comply with 42 CFR 431.304. The Contractor agrees to publicize provisions governing the confidential nature of information about Enrollees, including the legal sanctions imposed for improper disclosure

and use. The Contractor must include these provisions in the Enrollee handbook and provide copies of these provisions to Enrollees and to other persons and agencies to which information is disclosed.

29.1.9.2 In addition to the requirements expressly stated in this Article 29, the Contractor must comply with any policy, rule, or reasonable requirement of ASES that relates to the safeguarding or disclosure of information relating to Enrollees, the Contractor's operations, or the Contractor's performance of this Contract.

29.1.9.3 In the event of the expiration of this Contract or termination thereof for any reason, all confidential information disclosed to and all copies thereof made by the Contractor must be returned to ASES or, at ASES's option, erased or destroyed. The Contractor must provide ASES certificates evidencing such destruction.

29.1.9.4 The Contractor's contracts with practitioners and other Providers shall explicitly state expectations about the confidentiality of ASES's confidential information and Enrollee records.

29.1.9.5 The Contractor shall afford Enrollees and/or their Authorized Representatives the opportunity to approve or deny the release of identifiable personal information by the Contractor to a person or entity outside of the Contractor, except to duly authorized Subcontractors, Providers or review organizations, or when such release is required by law, regulation, or quality standards.

29.1.9.6 This Article 29 does not restrict the Contractor from making any disclosure pursuant to any applicable law, or under any court or government agency, provided that the Contractor provides immediate notice to ASES of such order.

29.1.10 Disclosure of ASES's Confidential Information

29.1.10.1 The Contractor shall Immediately report to ASES any and all unauthorized disclosures or uses of confidential information of which it or its Subcontractors, consultants, or Agents is aware or has knowledge. The Contractor acknowledges that any publication or disclosure of confidential information to others may cause immediate and irreparable harm to ASES and may constitute a violation of Puerto Rico or Federal statutes. If the Contractor, its Subcontractors, consultants, or Agents should publish or disclose Confidential Information to others without authorization, ASES will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. ASES will have the right to recover from the Contractor all damages and liabilities caused by or arising from the Contractor's, its Subcontractors', Network Providers', representatives', consultants', or Agents' failure to protect confidential Information. The

Contractor will defend with counsel approved by ASES, indemnify and hold harmless ASES from all damages, costs, liabilities, and expenses caused by or arising from the Contractor's, or its Subcontractors', Providers', representatives', consultants' or Agents' failure to protect confidential Information. ASES will not unreasonably withhold approval of counsel selected by the Contractor.

29.1.11 The Contractor shall remove any person from performance of services hereunder upon notice that ASES reasonably believes that such person has failed to comply with the confidentiality obligations of this Contract. The Contractor shall replace such removed personnel in accordance with the staffing requirements of this Contract.

29.1.12 ASES, the Government of Puerto Rico, Federal officials as authorized by Federal law or regulations, or the Authorized Representatives of these Parties shall have access to all confidential information in accordance with the requirements of Puerto Rico and Federal laws and regulations.

29.1.13 The confidentiality provisions contained in this Contract survive the termination of this contract and shall bind the Contractor, and its PMGs and Network Providers, so long as they maintain any "protected health information" relating to Enrollees, as such term is defined by 45 CFR Parts 160 and 164.

29.2 HIPAA Compliance

29.2.1 The Contractor shall assist ASES in its efforts to comply with HIPAA and its amendments, rules, procedures, and regulations. To that end, the Contractor shall cooperate with and abide by any data privacy, security or other requirements mandated by HIPAA or any other applicable laws. The Contractor acknowledges that HIPAA requires the Contractor and ASES to sign documents for compliance purposes, including but not limited to a business associate agreement. The parties agree to the terms of the HIPAA Business Associate Agreement included as Attachment 18 to this Contract, which is incorporated by reference. The Contractor shall cooperate with ASES on these matters and sign whatever documents may be required for HIPAA compliance and abide by their terms and conditions. This Agreement, including the HIPAA Business Associate Agreement, shall be construed in a manner that allows ASES to comply with applicable law. Contractor shall be responsible for ensuring that individuals have the right to access and amendment of PHI and accounting of disclosures, with respect to PHI created, received, maintained or transmitted by Contractor. Contractor shall ensure that Enrollees receive a Notice of Privacy Practices as required by HIPAA.

29.3 Data Breach

29.3.1 The Contractor shall Immediately report to ASES, as required in Section 13402s of the HITECH Act of any actual or suspected event where ASES's Data could be exposed in a non-authorized or illegal circumstance, and/or when any Data Breach occurs. The Contractor must take all reasonable steps to mitigate the Breach, notify

actual or potentially impacted Enrollees, and provide appropriate notice to the applicable State and Federal regulatory agencies as required by law.

29.3.2 The Contractor agrees that, without unreasonable delay and in no event later than twenty-four (24) hours after any event, incident, irregularity, unauthorized access, unauthorized use, or reasonable suspicion that a Data Breach may have occurred regardless of whether it is later determined to constitute a reportable disclosure under applicable law the Contractor shall notify ASES of such event. This obligation is consistent with the breach-notification requirements under HIPAA and HITECH (45 CFR 164.400–414), which require covered entities and business associates to promptly report any actual, potential, or suspected compromise of protected health information, including incidents that may not ultimately meet the threshold of a reportable breach. The notification shall include sufficient information for ASES to understand the nature scope, and potential impact of the incident. Such notification shall include, to the extent available at the time of the notification, the following information:

29.3.2.1 Description of the Incident; A brief narrative of what occurred, including the date and time of the incident and the date and time it was discovered.

29.3.2.2 Type of Information Involved; A description of the data elements involved (e.g., names, addresses, Social Security numbers, medical information, financial information).

29.3.2.3 Individuals Affected: The approximate number of individuals whose information may have been accessed, used, or disclosed.

29.3.2.4 Cause of the Incident: Whether the incident resulted from internal error, system failure, unauthorized access, malicious activity, or any other cause.

29.3.2.5 Containment Actions: A description of the steps taken to mitigate or contain the incident.

29.3.2.6 Corrective Measures: A description of the actions taken or planned to prevent recurrence.

29.3.2.7 Law Enforcement Involvement: Whether any law enforcement agency has been notified or is involved.

29.3.2.8 Subcontractor Involvement: Whether any subcontractor was involved in the incident.

29.3.2.9 Assessment of Potential Harm: A preliminary evaluation of the potential impact on affected individuals.

29.3.3 The Contractor shall have a duty to supplement the information contained in the notification as it becomes available and to cooperate with ASES. The notification required by this Section shall not include any PHI.

29.3.4 The Contractor shall submit a monthly Privacy and Confidentiality Report. The report shall identify and describe any event, incident, unauthorized access, unauthorized use, or reasonable suspicion that a Data Breach may have occurred regardless of whether it is later determined to constitute a reportable disclosure under applicable law involving the loss, theft, or unauthorized use or access of Enrollee PHI. At a minimum, the report shall include: (i) the specific date on which the incident occurred or was discovered; (ii) the date on which the Contractor notified ASES; (iii) a concise description of the nature and scope of the incident, including the type of PHI involved and how the incident was identified; (iv) the actions taken by the Contractor to investigate, contain, and mitigate the incident; (v) the number of Enrollees actually or potentially affected; (vi) and any mitigation or preventive measures implemented to avoid recurrence of similar incidents..

29.3.5 The Contractor must submit an annual Privacy and Confidentiality report with all suspects and incidents that may have occurred during the contracted year as part of Appendix L. The annual report must include, at minimum: (i) the date of the incident; (ii) the date of notification to ASES; (iii) the nature of the event; (iv) the scope of the incident; (v) the contractor's response to the incident; (vi) the number of individuals actually or potentially affected; (vii) the number of OCR notifications; (viii) any mitigation measures taken by the contractor to prevent similar incidents; (ix) root cause analysis; (x) any other information generated during the corrective action plan. In cases where the event is not reportable to the OCR, an explanatory note must be made. Similarly, cases that are not reported to the OCR because the notification period expires 60 days after the end of the contract year must be submitted amended by March 15, 2028.

ARTICLE 30 TERMINATION OF CONTRACT

30.1 General Procedures

30.1.1 In addition to any other non-financial remedy set forth in this Contract or available by law, or in lieu of any financial Remedy contained in Articles 16 and 17 of this Contract or available by law, and subject to compliance with the termination procedures set forth in Section 30.8 below, ASES may terminate this Contract for any or all of the following reasons:

30.1.1.1 Default by the Contractor, upon thirty (30) Calendar Days' notice, unless ASES, in its reasonable discretion, determines that the Contractor has cured the default to ASES's satisfaction within the notice period. Default includes any action that threatens the health, safety and welfare of the Contractor's Enrollees or that constitutes an unacceptable practice that adversely affects the fiscal integrity of the Medicare Platino Program;

30.1.1.2 Immediately, in the event of insolvency or declaration of bankruptcy by the Contractor;

30.1.1.3 Immediately, if Contractor has its Certificate of Authority suspended, limited, non-renewed or revoked by the Insurance Commissioner;

30.1.1.4 Immediately, when sufficient appropriated funds no longer exist for the payment of ASES's obligation under this Contract;

30.1.1.5 In the event that the Contractor or any of its shareholders, director, officers, or employees fall under the prohibition stated in Section 10.4.1.1 or 10.4.1.2 of this Contract; or

30.1.1.6 In the event that the Contractor fails to renew its contract with CMS pursuant to Sections 1851 to 1859 of the Social Security Act to offer the Medicare Advantage plan to Enrollees residing in the Service Area specified in Appendix A. In such instances, the Contractor shall notify ASES of the termination or failure to renew its contract with CMS Immediately upon knowledge of the impending termination or failure to renew.

30.1.2 The Contractor shall have a limited right of termination of this Contract only in the events described in Section 30.10 of this Contract.

30.1.3 Each Party shall have the opportunity to cure any default alleged in a termination notice sent pursuant to this Article 30, upon receiving a written termination notice the other Party. With respect to termination by ASES, the Contractor shall have the right to submit to ASES a written Corrective Action Plan containing terms and conditions acceptable to ASES in its sole discretion to cure such default or an explanation of non-default in the thirty (30) Calendar Day period from the date of receipt of ASES's written termination notice and such plan or explanation of non-default is accepted by ASES, in ASES's sole discretion, which acceptance shall not be unreasonably withheld, conditioned or delayed.

30.1.4 Notwithstanding the termination of this Contract pursuant to this Article 30 for any reason, the Contractor shall remain obligated to provide the Administrative Functions as described in Article 31, including but not limited to the payment of Claims for Covered Services provided to Enrollees prior to the Termination Date and as specified in the Patient's Bill of Rights Act through the Runoff Period.

30.1.5 Continuing Obligations of ASES. Notwithstanding the termination of this Contract for pursuant to this Article 30 for any reason, ASES shall remain obligated to pay to the Contractor the PMPM through the Termination Date (inclusive of the Transition Period).

30.1.6 Termination Procedures to be Strictly Followed. No termination of this Contract shall be effective unless the termination procedures under Section 30 of this Contract have been strictly followed or waived by the Parties.

30.2 Termination by Default

30.2.1 In the event ASES determines that the Contractor has defaulted by failing to carry out the terms or conditions of this Contract or by failing to meet the applicable requirements in sections 1932 and 1903(m) of the Social Security Act, or in the event that ASES determines that the Contractor falls within the prohibitions stated in Section 10.4.1.1 or 10.4.1.2, ASES may terminate the Contract in addition to or in lieu of any other remedies set out in this Contract or available by law.

30.2.2 Before terminating this Contract, ASES will:

30.2.2.1 Provide written notice of the intent to terminate at least thirty (30) Calendar Days prior to the Termination Date, stating the reason for the termination and the time and place of a hearing, to take place at least fifteen (15) Calendar Days after the date of mailing of the notice of intent to terminate, to give the Contractor an opportunity to appeal the determination or cure the default;

30.2.2.2 Provide written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of the termination; and

30.2.2.3 For an affirming decision, give Enrollees of the Contractor notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving services following the Termination Date of the Contract.

30.3 Termination for Convenience

30.3.1 ASES may terminate this Contract for convenience and without cause upon thirty (30) Calendar Days written notice. Termination for convenience shall not be a breach of the Contract by ASES. The Contractor shall be entitled to receive and shall be limited to just and equitable compensation for any satisfactory authorized work performed as of the Termination Date of the Contract.

30.4 Termination for Insolvency or Bankruptcy

30.4.1 The Contractor's insolvency, or the Contractor's filing of a petition in bankruptcy, shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy, the Contractor shall immediately advise ASES. If ASES reasonably determines that the Contractor's financial condition is not sufficient to allow the Contractor to provide the services as described herein in the manner required by ASES, ASES may terminate this Contract in whole or in part, Immediately or in stages. The Contractor's financial condition shall be presumed not sufficient to allow the Contractor to provide the services described herein, in the manner required by ASES if the Contractor cannot demonstrate to ASES's satisfaction that the Contractor has risk reserves and a minimum net worth sufficient to meet the statutory standards for licensed health care plans, as required under this Contract. The Contractor shall cover continuation of services to Enrollees for the duration of period for which payment has been made, as well as for inpatient admissions up to discharge.

30.4.2 In the event that this Contract is terminated because of the Contractor's insolvency, the Contractor shall guarantee that Enrollees shall not be liable for:

30.4.2.1 The Contractor's debts;

30.4.2.2 The Covered Services provided to the Enrollee, for which ASES does not pay the Contractor or its Network Providers;

30.4.2.3 The Covered Services provided to the Enrollee, for which ASES or the Contractor does not pay a Provider who furnishes the services under a contractual, Referral, or other arrangement; or

30.4.2.4 Payment for Covered Services furnished under a contractual, Referral, or other arrangement, to the extent that those payments are in excess of the amount that the Enrollee would owe if the Contractor provided the services directly.

30.4.3 The Contractor shall cover continuation of services to Enrollees for the duration of the period for which payment has been made by ASES, as well as for inpatient admissions up to discharge.

30.5 Termination for Insufficient Funding

30.5.1 In the event that Federal and/or Puerto Rico funds to finance this Contract become unavailable or insufficient, ASES may terminate the Contract in writing, unless both Parties agree, through a written amendment, to a modification of the obligations under this Contract.

30.5.2 The Termination Date of the Contract when the Contract is terminated due to insufficient funding shall be ninety (90) Calendar Days after ASES delivers written notice to the Contractor, unless available funds are insufficient to continue payments in full during the ninety (90) Calendar Day period, in which case ASES shall give the Contractor written notice of an earlier date at which the Contract shall terminate.

30.5.3 Upon termination, the Contractor shall comply with the phase-out obligations established in Article 31 of this Contract.

30.5.4 In the event of termination for insufficient funding, the Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the Termination Date of the Contract.

30.5.5 Availability of funds shall be determined solely by ASES.

30.6 ASES may terminate this Contract for any other just reason upon thirty (30) Calendar Days written notice.

30.7 Termination Procedures

30.7.1 Upon termination of this Contract, the Contractor shall:

30.7.1.1 Stop work under the Contract on the date and to the extent specified in the notice of termination;

30.7.1.2 Place no further orders or subcontract for materials, services, or facilities, except as may be necessary for completion of such portion of the work under the Contract as is not terminated;

30.7.1.3 Terminate all orders and subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;

30.7.1.4 Assign to ASES, in the manner and to the extent directed by ASES, all of the right, title, and interest of Contractor under the orders or subcontracts so terminated, in which case ASES will have the right, at its discretion, to settle or pay any or all Claims arising out of the termination of such orders and subcontracts;

30.7.1.5 With the prior written approval of ASES, settle all outstanding liabilities and all Claims arising out of such termination or orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of this Contract;

30.7.1.6 Complete the performance of such part of the work that was not terminated by the notice of termination;

30.7.1.7 Take such action as may be necessary, or as ASES may direct, for the protection and preservation of any and all property or information related to the Contract that is in the possession of the Contractor and in which ASES has or may acquire an interest;

30.7.1.8 Promptly make available to ASES, or to another MCO acting on behalf of ASES, any and all records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this Contract. Such records shall be provided at no expense to ASES;

30.7.1.9 Promptly supply all information necessary to ASES, or another ASES plan acting on behalf of ASES, for reimbursement of any outstanding Claims at the time of termination; and

30.7.1.10 Submit a termination/transition plan to ASES for review and prior written approval that includes commitments to carry out at minimum the following obligations:

30.7.1.10.1 Provide Enrollees continuation of all the Covered Services and Benefits during a defined transition period, such transition period to be determined by ASES;

30.7.1.10.2 Comply with all duties and/or obligations incurred prior to the actual Termination Date of the Contract, including but not limited to, the Grievance and Appeal process as described in Article 11;

30.7.1.10.3 Maintain Claims processing functions as necessary for ten (10) consecutive months from the Termination Date of the Contract in order to complete adjudication of all Claims;

30.7.1.10.4 Create a task force to reconcile and certify any pending and outstanding balances in connection with services rendered by the Contractor under the Contract and previous contracts between ASES and the Contractor.

30.7.1.10.5 File all reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;

30.7.1.10.6 Collaborate with ASES in issuing all necessary notifications to members and providers at least thirty (30) calendar days prior to the effective date of the change and as required by the contract, or as required by applicable law, with respect to notifications to members. These notifications shall not be limited to a single notice; the number of notifications shall be at ASES's discretion, based on its assessment of members' transfers to other plans. These notifications shall have no time limit or limit on the number of notices but shall depend on the success of transferring beneficiaries to other MAOs.;

30.7.1.10.7 Ensure the efficient and orderly transition of Enrollees from coverage under this Contract to coverage under any new arrangement developed or agreed to by ASES, including cooperation with another contractor, as provided in Article 31;

30.7.1.10.8 Ensure the proper identification of the Enrollees requiring the authorization for either prescription medications or DME to avoid any interruptions in services by providing such Data to ASES as contemplated in the transition plan;

30.7.1.10.9 The Contractor will send ASES all scripts used in call centers to communicate with enrollees during the transition period;

30.7.1.10.10 The Contractor will provide ASES with a list containing specific enrollee information, including at a minimum the enrollee's name, mailing address, phone number, alternate phone number, and Healthcare identification (Medicaid/Medicare). Indicate whether the member is in a long-term care facility, the name of the facility, the name of the contact person, and the facility's phone number. The MAO must submit an updated version of this list weekly to the Director of ASES's Customer Service Office;

30.7.1.10.11 Maintain the financial requirements and insurance set forth in this Contract until ASES provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled;

30.7.1.10.12 Submit reports to ASES as directed but no less frequently than every thirty (30) Calendar Days, detailing the Contractor's progress in completing its continuing obligations under this Contract, until completion; and

30.7.1.10.13 Meet with ASES personnel, as requested, to ensure satisfactory completion of all obligations under the Termination Plan.

30.7.2 This Termination Plan shall be subject to review and approval by CMS.

30.7.3 Upon completion of these continuing obligations, the Contractor shall submit a final report to ASES describing how the Contractor has completed its continuing obligations. ASES will advise, within twenty (20) Calendar Days of receipt of this report, if all of the Contractor's obligations are discharged. If ASES finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, then ASES will require the Contractor to submit a revised final report to ASES for approval and take any other action necessary to discharge all of its duties under this Contract, as directed by ASES.

30.7.4 Except as provided in this Article 30 a notification that ASES intends to terminate this Contract shall not release the Contractor from its obligations to pay for Covered Services rendered or otherwise to perform under this Contract.

30.8 Termination Claims

30.8.1 After receipt of a notice of termination, the Contractor shall submit to ASES any termination claim in the form, and with the certification prescribed by, ASES. Such claim shall be submitted promptly but in no event later than ten (10) months from the Termination Date of the Contract. Upon failure of the Contractor to submit its termination claim within the time allowed, ASES may determine, on the basis of information available, the amount, if any, due to the Contractor by reason of the termination and shall thereupon cause to be paid to the Contractor the amount so determined.

30.8.2 Upon receipt of notice of termination, the Contractor shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this Contract or any other contract. Upon termination the Contractor shall be paid in accordance with the following:

30.8.2.1 At the Contract price(s) for services delivered to and accepted by ASES; and/or

30.8.2.2 At a price mutually agreed upon by the Contractor and ASES for partially completed services.

30.8.3 In the event the Contractor and ASES fail to agree in whole or in part as to the amounts with respect to costs to be paid to the Contractor in connection with the total or partial termination of work pursuant to this Article, ASES will determine, on the basis of information available, the amount, if any, due to the Contractor by reason of termination and shall pay to the Contractor the amount so determined.

30.9 Limited Right of Termination by the Contractor

30.9.1 Subject to compliance with the termination procedures set forth in Section 30.8, the Contractor may terminate this Contract under the following circumstances:

30.9.2 Termination Due to ASES's Financial Breach. Upon fifteen (15) Calendar Days written notice, in the event ASES defaults in making payment of three (3) consecutive monthly PMPM Payments and fails to cure such breach within the notice period. For purposes of this Section, a default in making payment does not include instances where ASES has made any Withhold payments pursuant to the terms of this Contract, provided that ASES has given the Contractor advance written notice of any such Withhold.

30.9.3 Termination Due to Insufficient Funding. Immediately, upon receipt from ASES of a written notice pursuant to Section 30.5 that appropriated federal and/or Puerto Rico funds become unavailable or that such funds will be insufficient for the payment of ASES's obligation under this Contract when due, unless both Parties agree, through a written amendment, to a modification of the obligations under this Contract.

ARTICLE 31 PHASE-OUT AND COOPERATION WITH OTHER CONTRACTORS

31.1 If, in the best interest of Enrollees of the Medicare Platino Program, ASES terminates any Medicare Platino Program contract, the Contractor shall, upon the request of ASES, assume responsibility for the geographic areas (municipalities or Service Regions) previously managed by any MCO or other contractor whose contractual arrangement with ASES was terminated, in accordance with the contracted PMPM Payment, pursuant to the written amendment of the Contract, if required.

31.2 If in the best interest of Enrollees, ASES develops and implements new projects that impact the scope of services, the Contractor shall assist in the transition process, after receiving at least ninety (90) Calendar Days written notice from ASES of such change, and pursuant to written amendment of the Contract, if required. PMPM Payments shall be adjusted accordingly.

31.3 In the event that ASES has entered into, or enters into, agreements with other contractors for additional work related to the Benefits rendered hereunder, the Contractor agrees to cooperate fully with such other contractors. The Contractor shall not commit any act or omission that will interfere with the performance of work by any other contractor, or actions taken by ASES to facilitate the work.

31.4 In the event that a buy-down process (transition of coverage) is triggered with full dual-eligible beneficiaries, the Contractor agrees to manage this transition seamlessly to prevent any gaps in core medical care or disruption of essential provider services. All claims processed

under the post-buy-down Plan Vital coverage must continue to adhere strictly to the Puerto Rico Prompt Payment Act and applicable federal guidelines.

ARTICLE 32 COMPLIANCE WITH ALL LAWS

32.1 Nondiscrimination

32.1.1 The Contractor shall comply with applicable Federal and Puerto Rico laws, rules, and regulations, and the Puerto Rico policy relative to nondiscrimination in employment practices because of political affiliation, religion, race, color, sex, physical handicap, age, or national origin. Applicable Federal nondiscrimination law includes, but is not limited to, Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972, as amended; the Age Discrimination Act of 1975, as amended; Equal Employment Opportunity and its implementing regulations (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375); the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1993 and its implementing regulations (including but not limited to 28 CFR § 35.100 et seq.); and Section 1557 of PPACA. Nondiscrimination in employment practices is applicable to employees for employment, promotions, dismissal and other elements affecting employment.

32.1.2 The Contractor shall comply with all provisions of the Puerto Rico Patient's Bill of Rights and its implementing regulation, which prohibit discrimination against any patient, as well as any other applicable Federal or Puerto Rico laws that pertain to Enrollee rights. All employees and contracted Providers must observe and protect those rights.

32.2 Compliance with All Laws in the Delivery of Service

32.2.1 The Contractor agrees that all work done as part of this Contract will comply fully with and abide by all applicable Federal and Puerto Rico laws, rules, directives, manuals, circular and normative letters, regulations, statutes, policies, or procedures, existing now or in the future, that may govern the Contract, including but not limited to those listed in Appendix J to this Contract.

32.2.2 All applicable Puerto Rico and Federal laws, rules, and regulations, consent decrees, court orders, policy letters, directives, manuals, circular and normative letters, and policies and procedures, existing now or in the future, including but not limited to those described in Appendix J to this Contract, are hereby incorporated by reference into this Contract. Any change in those applicable laws and requirements, including any new law, regulations, directives, manuals, circular or normative letter, or policy guidance, shall be automatically incorporated into this Contract by reference as soon as it becomes effective.

32.2.3 To the extent that applicable laws, rules, regulations, statutes, policies, or procedures require the Contractor to take action or inaction, any costs, expenses, or fees associated with that action or inaction shall be borne and paid by the Contractor solely. Such compliance-associated costs include, but are not limited to, attorneys' fees, accounting fees, research costs, or consultant costs, where these costs are related to,

arise from, or are caused by compliance with any and all laws. In the event of a disagreement on this matter, ASES's determination on this matter shall be conclusive and not subject to appeal.

32.2.4 The Contractor shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in Data.

32.2.5 The Contractor certifies and warrants to ASES that at the time of execution of this Contract: (i) it is a corporation duly authorized to conduct business in Puerto Rico, and has filed all the required income tax returns for the preceding five years; and (ii) it filed its report due with the Office of the Commissioner of Insurance during the five (5) years preceding the Execution Date of this Contract.

ARTICLE 33 CONFLICT OF INTEREST AND CONTRACTOR INDEPENDENCE

33.1 The duty to provide information about interests and conflicting relations is continuous and extends throughout the Contract Term.

33.2 The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any material manner or degree with or have a material adverse effect on the performance of its services hereunder. The Contractor further covenants that in the performance of the Contract no person having any such interest shall be employed. The Contractor shall submit a conflict-of-interest form, attesting to these same facts,

by January 10 after the Effective Date of the Contract; and at any time, within fifteen (15) Calendar Days of request by ASES.

33.3 It shall be the responsibility of the Contractor to maintain independence and to establish necessary policies and procedures to assist the Contractor in determining if the actual individuals performing work under this Contract have any impairment to their independence.

33.4 The Contractor further agrees to take all necessary actions to eliminate threats to impartiality and independence, including but not limited to reassigning, removing, or terminating Providers or Subcontractors.

ARTICLE 34 CHOICE OF LAW OR VENUE

34.1 This Contract shall be governed in all respects by the laws of Puerto Rico. Any lawsuit or other action brought against ASES or the Government of Puerto Rico based upon or arising from this Contract shall be brought in a court of competent jurisdiction in Puerto Rico.

ARTICLE 35 ATTORNEY'S FEES

35.1 In the event that either Party deems it necessary to take legal action to enforce any provision of this Contract, and in the event ASES prevails, the Contractor agrees to pay all expenses of such an action including reasonable attorney's fees and costs at all stages of litigation as awarded by the court, a lawful tribunal, a hearing officer, or an administrative law judge. The term legal action shall be deemed to include administrative proceedings of all kinds, as well as all actions regarding the law or equity.

ARTICLE 36 SURVIVABILITY

36.1 The terms, provisions, representations, and warranties contained in this Contract shall survive the delivery or provision of all services hereunder.

ARTICLE 37 PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED AND SUSPENDED

37.1 The Contractor certifies that it is not presently debarred, suspended, proposed for debarment, or declared ineligible for award of contracts by any Federal or Puerto Rico agency. In addition, the Contractor certifies that it does not employ or subcontract with any person or entity that could be excluded from participation in the Medicaid Program under 42 CFR 1001.1001 (exclusion of entities owned or controlled by a sanctioned person) or 1001.1051 (exclusion of individuals with ownership or control interest in sanctioned entities). Any violation of this Article shall be grounds for termination of the Contract.

ARTICLE 38 WAIVER

38.1 No covenant, condition, duty, obligation, or undertaking contained in or made a part of the Contract shall be waived except by the written agreement of the Parties. Forbearance or

indulgence in any form or manner by either Party in any regard whatsoever shall not constitute a waiver of the covenant, conditions, duties, obligations, and undertakings to be kept, performed, or discharged by the Party to which the same may apply. Notwithstanding any such forbearance or indulgence, the other Party shall have the right to invoke any Remedy available under law or equity until complete performance or satisfaction of all such covenants, conditions, duties, obligations, and undertakings.

38.2 The waiver by ASES of any breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision or any subsequent breach of the same or any other provision contained in this Contract and shall not establish a course of performance between the Parties contradictory to the terms hereof. No term or condition of the Contract shall be held to be waived, modified, or deleted except by an instrument, in writing, signed by the Parties thereto.

ARTICLE 39 FORCE MAJEURE

39.1 Neither Party of this Contract shall be held responsible for delays or failures in performance resulting from acts beyond the control of each Party. Such acts shall include, but not be limited to, acts of God, strikes, riots, lockouts, acts of war, epidemics, fire, earthquakes, or other disasters.

ARTICLE 40 BINDING

40.1 This Contract and all of its terms, conditions, requirements, and amendments shall be binding on ASES and the Contractor and for their respective successors and permitted assigns.

ARTICLE 41 TIME IS OF THE ESSENCE

41.1 Time is of the essence in this Contract. Any reference to "days" shall be deemed Calendar Days unless otherwise specifically stated.

ARTICLE 42 AUTHORITY

42.1 ASES has full power and authority to enter into this Contract as does the person acting on behalf of and signing for the Contractor. Additionally, the person signing on behalf of the Contractor has been properly authorized and empowered to enter into this Contract on behalf of the Contractor and to bind the Contractor to the terms of this Contract. Each Party further acknowledges that it has had the opportunity to consult with and/or retain legal counsel of its

choice and read this Contract. Each party acknowledges that it understands this Contract and agrees to be bound by it.

ARTICLE 43 ETHICS IN PUBLIC CONTRACTING

43.1 The Contractor understands, states, and certifies that it made its Proposal without collusion or Fraud and that it did not offer or receive any kickbacks or other inducements from any other Contractor, supplier, manufacturer, or Subcontractor in connection with its Proposal.

ARTICLE 44 CONTRACT LANGUAGE INTERPRETATION

44.1 The Contractor and ASES agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, ASES's interpretation of the Contract language in dispute shall control and govern.

ARTICLE 45 ARTICLE AND SECTION TITLES NOT CONTROLLING

45.1 The Article and Section titles used in this Contract are for reference purposes only and shall not be deemed to be a part of this Contract.

ARTICLE 46 LIMITATION OF LIABILITY/EXCEPTIONS

46.1 Nothing in this Contract shall limit the Contractor's indemnification liability or civil liability arising from, based on, or related to claims brought by ASES or any Third Party or any claims brought against ASES or the Government of Puerto Rico by a Third Party or the Contractor.

ARTICLE 47 COOPERATION WITH AUDITS

47.1 The Contractor shall assist and cooperate with ASES in any and all matters and activities related to or arising out of any audit or review, whether Federal, private, or internal in nature, at no cost to ASES.

47.2 The Parties also agree that the Contractor shall be solely responsible for any costs it incurs for any audit related inquiries or matters. Moreover, the Contractor may not charge or collect any fees or compensation from ASES for any matter, activity, or inquiry related to, arising out of, or based on an audit or review.

47.3 ASES reserves the right to audit the Contractor and/or its Subcontractors at any time during the term of the Contract. The Contractor and/or its Subcontractors shall be solely responsible for the cost of such audits.

ARTICLE 48 OWNERSHIP AND FINANCIAL DISCLOSURE

48.1 The Contractor and Subcontractors shall disclose and provide financial statements for each person or corporation with an ownership or control interest of five percent (5%) or more

of its entity. For the purposes of this Section, a person or corporation with an ownership or control interest shall mean a person or corporation:

48.1.1 That owns directly or indirectly five percent (5%) or more of the Contractor's/Subcontractor's capital or stock or received five percent (5%) or more of its profits;

48.1.2 That has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor/Subcontractor or by its property or assets, and that interest is equal to or exceeds five percent (5%) of the total property and assets of the Contractor/Subcontractor; and

48.1.3 That is an officer or director of the Contractor/Subcontractor (if it is organized as a corporation) or is a partner in the Contractor's/Subcontractor's organization (if it is organized as a partnership).

48.2 As per 42 CFR 455.104, disclosure by the Contractor and any of its Subcontractors for review by ASES will include the following information on ownership and control:

48.2.1 The name and address of any person (individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

48.2.2 Date of birth and Social Security Number (in the case of an individual).

48.2.3 Other tax identification number (in the case of a corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) or in any Subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent (5%) or more interest.

48.2.4 Whether the person (individual or corporation) with an ownership or control interest in the disclosing entity (or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person (individual or corporation) with an ownership or control interest in any Subcontractor in which the disclosing entity (or fiscal agent or managed care entity) has a five percent (5%) or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

48.2.5 The name of any other disclosing entity (or fiscal agent or managed care entity) in which an owner of the disclosing entity (or fiscal agent or managed care entity) has an ownership or control interest.

48.2.6 The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity (or fiscal agent or managed care entity).

48.2.7 Disclosures from providers or disclosing entities. Providers or disclosing entities shall comply with the information disclosure required by Section 48.2. Disclosure from any provider or disclosing entity is due at any of the following times:

48.2.7.1 Upon the provider or disclosing entity submitting the provider application.

48.2.7.2 Upon the provider or disclosing entity executing the provider agreement.

48.2.7.3 Upon request of the Medicaid agency during the re-validation of enrollment process under 42 CFR 455.414.

48.2.7.4 Within 35 days after any change in ownership of the disclosing entity.

48.2.8 Disclosures from fiscal agents. Fiscal agents shall comply with the information disclosure required by Section 48.2. Disclosures from fiscal agents are due at any of the following times:

48.2.8.1 Upon the fiscal agent submitting the proposal in accordance with the Government of Puerto Rico's procurement process.

48.2.8.2 Upon the fiscal agent executing the contract with the Government of Puerto Rico.

48.2.8.3 Upon renewal or extension of the contract.

48.2.8.4 Within thirty-five (35) Calendar Days after any change in ownership of the fiscal agent.

48.2.9 Disclosures from managed care entities. Managed care entities, including the Contractor, shall comply with the information disclosure required by Section 48.2. Disclosures from managed care entities (MCOs, PIHPs, PAHPs, and HIOs), are due at any of the following times:

48.2.9.1 Upon the managed care entity submitting the proposal in accordance with the Government of Puerto Rico's procurement process.

48.2.9.2 Upon the managed care entity executing, renewing or extending the contract with the Government of Puerto Rico.

48.2.10 Within thirty-five (35) Calendar Days after any change in ownership of the managed care entity.

ARTICLE 49 AMENDMENT IN WRITING

49.1 No amendment, waiver, termination, or discharge of this Contract, or any of the terms or provisions hereof, shall be binding upon either Party unless confirmed in writing by ASES and any other appropriate governmental agency. Additionally, CMS approval shall be required before any such amendment is effective. Any agreement of the Parties to amend, modify, eliminate, or otherwise change any part of this Contract shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be in full force and effect as set out herein.

49.2 ASES reserves the authority to seek an amendment to this Contract at any time if such an amendment is necessary in order for the terms of this Contract to comply with Federal law, the laws of Puerto Rico or the Government of Puerto Rico Fiscal Plan as certified by the Financial Oversight and Management Board for Puerto Rico pursuant to the Puerto Rico Oversight, Management and Economic Stability Act of 2016. The Contractor shall consent to any such amendment.

49.3 ASES also reserves the right to amend or partially terminate the Contract at any time if such amendment or partial termination is necessary to implement a demonstrative plan to incorporate the new public health policies and/or strategies of the Government of the Government of Puerto Rico.

ARTICLE 50 CONTRACT ASSIGNMENT

50.1 The Contractor shall not assign this Contract, in whole or in part, without the prior written consent of ASES, and any attempted assignment not in accordance herewith shall be null and void and of no force or effect.

50.1 The Contractor agrees that, in the event an assignment of any part of this Contract is approved by ASES, that Contractor shall remain legally responsible to ASES for carrying out all activities under this Contract and that no Subcontract shall limit or terminate Contractor's responsibility.

ARTICLE 51 SEVERABILITY

51.1 If any Article, Section, paragraph, term, condition, provision, or other part of this Contract (including items incorporated by reference) is judged, held, declared, or found to be voidable, illegal, unenforceable, invalid or void, then both ASES and the Contractor shall be relieved of all obligations arising under such provision. However, if the remainder of the Contract is capable of being performed, it shall not be affected by such declaration or finding and those duties and tasks shall be fully performed. To this end, the provisions of the Contract are declared to be severable.

ARTICLE 52 ENTIRE AGREEMENT

52.1 This Contract, including those attachments, schedules, appendices, exhibits and addenda that have been specifically incorporated herein, as well as written plans submitted by

Contractor and approved by ASES, constitutes the entire agreement between the Parties with respect to the subject matter herein and supersedes all prior negotiations, representations, or contracts. No written or oral agreements, representatives, statements, negotiations, understandings, or discussions that are not set out, referenced, or specifically incorporated in this Contract shall in any way be binding or of effect between the Parties.

ARTICLE 53 INDEMNIFICATION

53.1 The Contractor hereby releases and agrees to indemnify and hold ASES, the Government of Puerto Rico, and its departments, agencies, and instrumentalities harmless from and against any and all claims, demands, liabilities, losses, costs or expenses, and attorneys' fees, caused by, growing out of, or arising from this Contract, due to any act or omission on the part of the Contractor, its Agents, employees, customers, invitees, licensees, or others working at the direction of the Contractor or on its behalf, or due to any breach of this Contract by the Contractor, or due to the application or violation of any pertinent Federal, Puerto Rico or local law, rule or regulation. This indemnification extends to the successors and assigns of the Contractor and survives the termination of the Contract and the dissolution or, to the extent allowed by the law, the bankruptcy of the Contractor.

ARTICLE 54 NOTICES

54.1 All notices, consents, approvals, and requests required or permitted shall be given in writing and shall be effective for all purposes if hand delivered or sent by (i) personal delivery, (ii) expedited prepaid delivery service, either commercial or US Postal Service, with proof of attempted delivery, (iii) telecopies, or (iv) electronic mail, in each case of (iii) and (iv), with acknowledged receipt, and all addressed as follows:

54.1.1 If to ASES at:

Mailing Address:	Physical Address:
Administración de Seguros de Salud P.O. Box 195661 San Juan, PR 00919-5661 Attention: Executive Director	Administración de Seguros de Salud Urb. Caribe 1549 Calle Alda San Juan, PR 00926-2712

54.1.2 If to Contractor at:

Mailing Address:	Physical Address:
MMM Healthcare, LLC. PO Box 71114 San Juan, Puerto Rico 00936	MMM Healthcare, LLC. 350 Ave. Chardón #500 San Juan, Puerto Rico 00918

54.1.3 All notices, elections, requests, and demands under this Contract shall be effective and deemed received upon the earliest of (i) the actual receipt of the item by personal delivery or otherwise, (ii) two (2) Business Days after being deposited with a

nationally recognized overnight courier service as required above, (iii) three (3) Business Days after being deposited in the US mail as required above or (iv) on the day sent if sent by facsimile with voice confirmation on or before 4:00 p.m. Atlantic Time on any Business Day or on the next Business Day if so delivered after 4:00 p.m. Atlantic Time or on any day other than a Business Day. Rejection or other refusal to accept or the inability to deliver because of changed address of which no notice was given as herein required shall be deemed to be receipt of the notice, election, request, or demand sent.

ARTICLE 55 OFFICE OF THE COMPTROLLER

55.1 ASES will file this Contract in the Office of the Comptroller of Puerto Rico within fifteen (15) Calendar Days from the Effective Date of the Contract.

ARTICLE 56 CONTRACT APPLICABILITY

56.1 Due to the nature of the Platino product as supplemental Medicaid Wraparound coverage, the provisions contained herein shall apply only for the benefits included in the Wraparound Table, Appendix C(2), as approved by CMS, in as much as CMS has primary jurisdiction over the regulation of Medicare.

ARTICLE 57 INVALIDATED PROGRAM FEATURES

57.1 Should any part of the scope of work under this Contract relate to a state program that is no longer authorized by law (e.g., which has been vacated by a court of law, or for which CMS has withdrawn federal authority, or which is the subject of a legislative repeal), the Contractor must do no work on that part after the effective date of the loss of program authority. ASES must adjust Capitation rates to remove costs that are specific to any program or activity that is no longer authorized by law. If the Contractor works on a program or activity no longer authorized by law after the date the legal authority for the work ends, the Contractor will not be paid for that work. If the state paid the Contractor in advance to work on a no-longer-authorized program or activity and under the terms of this contract the work was to be performed after the date the legal authority ended, the payment for that work should be returned to ASES. However, if the Contractor worked on a program or activity prior to the date legal authority ended for that program or activity, and ASES included the cost of performing that work in its payments to the Contractor, the Contractor may keep the payment for that work even if the payment was made after the date the program or activity lost legal authority.

(Signatures on following page)

SIGNATURE PAGE

IN WITNESS WHEREOF, the Parties state and affirm that they are duly authorized to bind the respected entities designated below as of the day and year indicated.

ADMINISTRACIÓN DE SEGUROS DE SALUD DE PUERTO RICO (ASES)

07/06/2026

Carlos A. Santiago Rosario, Esq., LL.M., MSHA, FACHE, CHC
Executive Director
EIN: 66-0500678

Date

MMM HEALTHCARE, LLC.

07/06/2026

Agustín González Cuadrado
President
EIN: 66-0588600

Date

Account No.: 246-5377-5381-P01, P02-2027;
247-5377-5381-P01, P02-2028