MOLINA HEALTHCARE OF OHIO, INC.
PROVIDER SUMMARY DISCLOSURE FORM

(1) Compensation Terms

a. Manner of Payment

i. Medicaid (CFC, ABD, AEP)

☐ Fee-For-Service:

☒ Other: See Attachment D Compensation Schedule

ii. Medicare-Medicaid Program (ICDS, CFAD)

☐ Fee-For-Service:

☒ Other: See Attachment D Compensation Schedule

b. Medicaid Fee schedule available at: http://medicaid.ohio.gov/providers/FeeScheduleAndRates.aspx

c. Medicare Fee schedule available at: http://www.cms.hhs.gov/home/medicare.asp

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

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

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

(3) Term of this contract: Evergreen

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

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

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

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

IMPORTANT INFORMATION – PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Provider Service Agreement as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Agreement constitute the rights of the parties. Reading this Summary Disclosure Form is not a substitute for reading the entire Agreement. When you sign the Agreement, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Agreement. Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.

MOLINA HEALTHCARE OF OHIO, INC.
DENTAL PROVIDER SERVICES AGREEMENT

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

RECITALS

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

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

C. Provider is licensed to render certain health care services and desires to provide such services to Health Plan's Members in connection with Health Plan's contractual obligations to provide and/or arrange for health care services for Health Plan's Members.

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

ARTICLE ONE – DEFINITIONS

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

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

ARTICLE TWO - PROVIDER OBLIGATIONS

2.1 **Provision of Covered Services.** Provider agrees to provide Covered Services to Members within the scope of Provider's business and practice, and in accordance with applicable Law and the terms of this Agreement including the Provider Manual and Health Plan's QI and UM Programs.

2.2 **Provider Standards.**

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

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

c. **Prior Authorization.** If Provider determines that it is Medically Necessary to consult or obtain services from other health professionals that are Medically Necessary, Provider will obtain the prior authorization of Health Plan in accordance with Health Plan's Provider Manual unless the situation is one involving the delivery of Emergency Services. Upon and following such referral, Provider will coordinate the provision of such Covered Services to Members and ensure continuity of care.

d. **Use of Participating Providers.** Except in the case of Emergency Services, Provider will utilize Health Plan's Participating Providers to provide Covered Services to Members.

e. **Member Eligibility Verification.** Provider will verify eligibility of Members prior to rendering services.

f. **Admissions.** Provider will cooperate with and comply with Health Plan's hospital admission and prior authorization procedures.

g. **Emergency Room Referral.** If Provider refers a Member to an emergency room for Covered Services, Provider will notify Health Plan within twenty-four (24) hours of the referral.

h. **Prescriptions.** Except with respect to prescriptions and pharmaceuticals ordered for in-patient hospital services, Provider will abide by Health Plan's drug formularies and prescription policies, including those regarding the prescription of generic or lowest cost alternative brand name pharmaceuticals. Provider will obtain prior authorization from Health Plan if Provider believes a generic equivalent or formulary drug should not be dispensed. Provider acknowledges the authority of Health Plan contracting pharmacists to substitute generics for brand name pharmaceuticals unless counter indicated on the prescription by the Provider.

i. **Availability of Services.** Provider will make necessary and appropriate arrangements to assure the availability of Covered Services to Members for emergency or urgent dental needs. Provider will meet the applicable standards for timely access to care and services as referenced in the Provider Manual, taking into account the urgency of the need for the services.

j. **Treatment Alternatives.** Health Plan encourages open Provider-Member communication regarding appropriate treatment alternatives. Health Plan promotes open discussion between Provider and Members regarding Medically Necessary or appropriate patient care, regardless of limitations on Covered Services. Provider is free to communicate any and all treatment options to Members regardless of benefit coverage limitations.

k. **Member Rights.** Provider shall observe, protect and promote the rights of Members.

2.3 **Subcontracts.** Provider will not enter into any subcontract agreement for the provision of Covered Services without the prior written consent of Health Plan. Any subcontract agreement entered into by Provider for the delivery of Covered Services will be in writing and will bind the subcontractor to the terms and conditions of this Agreement including, but not limited to, licensure, insurance, and billing of Members for Covered Services.

2.4 **Promotional Activities.** At the request of Health Plan, Provider will (a) display Health Plan promotional materials in its offices and facilities as practical, and (b) cooperate with and participate in all reasonable Health Plan marketing efforts. Provider will not use Health Plan's name in any advertising or promotional materials without the prior written permission of Health Plan.

2.5 **Nondiscrimination.**

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

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

2.6 **Recordkeeping.**

a. **Maintaining Member Dental/Medical Record.** Provider will maintain a dental/medical record for each Member to whom Provider renders health care services. Provider will open each Member's dental/medical record upon the Member's first encounter with Provider. The Member's dental/medical record will contain all information required by Law, generally accepted and prevailing professional practice, applicable government sponsored health programs, and all Health Plan policies and procedures. Provider will retain all such records for at least ten (10) years. This section will survive the termination of this Agreement.

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

c. **National Provider Identifier ("NPI").** In accordance with applicable statutes and regulations of the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, Provider will comply with the Standard Unique Identifier for Health Care Provider regulations promulgated under HIPAA (45 CFR Section 162.402, et seq.) and use only the NPI to identify HIPAA covered health care providers in standard transactions. Provider will utilize an NPI from the National Plan and Provider Enumeration System ("NPPES") for itself or for any subpart of the Provider. Provider will make best efforts to report its NPI and any subparts to Health Plan. Provider will report any changes in its NPI or subparts to Health Plan within thirty (30) days of the change. Provider will use its NPI to identify itself on all Claims and encounters (both electronic and paper formats) submitted to Health Plan.

d. **Delivery of Patient Care Information.** Provider will promptly deliver to Health Plan, HPDA or Health Plan designee(s), upon request and/or as may be required by Law, Health Plan's policies and procedures, applicable government sponsored health programs, Health Plan's contracts with the government agencies, or third party payors, any information, statistical data, encounter data, or patient treatment information pertaining to Members served by Provider, including but not limited to, any and all information requested by Health Plan in conjunction with utilization review and management, grievances, peer review, HEDIS studies, Health Plan's Quality Improvement Program, Consumer Assessment of Healthcare Providers and Systems (CAHPS) or Claims payment. Provider will further provide direct access to said patient care information as requested by Health Plan and/or as required by any governmental agency or any appropriate state and federal authority having jurisdiction over Health Plan. Health Plan will have the right to withhold compensation from Provider in the event that Provider fails or refuses to promptly provide any such information to Health Plan. This section will survive the termination of this Agreement.

e. **Member Access to Health Information.** Provider will give Health Plan, HPDA, and Members access to Members' health information including, but not limited to, dental/medical records and billing records, in accordance with applicable Law, applicable government sponsored health programs, and Health Plan's policies and procedures. This section will survive the termination of this Agreement.

f. **Member Care Coordination.** If Provider is a dental specialist, then Provider will report the results of all dental examinations to the Member's general or pediatric dentist. If Provider cannot identify the Member's general or pediatric dentist, Provider should contact Health Plan directly for assistance.

2.7 **Program Participation.**

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

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

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

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

   Provider Manual. Provider will comply with and render Covered Services in accordance with the contents, instructions and procedures set forth in the Provider Manual, which may be amended from time to time at Health Plan's sole discretion.

e. **Supplemental Materials.** In addition to the contents, instructions, and procedures set forth in Health Plan's Provider Manual, Health Plan may periodically promulgate bulletins or other written materials that may or may not be used to supplement the Provider Manual ("Supplemental Materials"). Health Plan may issue such Supplemental Materials in an electronic format. Provider can obtain paper copies upon request. Revisions to the Supplemental Materials shall become binding upon Provider as of the effective date indicated on the Supplemental Materials. If applicable, such effective date shall be determined in accordance with the terms of this Agreement.

f. **Government Contracts.** Provider acknowledges that Health Plan has entered into contracts with state and federal agencies for the arrangement of health care services for Members through government sponsored programs, including the State Contract(s). Provider will comply with any term or condition of those government sponsored program contracts that are applicable to the Covered Services to be performed under this Agreement. Health Plan will give Provider a copy of the State Contract(s), and any other applicable contract, upon request by Provider.

g. **Health Education/Training.** Provider will participate in and cooperate with Health Plan's Provider education and training efforts as well as Member education and efforts. Provider will also comply with all Health Plan health education, cultural and linguistic standards, policies, and procedures, and such standards, policies, and procedures as may be necessary for Health Plan to comply with its contracts with employers, the state, or federal government. Provider will ensure that Provider promptly delivers to Provider's constituent providers, if any, all informational, promotional, educational, or instructional materials prepared by Health Plan regarding any aspect of providing Covered Services to Members.

h. **Health Plan's Electronic Processes and Initiatives.** Provider will participate in and comply with Health Plan's electronic processes and initiatives, including but not limited to electronic submission of prior authorization, Health Plan access to electronic dental/medical records, electronic claims filing, electronic data interchange ("EDI"), electronic remittance advice and electronic funds transfers, registration and use of Health Plan's interactive web portal. Such programs, registration, and use are contained and described in the Provider Manual or as Supplemental Materials.

i. **Robocalls**. If it is determined that robocalls can be conducted in accordance with all state and federal laws and regulations, including but not limited to Federal Communication Commission (FCC)

regulations and Medicaid regulations, Provider will accept robocalls from Molina and its subcontractors involved in executing this program and Agreement.

2.8 **Licensure and Standing.**

a. **Licensure.** Provider warrants and represents that it is appropriately licensed to render health care services within the scope of Provider's practice, including having and maintaining a current narcotics number, where appropriate, issued by all proper authorities. Provider will provide evidence of licensure to Health Plan upon request. Provider will maintain its licensure in good standing, free of disciplinary action, and in unrestricted status throughout the term of this Agreement. Provider will immediately notify Health Plan of any change in Provider's licensure status, including any disciplinary action taken or proposed by any licensing agency responsible for oversight of Provider.

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

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

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

e. **Liability Insurance.** Provider will maintain premises and professional liability insurance in coverage amounts appropriate for the size and nature of Provider's facility and the nature of Provider's health care activities. Such coverage will be effective as of the Effective Date of the Agreement. Every dental Provider will maintain, at a minimum, professional liability insurance with limits of not less than one million dollars ($1,000,000) per occurrence and three million dollars ($3,000,000) in the aggregate for the policy year and for each individual dental Provider. Provider will deliver copies of such insurance policies to Health Plan within five (5) business days of a written request by Health Plan. Provider will give at least fifteen (15) days advance written notice to Health Plan prior to cancellation of such insurance.

2.9 **Claims Payment.**

a. **Submitting Claims.** Provider will promptly submit to HPDA Claims for Covered Services rendered to Members. All Claims will be submitted electronically or on the most current standard American Dental Association (ADA) form or successor format acceptable to and approved by HPDA, and will include any and all dental/medical records pertaining to the Claim if requested by HPDA or otherwise required by Health Plan's policies and procedures. Except as otherwise provided by Law or provided by government sponsored program requirements, any Claims that are not submitted by Provider to HPDA within one hundred eighty (180) days of providing the Covered Services that are the subject of

the Claim will not be eligible for payment, and Provider hereby waives any right to payment therefore. Claims shall be submitted in a standard format (electronic, ADA Claims format, or successor format) as determined by Health Plan that has been approved by HPDA.

b. **Compensation.** HPDA will process and release payment for Provider's Clean Claims for Covered Services provided to Members, including Emergency Services, in accordance with applicable Law and in accordance with the compensation schedule set forth in Attachment D. Provider will accept such payment, applicable co-payments, deductibles, and coordination of benefits collections as payment in full for services provided under this Agreement. Provider will not balance bill Members for any Covered Services.

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

d. **Coordination of Benefits.** Health Plan is a secondary payer in any situation where there is another payer as primary carrier. Provider will make reasonable inquiry of Members to learn whether Member has health insurance or health benefits other than from Health Plan or is entitled to payment by a third party under any other insurance or plan of any type, and Provider will immediately notify Health Plan and HPDA of said entitlement. In the event that coordination of benefits occurs, Provider will be compensated in an amount equal to the allowable Clean Claim less the amount paid by other health plans, insurance carriers and payors, not to exceed the amount specified in Attachment D.

e. **Offset.** Except as otherwise provided by law or provided by government sponsored program requirements, in the event that a Claim has been overpaid or paid in duplicate, or in the event that funds were paid which were not provided for under this Agreement, Provider will make repayment to HPDA within sixty (60) days of receipt of written notification by Health Plan or HPDA of the overpayment, duplicate payment, or other excess payment or within sixty (60) days of Provider's identification of the overpayment, duplicate payment, or other excess payment as required by Law. In addition to any other contractual or legal remedy, HPDA may recover the amounts owed by way of offset or recoupment from current or future amounts due Provider by giving Provider not less than thirty (30) days notice. As a material condition to Health Plan's and HPDA's obligations under this Agreement, Provider agrees that the offset and recoupment rights set forth herein will be deemed to be and to constitute rights of offset and recoupment authorized in Law or in equity to the maximum extent legally permissible, and that such rights will not be subject to any requirement of prior or other approval from any court or other governmental authority that may now or hereafter have jurisdiction over Health Plan, HPDA, and/or Provider.

f. **Claims Review and Audit.** Provider acknowledges Health Plan's and HPDA's right to review Provider's Claims prior to payment for appropriateness in accordance with industry standard billing rules, including, but not limited to, current ADA and Current Dental Terminology (CDT) rules, CMS billing rules, CMS bundling/unbundling rules, National Correct Coding Initiatives (NCCI) Edits, CMS multiple procedure billing rules, and FDA definitions and determinations of designated implantable devices. Provider acknowledges Health Plan's and HPDA's right to conduct such review and audit on a line-by-line basis or on such other basis as Health Plan and HPDA deem appropriate, and Health Plan's and HPDA's right to exclude inappropriate line items to adjust payment and reimburse Provider at the revised allowable level. Provider also acknowledges Health Plan's and HPDA's right to conduct utilization reviews to determine medical necessity and to conduct post-payment billing audits. Provider will cooperate with Health Plan's audits of Claims and payments by providing access to requested Claims information, all supporting dental/medical records, Provider's charging policies, and other related data. HPDA will use established industry claims adjudication and/or clinical practices, state and federal guidelines, and/or Health Plan's or HPDA's policies and data to determine the appropriateness of the billing, coding and payment.

2.10 **Compliance with Law.** Provider will comply with all applicable Laws governing the delivery of Covered Services to Members including, but not limited to, title VI of the Civil Rights Act of 1964; title

IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation act of 1973; the Balanced Budget Act of 1997; and the Americans with Disabilities Act:

a. Provider acknowledges that all Medicaid Covered Services rendered pursuant to this Agreement are subject to applicable state licensing statutes, regulations and the State Contract(s). Accordingly, Provider will abide by those provisions set forth in Attachment E and the applicable State of Ohio Medicaid Addendum, which the parties acknowledge is made part of this Agreement referenced hereto and incorporated herein.

b. Provider acknowledges that all Covered Services rendered pursuant to the Medicare-Medicaid Program are subject to the additional provisions set forth in Attachment J and the applicable State of Ohio Medicaid Addendum, which the parties acknowledge is made part of this Agreement referenced hereto and incorporated herein.

2.11 **Provider Non-solicitation Obligations.** Provider will not unilaterally assign or transfer patients served under this Agreement to another medical group, IPA, or provider without the prior written approval of Health Plan. Nor will Provider solicit or encourage Members to select another health plan. Nothing in this provision is intended to limit Provider's ability to fully inform Members of all available health care treatment options or modalities.

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

2.13 **Advance Directive.** Provider will document all patient records with respect to the existence of an Advance Directive in compliance with the Patient Self-Determination Act (Section 4751 of the Omnibus Reconciliation Act of 1990), as amended, and other applicable Law.

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

2.16 **Notification of Network Change.** Where Provider is a dental group, independent practice association, or any other similar entity/organization, Provider will provide Health Plan and Members with timely prior written notification in the event a constituent provider terminates its contract with Provider. Said written notification will be in compliance with applicable Law or government sponsored program requirements.

2.17 **Disclosure**. Provider agrees to comply with 42 CFR 455.104, 42 CFR 455.105, and 42 CFR 455.106 related to federal disclosure requirements. Provider will provide the required disclosures to Health Plan within the timeframes specified in regulation.

ARTICLE THREE - HEALTH PLAN'S OBLIGATIONS

3.1 **Compensation.** HPDA will pay Provider in accordance with the terms and conditions of this Agreement and the compensation schedule set forth in Attachment D. Health Plan is responsible for overseeing and ensuring HPDA compliance with the terms of this Agreement.

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

3.3 **Prior Authorization Review.** HPDA will timely respond to requests for prior authorization and/or determination of Covered Services.

3.4 **Medical Necessity Determination.** HPDA's determination with regard to Medically Necessary services and scope of Covered Services under the Member's health program will govern. The primary concern with respect to all such determinations will be in the interest of the Member.

3.5 **Member Services.** Health Plan will provide services to Members including, but not limited to, assisting Members in selecting a dental provider, processing Member complaints and grievances, informing Members of the Health Plan's policies and procedures, providing Members with Member identification cards, providing Members with information about Health Plan, and providing Members with access to the Provider Directory, updated from time to time, identifying the professional status, specialty, office address, and telephone number of Health Plan Participating Providers.

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

3.7 **Dental Director.** Health Plan and/or HPDA will employ a dentist that will serve as the dental director who will be responsible for the management of the scientific, technical, and dental aspects of Health Plan.

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

ARTICLE FOUR - TERM AND TERMINATION

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

4.2 **Termination without Cause.** This Agreement may be terminated without cause by either party on at least one hundred and twenty (120) days prior written notice to the other party.

4.3 **Termination with Cause.** In the event of a breach of any material provision of this Agreement, the party claiming the breach may give the other party written notice of termination setting forth the facts underlying its claim(s) that the other party has breached the Agreement. The party receiving the notice of termination will have thirty (30) days from the date of receipt of such notice to remedy or cure the claimed breach to the satisfaction of the other party. During this thirty (30) day period, the parties agree to meet as reasonably necessary and to confer in good faith in an attempt to resolve the claimed breach. If the party receiving the notice of termination has not remedied or cured the breach within such thirty (30) day period, the party who provided the notice of termination will have the right to immediately terminate this Agreement. Notwithstanding the forgoing, either party may immediately terminate this Agreement without providing the other party the opportunity to cure a material breach should the terminating party reasonably believe the material breach of this Agreement to be non-curable.

4.4 **Termination for Non Participation in New Product(s) Offers.** In the event Provider refuses to accept any new products by Health Plan; Health Plan may terminate this Agreement and direct Member(s) to

another provider by giving no sooner than one hundred eighty (180) days written notice to Provider. (ORC §3963.02(B)(3)(b).)

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

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

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

c. Provider loses or fails to obtain credentialed status;

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

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

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

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

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

4.6 **Enrollee Notifications Upon Termination.** Health Plan will provide notice of nonrenewal or termination of Provider to the Members served by Provider as required by Law. Provider will not contact Health Plan's Members upon termination of this Agreement.

4.7 **Continuation of Care.** In the event of termination of this Agreement, for the period of time required by Law and in accordance with any other continuation of care requirements set forth in this Agreement, by CMS or by the State of Ohio for the products and programs covered under this Agreement, Provider agrees to continue to provide Medically Necessary care to Members. In addition, Provider will assist Health Plan in transitioning Members to a new Participating Provider. Throughout any such continuation of care period, Health Plan will continue to meet all obligations assigned to it under this Agreement.

ARTICLE FIVE - GENERAL PROVISIONS

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

5.2 **Relationship of the Parties.** Nothing contained in this Agreement is intended to create, nor will it be construed to create, any relationship between the parties other than that of independent parties contracting with each other solely for the purpose of effectuating the provisions of this Agreement. This Agreement is not intended to create a relationship of agency, representation, joint venture, or employment between the parties. Nothing herein contained will prevent any of the parties from entering into similar arrangements with other parties. Each of the parties will maintain separate and independent management and will be responsible for its own operations. Nothing contained in this Agreement is intended to create, nor will be construed to create, any right in any third party, including but not limited to Health Plan's Members. Except for HPDA (only to the extent specified herein), no third party will have any right to enforce the terms of this Agreement.

5.3 **Governing Law.** This Agreement will be governed by the Laws of the State of Ohio.

5.4 **Entire Agreement.** This Agreement, together with Attachments, Amendments and incorporated documents or materials, contains the entire agreement between Health Plan and Provider relating to the rights granted and obligations imposed by this Agreement. Additionally, as to the Medicaid products offered by Health Plan and listed in Attachment C, the contract between the State of Ohio, Department of Health Services and the Health Plan is incorporated herein by reference and shall be the guiding and controlling document when interpreting the terms of this Agreement. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement are of no force or effect.

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

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

5.7 **Amendment.** Notwithstanding the Notice Amendment provisions set forth in Section 5.8 (Notice Amendment) and its subparts, Health Plan may, without Provider's consent, immediately amend this Agreement to maintain consistency and/or compliance with any state or federal law, policy, directive, or government sponsored program requirement. Health Plan may otherwise amend this Agreement in accordance with Section 5.8 a.

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

a. If an amendment to this Agreement is not a Material Amendment, Health Plan shall provide Provider notice of the amendment at least fifteen (15) days prior to the effective date. Health Plan shall provide all other notices to Provider pursuant to Section 5.12 (Notice).

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

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

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

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

5.10 **Arbitration.** Any claim or controversy arising out of or in connection with this Agreement will be resolved, to the extent possible, within forty-five (45) days through informal meetings and discussions held in good faith between appropriate representatives of the parties. Any remaining claim or controversy will be resolved through binding arbitration conducted by a single arbitrator in accordance with the American Arbitration Association ("AAA") Commercial Arbitration Rules, then in effect, in Columbus,

Ohio; provided, however, matters that primarily involve Provider's professional competence or conduct will not be eligible for arbitration. If possible, the arbitrator will be an attorney with at least fifteen (15) years of experience, including at least five (5) years experience in managed health care. The parties will conduct a mandatory settlement conference at the initiation of arbitration, to be administered by AAA. The arbitrator will have no authority to provide a remedy or award damages that would not be available to such prevailing party in a court of law, nor will the arbitrator have the authority to award punitive damages. Each party will bear its own costs and expenses, including its own attorneys' fees, and will bear an equal share of the arbitrator's and administrative fees of arbitration. The parties agree to accept any decision by the arbitrator as a final determination of the matter in dispute, and judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction. Arbitration must be initiated within one year of the earlier of the date the claim or controversy arose, was discovered, or should have been discovered with reasonable diligence; otherwise it will be deemed waived. The use of binding arbitration will not preclude a request for equitable and injunctive relief made to a court of appropriate jurisdiction.

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

Attachment A – Provider Identification Sheet

Attachment B – Definitions

Attachment C – Products/Programs

Attachment D – Compensation Schedule

Attachment E – Ohio Health Insuring Corporations, Required State Licensing Provisions

Attachment J – Medicare-Medicaid Program Requirements

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

If to Health Plan:

Molina Healthcare of Ohio, Inc.
3000 Corporate Exchange Drive
Columbus, OH 43231

Attention: President

If to Provider: _____

_____

_____

Attention: _____

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

the transmission, provided a copy is also delivered via delivery or mail. Additional manners of notice specified in this section and deemed sufficiently given may include electronic mail, or other means of electronic delivery such as Health Plan's or HPDA's website and interactive web portal.

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

5.14 **Confidentiality**. Provider recognizes that this Agreement and all material provided to Provider by Health Plan, including Member lists, is confidential and not the property of Provider. Provider shall not use such information for any purpose other than to accomplish the purposes of this Agreement. Provider shall not disclose or release this Agreement or such material to any third-party without the prior written consent of Health Plan or the applicable HPDA.

SIGNATURE AUTHORIZATION

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

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

ATTACHMENT A
Provider Identification Sheet

Continuation Page

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

PRACTICE SITE 1 **Clinic Name:** _____
Physical Address: _____
City, ST, Zip: _____
Physical Phone #: _____ Physical Fax #: _____
Billing Address same as Practice Site 1? ☐ Y ☐ N (If no, please complete billing information below
Billing Address: _____
City, ST, Zip: _____
Tax ID #: _____

PROVIDER NAME	SPECIALTY

PRACTICE SITE 2 **Clinic Name:** _____
Physical Address: _____
City, ST, Zip: _____
Physical Phone #: _____ Physical Fax #: _____
Billing Address same as Practice Site 1? ☐ Y ☐ N (If no, please complete billing information below
Billing Address: _____
City, ST, Zip: _____
Tax ID #: _____

PROVIDER NAME	SPECIALTY

(Add additional Attachment A continuation pages as needed)

ATTACHMENT B
Definitions

1. **Advance Directive** means a Member's written instructions, recognized under Law, relating to the provision of health care when the Member is not competent to make a health care decision as determined under Law. Examples of Advance Directives are living wills and durable powers of attorney for health care.
2. **Affiliate** shall mean an entity wholly owned or controlled by Health Plan.
3. **Agreement** means this Dental Provider Services Agreement, all attachments and incorporated documents or materials.
4. **Capitated Financial Alignment Demonstration (CFAD) Product** means the managed care program, which is a component of the MMP, established by the Centers for Medicare and Medicaid Services (CMS) through the capitated financial alignment demonstration in which the State of Ohio, CMS and Health Plan have entered into a three-way contract that governs the provision of health care services to Members eligible for both Medicaid and Medicare.
5. **Claim** means an invoice for Covered Services rendered to a Member by Provider, submitted in a format approved by Health Plan and with all service and encounter information required by Health Plan.
6. **Clean Claim** means a Claim that can be processed without obtaining additional information from Provider. Clean Claims do not include payments made to a Provider where the timing of the payment is not directly related to submission of a completed claim by Provider (e.g., capitation). A Clean Claim also does not include a Claim from Provider if Provider is under investigation for fraud or abuse, or a claim under review for medical necessity.
7. **CMS** means the Centers for Medicare and Medicaid Services, an administrative agency of the United States Government, responsible for administering the Medicare program.
8. **Covered Services** means those dental care services that are Medically Necessary, are within the normal scope of practice and licensure of a provider, are benefits of the Health Plan product which covers the Member, and are required to be provided by Health Plan pursuant to Health Plan's State Contract(s) and the Agreement.
9. **Emergency Medical Condition** means, in accordance with 42 CFR 438.114(a), a dental condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate dental attention to result in any of the following: (i) serious jeopardy to the health of a patient, including a pregnant woman or fetus; (ii) serious impairment to bodily functions; and/or (iii) serious dysfunction of any bodily organ or part.
10. **Emergency Services** means, in accordance with 42 CFR 438.114(a), covered inpatient and outpatient services that are as follows: (i) Furnished by a provider that is qualified to furnish these services; (ii) Needed to evaluate or stabilize an emergency medical condition.
11. **Grievance Program** means the procedures established by Health Plan to timely address Member and Provider complaints or grievances.
12. **Health Benefit Exchange** means the federal health benefit exchange established for Ohio pursuant to the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152, and referred to collectively as the Affordable Care Act; and regulations at 45 CFR Parts 153, 155, and 156.
13. **Health Plan** means Molina Healthcare of Ohio, Inc.
14. **Health Plan Dental Administrator (HPDA)** means Health Plan's designated third party administrator, that will provide and/or arrange for dental services in accordance with the terms and conditions of the Agreement and Health Plan's agreement with third party administrator. In the event Health Plan itself

administers, provides or arranges for any function related to the provision of dental services, all applicable references to HPDA shall then refer to Health Plan. Health Plan will notify Provider of such changes.

15. **HEDIS Studies** means Healthcare Effectiveness Data and Information Set.

16. **Integrated Care Delivery System (ICDS)** means a program, which is a component of the MMP, in which Members can choose not to participate in the CFAD and receive their Medicare benefits through Fee for Service (FFS) Medicare and a standalone Medicare Part D Plan; Program of All-inclusive Care for the Elderly (PACE); or a Medicare Advantage Part C plan and only receive Medicaid services through a managed care plan.

17. **Law** means all federal and state statutes and regulations applicable to the subject matter of this Agreement or the parties' performance of their duties and obligations hereunder, including but not limited, to the Health Insurance Portability and Accountability Act ("HIPAA"), the Provider Manuals, and the State Contract(s).

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

19. **Medically Necessary** means those medical services and supplies which are determined by Health Plan: (a) to be required to prevent, identify, or treat a Member's illness, injury, or disability; (b) to meet the following standards: (1) is consistent with the Member's symptoms or with prevention, diagnosis, or treatment of the Member's illness, injury, or disability; (2) is provided consistent with standards of acceptable quality of care applicable to the type of service, the type of provider, and the setting in which the service is provided; (3) is appropriate with regard to generally accepted standards of medical or dental practice; (4) is not medically contraindicated with regard to the Member's diagnoses, the Member's symptoms or other medically necessary services being provided to the Member; (5) is of proven medical value or usefulness and is not experimental in nature; (6) is not duplicative with respect to other services being provided to the Member; (7) is not solely for the convenience of the Member, the Member's family, or a provider; (8) with respect to prior authorization of a Covered Service is cost-effective compared to an alternative medically necessary service which is reasonably accessible to the Member; and (9) is the most appropriate supply or level of service that can safely and effectively be provided to the Member; and (c) to be consistent with the Provider Manual and policies.

20. **Medicare** means the Hospital Insurance Plan (Part A) and the Supplementary Medical Insurance Plan (Part B) provided under Title XVIII of the Social Security Act, as amended.

21. **Medicare Advantage** means the managed care program established by the Medicare Modernization Act of 2003 to serve Medicare eligible beneficiaries. Medicare Advantage plans generally cover Part A and Part B services and may also include Part D services.

22. **Medicare Advantage Special Needs Plan (MA-SNP)** means the managed care program established by the Medicare Modernization Act of 2003 which allows health plans to create specialized plans for beneficiaries who are eligible for Medicare and Medicaid.

23. **Medicare-Medicaid Program (MMP)** means the managed care program established by the Centers for Medicare and Medicaid Services (CMS) through the capitated financial alignment demonstration in which the state, CMS and Health Plan will enter into a three-way contract that will allow the health plan to provide care to beneficiaries eligible for both Medicaid and Medicare.

24. **Member(s)** means a person(s) enrolled in one of Health Plan's benefit products or a Health Plan affiliate's benefit product and who is eligible to receive Covered Services.

25. **Molina Health Benefit Exchange Product** means those health benefit programs offered and sold by Health Plan to individuals or employers who obtain health coverage through the Health Benefit Exchange.

26. **Participating Provider(s)** means those health professionals, hospitals, laboratories, skilled nursing and other facilities and providers which have contracted with Health Plan.

27. **Provider** means a dental service provider that has agreed to render Covered Services to Health Plan Members and to be bound by the terms and conditions of this Agreement.

28. **Provider Manual** means the compilation of Health Plan policies, procedures, standards and specimen documents, as may be unilaterally amended or modified from time to time by Health Plan, that have been compiled by Health Plan for the use and instruction of Provider, and to which Provider must adhere. Provider hereby acknowledges receipt of Health Plan's Provider Manual and acknowledges that Provider Manuals were made available to Provider for review prior to Provider's decision to enter into this Agreement. Health Plan's Provider Manuals are available in printed form and at the Health Plan's website.

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

30. **State Contract(s)** means the contract(s) between the Ohio Department of Medicaid and Health Plan that govern the provision of Medicaid-covered healthcare services to Members, as may be amended from time to time.

31. **Utilization Review and Management Program ("UM Program")** means the policies, procedures and systems developed by Health Plan and HPDA for monitoring the utilization of Covered Services by Members, including but not limited to under-utilization and over-utilization.

ATTACHMENT C

Products/Programs

The following Health Plan products are included in this Agreement and for which Provider has agreed to be a Participating Provider:

Medicaid Programs – including but not limited to:

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

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

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

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

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

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

ATTACHMENT D

Compensation Schedule

Fee for Service Payments

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

I. Medicaid (ABD, AEP, CFC):

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

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

II. Medicare-Medicaid (MMP):

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

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

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

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

ATTACHMENT E

Required Provisions

State Licensing Provisions

(Ohio Health Insuring Corporations)

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

1) Provider agrees that in no event, including but not limited to nonpayment by Health Plan, insolvency of Health Plan, or breach of this Agreement, shall Provider bill, charge or collect a deposit from, seek remuneration from or have any recourse against, a Member, person to whom health care services have been provided, or person acting on behalf of the Member, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to the persons referenced above, nor from any recourse against Health Plan or its successor.
   Prior to collecting fees for non-Covered Services delivered on a fee-for-service basis, Provider shall inform the Member that said services are not covered by Health Plan and obtain a written acknowledgment that documents the understanding and agreement of the Member.
   This provision shall survive the termination of the Agreement regarding Covered Services delivered while the Agreement was in effect, regardless of the reason for termination, including the insolvency of Health Plan.
2) Provider shall continue to provide Covered Services to Members as needed and to complete any Medically Necessary procedure begun but not finished at the time Health Plan's insolvency or discontinuance of operations.
   If this Agreement terminates while the Member is receiving inpatient care at a health care facility, then Provider shall continue to provide Covered Services which shall terminate at the earliest occurrence of any of the following: (a) upon the Member's discharge from the health care facility; (b) the attending physician determines that inpatient care is no longer medically indicated; or (c) the Member has used up his/her contractual benefit.
   In no event shall this provision require Provider to continue to provide any Covered Service after the occurrence of any of the following: (a) the end of the thirty (30) day period following the entry of a liquidation order under R.C. Chapter 3903; (b) the end of the Member's period of coverage for a contractual prepayment or premium; (c) the Member obtains equivalent coverage with another plan; (4) the Member or the Member's employer terminates coverage under its contract with Health Plan; or (5) the liquidator effects a transfer of Health Plan's contractual obligation under the Ohio Revised Code ("R.C.") 3903.21(A)(8).
3) Provider shall assure that the Covered Services provided to Members are performed in the same manner, on the same basis and in accordance with the same standards offered to all of the other respective patients of Provider and are available and accessible to all Members. It is understood that Provider shall not unlawfully differentiate or discriminate in the treatment of Members or in the quality of the health care services delivered to Members on the basis of race, color, religion, sex, sexual preference, age, disability, national origin, Veteran's status, ancestry, health status, need for health care services and without regard to the source of payments made for health care services rendered to a patient. In addition, Provider shall acknowledge his/her intent to observe, protect and promote Member rights as patients, including patient rights to privacy.

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

ATTACHMENT J
Medicare-Medicaid Program Requirements

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

1. Downstream Compliance. Provider agrees to require all of its first tier, downstream, and related entity(ies) that provide any services benefiting Health Plan's Medicare-Medicaid Program Members to agree in writing to all of the terms provided herein. (42 CFR 422.504(i)(3)(iii)).
2. Right to Audit. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information, including books, contracts and records, including medical records and documentation that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under Health Plan's contract with CMS, or as the Secretary may deem necessary to enforce Health Plan's contract with CMS. Provider agrees to make available, for the purposes specified in this paragraph, its premises, physical facilities and equipment, records relating to its Medicare-Medicaid Program Members, and any additional relevant information that CMS may require. HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through ten (10) years from the end of the final contract period between Health Plan and CMS or completion of audit, whichever is later. (42 CFR 422.504(e)(2), 42 CFR 422.504(e)(3), 42 CFR 422.504(e)(4) and 42 CFR422.504(i)(2)(ii).).
3. Confidentiality. Provider will comply with the confidentiality and Medicare-Medicaid Program Member record accuracy requirements set forth in 42 CFR 422.118. (42 CFR 422.504(a)(13).)
4. Hold Harmless/Cost Sharing. Provider agrees it may not under any circumstances, including nonpayment of moneys due to the providers by the Health Plan, insolvency of the Health Plan, or breach of this Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Medicare-Medicaid Program Member, or any persons other than the Health Plan acting on their behalf, for services provided in accordance with this Agreement. The Hold Harmless clause will survive the termination of this Agreement, regardless of the cause of termination. (42 CFR 422.504(g)(1)(i)) and (42 CFR 422.504(g)(1)(iii).) In addition, Medicare-Medicaid Program Members will not be held liable for any Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services will be provided at zero-cost share to the Medicare-Medicaid Program Member.
5. Prompt Payment. Health Plan and Provider agree that Health Plan will pay all Clean Claims for Covered Services, which are determined by Health Plan to be payable, within sixty (60) days of the date such Claim is delivered by Provider to Health Plan and Health Plan determines such Claim is complete/clean. (42 CFR 422.520(b))
6. Reporting. Provider agrees to provide relevant data to support Health Plan in complying with the requirements set forth in 42 CFR 422.516 and 42 CFR 422.310. (42 CFR 504(a)(8).)
7. Compliance with Medicare Laws and Regulations. Provider will comply with all applicable Medicare laws, regulations, and CMS instructions. (42 CFR 422.504(i)(4)(v).)
8. Benefit Continuation. Provider agrees to provide for continuation of Medicare-Medicaid Program Member health care benefits (i) for all Medicare-Medicaid Program Members, for the duration of the period for which CMS has made payments to Health Plan for Medicare services; and (ii) for Medicare-Medicaid Program

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

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