Provider Policies & Procedures Manual

(March 2025)

Table of Contents

Provider Policies

Requirement to Bill under Group Taxpayer Identification Number

The following policy was adopted on October 14, 2024, by the Executive Management team of American Choice Healthcare, LLC to be effective for each Performance Year, prospective or retrospective.

All Participant Provider Agreements and Preferred Provider Agreements (collectively the "Provider Agreements" and each a "Provider Agreement") are amended to implement this Policy. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

Each Participant Provider entity and Preferred Provider entity (each a "Group") has an obligation to bill, and to ensure that its associated Practice Providers bill for services provided to Medicare beneficiaries assigned to the ACH ACO REACH (each an "ACO Beneficiary") exclusively under the taxpayer identification number ("TIN") of the Group during the term of the Group's Provider Agreement.

If a Group's Practice Providers bill for services to an ACO Beneficiary through a TIN other than the Group's TIN during the term of the Group's Provider Agreement (a "Billing Failure") then such Billing Failure shall constitute a breach of the Group's Provider Agreement. After written notice from ACH, Group shall have ninety (90) days to correct all claims for the ACO Beneficiaries which were filed under the incorrect TIN by refiling corrected claims with CMS for the ACO Beneficiaries under the Group's TIN and provide timely documentation to ACH of the corrected claims. Additionally, in the event of a Billing Failure, the Group will forfeit any Shared Savings due to Group and shall be required to immediately repay all advances of Shared Savings. ACH may also, at its option, terminate Group's Provider Agreement and pursue any other rights and remedies it has pursuant to the Provider Agreement.

In the event of a termination of a Group's Provider Agreement for a Billing Failure, Group is required to continue to provide care to the ACO Beneficiaries under the Group's TIN in accordance with the Provider Agreement until December 31st of the year of termination, unless CMS acknowledges the termination of the Provider Agreement sooner.

Failure to Execute and Submit Fee Reduction Agreement

The following policy was adopted on October 14, 2024, by the Executive Management team of American Choice Healthcare, LLC to be effective for each Performance Year, prospective or retrospective.

All Participant Provider Agreements and Preferred Provider Agreements (collectively the "Provider Agreements" and each a "Provider Agreement") are amended to implement this Policy. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

Each year CMS publishes a specific deadline by which each Participant Provider entity and Preferred Provider entity (each a "Group") must submit an executed Fee Reduction Agreement for the subsequent Performance Year. Failure of a Group to timely submit an executed Fee Reduction Agreement to ACH will result in a violation of ACO Rules and serves as grounds for immediate termination under the Provider Agreement. Unless a Group submits an executed Fee Reduction Agreement for the subsequent Performance Year prior to September 1, or such earlier date ACH specifies by written notice, the Group will be deemed to have violated ACO Rules and will be subject to immediate termination of the Group's Provider Agreement.

Additionally, in the event of a failure of a Group to timely submit an executed Fee Reduction Agreement before September 1, or such earlier date ACH specifies by written notice, the Group will forfeit any Shared Savings due to Group and shall be required to immediately repay to ACH all compensation advances the Group received from ACH.

In the event of a termination of a Group's Provider Agreement for failure to submit an executed Fee Reduction Agreement before September 1, or such earlier date ACH specifies by written notice, the Group is required to continue to provide care to the ACO Beneficiaries under the Group's TIN in accordance with the Provider Agreement until December 31st of the year of termination, unless CMS acknowledges the termination of the Provider Agreement sooner.

Forfeiture and Repayment of Shared Savings

The following policy was adopted on October 14, 2024, by the Executive Management team of American Choice Healthcare, LLC to be effective for each Performance Year, prospective or retrospective.

All Participant Provider Agreements and Preferred Provider Agreements (collectively the "Provider Agreements" and each a "Provider Agreement") are amended to implement this Policy. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

Each Participant Provider entity and Preferred Provider entity (each a "Group") will forfeit any Shared Savings payable to it and must repay any advances of compensation, labeled as Shared Savings or otherwise, paid to it if any of the following occur:

- CMS terminates the CMS Participation Agreement with ACH.
- CMS requires ACH to remove a Group or Practice Provider from ACH's Participant Provider List or Preferred Provider List.
- Group fails to execute a Fee Reduction Agreement for the subsequent Performance Year by September 1, or such earlier date ACH specifies by written notice.
- ACH terminates Group for breach of its Provider Agreement.
- ACH terminates Group for filing for bankruptcy, receivership, insolvency, reorganization, dissolution, liquidation or other similar proceedings under either state or federal laws.
- Group is no longer providing physician services to ACO Beneficiaries under the Group's TIN prior to the expiration of the Provider Agreement.
- Group is not in compliance with terms of the Provider Agreement or the CMS Participation Agreement.
- Group or Practice Provider requests an early termination of the Provider Agreement, and ACH accepts such request.
- ACH terminates Group pursuant to any termination provision in the Provider Agreement other than (i) a termination by ACH without cause, (ii) a termination by Group for an uncured breach, or (iii) a reason specified below (in the next paragraph) where Group does not forfeit shared savings.

A Group will not forfeit any Shared Savings payable to it based on any of the following:

- ACH requests to terminate the Provider Agreement without cause.
- ACH de-credentials Group.
- A Practice Provider retires.
- A Practice Provider dies or is permanently disabled.
- The Provider Agreement is terminated by the mutual agreement of Group and ACH.
- If applicable, Group terminates the Provider Agreement without cause pursuant to the terms of such Provider Agreement.

Repayment and Recoupment of Advanced Payments

The following policy was adopted on October 14, 2024, by the Executive Management team of American Choice Healthcare, LLC to be effective for each Performance Year, prospective or retrospective.

All Participant Provider Agreements and Preferred Provider Agreements (collectively the "Provider Agreements" and each a "Provider Agreement") are amended to implement this Policy. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

In the event a Participant Provider entity or Preferred Provider entity (each a "Group") receives any type of compensation advance for a Performance Year, labeled as Shared Savings, an Advance, or otherwise, which exceeds the Group's applicable portion of Shared Savings in the same Performance Year ("Excess Shared Savings") then Group shall be required to repay such advance to ACH upon demand. In addition, ACH, in its sole discretion, may withhold the amount of any Excess Shared Savings due to ACH from any amounts to due to Group in the same or subsequent Performance Year, including, but not limited to: CAP Advanced Shared Savings, CAP Bonus, CAP Payment, FFS Advanced Shared Savings, FFS bonus, FFS Reimbursement, and any commercial ACO program funds.

Effective Date of Termination of Provider Agreement

The following policy was adopted on October 14, 2024, by the Executive Management team of American Choice Healthcare, LLC to be effective for each Performance Year, prospective or retrospective.

All Participant Provider Agreements and Preferred Provider Agreements (collectively the "Provider Agreements" and each a "Provider Agreement") are amended to implement this Policy. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

In the event of a termination of a Participant Provider entity's or Preferred Provider entity's (each a "Group") Provider Agreement, for any reason then the Group is required to continue to provide care to the ACO Beneficiaries under the Group's TIN until December 31st of the year of termination, unless CMS acknowledges the termination of the Provider Agreement sooner.

Payment Suspension Policy

The following operational policy was adopted on March 14, 2023, by the Executive Management team of American Choice Healthcare, LLC.

Participating Provider Payments will be suspended for the following issues:

- Projected shared savings (% of benchmark) are 3% or below, based on Third-party actuarial firm's quarterly base projection report, all advances will be suspended. Third-party actuarial firm's quarterly report will be adjusted to 0% for coding and/or care management impacts.
- Provider termination
- Provider non-compliance issue

For active practices, Fee Reduction Reimbursements will not be affected and will continue to receive cash compensation based on their contract.

Once a practice is suspended for all advances, the practice will receive the letter in Exhibit A, issued by Finance. The practice will remain on suspension for the remaining portion of the performance period and re-evaluated for the future performance period.

Executive Management will meet quarterly to review future third-party actuarial firm's projection reports and suspend additional practices on a quarterly basis.

For terminated practices, all payments will be suspended including Fee Reduction Reimbursements, PQEM Advance, Annual Wellness Visit Advance and 8+ Visit Advance. At final reconciliation, any funds owed to the terminated practice will be distributed. Terminated practices will receive a letter.

For non-compliant practices, all payments will be suspended including Fee Reduction Reimbursements, PQEM Advance, Annual Wellness Visit Advance and 8+ Visit Advance.

Executive Management will have the ability to make exceptions to this policy on a case-by-case basis, which will be documented via email and uploaded to the contract management system.

Finance will maintain the roster of all practices that are currently in a suspension status via the contract management system.

Exhibit A

@@Signature-2-Date@@

[insert Legal Business Name]
[insert Address], [insert Suite]
[insert City], [insert ST] [insert Zip Code]

ACCOUNT UPDATE – SHARED SAVINGS PROJECTIONS

Dear Provider,

After having reviewed the most recently available, third-party, performance trending data for your practice, American Choice Healthcare ("ACH") projects that [insert Legal Business Name] may not generate Shared Savings. Accordingly, ACH will pause all advanced shared savings payments at this time. Please see your Agreement for more detail, Exhibit B, Section 3, Section 5 and Schedule 1.

Please note, this payment change only affects **advances** on shared savings. If any shared savings is earned it will still be paid during final reconciliation of the plan year, minus any advances. ACH will continue to pay the PCC Fee Reductions on your claims as normal.

ACH remains confident in your ability to generate shared savings and believes in your ability to change this trend. In order to resume advanced shared savings payments, your practice must show two consecutive quarters of positive financial performance.

We highly encourage you to work closely with your Provider Success Specialist to identify areas of opportunity to expeditiously emerge from the pause. Our team is always here to support you every step of the way.

Sincerely,

Capitation Payment Suspension Policy

The following operational policy was adopted on July 2023, by the Executive Management team of American Choice Healthcare, LLC.

Capitated Provider Payments will be suspended for the following issues:

- Projected Enhanced Primary Care Capitation, based on third-party actuarial firm's quarterly base projection report, becomes greater than the estimated shared savings projection will be suspended.
- Provider termination.

For active practices, Capitation payments will not be affected and will continue to receive cash compensation based on their contract.

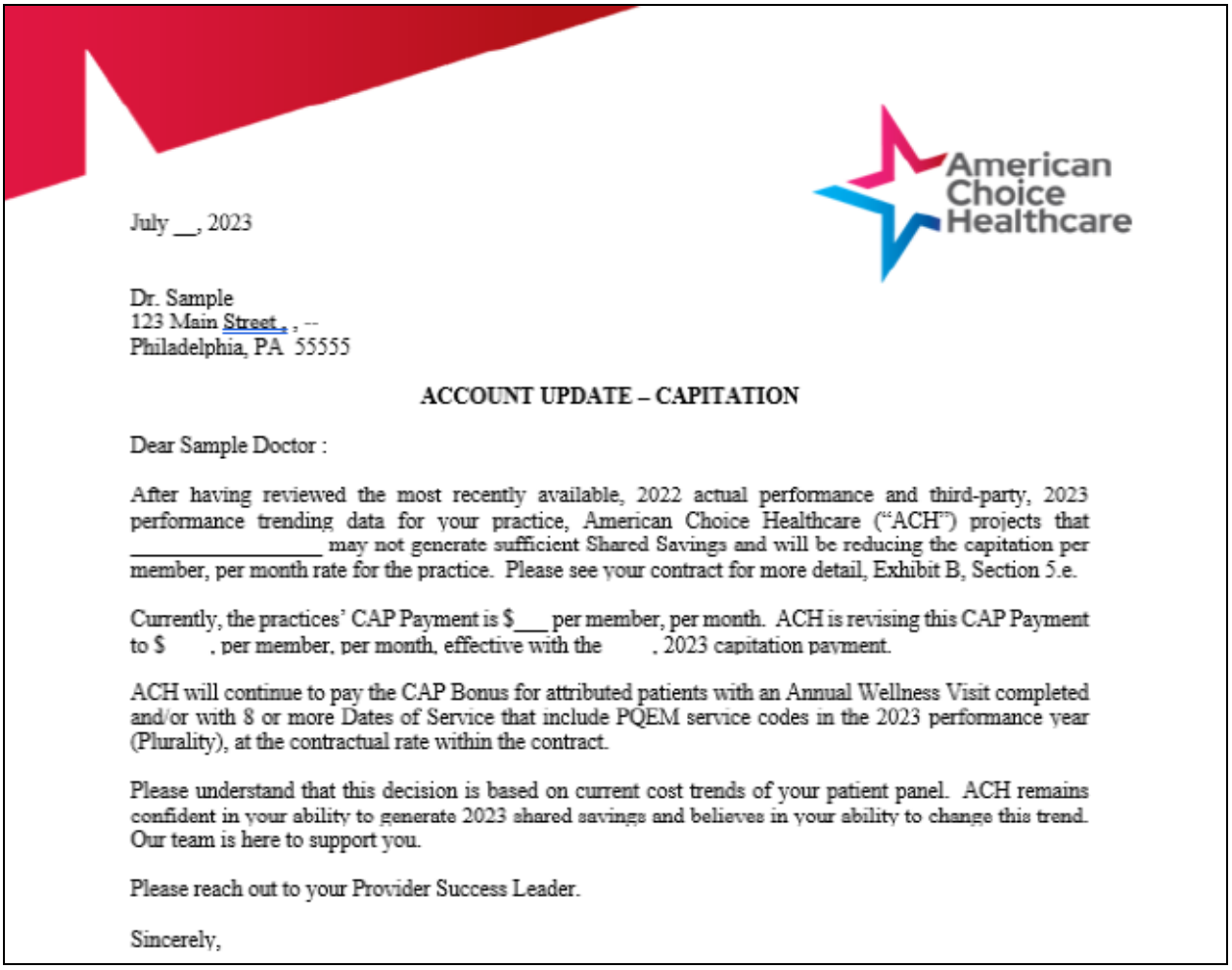
Once a practice is suspended for Capitation payments, the practice will receive the letter in Exhibit A, issued by Finance. The practice will remain on suspension for the remaining portion of the performance period and re-evaluated for the future performance period.

Executive Management will meet quarterly to review future third-party actuarial firm's projection reports and suspend additional practices on a quarterly basis.

For terminated practices, all capitation payments will be immediately suspended. At final reconciliation, any funds owed to the terminated practice will be distributed. Terminated practices will receive a letter similar to Exhibit A.

Executive Management will have the ability to adjust the capitation payments. Adjustments include reductions or a suspension of their monthly capitation payments. Based upon review of both Base Primary Care Capitation vs Enhanced Primary Care Capitation, the executive team will review both items in comparison to the CMS data received.

Exhibit A



July __, 2023

Dr. Sample
123 Main Street , , --
Philadelphia, PA 55555

ACCOUNT UPDATE – CAPITATION

Dear Sample Doctor :

After having reviewed the most recently available, 2022 actual performance and third-party, 2023 performance trending data for your practice, American Choice Healthcare ("ACH") projects that _____ may not generate sufficient Shared Savings and will be reducing the capitation per member, per month rate for the practice. Please see your contract for more detail, Exhibit B, Section 5.e.

Currently, the practices' CAP Payment is $___ per member, per month. ACH is revising this CAP Payment to $, per member, per month, effective with the , 2023 capitation payment.

ACH will continue to pay the CAP Bonus for attributed patients with an Annual Wellness Visit completed and/or with 8 or more Dates of Service that include PQEM service codes in the 2023 performance year (Plurality), at the contractual rate within the contract.

Please understand that this decision is based on current cost trends of your patient panel. ACH remains confident in your ability to generate 2023 shared savings and believes in your ability to change this trend. Our team is here to support you.

Please reach out to your Provider Success Leader.

Sincerely,

Payment Suspension Lifted Policy

The following operational policy was adopted on November 11, 2023, by the Executive Management team of American Choice Healthcare, LLC.

Participating Provider Payments Suspensions will be lifted for the following reason:

- Projected shared savings (% of benchmark) are above 3% for one quarter, based on Third-party actuarial firm's quarterly base projection report, only Annual Wellness Visits and 8+ Visits Advance suspensions will be lifted. Third-party actuarial firm's quarterly report will be adjusted to 0% for coding and/or care management impacts.

- Projected shared savings (% of benchmark) are above 3% for two consecutive quarters, based on Third-party actuarial firm's quarterly base projection report, PQEM Advance suspension will be lifted (all advance payments are now reinstated). Third-party actuarial firm's quarterly report will be adjusted to 0% for coding and/or care management impacts.

For active practices, Fee Reduction Reimbursements will not be affected and will continue to receive cash compensation based on their contract.

After one quarter of positive shared savings, the practice will receive the letter in Exhibit A, issued by Finance. The practice will no longer be suspended for the remaining portion of the performance period and re-evaluated for the future performance period.

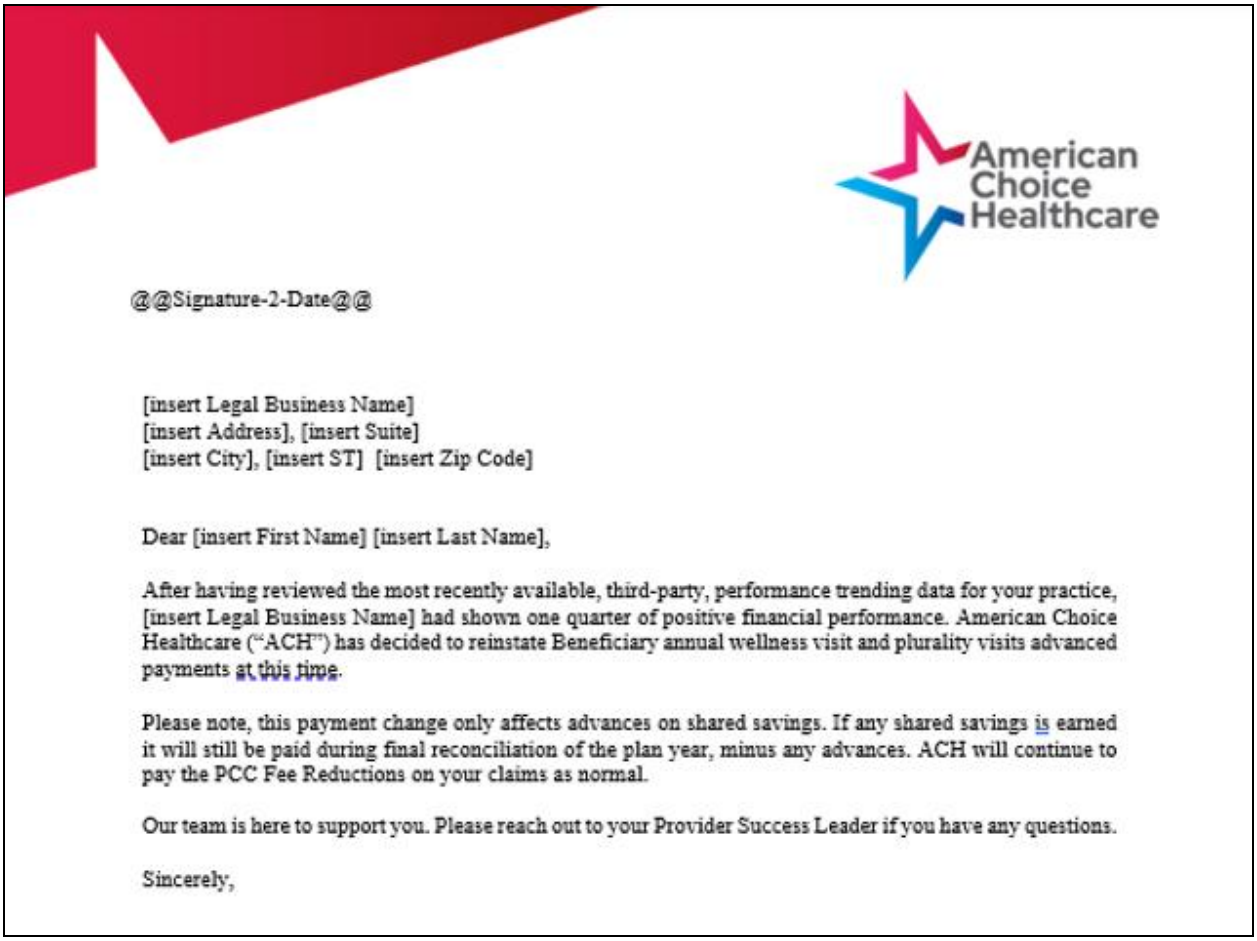
After a second consecutive quarter of positive shared savings, the practice will receive a letter, issued by Finance. The practice will no longer be suspended for the remaining portion of the performance period and re-evaluated for the future performance period.

Executive Management will meet quarterly to review future third-party actuarial firm's projection reports and reinstate additional practices on a quarterly basis.

Executive Management will have the ability to make exceptions to this policy on a case-by-case basis, which will be documented via email uploaded to the contact management system.

Finance will maintain the roster of all practices that have been lifted from a suspension status via the contract management system.

Exhibit A



@@Signature-2-Date@@

[insert Legal Business Name]
[insert Address], [insert Suite]
[insert City], [insert ST] [insert Zip Code]

Dear [insert First Name] [insert Last Name],

After having reviewed the most recently available, third-party, performance trending data for your practice, [insert Legal Business Name] had shown one quarter of positive financial performance. American Choice Healthcare ("ACH") has decided to reinstate Beneficiary annual wellness visit and plurality visits advanced payments at this time.

Please note, this payment change only affects advances on shared savings. If any shared savings is earned it will still be paid during final reconciliation of the plan year, minus any advances. ACH will continue to pay the PCC Fee Reductions on your claims as normal.

Our team is here to support you. Please reach out to your Provider Success Leader if you have any questions.

Sincerely,

Termination of Payments Policy

The following operational policy was adopted on 07/1/ 2023, by the Executive Management team of American Choice Healthcare, LLC.

Provider Payments will be terminated for the following issues:

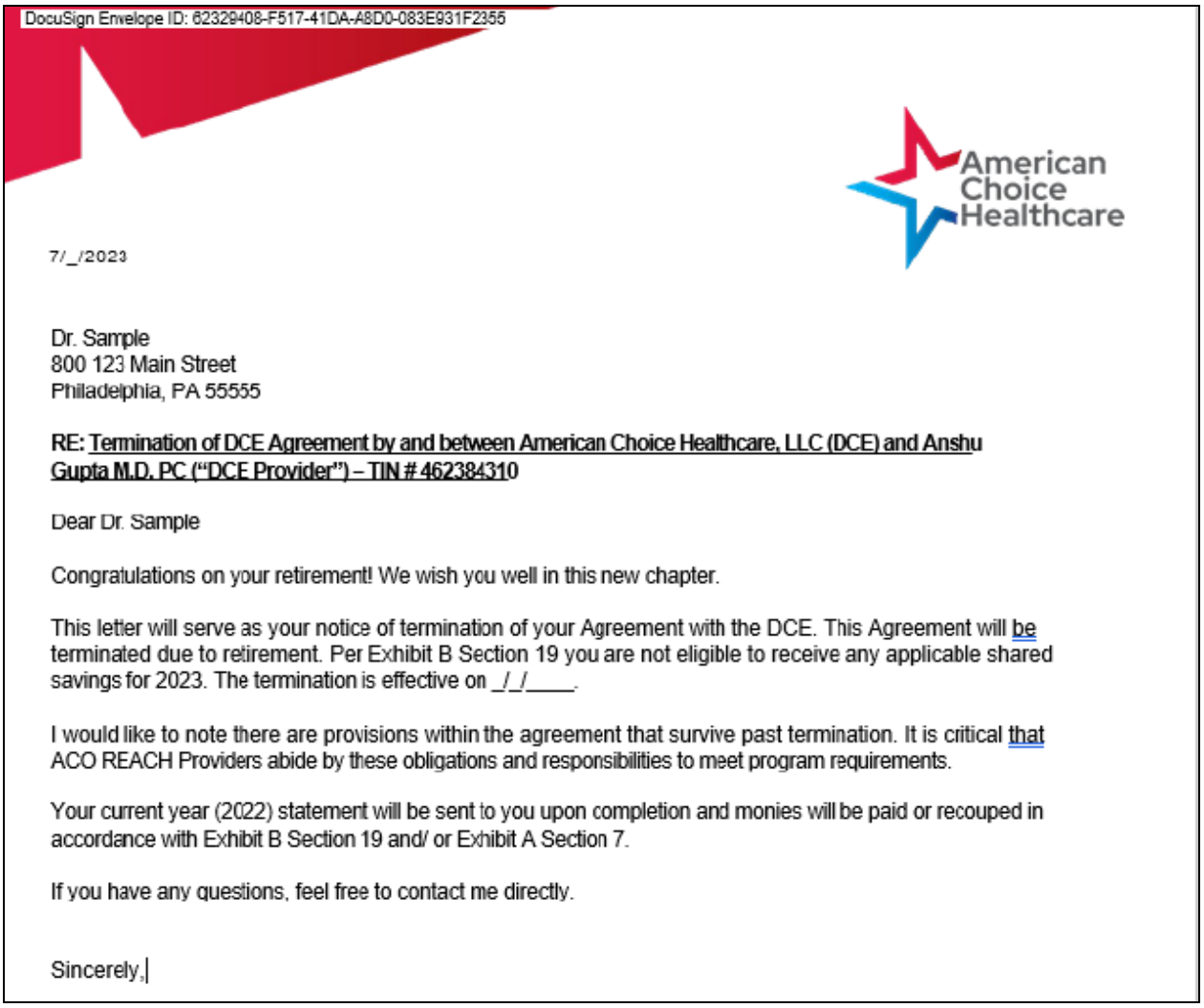
Termination Types	Notification Time Period	Exhibit
Termination of Agreement Performance	60 Days	Exhibit B
Provider Retirement	5 Days	Exhibit A
Provider Death	5 Days	
Termination of Agreement by CMS	Immediately in some cases with notice (TBD)	Exhibit B
Change In Control	90 Days	

For terminated practices, all payments will be immediately suspended including Capitation, Fee Reduction Reimbursements, PQEM Advance, Annual Wellness Visit Advance and 8+ Visit Advance. At final reconciliation, any funds owed to the terminated practice will be distributed. Terminated practices will receive a letter like Exhibit A.

Executive Management can make exceptions to this policy case-by-case, which will be documented via email and uploaded to the contract management system.

Contracting will maintain the roster of all practices currently in a terminated status.

Exhibit A



DocuSign Envelope ID: 62329408-F517-41DA-A8D0-083E931F2355

7/_/2023

Dr. Sample
800 123 Main Street
Philadelphia, PA 55555

RE: Termination of DCE Agreement by and between American Choice Healthcare, LLC (DCE) and Anshu Gupta M.D. PC ("DCE Provider") – TIN # 462384310

Dear Dr. Sample

Congratulations on your retirement! We wish you well in this new chapter.

This letter will serve as your notice of termination of your Agreement with the DCE. This Agreement will be terminated due to retirement. Per Exhibit B Section 19 you are not eligible to receive any applicable shared savings for 2023. The termination is effective on _/_/____.

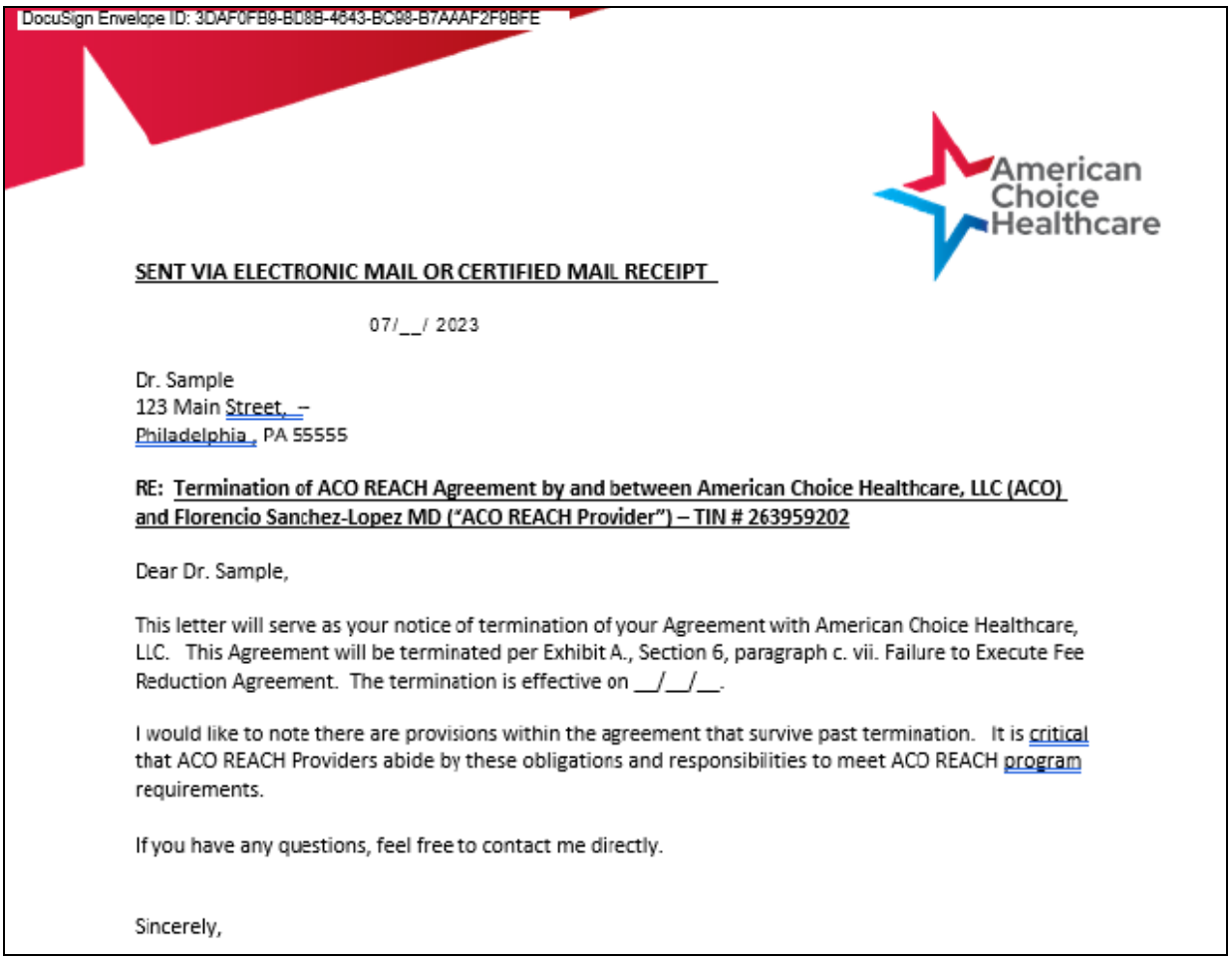
I would like to note there are provisions within the agreement that survive past termination. It is critical that ACO REACH Providers abide by these obligations and responsibilities to meet program requirements.

Your current year (2022) statement will be sent to you upon completion and monies will be paid or recouped in accordance with Exhibit B Section 19 and/ or Exhibit A Section 7.

If you have any questions, feel free to contact me directly.

Sincerely,

Exhibit B



DocuSign Envelope ID: 3DAF0FB9-BD8B-4643-BC98-B7AAAF2F9BFE

SENT VIA ELECTRONIC MAIL OR CERTIFIED MAIL RECEIPT

07/__/ 2023

Dr. Sample
123 Main Street, –
Philadelphia , PA 55555

RE: Termination of ACO REACH Agreement by and between American Choice Healthcare, LLC (ACO) and Florencio Sanchez-Lopez MD ("ACO REACH Provider") – TIN # 263959202

Dear Dr. Sample,

This letter will serve as your notice of termination of your Agreement with American Choice Healthcare, LLC. This Agreement will be terminated per Exhibit A., Section 6, paragraph c. vii. Failure to Execute Fee Reduction Agreement. The termination is effective on __/__/__.

I would like to note there are provisions within the agreement that survive past termination. It is critical that ACO REACH Providers abide by these obligations and responsibilities to meet ACO REACH program requirements.

If you have any questions, feel free to contact me directly.

Sincerely,

Bad Debt Policy

The following operational policy was adopted on 3/1/2024, by the Executive Management team of American Choice Healthcare, LLC.

Participating Providers will be applicable to bad credit debt when:

- Poor performance results in negative shared savings, and the provider has received advances.
- Overpayment of advances over shared savings earned.

At the end of the performance year, the Finance Department will run a reconciliation per provider to review their respective benchmark, costs and expenses incurred. After the reconciliation is completed, the Finance Department and Executive Management team (or its authorized designee) will review together the total estimated shared savings generated and advances (Annual Wellness Visit Advance, and 8+ Visit Advance and PQEM) paid to the provider and approve any remaining amount to recoup from participating providers.

Once the Executive Management team approves Account Receivable balances, they will be provided to the contracting and accounting teams to enter in their respective ERP systems while finance will generate three escalation letters that will also need to be approved by the management and legal teams (please see Exhibits A, B and C). After the letters are approved, they will be sent out to the participating provider with the assistance of the customer service team. Copies of the letters will be maintained in American Choice Healthcare, LLC's company files.

The contracting team will ensure that balances are updated in Contract Logix, so that the Finance Department can oversee payments made towards the balance owed, and the accounting team will make sure that depending on the settlement option, credits are successfully applied, and the balance is appropriately reduced.

AR balances will also be provided to the Performance Improvement management team since they are the direct point of contact for participating providers to answer questions.

The Finance Department will review accounting payment reports on a weekly basis to update Contract Logix and generate reports for the Executive Management team as needed.

Collections Agency

Atradius Collections

Fee Schedule

USA

	Commission on collected amounts			
	≤ $1,500	1,500- 10,000	10,000-100,000	> 100,000
Americas I	22.5%	18%	14%	10%
Americas II	25%	25%	20%	18%
Europe I	20%	18%	15%	12%
Europe II	22.5%	18%	15%	12%
APAC I	25%	25%	20%	18%
APAC II	25%	25%	20%	18%
Rest of the World	30%	30%	25%	20%

** 2% additional on rates for invoices over 365 days old / 1 year

Countries: an overview of all countries can be found on the next page.

Success Fees: calculated as percentage of the collected amounts, charges apply on the total collected amount
Return of Merchandise: 50% above case fee (based on the value of merchandise returned)
Case Withdrawn Pending Collection: 10% unpaid case balance
Discovery of Payment: 10% of payment

Besides amicable collections we offer all these additional services:

Bankruptcy Filing Fee: $350 USD will be charged for lodging a claim
$125 USD annual fee will be charged for the monitoring activities of the claim

Legal Forwarding Fee: **Domestic Cases:** 25% of collected amount (USA Rates)
Export Cases: Costs of third party are transferred to the customer including Attorney Fees, Court Cost, Suit Cost, and other legal fees.
Administrative fee for preparation of the file for legal action: $400 USD

Debt Collectors International

Our blanket rates when we recover your money are as follows. 30% if the debt is within a year in age, 40% if the debt is over a year in age, and 50% if the debt is below $1,000.00 or if we have to proceed with litigation. Bear in mind, that if litigation or enforcement is necessary, we will petition the court for the maximum recovery allowed by law. When the initial complaint is filed, we will request attorney's fees, collection costs, pre-judgment and post-judgment interest, and cost reimbursement from the court. Therefore, the debtor is liable for all costs, and you have the opportunity to potentially retain 100% of the money owed to you

Exhibit A

Exhibit A
Active Providers Bad Debt Letter

12/19/2023

«Practice_Name_»
«Final_Address_»
«City_», «State», «Zipcode»
«Email_»

ACCOUNT UPDATE

Dear «Final_Authorized_Signer»,

This communication pertains to the Agreement between American Choice Healthcare, LLC ("ACH") and «Practice_Name_». We extend our sincere gratitude for your valuable participation in the 2022 DCE Program. ACH would like to take the opportunity to let you know that your FFS Advanced Shared Savings or CAP Advanced Shared Savings throughout the year exceeded the amount of Provider Shared Savings earned by your practice, generating an outstanding balance owed to ACH as per Schedule 1.1.e. or Schedule 1.2.e. Details can be found in the attached 2022 Lookback Practice Performance Report.

The practice now has an amount due of «AR_Amount». Please send a check payable to:

American Choice Healthcare, LLC
Attn: Customer Service
9725 NW 117th Ave , Suite 300
Miami, FL 33178

We kindly request your payment within 30 days; if we do not receive your payment within this window, ACH will start deducting the balance due from any future payments including, but not limited to: CAP Advanced Shared Savings, CAP Bonus, CAP Payment, FFS Advanced Shared Savings, FFS Bonus and FFS Reimbursement.

Your prompt attention to this matter is greatly appreciated. Should you have any questions, please do not hesitate to contact our Customer Service team by emailing us at ACHCustomerService@americanchoicehealthcare.com or calling (786) 206-1385.

Sincerely,

Michael Labinski

Vice President of Finance

Exhibit B

12/19/2023

«Practice_Name_»
«Final_Address_»
«City_», «State», «Zipcode»
«Email_»

ACCOUNT UPDATE

Dear «Final_Authorized_Signer»,

This communication pertains to the Agreement between American Choice Healthcare and (Practice Name). We extend our sincere gratitude for your valuable participation in the 2022 DCE Program. We would like to take the opportunity to let you know that your FFS Advanced Shared Savings or CAP Advanced Shared Savings throughout the year exceeded the amount of Provider Shared Savings earned by your practice generating an outstanding balance owed to American Choice Healthcare as per Schedule 1.1.e. or Schedule 1.2.e. Details can be found in the attached 2022 Lookback Practice Performance Report.

The practice now has an amount due of «AR_Amount». Please settle the outstanding amount by writing a check for the specified amount above. The check is made payable to:

American Choice Healthcare, LLC
Attn: Customer Service
9725 NW 117th Ave , Suite 300
Miami, FL 33178

We kindly request your response within 20 days to our customer service department. Your prompt attention to this matter is greatly appreciated, and we look forward to hearing from you.

Should you have any questions, please do not hesitate to contact our Customer Service team by emailing us at ACHCustomerService@americanchoicehealthcare.com or calling (786) 206-1385.

Sincerely,

Michael Labinski
Vice President of Finance

Exhibit C

Practice Name
Practice Address
City, State, Zip Code
Email

ACCOUNT UPDATE

Dear _____,

This communication pertains to the Agreement between American Choice Healthcare ("ACH") and (Practice Name). This is a reminder that we previously communicated that you have a balance owed of $_____. Please settle the outstanding amount by writing a check for the specified amount above. The check is made payable to:

American Choice Healthcare, LLC
Attn: Customer Service
9725 NW 117th Ave , Suite 300
Miami, FL 33178

If we do not hear from you or receive payment within the next 10 days, ACH will have no choice but to escalate the matter to our collections department.

We value your business and hope to resolve this matter promptly.

Should you have any questions, please do not hesitate to contact our Customer Service team by emailing us at ACHCustomerService@americanchoicehealthcare.com or calling (786) 206-1385.

Sincerely,

Michael Labinski
Vice President of Finance

Provider Success Team Specialist
@americanchoicehealthcare.com

Exhibit D

City, State, Zip Code
Practice email

ACCOUNT UPDATE

Dear _____,

This communication pertains to the Agreement between American Choice Healthcare ("ACH") and (Practice Name). We have not heard from you regarding your amount owed of $_____. This is a final reminder that your account has an outstanding balance due. Please settle the outstanding amount by writing a check for the specified amount above. The check is made payable to:

American Choice Healthcare, LLC
Attn: Customer Service
9725 NW 117th Ave , Suite 300
Miami, FL 33178

If we do not hear from you or receive payment within the next 10 days, ACH will have no choice but to hand over the matter to our collections agency. This may result in additional fees and potential legal action which could affect your credit score.

We value your business and hope to resolve this matter promptly.

Should you have any questions, please do not hesitate to contact our Customer Service team by emailing us at ACHCustomerService@americanchoicehealthcare.com or calling (786) 206-1385.

Sincerely,

Michael Labinski
Vice President of Finance

Provider Success Team Specialist
@americanchoicehealthcare.com

Update to Preferred Provider Agreements

The following policy was adopted on April 1, 2021, by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective for each Performance Year, prospective or retrospective.

All Preferred Provider Agreements (collectively the "Agreements" and each an "Agreement") are amended to conform to regulatory or legal requirements as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Other ACO Participation and Compliance Plan**" provision in Exhibit B of the Agreement is amended, to the extent not already included, to add the following subsection.

   Neither Provider nor any Practice Provider may participate in the Maryland Total Cost of Care Model.

Changes to Business Associate Agreement

The following policy was adopted on January 1, 2024, by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective for each Performance Year, prospective or retrospective.

All Business Associate Agreements (collectively the "BA Agreements" and each a "BA Agreement"), as incorporated into the Participant Provider Agreements and Preferred Provider Agreements, are amended as provided in this Policy to the extent not otherwise so provided. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the BA Agreement.

1. The last two sentences of the **Definitions** section of the BA Agreement are deleted in their entirety and replaced with the following.

   The terms used in this BA Agreement that are not otherwise defined shall have the meaning assigned to those terms in HIPAA and its corresponding guidance(s).

2. The first subsection under the **Permitted Uses and Disclosures by Business Associate** section of the BA Agreement is deleted in its entirety and replaced with the following.

   a. Business Associate may use or disclose PHI as Required by Law. Business Associate may also use and disclose and may create, receive, maintain, and transmit PHI in any manner that the underlying Covered Entity would be allowed to, and as necessary to perform its obligations under the underlying PA and as allowed by this BA Agreement. Business Associate may use and disclose PHI for any purpose associated with the treatment of patients, payment (including investigations of potential fraud or errors in claims data) or health care operations of Provider or related to enhancing the accountable care organization, its technology or participation or the provider network.

3. The **Term** subsection under the **Term and Termination** section of the BA Agreement is deleted in its entirety and replaced with the following.

   a. **Term**. The term of this BA Agreement shall be effective as of the Effective Date and shall terminate on the date Covered Entity terminates the PA, provided that the Parties thereafter may continue to use and disclose PHI for all purposes permitted herein until the completion of any close-out or post-termination obligations under the PA, as described in Exhibit A to the PA (including, but not limited to, the completion of any reconciliation or correction of any CMS reported expenditures used in calculating Shared Savings, as such term is defined in the PA), or as noted in (b) below.

4. The **Amendment** subsection under the **Miscellaneous** section of the BA Agreement is deleted in its entirety and replaced with the following.

   b. **Amendment**. The Parties agree to take such action as is necessary to amend this BA Agreement from time to time as is necessary for compliance with the requirements of HIPAA and any other applicable law. If HIPAA is amended, this BA Agreement shall be modified automatically so that its requirements align with the amended terms of HIPAA, except to the extent that the HIPAA amendment requires any modification to this BA Agreement to be approved by the parties in writing.

5. The **Effect of BA Agreement** subsection under the **Miscellaneous** section of the BA Agreement is deleted in its entirety and replaced with the following.

   d. **Effect of BA Agreement**. This BA Agreement is a part of and subject to the terms of the PA, inclusive of the ability to amend this BA Agreement through amendment of the Policies and Procedures (as such phrase is defined in the PA), except that to the extent any terms of this BA Agreement regarding the access, use, and/or disclosure of PHI conflict with any term of the PA, the terms of this BA Agreement shall govern. In the event of inconsistency between the provisions of this BA Agreement and mandatory provisions of HIPAA, as amended, or their interpretation by any court with authority over either Party, HIPAA, as interpreted by such court, shall control. Where the provisions of this BA Agreement are different than those mandated by HIPAA but are nonetheless permitted by such rules as interpreted by courts, the provisions of this BA Agreement shall control.

   Except as expressly stated herein or as provided by law, this BA Agreement shall not create any rights in favor of any third party.

6. To the extent any numbering or alphabetization is mislabeled, such numbering or alphabetization is hereby corrected.

Miscellaneous Provisions for 2023 Agreements

The following policy was adopted on January 1, 2024, by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective for each Performance Year, prospective or retrospective.

All Written Notices of Amendment and Restatement of 2023 Participant Provider Agreement (collectively the "Agreements" and each an "Agreement") are amended as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the Amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. To the extent a Provider has customized provisions in its Agreement, such provisions will not be affected by any amendments to the Policies and Procedures. Such provisions may only be amended by mutual agreement of the Provider and ACH. However, all other provisions in the Agreement shall be subject to any amendments to the Policies and Procedures as provided in the Agreement.

2. The term "FSS Advanced Shared Savings" shall also include the "Promotional Cash Bonus," if applicable.

3. The term "CAP Advanced Shared Savings" shall also include the "Promotional Cash Bonus," if applicable.

Regulatory and Legal Updates to 2023 Preferred Provider Agreements

The following policy was adopted by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective January 1, 2025, and applicable for each Performance Year, prospective or retrospective.

All Written Notices of Amendment and Restatement of 2023 Preferred Provider Agreement (collectively the "Agreements" and each an "Agreement") are amended to conform to regulatory or legal requirements as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Claims Reimbursement**" section on the second page of the Agreement is amended to delete reference to "Professional Risk Sharing Option" and replace it with reference to the "Global Risk Sharing Option" to comply with ACO REACH Requirements.

2. The "**Provider Certification**" section on the second page of the Agreement is deleted and replaced in its entirety as follows to comply with ACO REACH requirements, including requirements for contracting with Practice Providers.

> **Provider Certification**. Provider certifies that Provider's and its Practice Providers' participation in this Agreement is voluntary and not contingent on or related to receipt of referrals from ACH or its Network Providers. Additionally, Provider certifies that, prior to the Effective Date, each Practice Provider providing services pursuant to this Agreement shall execute a Practice Provider Support Agreement attached as Appendix 1 (the "Practice Provider Support Agreement"). All Practice Providers for a Performance Year will be listed on the Fee Reduction Agreement for such Performance Year. In the event Provider adds a new Practice Provider during a Performance Year, such Practice Provider will be automatically added to the Preferred Provider List at ACH's sole discretion in accordance with the terms of this Agreement and the ACO Rules but shall not participate in the program payment methodology until permitted by the applicable CMS standards.

3. The last two sentences of the "**Compliance with CMS Monitoring, Oversight and Evaluation Activities**" subsection under the "**Provider and Practice Provider Obligations**" section in Exhibit A of the Agreement are amended as follows to comply with ACO REACH requirements, including compliance with CMS monitoring and oversight activities:

> Provider will, and will require the Practice Providers and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to, cooperate with all CMS monitoring and oversight requests and activities, including any audits, demographic data, interviews, site visits, documentation and any other information CMS may request or monitoring technique CMS may conduct. Upon request, Provider shall, and shall require its Practice Providers to-certify that all data and information that is generated or submitted by Provider or other individuals or entities performing functions or services related to ACO Activities, including any quality data or other information or data relied upon by CMS in determining ACH's eligibility, are accurate, complete, and truthful.

4. The "**Practice Provider Availability**" subsection under the "**Provider and Practice Provider Obligations**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to comply with Law:

> **Practice Provider Availability**. Provider shall ensure that Covered Services, when necessary, are available twenty-four (24) hours a day, seven (7) days a week, including coverage after hours or when a Practice Provider is otherwise absent, as required by applicable regulations and law and consistent with the availability of services provided to those patients who are not REACH Beneficiaries.

5. The term "business days" in the "**Disciplinary Action**" subsection under the "**Provider and Practice Provider Obligations**" section of Exhibit A of the Agreement is replaced with "calendar days."

6. The "**No Exclusion**" subsection under the "**Provider Representations, Warranties and Covenants; Notifications**" section in Exhibit A of the Agreement is amended to include "or their employees" to conform to Law and correct grammatical oversights and shall be restated as follows:

> **No Exclusion**. Neither Provider, Practice Provider, nor any of their respective Affiliates or their employees are excluded under the HHS Office of Inspector General's List of Excluded Individuals/Entities, the U.S. General Services Administration's Excluded Parties List System, or otherwise excluded from participation in Medicare or other federal health care programs, or are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

7. The "**Authorization**" subsection under the "**Provider Representations, Warranties and Covenants; Notifications**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to conform to ACO REACH requirements, including contracting requirements for Practice Providers:

> **Authorization**. Provider is authorized to act on behalf of its Practice Providers and shall provide, upon request, evidence of such authority. Provider also agrees that the executor of this Agreement is the authorized signer listed in CMS' PECOS system;

8. The "**Excluded Individuals**" subsection under the "**ACH Representations and Warranties**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to conform to Law:

> **Excluded Individuals**. Neither ACH nor any of its Affiliates or their employees are an Excluded Individual; and

9. The "**ACH Board**" subsection under the "**ACH Representations and Warranties**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to conform to Law:

> ACH is a health care provider-led organization. ACH's Board is duly authorized to execute the clinical oversight functions of ACH pursuant to the ACO REACH Agreement. As of January 1, 2023, ACH's Board will have at least one Beneficiary member and a consumer advocate member who is a different person than the Beneficiary member. Additionally, as of January 1, 2023, 75% of ACH's Board shall be comprised of Participant Providers or their respective designated representatives. Any

designated representative of a Participant Provider must be an individual employed by or under contract with the Participant Provider.

10. The following sentence is hereby added as the last sentence of the "**Close-Out Obligations/Post-Termination Obligations**" subsection under the "**Termination**" section in Exhibit A of the Agreement to conform to ACO REACH requirements, including prohibitions against engaging in certain activities after termination of the Agreement.

After the effective date of termination of this Agreement, Provider and Practice Providers shall not engage in any ACO Activities, Marketing Activities, Voluntary Alignment Activities, Benefit Enhancements, or Beneficiary Engagement Incentives with REACH Beneficiaries.

11. The "**Other ACO Participation**" section in Exhibit B of the Agreement is renamed as "**Other ACO Participation and Compliance Plan**" and is deleted and replaced in its entirety as follows to comply with ACO REACH requirements, including prohibitions on other ACO participation and implementation of a compliance plan:

Other ACO Participation and Compliance Plan.

a. If Provider or a Practice Provider was previously terminated from another ACO, Provider shall notify ACH the cause of termination and what safeguards are now in place to enable Provider or Practice Provider to participate in ACH for the full term of the ACO REACH Agreement.

b. ACH shall have a compliance plan consistent with CMS requirements, including a process for Provider, Practice Providers, and other individuals or entities performing functions or services related to ACO Activities to anonymously report suspected problems related to ACH and its compliance officer ("Compliance Plan"). Provider acknowledges and agrees to the Compliance Plan and agrees to require its Practice Providers to review, understand and acknowledge the Compliance Plan.

12. The following sentence is added to the end of the first subsection under the "**Maintenance of Records and Audits**" section in Exhibit B of the Agreement to conform to ACO REACH requirements regarding record keeping and audits:

Provider and its Practice Providers shall maintain Records of services performed under this Agreement, ACH's, Provider's and Practice Providers' compliance with the ACO REACH Model Program, the quality of services performed, data related to Medicare utilization and costs, quality performance measures, and financial arrangements related to this Agreement or the ACO REACH Agreement, or such other Records as ACH may deem necessary to enforce the ACO REACH Agreement.

13. The following sentence is added to the end of the third subsection under the "**Maintenance of Records and Audits**" section in Exhibit B of the Agreement to conform to ACO REACH requirements regarding record keeping and audits:

Provider will, and shall require Practice Providers to, ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during the site visit.

14. The third subsection under the "**Reporting and Disclosure; Submission of Encounter and Other Data**" section in Exhibit B of the Agreement is moved to the fourth subsection, and the following subsection is added as the third subsection to comply with ACO REACH requirements:

c. Provider shall comply with CMS's CAHPS survey or patient experience program.

Network Alignment Updates to 2023 Preferred Provider Agreements

The following policy was adopted by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective January 1, 2025, and applicable for each Performance Year, prospective or retrospective.

All Written Notices of Amendment and Restatement of 2023 Preferred Provider Agreement (collectively the "Agreements" and each an "Agreement") are amended to align with network-wide contractual provisions as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Participation**" subsection under the "**Provider Representations, Warranties and Covenants; Notifications"** section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to align EHR requirements for all Preferred Providers.

> **Participation**. Provider will participate, in a timely manner, with all programs, Technology Solutions, processes, services, and requirements of ACH relating to programs as may be adopted by ACH or CMS from time to time. At the sole election of ACH or its designee, Provider shall allow ACH, or its designee, access to any necessary medical records or documents, whether electronic or paper relating to reporting requirements of ACH and other operations matters. Provider agrees that access shall include, but is not limited to, an ability to independently access the appropriate sections of Provider's EHR. If Provider does not maintain health information in an electronic format or fails to provide access to EHR, Provider will, and require its Practice Providers to, grant ACH access to the complete heath data, and patient contact information for its REACH Beneficiaries, and Provider shall provide any selected data by faxing it to ACH via fax number, scanning and sending it via secure email, or at ACH's option, in person at an on-site visit. On site visit out-of-pocket expenses will be reimbursed by Provider. ACH may offset any payment due Provider with such out-of-pocket expenses. Provider will obtain any consents or authorization for the collection of health data from each REACH Beneficiary as may be required by federal or state law or HIPAA; and

2. The "**Termination Without Cause**" subsection under the "**Termination**" section of Exhibit A is deleted and replaced in its entirety as follows to align the termination provisions with termination requirements for all Preferred Providers:

> **Termination Without Cause**. ACH may terminate Provider without cause at any time, upon thirty (30) days' prior written notice to Provider.

3. The "**Amendments**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to align Amendment requirements for all Preferred Providers.

> **Amendments**. This Agreement may be amended or modified from time to time in the manner set forth in this Section 8. Amendments necessary to effect compliance with laws, to reflect modifications made by CMS with respect to the ACO REACH Model Program (including any extension thereof, or any successor program thereto), or to reflect any amendments or additions made to Policies and Procedures that affect this Agreement, may be made solely by ACH, without the consent of Provider, and shall be effective as stated in ACH's Policies and Procedures. However, ACH will

provide each Provider a written notice of the amendment or addition to its Policies and Procedures with a web link to review the content of the new Policies and Procedures online. Provider agrees, and will assure that its Practice Providers agree, to fully cooperate in executing documents or in any other manner deemed reasonably necessary by ACH consistent with any amendment. Changes to the "List of Individual and Organizational Identifiers" in the Appendix to the Fee Reduction Agreement made after the Effective Date shall be effective when such changes are added to the Preferred Provider List at ACH's sole discretion pursuant to the ACO Rules. No amendment is necessary to effectuate such changes.

4. In the "**Dispute Resolution**" subsection under the "**Miscellaneous**" section of Exhibit A of the Agreement, reference to "American Arbitration Association ('AAA')" is deleted and replaced with "American Health Law Association ('AHLA')" and all references to "AAA" are deleted and replaced with "AHLA" to align arbitration requirements for all Preferred Providers.

Administrative Updates to 2023 Preferred Provider Agreements

The following policy was adopted by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective January 1, 2025, and applicable for each Performance Year, prospective or retrospective.

All Written Notices of Amendment and Restatement of 2023 Preferred Provider Agreement (collectively the "Agreements" and each an "Agreement") are amended to address administrative changes to the Agreements as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Data Use Agreement**" Exhibit of the Agreement is deleted in its entirety to align contracting requirements for all Preferred Providers, and all Exhibits are alphabetized accordingly, and all cross-references are automatically updated to conform to such alphabetization.

2. The "**Practice Provider Support Agreement**" Exhibit of the Agreement is relabeled as "Appendix 1" to the Agreement, and all Exhibits are alphabetized accordingly, and all cross-references are automatically updated to conform to such alphabetization.

3. The "**Definitions**" section in Exhibit A of the Agreement is removed from Exhibit A and moved to a newly created Exhibit titled "**Glossary of Terms**" as an administrative update to the Agreement. All sections in Exhibit A are renumbered to account for the removal of the Definitions section.

4. The "**Billing of Claims**" subsection under the "**Provider Representations and Warranties and Covenants; Notification**" section in Exhibit A of the Agreement is deleted in its entirety to align contractual provisions for all Preferred Providers, and all subsections are relabeled alphabetically to account for the deletion.

5. The "**Change of Circumstances**" subsection under the "**Provider Representations and Warranties and Covenants; Notification**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to align the location of notice requirements for all Preferred Providers, and all subsections are relabeled alphabetically to account for the deletions.

> **Change of Circumstances**. Provider shall notify ACH of any change in circumstances pursuant to Section 5 of this Exhibit A.

6. The "**Other Participation**" and "**No Prior Termination**" sections under the "**Provider Representations and Warranties and Covenants; Notification**" section in Exhibit A of the Agreement are deleted in their entirety to align contractual provisions for all Preferred Providers.

7. The following is added as new section 5 in Exhibit A titled "**Required Notifications**" to align the location of notice requirements for all Preferred Providers, and all sections are relabeled numerically to account for the addition.

5. **Required Notifications**. Upon execution of this Agreement, Provider will designate Provider's contact person for all matters relating to this Agreement, pursuant to written notice delivered to ACH. Additionally, Provider will provide fifteen (15) calendar days written notice to ACH:

a. of any change to the Demographic Information;

b. of any change to the roster of Practice Providers participating in ACH, including any addition of or termination of any Practice Provider or other individual or entity, that bills for items and services furnished to Medicare fee-for-service Beneficiaries under a billing number assigned to the TIN of Provider;

c. upon any change to any Provider representations or warranties;

d. if Provider, or any of its Practice Providers, is required to update its Medicare enrollment information with CMS and such notice shall contain the corresponding updates made to its Medicare enrollment information with CMS; and

e. subject to any limitations or restrictions imposed by law, or as otherwise provided in this Agreement, of any action taken by, or against, Provider or any of its Practice Providers that could, in the opinion of Provider, materially affect Provider's, or such Practice Provider's, ability to render professional services in one or more care settings, or that could have an adverse impact on ACH.

8. The "**Violation of ACO REACH Agreement**" termination subsection under the "**Immediate Termination by ACH Upon Written Notice**" subsection under the "**Termination**" section in Exhibit A of the Agreement is deleted and replaced in its entirety with the following to align such termination provision with termination requirements for all Preferred Providers and remove inapplicable language.

Violation of ACO REACH Agreement. Provider or any of its Practice Providers causing, or being deemed by ACH with good reason to be likely to cause, ACH to be in violation of the ACO REACH Agreement, Business Associate Agreement, or any applicable federal or state laws, regulations or rules, including, without limitation, the ACO Rules;

9. The four romanettes under the "**Notice**" subsection under the "**Miscellaneous**" section of Exhibit A of the Agreement are deleted in their entirety to align the location of notice requirements for all Preferred Providers.

10. The "**REACH Objectives**" section in Exhibit B of the Agreement is deleted in its entirety to align requirements for all Preferred Providers and remove superfluous language, and all provisions are renumbered for conformance purposes.

11. The "**Other ACO Participation**" section in Exhibit B of the Agreement is renamed as "**Other ACO Participation and Compliance Plan**."

12. The "**Fee Reduction Agreement**" section in Exhibit B of the Agreement is deleted in its entirety to align requirements for all Preferred Providers and remove superfluous language, and all provisions are renumbered for conformance purposes.

13. The last three sentences of the "**Monitoring**" section in Exhibit B of the Agreement are deleted in their entirety to align monitoring requirements for all Preferred Providers and remove superfluous language.

14. The "**CMS Data Use Agreement**" section in Exhibit B of the Agreement is deleted in its entirety to align contracting requirements of all Preferred Providers and remove inapplicable language. All subsequent sections are renumbered accordingly.

15. The "**Certifications/Attestation**" section in Exhibit B of the Agreement is deleted in its entirety to align contracting requirements of all Preferred Providers and remove superfluous language. All subsequent sections are renumbered accordingly.

16. Sections B, D, G, H, L and M in the "**ACO REACH Model Program Requirements**" Exhibit are deleted in their entirety to align the provisions of the Agreement for all Preferred Providers and remove superfluous language. All remaining sections are relabeled in alphabetical order.

17. All internal cross-references are corrected to the extent of any erroneous citations.

18. The newly created Exhibit for the "**Glossary of Terms**" is amended as follows:

a. All internal references to "below" are amended to read "of Exhibit A."

b. All internal cross-references are corrected to the extent of any erroneous citations.

c. The following term and definition are added to the Glossary of Terms:

Demographic Information means the demographic data for Provider and each of its Practice Providers, including their address, phone number, business hours, email address, tax identification number, national provider identifier, licensure, certification, accreditation, Medicare or Medicaid qualification, medical staff privileges at either a participating or non-participating hospital and Drug Enforcement Agency status, practice ownership, entity status (e.g., change from sole proprietorship to corporation or LLC), key personnel with access to Technology Solutions, or contact persons, and any additional demographic information contained in the PECOS."

d. The definition of "Health Equity" is deleted and replaced in its entirety as follows:

Health Equity means the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to Underserved Communities.

e. The definition of "PECOS" is deleted and replaced in its entirety as follows:

PECOS means the Medicare Provider Enrollment, Chain, and Ownership System

f. The following term and definition are added to the Glossary of Terms:

Practice Provider Support Agreement has the meaning set forth in Section 5 of the Agreement.

Regulatory and Legal updates to 2023 Participant Provider Agreements

The following policy was adopted by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective January 1, 2025, and applicable for each Performance Year, prospective or retrospective.

All Written Notices of Amendment and Restatement of 2023 Participant Provider Agreement (collectively the "Agreements" and each an "Agreement") are amended to conform to regulatory or legal requirements as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

15. The "**Compensation**" section on the second page of the Agreement is deleted and replaced in its entirety as follows to comply with ACO REACH Requirements, including explanation of the REACH Capitation Payment Mechanism, Risk Sharing Option, and Fee Reduction Agreement:

> **Compensation**. ACH has elected to participate in the Global Risk Sharing Option under the ACO REACH Model Program. Additionally, ACH has elected PCC Payment as its REACH Capitation Payment Mechanism and has elected the APO. Provider agrees to participate in PCC Payment and accept a PCC Fee Reduction. By participating in the ACO REACH Model Program, Provider shall receive compensation as described in Exhibit B. Provider shall also execute a Fee Reduction Agreement attached as Exhibit F. Provider's agreement to participate in PCC Payment and the APO, if applicable, as provided in the Fee Reduction Agreement, applies for the full Performance Year. A new Fee Reduction Agreement must be executed annually prior to the start of each Performance Year. In addition, Provider shall maintain records of all remuneration paid or received according to this Agreement.

16. The "**Provider Certification**" section on the second page of the Agreement is deleted and replaced in its entirety as follows to comply with ACO REACH requirements, including requirements for contracting with Practice Providers.

> **Provider Certification**. Provider certifies that Provider's and its Practice Providers' participation in this Agreement is voluntary and not contingent on or related to receipt of referrals from ACH or its Participant Providers. Additionally, Provider certifies that, prior to the Effective Date, each Practice Provider providing services pursuant to this Agreement shall execute a Practice Provider Support Agreement, which ACH will supply to Provider prior to the Effective Date (the "Practice Provider Support Agreement").

17. The last two sentences of the "**Compliance with CMS Monitoring, Oversight and Evaluation Activities**" section in Exhibit A of the Agreement are amended as follows to comply with ACO REACH requirements, including compliance with CMS monitoring and oversight activities:

> Provider will, and will require the Practice Providers and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to, cooperate with all CMS monitoring and oversight requests and activities, including any audits, demographic data, interviews, site visits, documentation and any other information CMS may request or monitoring technique CMS may conduct. Upon request, Provider shall, and shall require its Practice Providers to certify, that all

data and information that is generated or submitted by Provider or other individuals or entities performing functions or services related to ACO Activities, including any quality data or other information or data relied upon by CMS in determining ACH's eligibility, are accurate, complete, and truthful.

18. The "**Practice Provider Availability**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to comply with Law:

Practice Provider Availability. Provider shall ensure that Covered Services, when necessary and consistent with the availability of services provided to those patients who are not REACH Beneficiaries, are available twenty-four (24) hours a day, seven (7) days a week, including coverage after hours or when a Practice Provider is otherwise absent, as required by applicable regulations and law.

19. The "**No Exclusion**" section in Exhibit A of the Agreement is amended to include "or their employees" to conform to Law and correct grammatical oversights and shall be restated as follows:

No Exclusion. Neither Provider, Practice Provider, nor any of their respective Affiliates or their employees are excluded under the HHS Office of Inspector General's List of Excluded Individuals/Entities, the U.S. General Services Administration's Excluded Parties List System, or otherwise excluded from participation in Medicare or other federal health care programs, or are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any federal department or agency;

20. The "**Authorization**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to conform to ACO REACH requirements, including contracting requirements for Practice Providers:

Authorization. Provider is authorized to act on behalf of its Practice Providers and shall provide, upon request, evidence of such authority. Provider also agrees that the executor of this Agreement is the authorized signer listed in CMS's PECOS system;

21. The "**Excluded Individuals**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to conform to Law:

Excluded Individuals. Neither ACH nor any of its Affiliates or their employees are an Excluded Individual; and

22. The "**CMS Recognition of Termination**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to conform to ACO REACH requirements, including requirements for removing Participant Providers during a Performance Year.

Effective Date of Termination. Provider and ACH agree that termination of this Agreement shall not be deemed effective until the earlier of: (i) December 31 of the Performance Year in which written notice of termination is effective; or (ii) the date that CMS acknowledges such termination and terminates Provider's Fee Reduction Agreement. Until such termination occurs Provider and ACH have a legal and fiduciary duty to coordinate care for REACH Beneficiaries, and ACH or its designee will continue any such necessary communication or services to fulfill such duty. This Agreement

shall immediately terminate if CMS terminates the ACO REACH Agreement, subject only to any notice requirements or conditions set by CMS.

23. The following sentence is hereby added as the last sentence of the "**Close-Out Obligations/Post-Termination Obligations**" section in Exhibit A of the Agreement to conform to ACO REACH requirements, including prohibitions against engaging in certain activities after termination of the Agreement.

After the effective date of termination of this Agreement, Provider and Practice Providers shall not engage in any ACO Activities, Marketing Activities, Voluntary Alignment Activities, Benefit Enhancements, or Beneficiary Engagement Incentives with REACH Beneficiaries.

24. The "**Other ACO Participation**" section in Exhibit B of the Agreement is renamed as "**Other ACO Participation and Compliance Plan**" and is deleted and replaced in its entirety as follows to comply with ACO REACH requirements, including prohibitions on other ACO participation and implementation of a compliance plan:

Other ACO Participation and Compliance Plan.

a. Provider is prohibited, and will prohibit its Practice Providers, from participating in ACO during the term of this Agreement if Provider or an individual Practice Provider participates in: (i) another entity participating in the ACO REACH Model Program; (ii) any other MSSP ACO (if Provider or any of its Practice Providers submit claims to Medicare for Primary Care Services); (iii) an independence at home medical practice pilot program under Section 1866E of the Act; (iv) a model tested or expanded under Section 1115A of the Act that involves shared savings, (v) the Maryland Total Cost of Care Model, the Primary Care First Model, or the Independence at Home Demonstration; or (vi) any other Medicare initiative that involves shared savings, except as specifically permitted by CMS. Accordingly, Provider represents, warrants, and covenants, and shall attest upon written request, that neither Provider, Practice Provider, nor any Affiliate for which REACH Beneficiaries are aligned to ACH, is currently participating or will subsequently participate in the MSSP under the same or a different name, or is related to or has an affiliation with another ACO entity.

b. If Provider or a Practice Provider was previously terminated from another ACO entity, Provider shall notify ACH the cause of termination and what safeguards are now in place to enable Provider or Practice Provider to participate with ACH for the full term of the ACO REACH Agreement.

c. ACH shall have a compliance plan consistent with CMS requirements, including a process for Provider, Practice Providers, and other individuals or entities performing functions or services related to ACO Activities to anonymously report suspected problems related to ACH and its compliance officer ("Compliance Plan"). Provider acknowledges and agrees to the Compliance Plan and agrees to require its Practice Providers to review and acknowledge the Compliance Plan.

25. The "**Primary Care Compensation**" section in Exhibit B of the Agreement is renamed "**FFS Reimbursement for Primary Care Compensation**" and subsection (a) of that section is deleted and replaced in its entirety as follows to conform to ACO REACH requirements, including explanation of PCC Payment requirements.

a. ACH has elected to participate in PCC Payment under the ACO REACH Model Program. As part of ACH's elected PCC Payment, Provider is required to use FFS Reimbursement compensation terms for PCC Eligible Services. For each Performance Year, Provider shall receive a reduced payment from CMS for PCC Eligible Services at the level provided in Schedule 1 to this Exhibit B. The percentage of Provider's FFS Reimbursement and PCC Fee Reduction will be adjusted each Performance Year as required by the ACO REACH Agreement. By executing the Fee Reduction Agreement, the Provider agrees to the written arrangement outlined in that document. Additional compensation terms for the FFS Reimbursement compensation shall be as provided in Schedule 1 to this Exhibit B.

26. The following sentence is added to the end of the first subsection under the "**Maintenance of Records and Audits**" section in Exhibit B of the Agreement to conform to ACO REACH requirements regarding record keeping and audits:

Provider and its Practice Providers shall maintain records of services performed under this Agreement, ACH's, Provider's and Practice Providers' compliance with the ACO REACH Model Program, the quality of services performed, data related to Medicare utilization and costs, quality performance measures, ACO distributions, records of remuneration paid or received pursuant to any arrangement between Provider and its Practice Providers and all other remuneration received pursuant to this Agreement, other financial arrangements to related to this Agreement or the ACO REACH Agreement, or such other Records as may deemed necessary to enforce the ACO REACH Agreement.

27. The second subsection under the "**Maintenance of Records and Audits**" section in Exhibit B of the Agreement is deleted and replaced in its entirety as follows to conform to ACO REACH requirements regarding record keeping and audits:

b. Upon request, Provider shall give, and shall require its Practice Providers and other individuals or entities performing functions or services related to ACO Activities or Marketing Activities to give, ACH, and the government, including HHS, the Comptroller General of the United States, CMS or their designees, the right to access, audit, evaluate, and inspect any Records of Provider, its Practice Provider, or its transferee that pertain to any aspect of this Agreement or the ACO REACH Agreement, including, without limitation, services performed under this Agreement, ACH's, Provider's and Practice Providers' compliance with the ACO REACH Model Program, the quality of services performed, data related to Medicare utilization and costs, quality performance measures, ACO distributions, records of remuneration paid or received pursuant to any arrangement between Provider and its Practice Providers and all other remuneration paid or received pursuant to this Agreement, other financial arrangements related to this Agreement or the ACO REACH Agreement, or such other Records as may deemed necessary to enforce the ACO REACH Agreement. Provider shall furnish, and shall require its Practice Providers to furnish, such access, audit, evaluation, and inspection rights by providing copies of such Records to ACH at no additional cost and ACH will provide such Records directly to the applicable regulatory agency, unless ACH, in its discretion, directs Provider to furnish copies directly to the applicable regulatory agency.

28. The following sentence is added to the end of the third subsection under the "**Maintenance of Records and Audits**" section in Exhibit B of the Agreement to conform to ACO REACH requirements regarding record keeping and audits:

Provider will, and shall require Practice Providers to, ensure that personnel with the appropriate responsibilities and knowledge associated with the purpose of the site visit are available during the site visit.

29. The third subsection under the "**Reporting and Disclosure; Submission of Encounter and Other Data**" section in Exhibit B of the Agreement is moved to the fourth subsection, and the following subsection is added as the third subsection to comply with ACO REACH requirements:

c. Provider shall comply with ACH's CAHPS survey or patient experience program.

30. The term "**FFS Bonus Payment**" is replaced with "**FFS Advance Payment**" throughout the Agreement to conform to prior updates to the Policies and Procedures.

31. The fifth subsection under the "**FFS Reimbursement**" section of Schedule 1 to Exhibit B of the Agreement is deleted and replaced in its entirety to conform to prior updates to Policies and Procedures.

e. The total amount of Advanced PQEM, FFS Advance Payments, for a Performance Year shall be referred to as advanced shared savings ("FFS Advanced Shared Savings"). If FFS Advanced Shared Savings exceeds Provider Shared Savings for the Performance Year in which the FFS Advanced Shared Savings were paid, such difference will be deducted from the subsequent Performance Year Provider Shared Savings."

17. The ninth subsection under the "**Performance and Engagement**" section of the "**Provider Performance Standards**" Exhibit of the Agreement is deleted and replaced in its entirety as follows to conform to Law:

i. Fully utilize a Certified Electronic Health Record Technology ("CEHRT"), as such term is defined under 42 CFR § 414.1305, in a manner sufficient to meet the applicable requirements of 42 CFR § 414.1415(a)(1)(i), including any amendments thereto.

Network Alignment Updates to 2023 Participant Provider Agreements

The following policy was adopted by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective January 1, 2025, and applicable for each Performance Year, prospective or retrospective.

All Written Notices of Amendment and Restatement of 2023 Participant Provider Agreement (collectively the "Agreements" and each an "Agreement") are amended to align with network-wide contractual provisions as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Participation**" subsection under the "**Provider Representations, Warranties and Covenants; Notifications**" section in Exhibit A is deleted and replaced in its entirety as follows to align EHR requirements for all Participant Providers.

> j. **Participation**. Provider will participate, in a timely manner, with all programs, Technology Solutions, processes, services, and requirements of ACH relating to programs as may be adopted by ACH or CMS from time to time. At the sole election of ACH or its designee, Provider shall allow ACH, or its designee, access to any necessary medical records or documents relating to reporting requirements of ACH and other operations matters. Provider agrees that access shall include, but is not limited to, an ability to independently access the appropriate sections of Provider's EHR. If Provider fails to provide access to EHR, Provider will, and require its Practice Providers to, grant ACH access to the complete heath data and patient contact information for its REACH Beneficiaries, and Provider shall provide any selected data by faxing it to a HIPAA fax number, scanning and sending it via secure email, or at ACH's option, in person at an on-site visit. On site visit out-of-pocket expenses will be reimbursed by Provider. ACH may offset any payment due Provider with such out-of-pocket expenses. Provider will obtain any consents or authorization for the collection of health data from each REACH Beneficiary as may be required by federal or state law or HIPAA; and

2. The "**Termination Without Cause**" section in Exhibit A, is deleted and replaced in its entirety as follows to align the termination provisions with termination requirements for all Participant Providers:

> **Termination Without Cause**. ACH may terminate Provider without cause at any time upon thirty (30) days' prior written notice to Provider.

3. In the "**Dispute Resolution**" section of Exhibit A of the Agreement, reference to "American Arbitration Association ('AAA')" is deleted and replaced with "American Health Law Association ('AHLA')" and all references to "AAA" are deleted and replaced with "AHLA" to align arbitration requirements for all Participant Providers.

4. The "**Refusal Right**" section of Exhibit A of the Agreement, if not intentionally omitted, is deleted and replaced in its entirety as follows to align such provision for all applicable Participant Providers.

> **Right of First Offer**. If, at any time during the Term and thereafter, until the first anniversary date of the termination of this Agreement, Provider proposes to initiate a sale of substantially all of its assets or a majority equity interest in Provider ("Proposed Transfer"), the Provider must first deliver to ACH prior written notice of the intent to do so (the "Proposed Transfer Notice") specifying (i) the nature of the Proposed Transfer, (ii) the terms of the Proposed Transfer and (iii) a proposed price that ACH (or an affiliate or assignee thereof) may purchase such assets or equity interest from the Provider

("ROFO Price"). Such Proposed Transfer Notice shall be treated as confidential by ACH and shall not be disclosed to any other person other than ACH's representatives. ACH, its parent or affiliates shall have the right (the "Right of First Offer"), but not the obligation, to offer to purchase all of such assets or equity interest. ACH (or a designated affiliate or designee thereof) shall have a period of thirty (30) business days from the date the Proposed Transfer Notice is received ("Notice Period") to elect to exercise its Right of First Offer, by delivering to the Provider a written notice of such election which will include the material terms of such purchase (the "ROFO Notice"). If, upon receipt by ACH of a Proposed Transfer Notice, ACH (or a designated affiliate or designee thereof) does not deliver a ROFO Notice with respect to such Proposed Transfer Notice within the Notice Period, then the Practice shall be free to consummate a Transfer of such assets or equity interest to any person at or above the ROFO Price."

5. The second subsection under the "**FFS Reimbursement for Primary Care Compensation**" section in Exhibit B of the Agreement is amended to delete the last sentence of such subsection to align FFS Reimbursement requirements for all Participant Providers.

6. The first subsection under the "**Shared Savings**" section in Exhibit B of the Agreement is deleted and replaced in its entirety as follows to align Shared Savings requirements for all Participant Providers.

a. Provider acknowledges and agrees that ACH will account for all premium amounts ACH receives from CMS and that claims payments will be expensed for Covered Services. After reconciliation, the gross Shared Savings, if any, received from CMS will be pooled and the amount of each Practice Provider's gross Shared Savings (as determined in Section 5.b. below), shall be divided by the total amount of gross Shared Savings to calculate each Practice Provider's percentage of gross Shared Savings ("Percentage of GSS"). Gross Shared Savings shall be reduced at the discretion of ACH's Board of Managers. The Gross Shared Savings will be further reduced, as appropriate, by ACH expenses, including ACH administrative expenses, stop loss insurance premiums, surety guarantee fees, letter of credit expenses, aggregate stop loss insurance premiums, sequestration fees, and such other expenses or fees provided in Schedule 1 to this Exhibit B, to calculate the net Shared Savings attributable to Provider and its Practice Providers ("Net Shared Savings"). Net Shared Savings will be calculated based on the performance of ACH as a whole and not on the performance of individual Practice Providers. For accounting purposes, each Practice Provider shall be attributed a portion of Net Shared Savings equal to the product of such Practice Provider's Percentage of GSS multiplied by Net Shared Savings ("Provider Shared Savings").

7. The second subsection under the "**Shared Savings**" section in Exhibit B of the Agreement is deleted and replaced in its entirety as follows to align Shared Savings requirements for all Participant Providers.

b. The determination of each Practice Provider's gross Shared Savings will be made on a non-discriminatory basis, taking into account the volume of REACH Beneficiaries supplied and serviced by each Practice Provider; quality metrics measurements; each Practice Providers' individual performance, efficiency, attributed membership and prior deficits; ACH returns on overhead, including all insurances (stop loss, surety guarantee fees), and all sequestration withholds from CMS; and such other factors determined to be relevant by the ACH management committee and the ACH Board, as permitted under federal and Florida law. In all events, gross Shared Savings shall be determined by the management committee of the ACH Board in its sole discretion.

8. The second romanette in the fourth subsection under the "**Shared Savings**" section in Exhibit B of the Agreement is deleted and replaced in its entirety as follows to align Shared Savings requirements for all Participant Providers.

ii. Satisfy all the terms and conditions in the Agreement, the CMS metrics, ACH's quality assurance and improvement programs, evidence-based clinical guidelines, Policies and Procedures, any requirement implemented by ACH's Board of Managers and other criteria as adopted by ACH from time to time, as determined by the Management Committee of the ACH Board in its sole discretion; and

9. The following sentence is added to the end of the seventh subsection under the "**Shared Savings**" section in Exhibit B of the Agreement to align Shared Savings requirements for all Participant Providers.

Some terminations may require full payment of Provider's Deficit at ACH's discretion.

10. The second subsection under the "**FFS Reimbursement**" section in Schedule 1 to Exhibit B of the Agreement is amended to add the following to the end of the provision to align FFS Reimbursement requirements for all Participant Providers.

so long as Provider is eligible as provided in Section 5.d. of Exhibit B (previously, Section 7.9 of Exhibit B).

Administrative Updates to 2023 Participant Provider Agreements

The following policy was adopted by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective January 1, 2025, and applicable for each Performance Year, prospective or retrospective.

All Written Notices of Amendment and Restatement of 2023 Participant Provider Agreement (collectively the "Agreements" and each an "Agreement") are amended to address administrative changes to the Agreements as follows. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Data Use Agreement**" Exhibit of the Agreement and the "**Practice Provider Support Agreement**" Exhibit of the Agreement are deleted in their entirety to align contracting requirements for all Participant Providers, and all Exhibits are alphabetized accordingly, and all cross-references are automatically updated to conform so such alphabetization.

2. The "**Definitions**" section in Exhibit A of the Agreement is removed from Exhibit A and moved to a newly created Exhibit titled "**Glossary of Terms**" as an administrative update to the Agreement. All sections in Exhibit A are renumbered to account for the removal of the Definitions section.

3. The "**Billing of Claims**" section in Exhibit A of the Agreement is deleted in its entirety to align contractual provisions for all Participant Providers, and all subsections are relabeled alphabetically to account for the deletion.

4. The "**Change of Circumstances**" section in Exhibit A of the Agreement is deleted and replaced in its entirety as follows to align the location of notice requirements for all Participant Providers.

> **Change of Circumstances**. Provider shall notify ACH of any change in circumstances pursuant to Section 5 of this Exhibit A;

5. The following is added as a new section in Exhibit A titled "**Required Notifications**" to align the location of notice requirements for all Participant Providers and is numbered accordingly.

> **Required Notifications**. Upon execution of this Agreement, Provider will designate Provider's contact person for all matters relating to this Agreement, pursuant to written notice delivered to ACH. Additionally, Provider will provide fifteen (15) calendar days written notice to ACH:
>
> a. of any change to the Demographic Information;
>
> b. of any change to the roster of Practice Providers participating in ACH, including any addition of or termination of any Practice Provider or other individual or entity, that bills for items and services furnished to Medicare fee-for-service Beneficiaries under a billing number assigned to the TIN of Provider;
>
> c. upon any change to any Provider representations or warranties;
>
> d. if Provider, or any of its Practice Providers, is required to update its Medicare enrollment information with CMS and such notice shall contain the corresponding updates made to its Medicare enrollment information with CMS; and

e. subject to any limitations or restrictions imposed by law, or as otherwise provided in this Agreement, of any action taken by, or against, Provider or any of its Practice Providers that could, in the opinion of Provider, materially affect Provider's, or such Practice Provider's, ability to render professional services in one or more care settings, or that could have an adverse impact on ACH."

6. The "**Violation of ACO REACH Agreement**" subsection under the "**Immediate Termination by ACH Upon Written Notice**" section in Exhibit A of the Agreement is deleted and replaced in its entirety with the following to align such termination provision with termination requirements for all Participant Providers and remove inapplicable language.

> **Violation of ACO REACH Agreement**. Provider or any of its Practice Providers causing, or being deemed by ACH with good reason to be likely to cause, ACH to be in violation of the ACO REACH Agreement, Business Associate Agreement, or any applicable federal or state laws, regulations or rules, including, without limitation, the ACO Rules;

7. The "**Failure to Make Requested Payment**" subsection under the "**Termination by ACH Upon Prior Written Notice**" section in Exhibit A of the Agreement, is deleted in its entirety to remove an inapplicable provision.

8. The "**General**" subsection under the "**Non-Competition, Non-Solicitation, and Non-Disparagement**" section of Exhibit A of the Agreement is amended to delete the last sentence of such provision to align general requirements for all Participant Providers and remove superfluous language.

9. The four subsections under the "**Notice**" section in Exhibit A of the Agreement are deleted in their entirety to align the location of notice requirements for all Participant Providers.

10. The second subsection under the "**Remedies**" section of Exhibit A of the Agreement is deleted in its entirety, including all six subsections thereto, to align the remedy requirements for all Participant Providers and to remove an inapplicable provision. The subsections of the Remedies section are renumbered accordingly.

11. The "**REACH Objectives**" section in Exhibit B of the Agreement is deleted in its entirety to align requirements for all Participant Providers and remove superfluous language, and all provisions are renumbered for conformance purposes.

12. The "**Fee Reduction Agreement**" section in Exhibit B of the Agreement is deleted in its entirety to align requirements for all Participant Providers and remove superfluous language, and all provisions are renumbered for conformance purposes.

13. The sixth subsection under the "**FFS Reimbursement for Primary Care Compensatio**n" section in Exhibit B of the Agreement is deleted in its entirety to align FFS Reimbursement requirements for all Participant Providers and remove inapplicable language.

14. The last three sentences of the "**Monitoring**" section in Exhibit B of the Agreement are deleted in their entirety to align monitoring requirements for all Participant Providers and remove superfluous language.

15. The "**CMS Data Use Agreement**" section in Exhibit B of the Agreement is deleted in its entirety to align contracting requirements of all Participant Providers and remove inapplicable language. All subsequent sections are renumbered accordingly.

16. The "**Certifications/Attestation**" section in Exhibit B of the Agreement is deleted in its entirety to align contracting requirements of all Participant Providers and remove superfluous language. All subsequent sections are renumbered accordingly.

17. The fourth subsection under the "**FFS Reimbursement**" section in Schedule 1 to Exhibit B of the Agreement is deleted and replaced in its entirety to align FFS Reimbursement requirements for all Participant Providers.

> The PCC Fee Reduction payment and Advanced PQEM will be paid by ACH every two weeks, unless circumstances do not allow for timely payments, including but not limited to instances when all requisite CMS data is not then available to accurately and completely determine payments, the payment will be made as soon as such data is available. FFS Advance Payments will be paid quarterly, within 120 days following the end of each calendar quarter, except that if all requisite CMS data is not then available to accurately and completely determine payments, the payment will be made as soon as such data is available.

18. The "**CAP Payment**" section and the "**Intentionally Omitted**" section in Schedule 1 to Exhibit B are deleted in their entirety to align compensation provisions of all Participant Providers and remove inapplicable provisions.

19. The first sentence of the "**Performance and Engagement**" section in Exhibit D of the Agreement is deleted and replaced in its entirety as follows to align performance and engagement requirements for all Participant Providers and remove inapplicable requirements.

> Provider shall demonstrate commitment to all Performance and Engagement Goals each Performance Year.

20. Sections B, D, G, H, L and M in the "**ACO REACH Model Program Requirements**" Exhibit are deleted in their entirety to align the provisions of the Agreement for all Participant Providers and remove superfluous language. All remaining sections are relabeled in alphabetical order.

21. All internal cross-references are corrected to the extent of any erroneous citations.

22. The newly created Exhibit for the "**Glossary of Terms**" is amended as follows:

    a. All internal references to "below" are amended to read "of Exhibit A."

    b. All internal cross-references are corrected to the extent of any erroneous citations.

    c. The definition of "**Base PCC**" is deleted and replaced in its entirety as follows:

    > ***Base PCC*** is defined by CMS as an amount of estimated payment intended to approximate the primary-care based services provided by a Provider on Capitated Payments to aligned beneficiaries by the ACO REACH Participant Providers and Preferred Providers taking part in PCC."

    d. The term and definition of "**Beneficiary Alignment File**" are deleted in their entirety.

    e. The terms and definitions of "**CAP Advanced Shared Savings**," "**Cap Bonus**" and "**CAP Payment**" are deleted in their entirety.

f. The following term and definition are added to the "**Glossary of Terms**":

Demographic Information means the demographic data for Provider and each of its Practice Providers, including their address, phone number, business hours, email address, tax identification number, national provider identifier, licensure, certification, accreditation, Medicare or Medicaid qualification, medical staff privileges at either a participating or non-participating hospital and Drug Enforcement Agency status, practice ownership, entity status (e.g., change from sole proprietorship to corporation or LLC), key personnel with access to Technology Solutions, or contact persons, and any additional demographic information contained in the PECOS."

g. The term and definition of "**Deficit Risk**" are deleted in their entirety.

h. The term "**FFS Bonus**" is deleted and replaced with the term "**FSS Advanced Payment**."

i. The terms and definitions of "**Offer**"," **Offer Notice**," and "**Offeror**" are deleted in their entirety.

j. The definition of "**PCC Eligible Services**" is amended to delete the last sentence.

k. The definition of "**PECOS**" is deleted and replaced in its entirety as follows:

PECOS means the Medicare Provider Enrollment, Chain, and Ownership System

l. The following term and definition are added to the Glossary of Terms:

Practice Provider Support Agreement has the meaning set forth in Section 6 of the Agreement.

m. The term and definition of "**Premium Fee**" are deleted in their entirety.

n. The following is added to the end of the definition of "**Primary Care Services**":

The ACO REACH Agreement provides the list of Primary Care Services and the applicable codes for each Performance Year. CMS may update such list prior to the start of any Performance Year. ACH will notify Provider upon notice from CMS of any change to the list for a subsequent Performance Year.

o. The terms and definitions of "**Purchase Right**" and "**Purchase Right Notice**" are deleted in their entirety.

p. The term and definition of "**Success Fee**" are deleted in their entirety.

q. The following terms are added to the Glossary of Terms and are defined to have the meaning set forth in Section 11 of Exhibit A of the Agreement, to the extent applicable:

Notice Period
Proposed Transfer
Proposed Transfer Notice
Right of First Offer
ROFO Notice
ROFO Price

Performance Year 2025 Updates to Participant Provider and Preferred Provider Agreements

The following policy was adopted to be effective January 1, 2025, by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective beginning Performance Year 2025.

All Participant Provider Agreements and Preferred Provider Agreements (collectively the "Agreements" and each an "Agreement") are amended to conform to the Fourth Amended and Restated Participation Agreement by and between the Center for Medicare Services ("CMS") and ACH dated December 6, 2024. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Other ACO Participation and Compliance Plan**" section of Exhibit B of the Agreement is amended to add the following section and subsections:

   A Participant Provider and a Preferred Provider may participate in the Guiding an Improved Dementia Experience model (the "GUIDE Model").

   i. A Participant Provider and a Preferred Provider who participates in the GUIDE Model should refer to the CMS GUIDE Participation Agreement for billing guidance resulting from overlapping participation.

   ii. A Participant Provider and a Preferred Provider who participates in the GUIDE Model may not bill CMS for any of the GUIDE Overlap Services for a REACH Beneficiary that is also a GUIDE Beneficiary (as that term is defined in the GUIDE Model Participation Agreement).

2. The "**Glossary of Terms**" Exhibit is amended to add the following definitions:

   "**GUIDE Overlap Services**" means the services listed in Appendix F, Table 4 to the Guiding an Improved Dementia Experience (GUIDE) Model Participation Agreement that, when provided to a GUIDE Beneficiary (as the term is defined in the GUIDE Model Participation Agreement): (1) a GUIDE Model Participant (as the term is defined in the GUIDE Model Participation Agreement) receives a Dementia Care Management Payment (DCMP); and (2) a GUIDE Practitioner (as the term is defined in the GUIDE Model Participation Agreement) may not bill under the Medicare Physician Fee Schedule Services.

   "**GUIDE Payments**" means the payments made pursuant to the GUIDE Model Participation Agreement, including GUIDE Dementia Care Management Payments (DCMP), payments for GUIDE Respite Services, and GUIDE Infrastructure Payments.

Network Alignment Updates to All Participant Provider and Preferred Provider Agreements

The following policy was adopted on January 1, 2025, by the Executive Management team of American Choice Healthcare, LLC ("ACH") to be effective for each Performance Year, prospective or retrospective.

All Participant Provider Agreements and Preferred Provider Agreements (collectively the "Agreements" and each an "Agreement") are hereby amended to align with network-wide contractual provisions to the extent such Agreements are not already so amended. This Policy shall serve as written explanation of the amendment, and the caption above specifies the purpose of the amendment. Capitalized terms used in this Policy but not defined have the meanings set forth in the Agreement.

1. The "**Term**" section of the Agreement is amended to add the following sentence at the end of the provision.

   Notwithstanding the foregoing, Provider agrees to participate in any extension of or successor program to the ACO REACH Model Program, and the Term shall automatically renew to coincide with such extension or successor program.

2. The "**Provider Certification**" section of the Agreement is relabeled as "**Provider Certification; Practice Provider Identification**" and amended to add the following sentence at the end of the provision.

   All Practice Providers for a Performance Year will be listed on the Fee Reduction Agreement for such Performance Year. In the event Provider adds a new Practice Provider during a Performance Year, such Practice Provider will be automatically added to the Participant Provider List or Preferred Provider List (as applicable) at ACH's sole discretion in accordance with the terms of this Agreement and the ACO Rules but shall not participate in the program payment methodology until permitted by the applicable CMS standards.

3. The "**Participation**" subsection under the "**Provider Representations, Warranties and Covenants; Notification**" section of **Exhibit A** of the Agreement is amended to delete the phrase "a HIPAA fax number" and replace it with "ACH via fax number."

4. The "**Amendment**" section of **Exhibit A** of the Agreement is deleted and replaced in its entirety as follows.

   Amendments. This Agreement may be amended or modified from time to time in the manner set forth in this Section 8. Amendments necessary to effect compliance with laws, to reflect modifications made by CMS with respect to the ACO REACH Model Program (including any extension thereof, or any successor program thereto as specified in Section 3 of this Agreement), or to reflect any amendments or additions made to Policies and Procedures that affect this Agreement, may be made solely by ACH, without the consent of Provider, and shall be effective as stated in ACH's Policies and Procedures. However, ACH will provide each Provider a written notice of the amendment or addition to its Policies and Procedures with a web link to review the content of the new Policies and Procedures online. Provider agrees, and will assure that its Practice Providers agree, to fully cooperate in executing documents or in any other manner deemed reasonably necessary by ACH consistent with any amendment. Changes to the "List of Individual and Organizational Identifiers" in the Appendix to the Fee Reduction Agreement made after the Effective

Date shall be effective when such changes are added to the Participant Provider List or Preferred Provider List (as applicable) at ACH's sole discretion pursuant to the ACO Rules. No amendment is necessary to effectuate such changes.

5. The third subsection under the "**Reporting and Disclosure; Submission of Encounter and Other Data**" section of **Exhibit B** of the Agreement is amended to replace the phrase "ACH's CAHPS survey" with "CMS's CAHPS survey."