WELLCARE NEW JERSEY MEDICARE ADVANTAGE AND/OR MEDICAID/FAMILYCARE

PARTICIPATING PROVIDER AGREEMENT

ANCILLARY

THIS PARTICIPATING PROVIDER AGREEMENT ("**Agreement**") is made and entered into as of _____ ("**Effective Date**") by and between WellCare Health Plans of New Jersey, Inc. ("**Health Plan**") and _____ ("**Contracted Provider**"). Health Plan and Contracted Provider are sometimes referred to together as the "**Parties**" and individually as a "**Party**".

WHEREAS, Health Plan issues (or is pursuing a license allowing it to issue) health benefit plans and seeks to include health care providers in one or more provider networks for such plans; and

WHEREAS, Contracted Provider provides health care items and services to the general public by health care providers employed by Contracted Provider; and

WHEREAS, Health Plan and Contracted Provider desire to enter into this Agreement whereby Contracted Provider will provide health care items and services to Health Plan's health benefit plan enrollees in exchange for payments from Health Plan, all subject to and in accordance with the terms and conditions of this Agreement;

NOW THEREFORE, the Parties agree as follows:

1. Construction.

1.1. The base part of this Agreement is designed for use with a variety of providers and Benefit Plans. Provisions specific to particular providers and Benefit Plans are included in Attachments to the Agreement.

1.2. NJ Medicaid/FamilyCare Managed Care. Attachments B-1 and B-2 setting forth New Jersey regulatory and Medicaid/FamilyCare managed care program requirements are expressly incorporated into this Agreement and are binding upon the Parties to this Agreement. In the event of any inconsistent or contrary language among Attachments B-1 and B-2 and any other part of this Agreement, including any attachments or exhibits, the Parties agree that the provisions of Attachments B-1 and B-2 shall prevail with respect to Benefit Plans under the New Jersey Medicaid/FamilyCare managed care program.

1.3. The following rules of construction apply to this Agreement: (a) the word "**include**", "**including**" or a variant thereof shall be deemed to be without limitation; (b) the word "**or**" means "and/or"; (c) the word "**day**" means calendar day unless otherwise specified; (d) the term "**business day**" means Monday through Friday, except Federal holidays; (e) all words used in this Agreement will be construed to be of such gender or number as the circumstances require; (f) references to specific statutes, regulations, rules or forms, such as CMS 1500 and UB-04 forms, include subsequent amendments or successors to them; and (g) references to a government department or agency include any successor departments or agencies to it.

2. Definitions. In addition to terms defined elsewhere in this Agreement, the following capitalized terms when used in this Agreement shall have the meanings set forth below. If an identical term is defined in a Program Attachment, the definition in the Program Attachment shall control with respect to Benefit Plans governed by the Program Attachment.

2.1. "**Affiliate**" means, with respect to a particular entity, another entity that directly, or indirectly through one or more intermediaries, controls, is controlled by or is under common control with, the entity. An entity "**controls**" an entity in which it has the power to vote, directly or indirectly, 50 percent or more of the voting interests in such entity or in the case of a partnership if it is a general partner, or the power to direct or cause direction of management and policies of such entity, whether through the ownership of voting shares, by contract or otherwise.

2.2. "**Benefit Plan**" means a health benefit policy or other health benefit contract or coverage document (a) issued by Health Plan or (b) administered by Health Plan pursuant to a Government Contract. Benefit Plans and their designs are subject to change periodically.

2.3. Intentionally deleted.

2.4. "**Clean Claim**" means a claim for Covered Services provided to a Member that (a) is received timely by Health Plan, (b) has no defect, impropriety, or lack of substantiating documentation from the Member's medical record regarding the Covered Services, (c) is not subject to coordination of benefits or subrogation issues, (d) is on a completed, legible CMS 1500 form or UB-04 form or electronic equivalent that follows then current HIPAA Administrative Simplification ASC X12 837 standards and additional Health Plan specific requirements in the WellCare Companion Guide, including all then current guidelines regarding coding and inclusive code sets, and (e) includes all relevant information necessary for Health Plan to (1) meet requirements of Laws and Program Requirements for reporting of Covered Services provided to Members, and (2) determine payor liability, and ensure timely processing and payment by Health Plan. A Clean Claim does not include a claim from a Contracted Provider who is under investigation for fraud or abuse, or a claim under review for Medical Necessity.

2.5. "**Credentialing Criteria**" means Health Plan's criteria for the credentialing or re-credentialing of Providers that is consistent with New Jersey Department of Health licensure standards found at NJAC 8:39-1.1 et seq.

2.6. "**Covered Services**" means Medically Necessary health care items and services covered under a Benefit Plan.

2.7. "**DHHS**" means the U.S. Department of Health and Human Services, including its agency the Centers for Medicare and Medicaid Services ("**CMS**") and its Office of Inspector General ("**OIG**").

2.8. "**Emergency Services**" shall be as defined in the applicable Program Attachment.

2.9. "**Encounter Data**" means encounter information, data and reports for Covered Services provided to a Member that meets the requirements for Clean Claims.

2.10. "**Federal Health Care Program**" means a Federal health care program as defined in section 1128B(f) of the Social Security Act, and includes Medicare, Medicaid and CHIP.

2.11. "**Government Contract**" means a contract between Health Plan and a Governmental Authority or government authorized entity for Health Plan to provide health benefits coverage for Federal Health Care Program beneficiaries.

2.12. "**Governmental Authority**" means the United States of America, the States, or any department or agency thereof having jurisdiction over Health Plan, a Provider or their respective Affiliates, employees, subcontractors or agents.

2.13. "**Ineligible Person**" means an individual or entity who (a) is currently excluded, debarred, suspended or otherwise ineligible to participate in (i) Federal Health Care Programs, as may be identified in the List of Excluded Individuals/Entities maintained by the OIG, or (ii) Federal procurement or non procurement programs, as may be identified in the Excluded Parties List System maintained by the General Services Administration, (b) has been convicted of a criminal offense subject to OIG's mandatory exclusion authority for Federal Health Care Programs described in section 1128(a) of the Social Security Act, but has not yet been excluded, debarred or otherwise declared ineligible to participate in such programs, or (c) is currently excluded, debarred, suspended or otherwise ineligible to participate in State medical assistance programs, including Medicaid or CHIP, or State procurement or non procurement programs as determined by a State Governmental Authority.

2.14. "**Laws**" means any and all applicable laws, rules, regulations, statutes, orders, standards, guidance and instructions of any Governmental Authority, as adopted, amended, or issued from time to time, including (a) the Social Security Act, including Titles XVIII ("**Medicare**"), XIX ("**Medicaid**") and XXI (State Children's Health Insurance Program or "**CHIP**"), (b) the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**"), (c) Federal and State privacy laws other than HIPAA, (d) Federal and State laws regarding patients' advance directives, (e) State laws and regulations governing the business of insurance, (f) State laws and regulations governing third party administrators or utilization review agents, and (g) State laws and regulations governing the provision of health care services.

2.15. "**Medically Necessary**" or "**Medical Necessity**" shall be as defined in the applicable Program Attachment.

2.16. "**Member**" means an individual properly enrolled in a Benefit Plan and eligible to receive Covered Services at the time such services are rendered.

2.17. "**Member Expenses**" means copayments, coinsurance, deductibles or other cost share amounts, if any, that a Member is required to pay for Covered Services under a Benefit Plan.

2.18. Intentionally deleted.

2.19. "**Participating Provider**" means an individual or entity that has entered into an agreement with Health Plan or a Health Plan contractor to provide or arrange for the provision of Covered Services to Members.

2.20. "**Principal**" means a person with a direct or indirect ownership interest of five percent or more in Provider.

2.21. "**Program**" means (a) a Federal Health Care Program, or (b) a commercial insurance program, including a program created under Laws regarding commercial health insurance exchanges.

2.22. "**Program Attachment**" means an attachment to this Agreement describing the terms and conditions of a Provider's participation in Benefit Plans under a Program.

2.23. "**Program Requirements**" means the requirements of Governmental Authorities governing a Benefit Plan, including where applicable the requirements of a Government Contract.

2.24. "**Provider**" means (a) Contracted Provider or (b) other individual or entity that is subject to an employment arrangement with Contracted Provider to provide or arrange for the provision of Covered Services to Members under this Agreement.

2.25. "**Provider Manual**" means, collectively, Health Plan's provider manuals, quick reference guides and educational materials setting forth Health Plan's requirements, rules, policies and procedures applicable to Participating Providers, as adopted or amended by Health Plan from time to time, including requirements, rules, policies and procedures regarding fraud, waste and abuse; health plan accreditation, credentialing/re-credentialing of providers, Member eligibility verification, prior authorization, submission of claims and encounter data (including the WellCare Companion Guide), claims payment, overpayment recoupment, utilization review/management, disease and case management, quality assurance/improvement, model of care, advance directives, collection of Member Expenses, Member rights, including reimbursement of Member Expenses collected in excess of the maximum out of pocket amount under a Benefit Plan; and Member or provider grievances and appeals.

2.26. "**State**" means any of the 50 United States, the District of Columbia or a U.S. territory.

2.27. Intentionally deleted.

2.28. "**WellCare Companion Guide**" means the transaction guide that sets forth data requirements and electronic transaction requirements for Clean Claims and Encounter Data submitted to Health Plan or its Affiliates, as amended from time to time. The WellCare Companion Guide is part of the Provider Manual.

3. Scope.

3.1. Intentionally deleted.

3.2. Providers may freely communicate with Members about their treatment regardless of benefit coverage limitations. Health Plan does not dictate or control clinical decisions respecting a Member's medical treatment or care. Medical care is the responsibility of the treating Provider regardless of any coverage determination by Health Plan. Nothing in this Agreement shall be interpreted to permit interference by Health Plan with communications between a Provider and a Member regarding the Member's medical condition or available treatment options.

3.3. This is not an exclusive agreement for either Party, and there is no guarantee (a) Health Plan will participate in any particular Program, or (b) any particular Benefit Plan will remain in effect.

3.4. Subject to Laws and Program Requirements, Health Plan reserves the right to create distinct provider networks for a Benefit Plan, and to determine Provider participation in such networks.

3.5. Subject to Laws and Program Requirements, Health Plan reserves the right to approve

any Provider's participation under this Agreement, or to terminate or suspend any Provider from participation under this Agreement or one or more particular Benefit Plans. Health Plan is not obligated to refer or assign a minimum number of Members to or maintain a minimum number of Members with a Provider.

4. Provider Responsibilities.

4.1. Principals. Contracted Provider warrants and represents that it has been provided with the "Provider Specific Requirements/Covered Services" information in Attachment A-1, and that it has provided Health Plan the information listed on Attachment A-2 titled "Information for Contracted Provider / Principals" for itself and all of its Principals as of the Effective Date, and with respect to the New Jersey Medicaid/FamilyCare Program, the additional information listed on Attachment A-3 titled "Additional Information for Contracted Provider / Principals" as of the Effective Date. Contracted Provider shall provide notice to Health Plan of any change in the information within 30 days of the change, or as otherwise set forth in the Attachment.

4.2. Providers. Contracted Provider warrants and represents that it has provided Health Plan with the information listed on Attachment A-4 titled "Information for Providers" for itself and the other Providers as of the Effective Date in a form and format acceptable to Health Plan. Contracted Provider shall provide notice to Health Plan of any change in the information within 30 days of the change.

4.2.1. Employed Providers. Contracted Provider shall maintain and enforce binding internal policies and procedures or agreements with its employed Providers that are consistent with and require adherence to this Agreement. Contracted Provider shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of its employed Providers.

4.2.2. Subcontracted Providers. The following only applies if Contracted Provider, such as an independent practice association, physician hospital organization or physician group, uses subcontracted Providers.

(a) Contracted Provider shall, and shall require its direct or indirect subcontracted Providers to, maintain and enforce written agreements with their respective subcontracted Providers that are consistent with and require adherence to this Agreement. Upon Health Plan's request, Contracted Provider shall provide Health Plan with copies of agreement templates used by itself and other Providers with their subcontracted Providers, and (1) copies of the first page, signature page and other pages necessary to identify the contracting parties and effective date for each such agreement, or (2) copies of entire agreements between itself or other Providers and the subcontracted Providers. In no event shall an agreement between or among Providers supersede this Agreement respecting matters covered by this Agreement. Notwithstanding anything to the contrary in any such agreement, this Agreement shall control over the terms of any such agreement in all respects as to matters covered by this Agreement.

(b) Subcontracted Providers shall maintain and enforce binding internal policies and procedures or agreements with their employed Providers that are consistent with and require adherence to this Agreement. Subcontracted Providers shall provide Health Plan with such information requested by Health Plan, or as required by a Governmental Authority or accreditation body, necessary to verify the employment of their employed Providers.

(c) Any obligation of Contracted Provider in this Agreement shall apply to subcontracted Providers to the same extent that it applies to Contracted Provider. Contracted Provider shall require the timely and faithful performance of this Agreement by subcontracted Providers.

(d) With respect to the New Jersey Medicaid/FamilyCare Program, all direct subcontracts between Contracted Provider and its downstream Providers or indirect subcontracts between Providers and their downstream Providers shall be subject to prior review and approval by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services and the Department of Banking and Insurance.

4.2.3 Credentialing. All Providers must meet the Credentialing Criteria. Subject to Laws and Program Requirements, (a) Health Plan conducts credentialing of providers before they begin providing Covered Services and re-credentialing from time to time thereafter as required for Health Plan's compliance with Laws, Program Requirements and accreditation standards, and Providers shall consent to and cooperate with such credentialing/re-credentialing, which may include site reviews, and (b) until successful completion of credentialing of a provider by Health Plan, (i) the provider shall not be added as a Participating Provider under this Agreement, and (ii) the provision of, and payment for, Health Plan authorized Covered Services to Members by the provider shall be subject to Health Plan's policies and procedures for non-participating providers.

4.3. Covered Services. Providers shall provide Covered Services described on Attachment A-1 to Members, subject to and in accordance with the terms and conditions of this Agreement.

4.3.1. Standards. Providers shall provide Covered Services in accordance with Laws and generally accepted standards of medical practice, including nationally recognized clinical protocols and guidelines where available. Providers shall ensure that Covered Services are available to Members on a 24 hour/day, 7 day/week basis, except Providers who do not provide Emergency Services shall ensure that Covered Services are available to Members in accordance with standard operating hours for each Provider location and shall maintain an after-hours phone service for individuals to seek instructions in the event of an emergency.

4.3.2. Eligibility. Except for Emergency Services, Providers shall verify Member eligibility in accordance with the Provider Manual before providing Covered Services to a Member. Health Plan provides member eligibility information through Health Plan's provider website and other means. For Emergency Services, Providers shall verify Member eligibility within 24 hours of the Member being stabilized or the Provider learning the individual may be a Member, whichever is later. Members' eligibility status is subject to retroactive disenrollment, and Health Plan may, unless prohibited by Laws and Program Requirements, recoup payments for items or services provided to such individuals after the effective date of disenrollment even if such items and services were authorized by Health Plan.

4.3.3. Prior Authorization. Except for Emergency Services or where prior authorization is not required by the Provider Manual, Providers shall obtain prior authorization for Covered Services in accordance with the Provider Manual. Except where not permitted by Laws or Program Requirements, Health Plan may deny payment for Covered Services where a Provider fails to meet Health Plan's requirements for prior authorization. Health Plan shall provide prior authorization decisions for non-emergency services within 15 days of a completed request by Provider. Prior authorizations shall be

effective upon the date of Medicaid eligibility if the Member is residing in Provider's skilled nursing facility Any denials or limitations of prior authorization requests shall be provided in writing in accordance with laws and regulations and appeal rights must be specified in such notices.

4.3.4. Referrals. When making a referral to another health care provider, a Provider shall furnish the other provider complete information on treatment procedures and diagnostic tests performed prior to such referral, which may include providing copies of the medical records.

4.3.5. Non-Covered Services. Every time a Provider provides items or services to a Member that are not Covered Services, before providing the items or services the Provider shall (a) inform the Member of the specific items or services that are not Covered Services and that they will not be paid for by Health Plan, and (b) obtain the Member's written agreement to pay for such specific items or services after being so advised. Provider shall contact Health Plan for a coverage determination in any case where Provider is unsure if an item or service is a Covered Service.

4.3.6. Subject to regulatory approval, Health Plan may enter into "carve-out" arrangements, under which Health Plan contracts with a third party to assume entire responsibility for a given type or category of Covered Service and delegates to that entity a broad range of basic management functions, provided the delegate has appropriate regulatory status under New Jersey law, as applicable. Such contracts are most common for mental health and substance abuse services, although Health Plan may use similar arrangements for prescription drugs, home health care, or other types of services. If Health Plan enters into such a carve-out arrangement, then, during the term of the arrangement, the type or category of Covered Service subject to the arrangement shall be outside the scope of this Agreement. Health Plan notifies providers of carve-out arrangements in accordance with the Provider Manual. With respect to the New Jersey Medicaid/FamilyCare Program, such carve-out arrangements are subject to approval of the New Jersey Department of Human Services and the New Jersey Department of Banking and Insurance. The terms of this Provider Agreement remain in full effect and Health Plan will ensure that the carve-out arrangement will cause no material changes to the Provider during the term of this agreement, including the contracted reimbursement rates, utilization review criteria, termination provisions, and other significant matters, other than which entity is handling basic management functions, such as claims processing, utilization review, and case management.

4.4. Claims and Encounter Data / EDI.

4.4.1. Clean Claims. Providers shall electronically prepare and submit Clean Claims to Health Plan within 180 days or such other time period required by Laws or Program Requirements, of the date of a Covered Service or the date of discharge from an inpatient facility, as the case may be. Unless prohibited by Laws and Program Requirements, Health Plan may deny payment for any claims that fail to meet Health Plan's submission requirements for Clean Claims or that are received after the time limit in this Agreement for filing Clean Claims.

4.4.2. Encounter Data. If Contracted Provider or other Provider is compensated by capitation, Contracted Provider shall, and shall require the other Providers to, electronically submit Encounter Data to Health Plan within 30 days of the last day of the month in which Covered Services were provided, or such shorter period necessary for Health Plan to comply with Laws or Program Requirements.

4.4.3. Additional Reports. If Health Plan requests additional information, data or

reports from a Provider regarding Covered Services to Members for any reason, including for purposes of risk adjustment data validation, even if Health Plan has already paid claims or accepted Encounter Data related to the Covered Services, the Provider shall provide the information, data or reports as requested by Health Plan.

4.4.4. NPI Numbers / Taxonomy Codes. Providers shall give Health Plan their National Provider Identification ("**NPI**") numbers and Provider taxonomy codes prior to becoming Participating Providers under this Agreement. Payment of compensation for Covered Services is conditioned on Providers including their NPI numbers and Provider taxonomy codes on claims or encounter data submitted under this Agreement, and Health Plan may deny payment for Covered Services where a Provider fails to meet these requirements.

4.4.5. Electronic Transaction Requirements. Provider shall submit all claims and encounter data to Health Plan electronically. Providers shall (a) follow the requirements for electronic data interchange in the then current (1) HIPAA Administrative Simplification transaction standards and (2) WellCare Companion Guide, and (b) submit all claims and encounter data either through a clearinghouse used by Health Plan or directly to Health Plan in accordance with the WellCare Companion Guide.

4.4.6. EFT / Remittance Advice. If a Provider is able to accept payments and remittance advice electronically, (a) the Provider shall register and complete the forms for electronic funds transfer and electronic remittance advice as soon as practicable, but no later than 60 days following Health Plan's confirmation of Provider's status as participating, and (b) Health Plan shall make all payments and remittance advice to the Provider electronically. If a Provider is not able to accept payments and remittance advice electronically, the Provider shall make good faith efforts to be able to accept electronic funds transfer and electronic remittance within 24 months of the Effective Date.

4.4.7. Coordination of Benefits. Health Plan shall coordinate payment for Covered Services in accordance with the terms of a Member's Benefit Plan and Laws. Providers shall provide Health Plan with electronic versions of explanations of benefits and other documents and information in their possession regarding insurance covering a Member that is primary to the Member's Benefit Plan. Providers shall bill primary insurers for items and services they provide to a Member before they submit claims for the same items or services to Health Plan. If Health Plan is not the primary payor for Covered Services provided to a Member, then when not prohibited by Laws or Program Requirements, Health Plan's payment to Provider for such services shall not exceed the compensation in this Agreement less amounts payable by the primary payor or payors, less Member Expenses. Except for the New Jersey Medicaid/FamilyCare managed care program, or if otherwise prohibited by Laws and Program Requirements, Health Plan may recoup payments for items or services provided to a Member where other insurers are determined to be responsible for such items and services.

4.4.8. Subrogation. Providers shall follow Health Plan policies and procedures regarding subrogation activity.

4.4.9. No payment made by Health Plan under this Agreement is intended as a financial incentive or inducement to reduce, limit or withhold Covered Services required by Members.

4.5. Member Protections.

4.5.1. Providers shall not discriminate in their treatment of Members based on Members' health status, source of payment, cost of treatment, participation in Benefit Plans, race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or genetic information.

4.5.2. In no event including nonpayment by Health Plan, Health Plan's insolvency or breach of the this Agreement, shall a Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons other than Health Plan acting on any Member's behalf, for amounts that are the legal obligation of Health Plan. This provision (a) shall survive termination or expiration of this Agreement regardless of the cause giving rise to termination or expiration, (b) shall be construed for the benefit of Members, (c) does not prohibit collection of Member Expenses where lawfully permitted or required, and (d) supersedes any oral or written agreement to the contrary now existing or hereafter entered into between a Provider and Members or persons acting on their behalf.

4.5.3. Regardless of any denial of a claim or reduction in payment to a Provider by Health Plan, in no event will a Member be responsible for payment for any Covered Services other than Member Expenses. However, Members shall not be responsible for Member Expenses where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement. If payment of an amount sought in a claim is denied or reduced by Health Plan, the Provider shall adjust Member Expenses accordingly.

4.5.4. Except where collection of Member Expenses is prohibited by Laws, Program Requirements or this Agreement, a Provider shall (a) collect Member Expenses directly from the Member, and (b) not waive, discount or rebate any such amounts except as permitted by and in accordance with Laws and Program Requirements regarding prohibited inducements to Federal Health Care Program beneficiaries.

4.5.5. Providers shall not bill Members for any items or services, such as missed appointments or administrative fees, where such billing is prohibited by Laws or Program Requirements.

4.6. Provider Manual. The Provider Manual supplements and is made a part of and incorporated into this Agreement, and Providers shall comply with the Provider Manual. Health Plan may amend the Provider Manual from time to time upon notice to Provider by posting to Health Plan's provider website, email or other means of notice permitted by this Agreement, provided that in the case of material revisions to the Provider Manual, Health Plan shall provide notice in accordance with the provisions of this Agreement regarding written notice. Changes to the Provider Manual shall become effective 30 days after such posting or notice, or as of such other time period required for Health Plan to comply with Laws, Program Requirements or accreditation standards. Providers shall have and maintain systems necessary for access to Health Plan's provider website, and check for revisions to the Provider Manual from time to time. Health Plan represents that the Provider Manual is consistent with this Agreement and in compliance with all applicable laws and regulations. Revisions to the Provider Manual that are material and unacceptable to Provider may be considered a basis for Provider to institute a Termination for Cause pursuant to Section 7.2.2. Health Plan and Provider agree to conduct informal dispute resolution prior to such terminations, during which the amendment to the Provider Manual shall be stayed as to Provider.

4.7. Quality Improvement. Providers shall comply with Health Plan quality improvement

programs, including those designed to improve quality measure outcomes in the then current Healthcare Effectiveness Data and Information Set (HEDIS) or other quality measures. Health Plan may audit Providers periodically and upon request Providers shall provide Records to Health Plan for HEDIS or other quality reasons and risk management purposes. Health Plan desires open communication with Providers regarding Health Plan's quality improvement initiatives and activities.

4.8. Bonus Programs. While there is no guarantee under this Agreement, Health Plan may offer certain Providers the opportunity to participate in bonus or incentive programs ("**Bonus Programs**"), which shall comply with Federal and State Laws and, with respect to the New Jersey Medicaid/FamilyCare program are subject to review and approval of the New Jersey Department of Banking and Insurance and the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, of any Bonus Program offered. If offered, a Bonus Program will be designed to promote preventive care, quality care or ensure the appropriate and cost effective use of Covered Services through appropriate utilization. Bonus Programs may be based in whole or part on Providers achieving certain quality benchmarks using HEDIS or some similar measure, achieving certain Member satisfaction, using electronic funds transfers and remittance or other objective criteria. If offered, Health Plan will set forth the specific terms and conditions of the Bonus Program in a separate policy and the Provider's participation shall be subject to the terms and conditions of this Agreement. Health Plan and Providers agree that no Bonus Program shall limit Medically Necessary services.

4.9. Utilization Management. Providers shall cooperate and participate in Health Plan's utilization review and case management programs. Health Plan's utilization review/case management programs may include provisions for (a) verification of eligibility and prior authorization for Covered Services, (b) concurrent and retrospective reviews, and (c) corrective action plans.

4.10. Member Grievances / Appeals. Providers shall comply with the Provider Manual, Laws and Program Requirements regarding Member grievances and appeals, including by providing information, records or documents requested by Health Plan and participating in the grievance/appeal process.

4.10.1. Compliance. In performing this Agreement, Providers shall comply with all Laws and Program Requirements. Providers shall (a) cooperate with Health Plan with respect to Health Plan's compliance with Laws and Program Requirements, including downstream requirements that are inherent to Health Plan's responsibilities under Laws or Program Requirements, and (b) not knowingly take any action contrary to Health Plan's obligations under Laws or Program Requirements.

4.10.2. Privacy / HIPAA. Providers shall maintain Member information and medical records in accordance with Laws, including Federal and State Laws related to privacy and confidentiality of Member information and medical records, including HIPAA, and shall use and disclose such information or records only in accordance with Laws and Program Requirements.

4.10.3. Fraud, Waste and Abuse. Providers shall comply with Laws designed to prevent or ameliorate fraud, waste, and abuse, including applicable provisions of Federal criminal law, the False Claims Act (31 USC §§ 3729 et. seq.), and the anti-kickback statute (section 1128B(b) of the Social Security Act).

4.10.4. Accreditation. Providers shall comply with policies and procedures required for Health Plan to obtain or maintain its accreditation from accreditation bodies, including the National

Committee for Quality Assurance or Utilization Review Accreditation Commission.

4.10.5. Compliance Program / Reporting. Provider shall comply with Health Plan compliance program requirements, including Health Plan's compliance training requirements, and after reasonable and diligent investigation, must report to Health Plan any confirmed fraud, waste, or abuse or criminal acts by Health Plan, Contracted Provider, other Providers, their respective employees or subcontractors, or by Members as required by law. Reports may be made anonymously through the WellCare fraud hotline at (866) 678-8355. Also, if DHHS publishes compliance program requirements that providers must follow as a condition of participation in Federal Health Care Programs, Contracted Provider shall, and shall require its subcontractors to, comply with such requirements.

4.10.6. Acknowledgement of Federal Funding. Claims, data and other information submitted to Health Plan pursuant to this Agreement may be used, directly or indirectly, for purposes of obtaining payments from Federal or State governments under Federal Health Care Programs, and payments that Providers receive under this Agreement may be, in whole or in part, from Federal funds.

(a) Providers shall, upon request of Health Plan, certify, based on its best knowledge, information and belief, that all data and other information directly or indirectly reported or submitted to Health Plan pursuant to this Agreement is accurate, complete and truthful.

(b) Providers shall not claim payment in any form, directly or indirectly, from a Federal Health Care Program for items or services covered under this Agreement, except for wrap around payments made directly by Governmental Authorities to certain qualified providers, such as Federally qualified health centers ("**FQHCs**") or rural health clinics ("**RHCs**") where applicable.

4.10.7. Ineligible Persons. Contracted Provider warrants and represents as of the Effective Date and throughout the term of the Agreement and the duration of post expiration or termination transition activities described in this Agreement, that none of it, its Principals or any individual or entity it employs or has contracted with to carry out its part of this Agreement is an Ineligible Person.

4.10.8. Compliance Audit. Health Plan shall be entitled to audit Providers with respect to compliance issues, including their compliance programs, and require them to address compliance issues through education, counseling or corrective action plans. Providers shall cooperate with Health Plan with respect to any such audit, including by providing Health Plan with Records and site access within such time frames as requested by Health Plan.

4.10.9. Intentionally Deleted.

4.11. Licensure. Providers shall secure and maintain all necessary licenses, certificates, permits, registrations, consents, approvals and authorizations that must be obtained by them to perform their obligations under this Agreement

4.12. Insurance. Contracted Provider and its subcontracted Providers shall secure and maintain for themselves and their employees commercial general liability and professional liability (malpractice) insurance coverage, or with respect to hospital providers only self insurance, for claims arising out of

events occurring during the term of this Agreement and any post expiration or termination activities under this Agreement, in amounts required to meet Credentialing Criteria, and worker's compensation insurance as required by State Laws. Contracted Provider and its subcontracted Providers shall, upon request of Health Plan, provide Health Plan with certificates of insurance or other evidence of coverage reflecting satisfaction of the foregoing requirements of this paragraph. Contracted Provider and the subcontracted Providers shall provide at least 30 days prior notice to Health Plan in advance of any material modification, cancellation or termination of their insurance.

4.13. Proprietary Information. In connection with this Agreement, Health Plan or its Affiliates may disclose to Providers, directly or indirectly, certain information that Health Plan or its Affiliate have taken reasonable measures to maintain as confidential and which derives independent economic value from not being generally known or readily ascertainable by the public ("**Proprietary Information**"). Proprietary Information includes Member lists, the compensation provisions of this Agreement, and other information relating to Health Plan's or its Affiliates' business that is not generally available to the public. Contracted Provider shall, and shall require its subcontractors to, hold in confidence and not disclose any Proprietary Information and not use Proprietary Information except (a) as expressly permitted under this Agreement, or (b) as required by Laws or legal or regulatory process. Contracted Provider shall, and shall require its subcontractors to, provide Health Plan with prior notice of any such disclosure required by Laws or legal or regulatory process so that Health Plan can seek an appropriate protective order. Contracted Provider shall, and shall require its subcontractors to, disclose Proprietary Information only in order to perform their obligations under this Agreement, and only to persons who have agreed to maintain the confidentiality of the Proprietary Information. The requirements of this Agreement regarding Proprietary Information shall survive expiration or termination of this Agreement.

4.14. Required Notices. In addition to any other notices required under this Agreement, Contracted Provider shall give notice to Health Plan immediately, but in no event later than within two business days, of the occurrence of any event that could reasonably be expected to impair the ability of a Provider to comply with the obligations of this Agreement, including any of the following: (a) an occurrence that causes any of the representations and warranties in this Agreement made by or on behalf of a Provider to be inaccurate, (b) a Provider fails to maintain insurance as required by this Agreement,(c) a Provider's license, certification expires or is suspended, revoked, conditioned or otherwise restricted, (d) a Provider is excluded, suspended or debarred from, or sanctioned under a Federal Health Care Program, (e) charges are filed against the entity or its principals for fraud, abuse, or other health care crime, (f) a Provider enters into a settlement related to any of the foregoing.

5. Health Plan Responsibilities.

5.1. ID Cards. Health Plan shall issue identification cards to Members and instruct them to present their cards to providers when seeking health care items and services.

5.2. Claims Processing. Health Plan shall pay or deny Clean Claims within the time period set forth in Attachment C. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines, and state specific regulations. These software programs may result in claim edits for specific procedure code combinations.

5.3. Compensation. Compensation shall be as set forth in Attachment C, and specifically as to New Jersey Medicaid/FamilyCare compensation in Attachment C-1. Providers shall accept such compensation (plus wrap around payments from Governmental Authorities to qualified providers such as FQHCs or RHCs where applicable) as payment in full for Covered Services rendered to Members and all other activities of Providers under this Agreement.

5.4. Medical Record Review. Health Plan shall be entitled to perform concurrent or retrospective reviews of medical records for utilization management purposes or to verify that items and services billed to or paid for by Health Plan were provided and billed correctly in accordance with this Agreement and the Provider Manual, or were Covered Services (including that such items and services were Medically Necessary).

5.5. Recoupment. Unless otherwise prohibited by Laws, Contracted Provider, for itself and the other Providers, authorizes Health Plan to deduct from amounts that may otherwise be due and payable to a Provider any outstanding amounts that the Provider may owe Health Plan for any reason, including Overpayments, in accordance with its recoupment policy and procedure. "**Overpayment**" for purposes of this Agreement means any funds that a Provider receives or retains to which the Provider is not entitled, including overpayments (a) for items and services later determined not to be Covered Services, (b) due to erroneous or excess reimbursement, (c) resulting from errors and omissions relating to changes in enrollment, claims payment errors, data entry errors or incorrectly submitted claims, or (d) for claims paid when Health Plan was the secondary payor and the Provider should have been reimbursed by the primary payor. An Overpayment also includes any payment Health Plan makes which is the obligation of and not paid by a Provider, including for improperly collected Member Expenses due a Member. Prior to deducting Overpayments, Health Plan shall provide the Provider notice in accordance with Health Plan's recoupment policy that an offset will be performed against future payments unless the Provider within such notice period either refunds or repays such amounts or provides Health Plan with a written explanation, with supporting documentation, disputing that such amounts should be refunded or repaid. If there are no future payments to offset, then the Provider shall repay Overpayments to Health Plan within 30 days, or such other timeframe as may be mandated by Laws or Program Requirements, of the Provider's receipt of notice of such Overpayment. Health Plan agrees not to seek repayment of an Overpayment from a Provider beyond the time period set forth in Health Plan's recoupment policy, unless a longer time is required by Laws or Program Requirements. Notwithstanding the above, there shall be no deadline within which Health Plan may seek recovery of an Overpayment in a case of fraud. This section shall survive expiration or termination of this Agreement.

5.6. Suspension of Payment. If DHHS suspends payments to a Provider while Governmental Authorities investigate a credible allegation of fraud (as determined by DHHS), then Health Plan may suspend the Provider and payments for Covered Services provided by the Provider during the period of the DHHS suspension of payments.

5.7. Health Plan Designees. Health Plan may delegate administrative functions related to Benefit Plan management to third parties. Provider shall cooperate with any Health Plan designee performing administrative functions for Health Plan to the same extent that it is required to cooperate with Health Plan.

5.8. Insurance. Health Plan shall maintain such policies of general and professional liability insurance in accordance Laws and to insure Health Plan against claims regarding Health Plan operations and performance under this Agreement.

6. Records, Access & Audits.

6.1. Maintenance. Contracted Provider shall, and shall cause its subcontractors to, maintain operational, financial and administrative records, contracts, books, files, data and other documentation related to the Covered Services provided to Members, claims filed and other services and activities conducted under this Agreement ("**Records**"). Contracted Provider shall ensure that such Records are kept in accordance with Laws, Program Requirements, generally accepted accounting principles (as applicable) and prudent record keeping practices and are sufficient to enable Health Plan to enforce its rights under this Agreement, including this section, and to determine whether Contracted Provider and its subcontractors and their respective employees are performing or have performed Contracted Provider's obligations in accordance with this Agreement, Laws and Program Requirements. Contracted Provider shall, and shall cause its subcontractors to, maintain such Records for the time period set forth in the applicable Program Attachment governing the Benefit Plan. Records that are under review or audit shall be retained until the completion of such review or audit if that date is later than the time frame indicated above.

6.2. Access & Audit. Health Plan shall have the right to monitor, inspect, evaluate and audit Contracted Provider and its subcontractors. In connection with any monitoring, inspection, evaluation or audit, Contracted Provider shall, and shall cause its subcontractors to, provide Health Plan with access to all Records, personnel, physical facilities, equipment and other information necessary for Health Plan or its auditors to conduct the audit. Within three business days of Health Plan's written request for Records, or such shorter time period required for Health Plan to comply with requests of Governmental Authorities, Contracted Provider shall, and shall cause its subcontractors to, compile and prepare all such Records and furnish such Records to Health Plan in a format reasonably requested by Health Plan. Copies of such Records shall be at no cost to Health Plan.

6.3. The requirements of this Agreement regarding Records, access and audit shall survive expiration or termination of this Agreement.

7. Term and Termination.

7.1. Term. The term of this Agreement shall begin on the Effective Date and continue for a period of one year, and thereafter shall renew for successive periods of one year each unless a Party provides notice of nonrenewal to the other at least 90 days before the end of the then current (initial or renewal) term (or 180 days in the case of a hospital Provider), unless and until the Agreement is terminated in accordance with the terms and conditions of the Agreement, including those in a Program Attachment.

7.2. Termination.

7.2.1. Termination for Convenience. Either Party may terminate this Agreement, in whole or with respect to any particular Program or Benefit Plan, at any time for any reason or no reason upon 90 days prior notice to the other (or 180 days in the case of a hospital Provider). Health Plan may terminate this Agreement as to any particular Provider at any time for any reason or no reason upon 90 days prior notice to Contracted Provider, except in the case of a hospital Provider where Health Plan must provide at least 180 days prior notice.

7.2.2. Termination for Cause.

(a) A Party may terminate this Agreement for material breach by the other Party of any of the terms or provisions of this Agreement by providing the other Party at least 90 days prior notice specifying the nature of the material breach. During the first 60 days of the notice period, the breaching Party may cure the breach to the reasonable satisfaction of the non-breaching Party.

(b) Health Plan may terminate this Agreement as to a particular Provider for a material failure by the Provider to comply with any of the terms or provisions of this Agreement by providing Contracted Provider at least 90 days prior notice specifying the nature of the material failure. During the first 60 days of the notice period, the affected Provider may cure the material failure to the reasonable satisfaction of Health Plan.

7.2.3. Immediate Termination. Health Plan may terminate this Agreement in its entirety, or with respect to a particular Provider, upon immediate notice to Contracted Provider upon the occurrence of any of the following: (a) necessary to prevent imminent harm to the health and safety of Members as determined by a Governmental Authority if such condition is not corrected in thirty (30) days, (b) a Provider suffers the loss, suspension or restriction of a license from a Governmental Authority or accreditation from an accreditation body required to carry out its obligations under this Agreement, including meeting the conditions of participation in applicable Programs, (c)(1) Contracted Provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, or (2) a subcontracting provider or vendor of provider becomes an Ineligible Person or voluntarily withdraws from participation in applicable Programs, and is not immediately terminated by Contracted Provider following receipt of notice concerning such, (d) a Governmental Authority orders Health Plan to terminate the Agreement, (e) a Provider fails to meet Credentialing Criteria after notice and an opportunity for cure, (g) a Provider fails to maintain insurance as required by this Agreement after notice and an opportunity for cure, (h) a Provider becomes insolvent, is adjudicated as bankrupt, has its business come into possession or control of any trustee in bankruptcy, has a receiver appointed for it, or makes a general assignment for the benefit of its creditors, and it cannot reasonably provide the levels or quality of

care to members as required by this Agreement.

7.2.4. Transition of Care. To ensure that a transition is undertaken in an orderly manner that maximizes Member safety and continuity of care, upon expiration or termination of this Agreement for any reason except for immediate termination, Providers shall (a) continue providing Covered Services to Members through (1) the lesser of the period of active treatment for a chronic or acute medical condition or up to 90 days, (2) the postpartum period for Members in their second or third trimester of pregnancy, or (3) such longer period required by Laws or Program Requirements, and (b) cooperate with Health Plan for the transition of Members to other Participating Providers. The terms and conditions of this Agreement shall apply to any such post expiration or termination activities, provided that if a Provider is capitated, Health Plan shall pay the Provider for such Covered Services at 100 percent of Health Plan's then current rate schedule for the applicable Benefit Plans. The transition of care provisions in this Agreement shall survive expiration or termination of this Agreement.

7.2.5. Notification to Members. Upon expiration or termination of this Agreement, Health Plan will communicate such expiration or termination to Members as required by and in accordance with Laws and Program Requirements. Providers shall obtain Health Plan's prior written approval of Provider communications to Members regarding the expiration or termination of this Agreement. The foregoing sentence shall not prevent a Provider from engaging in communications with his patient regarding the patient's health.

8. Dispute Resolution.

8.1. Provider Administrative Review and Appeals. Where applicable, a Provider shall exhaust all Health Plan's review and appeal rights in accordance with the Provider Manual before seeking any other remedy except as pertains to termination or non-renewal of the Agreement. Where required by Laws or Program Requirements, administrative reviews and appeals shall be subject to and resolved in accordance with administrative law.

8.2. Dispute Resolution. Except as prohibited by State Laws, and except as pertains to matters involving termination of the Agreement, all claims and disputes between Health Plan and a Provider related to this Agreement must be submitted to arbitration within one year of the act or omission giving rise to the claim or dispute, except for claims based on fraud, which must be brought within the State statute of limitation governing fraud claims. The failure to initiate arbitration within the foregoing time period will constitute waiver of such claims and disputes.

8.3. Negotiation. Before a Party initiates arbitration regarding a claim or dispute under this Agreement, the Parties shall meet and confer in good faith to seek resolution of the claim or dispute. If a Party desires to initiate the procedures under this section, the Party shall give notice (a "**Dispute Initiation Notice**") to the other providing a brief description of the nature of the dispute, explaining the initiating Party's claim or position in connection with the dispute, including relevant documentation, and naming an individual with authority to settle the dispute on such Party's behalf. Within 20 days after receipt of a Dispute Initiation Notice, the receiving Party shall give a written reply (a "**Dispute Reply**") to the initiating Party providing a brief description of the receiving Party's position in connection with the dispute, including relevant documentation, and naming an individual with the authority to settle the dispute on behalf of the receiving Party. The Parties shall promptly make an investigation of the dispute, and commence discussions concerning resolution of the dispute within 20 days after the date of the Dispute Reply. If a dispute has not been resolved within 30 days after the Parties have commenced

discussions regarding the dispute, either Party may submit the dispute to arbitration subject to the terms and conditions herein.

8.4. Arbitration. Except as barred or excepted by this Agreement, and except as to claims or disputes involving contract termination, all claims and disputes between the Parties shall be resolved by binding arbitration in Trenton, New Jersey. The arbitration shall be conducted through the American Arbitration Association ("**AAA**") pursuant to the AAA Commercial Arbitration Rules then in effect, subject to the following: Arbitration shall be commenced by completing and filing with AAA a Demand for Arbitration form in accordance with the Commercial Arbitration Rules setting forth a description of the dispute, the amount involved and the remedy sought, and sending notice of the demand to the opposing Party. The arbitration shall be held before a single arbitrator, unless the amount in dispute is more than $10 million, in which case it will be held before a panel of three arbitrators. In a case with a single arbitrator, the Parties shall select the arbitrator by agreement within 30 days of the date the Demand for Arbitration is filed, and if the Parties are unable to agree on the selection of an arbitrator within such time, AAA shall select an independent arbitrator. In the case of a panel, within 30 days of the date the Demand for Arbitration is filed each Party shall select an arbitrator, and the two arbitrators shall select the third arbitrator, and if the two arbitrators are unable to agree on the selection of a third arbitrator within such time, AAA shall select an independent third arbitrator. The arbitrator or panel may not certify a class or conduct class based arbitration. The decision of the arbitrator or panel shall be final and binding on the Parties. The award of the arbitrator or panel may be confirmed or enforced in any court having jurisdiction. Each Party shall assume its own costs related to the arbitration, including costs of subpoenas, depositions, transcripts, witness fees, and attorneys' fees. The compensation and expenses of the arbitrator and administrative fees or costs of the arbitration shall be borne equally by the Parties.

9. Miscellaneous.

9.1. Effective Date. With respect to the New Jersey Medicaid/FamilyCare Program, the Effective Date of this Agreement is subject to Health Plan obtaining final approval to amend its Certificate of Authority or other authorization to include NJ Medicaid/FamilyCare and the effective date of Health Plan's contract with the Department of Human Services to provide Covered Services to New Jersey Medicaid/FamilyCare enrollees.

9.2. Governing Law / Venue. This Agreement shall be governed by and construed and enforced in accordance with the laws of the State of New Jersey without regard to principles of conflict of laws, except that Federal law shall apply as to matters where New Jersey law is preempted by Federal law. Each of the Parties hereby agrees and consents to be subject to the exclusive jurisdiction and venue of State or Federal courts, as appropriate, located in New Jersey in any suit, action, or proceeding seeking to enforce any provision of, or based on any matter arising out of or in connection with, this Agreement.

9.3. Waiver of Jury Trial. Each Party hereby irrevocably and unconditionally waives, to the fullest extent it may legally and effectively do so, trial by jury in any suit, action or proceeding arising hereunder.

9.4. Equitable Relief. Notwithstanding anything in this Agreement, either Party may bring court proceedings to seek an injunction or other equitable relief to enforce any right, duty or obligation under this Agreement.

9.5. Independent Contractors. The Parties are independent contractors. This Agreement shall

not be deemed to create a partnership or joint venture, or an employment or agency relationship between the Parties. Neither Party has the right or authority to assume or create any obligation or responsibility on behalf of the other. Neither Party is liable for the acts of the other.

9.6. No Steering. For the term of this Agreement and for one year thereafter, Providers shall not engage in steering or otherwise directly or indirectly solicit any Member to join a competing health plan or induce any Member to cease doing business with Health Plan, not inclusive of counseling provided to Members who voluntarily seek assistance in regard to their health benefits, or in the event of termination of Provider by Health Plan.

9.7. No Offshore Contracting. With respect to the Medicare Advantage Program, Contracted Provider shall not perform any work related to this Agreement outside of the United States without Health Plan's prior written consent, which consent shall be conditioned upon notification to, or approval of, CMS as required. With respect to the New Jersey Medicaid/FamilyCare Program, under no circumstances shall Contracted Provider perform any work related to this Agreement outside of the United States.

9.8. The following applies to State plans: Contracted Provider shall not, and shall require its subcontractors not to, make any payments for items or services provided under a State plan to financial institutions or entities such as provider bank accounts or business agents located outside of the States. Further Contracted Provider shall not, and shall require its subcontractors not to, make payments to telemedicine providers located outside of the States, or payments to pharmacies located outside of the States. Any such funds paid may be recovered by Health Plan or a State Governmental Authority with applicable jurisdiction over a plan.

9.9. Third Parties. Except as otherwise provided in this Agreement, this Agreement is not a third party beneficiary contract and no provision of this Agreement is intended to create or may be construed to create any third party beneficiary rights in any third party, including any Member.

9.10. Notices. Except for non-material revisions to the Provider Manual, all notices required or permitted under this Agreement must be in writing and sent by (a) hand delivery, (b) U.S. certified mail, postage prepaid, return receipt requested, (c) overnight delivery service providing proof of receipt, (d) facsimile or (e) email, to the addresses of the Parties as set forth on the signature page. Each Party may designate by notice any future or different addresses to which notices will be sent. Notices will be deemed delivered upon receipt or refusal to accept delivery. Notice to Contracted Provider shall constitute notice to all Providers. Routine day to day operational communications between the Parties are not notices in accordance with this section.

9.11. Incorporation of Laws / Program Requirements / Accreditation Standards. All terms and conditions of this Agreement are subject to Laws, Program Requirements and accreditation standards. Any term, condition or provision now or hereafter required to be included in the Agreement by Laws, Program Requirements or accreditation standards shall be deemed incorporated herein and binding upon and enforceable against the Parties, regardless of whether or not the term, condition or provision is expressly stated in this Agreement. Health Plan may amend this Agreement upon notice to Contracted Provider to comply with Laws, Program Requirements or accreditation standards, and such amendment shall be effective upon receipt.

9.12. Amendment. With respect to the New Jersey Medicaid/FamilyCare Program, any

amendments to this Agreement are subject to review and approval by the New Jersey Department of Banking and Insurance and the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, as applicable. Except as otherwise set forth in this Agreement, any amendments to this Agreement shall be in writing and signed by both Parties. However, Health Plan may amend this Agreement upon 30 days prior notice to Contracted Provider, and if Contracted Provider objects to the amendment, Contracted Provider shall notify Health Plan of the objection within the 30 day notice period, and Health Plan may terminate this Agreement for convenience in accordance with this Agreement.

9.13. Assignment. With respect to the New Jersey Medicaid/FamilyCare Program, any assignment, delegation or transfer of this Agreement, in whole or in part, is subject to review and approval by the New Jersey Department of Banking and Insurance and the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, as applicable. Contracted Provider may not assign, delegate or transfer this Agreement, in whole or in part, without receiving all applicable and required regulatory approvals for transfer of the license, upon which Contracted Provider must notify the Health Plan of any approved change in ownership interests. Health Plan may assign this Agreement, in whole or in part, to any purchaser of the assets or successor to the operations of Health Plan or its Affiliate. As used in this section, the term "**assign**" or "**assignment**" includes a change of control of a Party by merger, consolidation, transfer, or the sale of the majority or controlling stock or other ownership interest in such Party, and excludes sales of stock or membership interests not resulting in a change in control by a new entity or individual.

9.14. Name, Symbol and Service Mark. The Parties shall not use each other's name, symbol, logo, or service mark for any purpose without the prior written approval of the other. However, (a) Providers may include Health Plan's or Benefit Plan names in listings of health plans the providers participate in, and (b) Health Plan may use information about Providers in information or publications identifying Participating Providers or as required by Laws or Program Requirements. Providers shall provide comparable treatment to Health Plan as provided to other managed care organizations with respect to marketing or the display of cards, plaques or other logos provided by Health Plan to identify Participating Providers to Members.

9.15. Other Agreements. If a Provider participates as a Participating Provider under more than one agreement with Health Plan for a particular Program, Health Plan will compensate the Provider for Covered Services it provides to Members of Benefit Plans in that Program under the agreement selected by Health Plan.

9.16. Health Plan Affiliates. If a Provider renders covered services to a member of a benefit plan issued or administered by a Health Plan Affiliate, the Health Plan Affiliate may pay for such covered services, and the Provider shall accept, the applicable out of network rates paid by the Health Plan Affiliate for the member's benefit plan. A list of Health Plan Affiliates is available in the Provider Manual or on Health Plan's provider website. There shall be no joint liability between or among Health Plan and its Affiliates.

9.17. Force Majeure. The Parties shall have and maintain disaster recovery plans in accordance with high industry standards. However, if either Party's performance under this Agreement is prevented, hindered or delayed by reason of any cause beyond the Party's reasonable control that cannot be overcome by reasonable diligence, including war, acts of terrorism, civil disorders, labor disputes (other than strikes within such Party's own labor force), governmental acts, epidemics, quarantines,

embargoes, fires, earthquakes, storms, or acts of God, such Party shall be excused from performance to the extent that it is prevented, hindered or delayed thereby, during the continuances of such cause; and such Party's obligations hereunder shall be excused so long as and to the extent that such cause prevents or delays performance. If a Provider is unable to perform under this Agreement due to an event as described in this paragraph, Health Plan may take whatever action is reasonable and necessary under the circumstances to ensure its compliance with Laws and Program Requirements and equitably adjust payments to the Provider until the Provider resumes its performance under this Agreement.

9.18. Severability. When possible, each provision of this Agreement shall be interpreted in such manner as to be effective, valid and enforceable under Laws. If any provision of this Agreement is held to be prohibited by, or invalid or unenforceable under Laws, such provision shall be ineffective only to the express extent of such prohibition, unenforceability or invalidity, without invalidating the remainder of this Agreement.

9.19. Waiver. No waiver shall be effective unless in writing and signed by the waiving Party. A waiver by a Party of a breach or failure to perform this Agreement shall not constitute a waiver of any subsequent breach or failure.

9.20. Entire Agreement. This Agreement, including the Attachments each of which are made a part of and incorporated into this Agreement, the Provider Manual and any addenda or amendments comprises the complete agreement between the Parties and supersedes all previous agreements and understandings (whether verbal or in writing) related to the subject matter of this Agreement.

9.21. Headings. The various headings of this Agreement are provided for convenience only and shall not affect the meaning or interpretation of this Agreement or any provision of it.

9.22. Interpretation. Both Parties have had the opportunity to review this Agreement with legal counsel, and any ambiguity found in this Agreement shall not be construed in a Party's favor on the basis that the other Party drafted the provision containing the ambiguity.

9.23. Survival. Any provision of this Agreement, including an Attachment, that requires or reasonably contemplates the performance or existence of obligations by a Party after expiration or termination of this Agreement shall survive such expiration or termination regardless of the reason for expiration or termination.

9.24. Rights Cumulative. Except as set forth herein, all rights and remedies of a Party in this Agreement are cumulative, and in addition to all legal rights and remedies available to such Party.

9.25. Counterparts / Electronic Signature. This Agreement may be executed in any number of counterparts. The exchange of copies of this Agreement and of signature pages by facsimile transmission or electronic mail shall constitute effective execution and delivery of this Agreement as to the parties and may be used in lieu of the original Agreement for all purposes.

9.26. Warranties and Representations. Each Party warrants and represents, as of the Effective Date and continuously thereafter throughout the entire term of this Agreement and during the post expiration or termination transition period described herein, as follows:

9.26.1. The Party is a corporation or other legally recognized entity duly incorporated or

organized, validly existing and in good standing under the laws of the State in which it is incorporated, organized or operating and it has the authority to transact business in each State in which it operates.

9.26.2. The Party has the corporate or company power and legal authority to, and has taken all necessary corporate or other action on its part to, authorize the execution and delivery of this Agreement and the performance of its obligations hereunder.

9.26.3. This Agreement has been duly executed and delivered by the Party, and constitutes a legal, valid, and binding agreement that is enforceable against such Party in accordance with its terms, except as limited by applicable bankruptcy, reorganization, moratorium and similar Laws affecting the enforcement of creditors' rights.

9.26.4. The execution and delivery of this Agreement and the performance of the Party's obligations hereunder do not (a) conflict with or violate any provision of the Party's organizational documents or Laws, or (b) conflict with, or constitute a default under, any contractual obligation of the Party.

9.27. Health Plan has not delegated any functions to Provider under this Agreement, unless there is a separate delegation schedule or addendum to this Agreement agreed to by both Parties. Any delegation of functions under this Agreement under the New Jersey Medicaid/FamilyCare Program is subject to review and approval by the New Jersey Department of Banking and Insurance and the New Jersey Department of Human Services, Division of Medical Assistance and Health Services, as applicable.

SIGNATURE PAGE FOLLOWS

SIGNATURE PAGE

IN WITNESS WHEREOF, the undersigned, with the intent to be legally bound, have caused this Agreement to be duly executed and effective as of the Effective Date.

WellCare Health Plans of New Jersey, Inc.

By: _____

Print Name: _____

Title: _____

Date: _____

Notice Address:

WellCare Health Plans of New Jersey, Inc.
33 Washington Street
Newark, NJ 07102
ATTN: Network Management

Fax:
Email: NJPR@wellcare.com

By: _____

Print Name: _____

Title: _____

Date: _____

Notice Address:

Name of Contracted Provider
Street Address
City, ST Zip
ATTN:

Fax:
Email:

ATTACHMENT A
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES

ANCILLARY PROVIDER

Subject to and in accordance with the terms and conditions of this Agreement, Contracted Provider shall provide or arrange for the provision of all Covered Services that are ancillary health care items or services available from the Providers that are within the scope of their medical or professional licenses or certifications.

ATTACHMENT A-1
PROVIDER SPECIFIC REQUIREMENTS / COVERED SERVICES
SKILLED NURSING FACILITY

1. Subject to and in accordance with the terms and conditions of this Agreement, Contracted Provider shall provide or arrange for the provision of all Covered Services that are skilled nursing facility ("SNF") based health care items or services available from the Providers. SNF based Covered Services those covered under the N.J. Medicaid fee for service program requirements and as consistent with N.J.A.C. 8:39-1.1 et seq.

2. The SNF Provider shall contact Health Plan prior to or within 24 hours of admission or Medicaid eligibility determination for authorization of care. Authorization for skilled nursing services shall be effective retroactive to the date of admission or the date of Medicaid eligibility for skilled nursing services.

3. In the case of nursing facility services, Health Plan agrees to assess "medical necessity" under the established N.J. Medicaid regulations governing eligibility set forth at N.J.A.C. 8:85-2.1. and related regulations and guidelines.

4. Payment rates for skilled nursing facility services shall at a minimum be those rates established as the approved and current New Jersey Department of Human Services' nursing home payment rates as authorized in the most current year's state Appropriations Act, and as published by DHS or its vendor.

ATTACHMENT A-2
INFORMATION FOR CONTRACTED PROVIDER / PRINCIPALS

1. Contracted Provider is a:

   _____ Sole Proprietor
   _____ Corporation
   _____ Partnership
   _____ Limited Liability Company
   _____ Professional Association

2. The Principals of Contracted Provider are:

NAME	ADDRESS	PERCENT OWNERSHIP	TITLE	DATE

ATTACHMENT A-3
(NJ MEDICAID/FAMILYCARE)
ADDITIONAL INFORMATION FOR CONTRACTED PROVIDER/PRINCIPALS AND SUBCONTRACTORS

With respect to the New Jersey Medicaid/FamilyCare Program, Contracted Provider acknowledges that this disclosure form (also found in the Appendix at B.7.37 of the Contract) shall be submitted by Health Plan to DMAHS annually and upon request, and agrees to provide a complete, accurate form to Health Plan at the time of initial contracting, annually thereafter, and upon request in accordance with federal and state law. Additionally, Contracted Provider acknowledges and understands that, as to other providers with whom it subcontracts and who will be in Health Plan's network, each shall provide a complete, accurate form to Health Plan at the time of initial contracting, annually thereafter, and upon request in accordance with federal and state law. Health Plan shall maintain copies of disclosure forms from providers, subcontractors, and subcontractors' providers. For definitions, procedures and requirements refer to 42 C.F.R. § 455.100-106. "Contract" means the contract for the New Jersey Medicaid/FamilyCare Program between Health Plan and the State of New Jersey. Attach separate sheet as needed.

I. Identifying Information of Disclosing Entity

Name of Disclosing Entity and D/B/A:				
Street Address:	City:	County:	State:	Zip Code:
Telephone No:		Medicaid Provider No:		

II. Ownership and Control Interest

A. Please list the information required by subsections 7.37.A.1 and 2 of the Contract:

1.	Name:	Relationship:	
		Percent of Ownership:	
	Address:	Date of Birth: *(For Individuals)*	
		SSN: *(For Individuals)*	
	IRS ID/Other Tax ID: *(For Corporations)*		

2.	Name:	Relationship:	
		Percent of Ownership:	
	Address:	Date of Birth: *(For Individuals)*	
		SSN: *(For Individuals)*	
	IRS ID/Other Tax ID: *(For Corporations)*		

3.	Name:	Relationship:	
		Percent of Ownership:	
	Address:	Date of Birth: *(For Individuals)*	
		SSN: *(For Individuals)*	
	IRS ID/Other Tax ID: *(For Corporations)*		

B. Please list the information required by subsection 7.37.A.3 of the Contract:

Name	Address	Relationship

C. Please list the information required by subsection 7.37.A.4 of the Contract:

1.	Name:	
	Address:	
	Date of Birth:	SSN:

2.	Name:	
	Address:	
	Date of Birth:	SSN:

3.	Name:	
	Address:	
	Date of Birth:	SSN:

III. Information related to business transactions.

Provide ownership information of
(1) Any subcontractor with whom disclosing entity has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and

(2) Any significant business transactions between disclosing entity and any wholly owned supplier, or between disclosing entity and any subcontractor, during the 5-year period ending on the date of the request.

Name	Address	Ownership

Disclose information on types of transactions with a "party in interest" as defined in Section 1318(b) of the Public Health Service Act (Section 1903(m)(4)(A) of the Social Security Act).

IV. Disclosure of Information on persons convicted of crimes.

Identity of any person who has ownership or control interest in disclosing entity, or is an agent or managing employee of disclosing entity; and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.

Are there any directors, officers, agents, or managing employees of the disclosing entity who have ever been convicted of a criminal offense related to their involvement in such programs established by Titles XVIII, XIX, or XX?

Yes ___ No ___ **If yes, list names and addresses of individuals or corporations.**

Name	Address

Whoever knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with the state agency or the secretary, as appropriate.

Name of Authorized Representative (Typed), Title

Signature **Date**

REMARKS:

ATTACHMENT A-4
INFORMATION FOR PROVIDERS

Contracted Provider shall provide the following information for (1) Contracted Provider, (2) each other Provider, and (3) each of their respective medical facilities:

- Name
- Address
- E-mail address
- Telephone and facsimile numbers
- Professional license numbers
- Medicare/Medicaid ID numbers
- Federal tax ID numbers
- Completed W-9 form
- National Provider Identifier (NPI) numbers
- Provider Taxonomy Codes
- Completed sample CMS 1500 form or UB-04 claim form
- Area of medical specialty
- Age restrictions (if any)
- Area hospitals with admitting privileges (where applicable)
- Whether Providers are employed or subcontracted with Contracted Provider using the designation "E" for employed or "C" for subcontracted.
- For a subcontracted Provider, whether its Providers are employed or contracted with the subcontracted Provider using the designation "E" for employed or "C" for contracted.
- Office contact person
- Office hours
- Billing office
- Billing office address
- Billing office telephone and facsimile numbers
- Billing office email address
- Billing office contact person
- Disclosure Statement

ATTACHMENT B
REGULATORY AND PROGRAM ATTACHMENTS

ATTACHMENT B-1
NEW JERSEY MEDICAID/FAMILYCARE REGULATORY ATTACHMENT

THIS NEW JERSEY MEDICAID/FAMILYCARE REGULATORY ATTACHMENT ("Medicaid/FamilyCare Regulatory Attachment") is incorporated into the Participating Provider Agreement **("Agreement")** entered into by and between Health Plan and Contracted Provider.

1. Construction. Contracted Provider has entered into the Agreement with Health Plan. This Medicaid/FamilyCare Regulatory Attachment is intended to supplement the Agreement by setting forth the Parties' rights and responsibilities related to the provision of Covered Services to Medicaid/FamilyCare Beneficiaries. In the event of any inconsistent or contrary language among Attachment B-1 and any other part of this Agreement (except Attachment B-2), the Parties agree that the provisions of Attachment B-1 shall prevail with respect to Benefit Plans under the New Jersey Medicaid/FamilyCare Managed Care Program.

2. Definitions**.** The following terms, and any terms defined in the Agreement, shall have the specified meanings when capitalized in this Attachment:

2.1. **"Claim"** means a request by a Medicaid/FamilyCare Beneficiary or enrollee, a participating health care provider, or a nonparticipating health care provider who has received an assignment of benefits from the Medicaid/FamilyCare Beneficiary or enrollee, for payment relating to health care services or supplies or dental services or supplies available to the Medicaid/FamilyCare beneficiary or enrollee through Health Plan under the New Jersey Medicaid/FamilyCare Program.

2.2. **"Clean Claim"** means: (a) the claim is for a service or supply covered by Health Plan under the New Jersey Medicaid/FamilyCare Program; (b) the claim is submitted with all the information requested by Health Plan on the claim form or in other instructions distributed to the Contracted Provider or Medicaid/FamilyCare Beneficiary; (c) the person to whom the service or supply was provided was covered by Health Plan on the date of service; (d) Health Plan does not reasonably believe that the claim has been submitted fraudulently; and (e) the claim does not require special treatment. Special treatment means that unusual claim processing is required to determine whether a service or supply is covered, such as claims involving experimental treatments or newly approved medications. The circumstances requiring special treatment should be documented in the claim file.

2.3. "**Covered Services**" means Medically Necessary health care items and services covered under Health Plan.

2.4. **"Department of Human Services (DHS)"** means the New Jersey Department of Human Services.

2.5. **"Department of Banking and Insurance (DOBI)"** means the New Jersey Department of Banking and Insurance.

2.6. **"Department of Health and Senior Services (DHSS)"** means the New Jersey Department of Health and Senior Services.

2.7. **"Division of Medical Assistance and Health Services (DMAHS)"** means the Division within the Department of Human Services responsible for administering the New Jersey Medicaid/FamilyCare Program.

2.8. **"Dually Eligible Individual"** means an individual who is eligible for both Medicare and Medicaid/FamilyCare.

2.9. **"Emergency Medical Condition"** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. With respect to a pregnant woman who is having contractions, an emergency exists where there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.

2.10. **"Emergency Services"** means those services that are furnished by a provider who is qualified to furnish such services and are needed to evaluate or stabilize an emergency medical condition.

2.11. **"Medicaid/FamilyCare"** refers to the program funded under Title XIX of the Social Security Act, administered by DMAHS in DHS, to provide Covered Services to eligible Medicaid/FamilyCare Beneficiaries.

2.12. **"Medicaid/FamilyCare Beneficiary"** means an individual eligible to receive services under the New Jersey Medicaid/FamilyCare Managed Care Program in accordance with N.J.A.C. 10:69, 10:70, 10:71, or 10:72.

2.13. A health care item or service is a "**Medical Necessity" or "Medically Necessary"** if a health care provider, exercising his prudent clinical judgment, would provide the item or service to a Member for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease; not primarily for the convenience of the Member or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease.

2.14. **"Medical Screening"** means an examination which is: (a) provided on hospital property, and provided for that patient for whom it is requested or required; (b) performed within the capabilities of the hospital's emergency room (including ancillary services routinely available to its emergency room); (c) performed purposely to determine if the patient has an emergency medical condition; and (d) performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by State statutes and rules and by hospital bylaws.

2.15. **"Member"** means an individual properly enrolled in Health Plan and eligible to receive Covered Services at the time such services are rendered.

2.16. **"Non-Covered Medicaid/FamilyCare Services"** means all services not covered under the New Jersey State Plan for the Medicaid/FamilyCare Managed Care Program.

2.17. **"Provider"** means any physician, hospital, facility or other health care professional who is licensed or otherwise authorized to provide healthcare services in the state or jurisdiction in which they are furnished, and who is contracted with Health Plan as a participating provider.

2.18. **"State"** means the State of New Jersey or any of its Departments or other governing authorities or authorized representatives.

2.19. **"Subcontract"** means any written agreement between Contracted Provider and a third party to perform a specified part of Contracted Provider's obligations under its contract with Health Plan.

2.20. **"Subcontractor"** means any third party who has a written agreement with Contracted Provider to perform a specified part of the Contracted Provider's obligations, and is subject to the same terms, rights, and duties as Contracted Provider.

2.21. **"Third Party Liability (TPL)"** means another party or entity, such as an insurance company, which is, or may be, responsible to pay for all or a part of the health care costs of a Medicaid/FamilyCare Beneficiary.

2.22. **"Urgent Care"** means treatment of a condition that is potentially harmful to a patient's health and for which his or her physician/CNP/CNS has determined it is medically necessary for the patient to receive medical treatment within 24 hours to prevent deterioration.

3. Submission, Acknowledgement, and Payment of Claims.

3.1. Submission, acknowledgement, and payment of claims under this Agreement shall be consistent with the Health Information Electronic Data Interchange Act ("HINT") set forth at N.J.A.C. 11:22-1.1, et. seq., including payment of clean claims within thirty (30) days for electronic submissions and forty (40) days for other than electronic submissions.

3.2. Notwithstanding Section 3.1 hereof, with respect to claims being submitted by Contracted Provider on behalf of a Member without an assignment of benefits, Contracted Provider shall file the claim within 60 days of the last date of service of that course of treatment. Where Contracted Provider is filing a claim under an assignment of benefits, Contracted Provider shall file the claim within 180 days of the last date of service of the course of treatment.

3.3. Contracted Provider shall have the right to contest the denial of any claim in accordance with N.J.A.C. 11:22-1.6, as more fully set forth in the Provider Manual.

3.4. Contracted Provider shall hold Medicaid/FamilyCare Beneficiaries harmless for the cost of any service or supply for which Health Plan provides benefits, whether or not the provider believes its compensation for the service or supply from Health Plan (directly or through a secondary contractor) is made in accordance with the reimbursement provision of the Agreement, or is otherwise inadequate.

3.5. Medicaid/FamilyCare Beneficiaries shall not be held harmless for payment of required copayments, deductibles or coinsurance, if any.

3.6. Contracted Provider shall not balance bill Medicaid/FamilyCare Beneficiaries who have obtained covered services or supplies through Health Plan's provider network mechanism.

3.7. Health Plan's contractual agreement with a secondary contractor shall provide that the secondary contractor's contract with its network providers shall include a provision whereby the provider is required to hold Health Plan's members harmless for the cost of any service or supply covered by Health Plan, whether or not the provider believes the compensation received is adequate.

4. Termination of Agreement.

4.1. Termination Generally. Any termination of the Agreement by Health Plan shall be in accordance with requirements of N.J.A.C. 11:24-3.5, as detailed below.

4.1.1. If the Agreement is terminated prior to the contract's termination date, then Health Plan shall provide at least 90 days prior written notice to Contracted Provider.

4.1.2. The notice of termination shall further advise Contracted Provider of the right to a hearing before a panel appointed by Health Plan and of the right to obtain the reason(s) for termination or non-renewal. If a reason(s) is not expressly stated in the notice of termination, Contracted Provider shall have the right to request a reason(s) for the termination in writing from Health Plan, and Health Plan shall provide a response in writing within 15 days of receipt of such request.

4.2. Provider Post-Termination Obligations. Contracted Provider acknowledges and agrees to continue to provide services to Medicaid/FamilyCare Beneficiaries in accordance with the compensation provisions set forth in Attachment C of the Agreement following termination of the Agreement, as required by N.J.A.C. 11:24-3.5. Pursuant to N.J.A.C. 11:24-3.5(c), the Health Plan will provide continued coverage of Covered Services at the contract price by a terminated health care professional for up to four (4) months where Medically Necessary for the member to continue treatment, except: (1) Pregnancy: continued coverage will continue to postpartum evaluation of the member, up to six (6) weeks after delivery; (2) Post-operative care: coverage will be continued for a period up to six (6) months; (3) Oncological treatment: coverage will be continued for a period up to one (1) year; (4) Psychiatric: coverage will be continued for a period up to one (1) year; (5) the Health Plan shall not be required to continue coverage in instances where termination of the health care professional was based upon: the Medical Director's opinion that the health care professional is an imminent danger to the patient or public health, safety and welfare; a determination of fraud or breach of contract by the health care professional; or, disciplinary action where the health care professional is the subject of inquiry by the State Board of Medical Examiners; (6) appeals of the determination as to the medical necessity of a member's continued treatment with a terminated health care professional are made in accordance with N.J.A.C. 11:24-8.5 - 8.7.

4.3. Termination Hearing. Contracted Provider has the right to request a hearing following receipt of a notice of termination, except when termination is based on: (a) nonrenewal of the contract; (b) a determination of fraud; (c) breach of contract by the Contracted Provider; or (d) the opinion of Health Plan's medical director that the Contracted Provider represents an imminent danger to a patient or the

public health, safety and welfare. Hearings for provider terminations shall be in accordance with N.J.A.C. 11:24-3.6, as set forth more fully in the Provider Manual. Contracted Provider's participation in the hearing process shall not be deemed to be an abrogation of the Contracted Provider's legal rights.

5. Complaints and Appeals.

5.1. Presentation and resolution of general complaints brought by Members or Medicaid/FamilyCare Beneficiaries or by Contracted Provider acting on behalf of a Member or Medicaid/FamilyCare Beneficiary shall be performed in accordance with N.J.A.C. 11:24-3.7, as set forth more fully in the Provider Manual.

5.2. Appeals of adverse benefits determinations brought by Members or Medicaid/FamilyCare Beneficiaries or by Contracted Provider acting on behalf of a Member or Medicaid/FamilyCare Beneficiary with the Member's or Medicaid/FamilyCare Beneficiary's consent shall be in accordance with N.J.A.C. 11:24-8.4 to 11:24-8.8, as set forth more fully in the Provider Manual.

5.3. Recoupment. A payor's claim for reimbursement shall be made for an overpayment of a previously paid claim no later than 18 months from the date of first payment on the claim, and providers shall have 45 days to submit reimbursement of an overpayment to the payor in accordance with N.J.S.A. 26:2J-8.1d(10 and (11).

5.4. Payment Disputes. Disputes made with respect to utilization management will not be subject to mandatory negotiation and arbitration under N.J.S.A. 26:2S-12 or payment disputes under N.J.S.A. 17B:27-44.2d. Disputes with respect to over or under payment shall be made in accordance with N.J.S.A. 26:2J-8.1e, following the two step internal and external appeals process wherein arbitration is potentially triggered at the second step.

6. Insurance.

6.1. Contracted Provider acknowledges and agrees that it shall maintain licensure, certification and adequate malpractice coverage.

6.2. With respect to a physician and dentist, malpractice insurance shall be at least $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

6.3. With respect to medical groups or health care facility providers, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

6.4. With respect to all other providers not otherwise under the auspices of a health care facility, malpractice insurance shall be maintained at least in an amount determined sufficient for their anticipated risk, but no less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

7. Responsibility of Health Care Facility. With respect to hospital or other health care facility contracts, and in accordance with N.J.A.C. 11:24-15.2(d)1 – 4, it is the responsibility of the health care facility (hospital) to follow clear procedures when granting and attending privileges to physicians;

notification must be provided by the Health Plan when such procedures are no longer appropriate. The admissions procedures for members will be done in accordance with New Jersey law as detailed below. The health care facility (hospital) agrees to admit Members to hospital: (i) upon orders of a participating Physician; or (ii) in the case of a Member requiring Emergency Care and subsequent inpatient services. The health care facility (hospital) agrees to notify Health Plan when members present at emergency rooms in a manner prescribed in Provider Manual. The health care facility (hospital) shall permit the Health Plan to conduct on-site inspections by the Health Plan's utilization management staff with respect to admissions and continued stays, and must ensure compliance with utilization management policies. Billing and payment procedures, schedules and negotiated arrangements will be made consistent with the New Jersey HINT law and as set forth in the Provider Manual. The Payor assumes no financial responsibility for admissions of Members which do not constitute Covered Services or which are provided in a manner that is inconsistent with the Provider Manual.

Clean claims and billing information will be submitted by the health care facility (hospital) within thirty (30) days (electronic submission), but not more than forty (40) days (written submission), from the date of Covered Service. The Health Plan reserves the right to deny payment to the health care facility (hospital) if clean claims have not been submitted to Health Plan within the above time frames. All Clean Claims must be submitted electronically or in writing to the HMO or Payor. The Payor will pay the health care facility (hospital) within the above time frame from receipt of Clean Claim from health care facility (hospital). The health care facility (hospital) will notify the Health Plan within 90 days of any prior implementation of increased charges. Any overpayment may be recouped in accordance with Section 5.3.

Notwithstanding the forgoing, with respect to claims being submitted by the Provider on behalf of the Member without an assignment of benefits, the Provider shall file the claim within 60 days of the last date of service of that course of treatment. Where the Provider is filing a claim under an assignment of benefits, the Provider shall file the claim within 180 days of the last date of service of the course of treatment.

ATTACHMENT B-2
MEDICAID/FAMILYCARE PROGRAM ATTACHMENT

As used in this Attachment, the terms "Subcontract" and "Subcontractor" shall be as defined in Attachment B-1. Contracted Provider shall, and shall require any Subcontractor to, include the following text verbatim in all Subcontracts (to the extent applicable to the Subcontract). The language either may be included in the body of the Subcontract or as an amendment.

Contracted Provider/Subcontractor agrees to serve Members enrolled in the New Jersey Medicaid/FamilyCare Program and, in so doing, to comply with all of the following provisions:

A. SUBJECTION OF AGREEMENT/SUBCONTRACT

This Agreement/Subcontract shall be subject to the applicable material terms and conditions of the contract between Health Plan and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon Health Plan.

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with Health Plan's provider network requirements shall be included in Health Plan's provider network to serve Managed Long Term Services and Supports (MLTSS) Members. In addition, if Health Plan wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. Health Plan must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be for a two year period from the date that the service comes into MLTSS, dependent upon available appropriation in each Fiscal Year. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2016. Thereafter Health Plan may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between Health Plan and the facility. This does not preclude volume-based rate negotiations and agreement between Health Plan and these providers.

2. The Any Willing Plan status also expires June 30, 2016.

3. Long term care pharmacy status as an Any Willing Provider shall not expire. Health Plan shall pay long term care pharmacies the rate negotiated between Health Plan and the pharmacy.

Claims payment for services to MLTSS Members. Health Plan shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial Management Services (VF/EA FMS) claims within the following timeframes:

1. HIPAA compliant electronically submitted Clean Claims shall be processed within fifteen (15) calendar days of receipt;

2. Manually submitted Clean Claims shall be processed within thirty (30) calendar days of receipt.

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

The Contracted Provider/Subcontractor agrees that it shall carry out its obligations as herein provided in a manner prescribed under applicable federal and State laws, regulations, codes, and guidelines including New Jersey licensing board regulations, the Medicaid, NJ KidCare, and NJ FamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

1. The Contracted Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.

2. The Contracted Provider/Subcontractor shall submit corrected claims within 365 days from the date of service.

3. The Contracted Provider/Subcontractor shall submit Coordination of Benefits (COB) claims within 60 days from the date of primary insurer's Explanation of Benefits (EOB) or 180 days from the dates of service, whichever is later.

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

The Contracted Provider/Subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this Agreement/Subcontract and any amendments thereto.

1. The parties to an Agreement/Subcontract with a provider with Any Willing Provider status shall only amend the Agreement/Subcontract unilaterally for statutory and regulatory changes, and upon mutual consent of the applicable parties with State approval.

D. EFFECTIVE DATE

This Agreement/Subcontract shall become effective only when Health Plan's agreement with the State takes effect.

E. NON-RENEWAL/TERMINATION OF AGREEMENT/SUBCONTRACT

The Contracted Provider/Subcontractor understands that Health Plan shall notify DMAHS and the Chief of Investigations of the Medicaid Fraud Division at least 30 days prior to the effective date of the suspension, termination, or voluntary withdrawal of the Contracted Provider/Subcontractor from participation in Health Plan's network. If the termination was "for cause," as related to fraud, waste and abuse, Health Plan's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless Health Plan can demonstrate it has in place a risk adjustment system that takes into account Member health-related differences when comparing across providers.

F. MEMBER-PROVIDER COMMUNICATIONS

1. Health Plan shall not prohibit or restrict Contracted Provider/Subcontractor from engaging in medical communications with Contracted Provider's/Subcontractor's patient, either explicit or implied, nor shall any provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication prohibit medical communication between Contracted Provider/Subcontractor and Contracted Provider's/Subcontractor's patient. Contracted Provider/Subcontractor shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the Agreement/Subcontract, if the professional is acting within the lawful scope of practice. Contracted Provider/Subcontractor shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

2. Nothing in Section F.1 shall be construed:

    a. To prohibit the enforcement, including termination, as part of this Agreement/Subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs,

policies, and procedures developed or operated by Health Plan to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between Contracted Provider/Subcontractor and their patients; or

b. To permit a health care provider to misrepresent the scope of benefits covered under this Agreement/Subcontract or to otherwise require Health Plan to reimburse Contracted Provider/Subcontractor for benefits not covered.

G. RESTRICTION ON TERMINATION OF AGREEMENT/ SUBCONTRACT BY HEALTH PLAN

Termination of providers with Any Willing Provider status is limited to State ordered termination as indicated in Section H below. Health Plan shall not terminate this Agreement/Subcontract for either of the following reasons:

1. Because Contracted Provider/Subcontractor expresses disagreement with Health Plan's decision to deny or limit benefits to a Member or because Contracted Provider/Subcontractor assists the Member to seek reconsideration of Health Plan's decision; or because Contracted Provider/Subcontractor discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by Health Plan or not, policy provisions of Health Plan, or the Contracted Provider's/Subcontractor's personal recommendation regarding selection of a health plan based on Contracted Provider's/Subcontractor's personal knowledge of the health needs of such patients.

2. Because Contracted Provider/Subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because Contracted Provider/Subcontractor practiced its profession in providing the most appropriate treatment required by its patients and provided informed consent within the guidelines of the law, including possible positive and negative outcomes of the various treatment modalities.

H. TERMINATION OF AGREEMENT/SUBCONTRACT – STATE

Contracted Provider/Subcontractor understands and agrees that the State may order the termination of this Agreement/Subcontract if it is determined that Contracted Provider/Subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any Member, including significant marketing abuses;

2. Takes any action that threatens the fiscal integrity of the Medicaid program;

3. Has its certification suspended or revoked by DOBI, the New Jersey Department of Health (DOH), and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

4. Becomes insolvent or falls below minimum net worth requirements;

5. Brings a proceeding voluntarily or has a proceeding brought against it involuntarily, under the Bankruptcy Act;

6. Materially breaches the Agreement/Subcontract; or

7. Violates state or federal law, including laws involving fraud, waste, and abuse.

I. NON-DISCRIMINATION

Contracted Provider/Subcontractor shall comply with the following requirements regarding nondiscrimination:

1. Contracted Provider/Subcontractor shall accept assignment of a Member and not discriminate against Medicaid/FamilyCare Program beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC § 2000d, § 504 of the Rehabilitation Act of 1973, 29 USC § 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC § 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The Contracted Provider/Subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the Contracted Provider/Subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Members who are "qualified individuals with a disability" covered by the provisions of the ADA. The Health Plan shall supply a copy of its ADA compliance plan to the Contracted Provider/Subcontractor.

   A "qualified individual with a disability" as defined pursuant to 42 USC § 12131 is an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

   Contracted Provider/Subcontractor shall submit to Health Plan a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that Contracted Provider/Subcontractor meets ADA requirements to the best of Contracted Provider's/Subcontractor's knowledge. Contracted Provider/Subcontractor

warrants that it will hold the State harmless and indemnify the State from any liability which may be imposed upon the State as a result of any failure of Contracted Provider/Subcontractor to be in compliance with the ADA. Where applicable, Contracted Provider/Subcontractor must abide by the provisions of Section 504 of the federal Rehabilitation Act of 1973, as amended, regarding access to programs and facilities by people with disabilities.

3. Contracted Provider/Subcontractor shall not discriminate against eligible persons or Members on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to Contracted Provider/Subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. Contracted Provider/Subcontractor shall comply with the Civil Rights Act of 1964 (42 USC 2000d), the regulations (45 CFR Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965, the New Jersey anti-discrimination laws including those contained within N.J.S.A. 10: 2-1 through N.J.S.A. 10: 2-4, N.J.S.A. 10: 5-1 et seq. and N.J.S.A. 10: 5-38, and all rules and regulations issued thereunder, and any other laws, regulations, or orders which prohibit discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. Contracted Provider/Subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this Agreement/Subcontract, or against any applicant for such employment because of race, creed, color, national origin, age, ancestry, sex, marital status, religion, disability or sexual or affectional orientation or preference.

5. Scope. This non-discrimination provision shall apply to but not be limited to the following: recruitment, hiring, employment upgrading, demotion, transfer, lay-off or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship included in P.L. 1975, Chapter 127.

6. Grievances. Contracted Provider/Subcontractor agrees to forward to Health Plan copies of all grievances alleging discrimination against Members because of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual or affectional orientation, physical or mental handicap for review and appropriate action within three (3) business days of receipt by Contracted Provider/Subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF HEALTH PLAN'S INSOLVENCY AND TO HOLD MEMBERS AND FORMER MEMBERS HARMLESS

1. Contracted Provider/Subcontractor shall remain obligated to provide all services for the duration of the period after Health Plan's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized Member, until the Member has been discharged from the inpatient facility.

2. Contracted Provider/Subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by Health Plan or the State, insolvency of Health Plan, or breach of agreement) will Contracted Provider/Subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, Members, or persons acting on their behalf, for Covered Services other than as provided in Section 2.P. of the contract between Health Plan and the State.

3. Contracted Provider/Subcontractor agrees that this provision shall survive the termination of this Agreement/Subcontract regardless of the reason for termination, including insolvency of Health Plan, and shall be construed to be for the benefit of Health Plan or Members.

4. Contracted Provider/Subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Contracted Provider/Subcontractor and Members, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of Covered Services provided under the terms and conditions of these continuation of benefits provisions.

5. Contracted Provider/Subcontractor agrees that any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the approval by the State.

6. Contracted Provider/Subcontractor shall comply with the prohibition against billing Members contained in 42 CFR 438.106, N.J.S.A. 30:4D-6(c), and N.J.A.C. 10:74-8.7.

K. INSPECTION

Contracted Provider/Subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services, the Medicaid Fraud Division (MFD) and other authorized State agencies, or their duly authorized representatives, to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the Agreement/Subcontract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by Contracted Provider/Subcontractor pertaining to such services, at any time during normal business hours (and after business hours when deemed necessary by DHS or DHHS, or MFD) at a New Jersey site designated by the State. Inspections may be unannounced for cause.

Contracted Provider/Subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by Contracted Provider/Subcontractor, prior to approval of their use for providing services to Members.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Agreement/Subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to Members. Upon request, at any time during the period of this Agreement/Subcontract, Contracted Provider/Subcontractor shall furnish any such record, or copy thereof, to DHS or DHS's External Quality Review Organization within 30 days of the request. If DHS determines, however, that there is an urgent need to obtain a record, DHS shall have the right to demand the record in less than 30 days, but no less than 24 hours.

DMAHS, MFD, or its designee, and the Medicaid Fraud Control Unit (MFCU), shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, related to this contract:

1. Financial records, including but not limited to tax returns, invoices, inventories, delivery receipts, Medicaid claims;

2. Medical records, including but not limited to medical charts, prescriptions, x-rays, treatment plans, medical administration records, records of the provision of activities of daily living, ambulance call reports;

3. Administrative documents, including but not limited to credentialing files, appointment books, prescription log books, correspondence of any kind with Health Plan, DMAHS, CMS, any other managed care contractor, Medicaid recipient, contracts with subcontractors, and contracts with billing service providers; and

4. All records required to be kept to fully disclose the extent of services provided to Medicaid recipients, pursuant to N.J.A.C. 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

Contracted Provider/Subcontractor shall agree to maintain all of its books and records in accordance with the general standards applicable to such book or record keeping.

M. RECORD RETENTION

Contracted Provider/Subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to Members. Such system shall collect all pertinent information relating to the medical management of each Member and make that information readily available to appropriate health professionals and DHS. Records must be retained for the later of:

1. Five (5) years from the date of service, or

2. Three (3) years after final payment is made under this Agreement/Subcontract and all pending matters are closed.

If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For Members who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with need to protect the Member's confidentiality.

If a Member disenrolls from the Health Plan, the Contracted Provider/Subcontractor shall release medical records of the Member as may be directed by the Member, authorized representatives of DHS and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the Member.

N. DATA REPORTING

Contracted Provider/Subcontractor agrees to provide all necessary information to enable Health Plan to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. Contracted Provider/Subcontractor further agrees to comply with the Prohibition on Use of Federal Funds for Lobbying provisions of Health Plan's agreement with the State.

2. Contracted Provider/Subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903(m) of the S.S.A., and N.J.A.C. 10:49-19.

3. Contracted Provider/Subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106 and complete a Disclosure Statement which will be maintained by Health Plan.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

Contracted Provider/Subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or Medicaid/FamilyCare A, B and ABP Members. Personal contributions to care for Medicaid/FamilyCare C Members and copayments for Medicaid/FamilyCare D Members shall be collected in accordance with the applicable Benefit Plan.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. Contracted Provider/Subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the Members and their eligible dependents from any and all claims or losses accruing or resulting from its negligence in furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement/Subcontract.

2. Contracted Provider/Subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the Members and their eligible dependents from liability deriving or resulting from its insolvency or inability or failure to pay or reimburse any other person, firm, or corporation furnishing or supplying work, services, materials, or supplies in connection with the performance of this Agreement/Subcontract.

3. Contracted Provider/Subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the Members and their eligible dependents from any and all claims for services for which Contracted Provider/Subcontractor receives payment.

4. Contracted Provider/Subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the Members and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data furnished to it under this Agreement/Subcontract, or for any libelous or otherwise unlawful matter contained in such data that Contracted Provider/Subcontractor inserts.

5. Contracted Provider/Subcontractor shall indemnify the State, its officers, agents and employees, and the Members and their eligible dependents from any injury, death, losses, damages, suits, liabilities judgments, costs and expenses and claim of negligence or willful acts or omissions of Contracted Provider/Subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. Contracted Provider/Subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by Contracted Provider/Subcontractor.

R. CONFIDENTIALITY

1. General. Contracted Provider/Subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of Contracted Provider/Subcontractor and Health Plan and DHS and pertaining to Members, shall be protected from unauthorized disclosure in accordance with the provisions of 42 USC § 1396(a)(7) (§ 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and

N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this Agreement/Subcontract including the U.S. Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For Members covered by Health Plan's Benefit Plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the Member's confidentiality.

2. Member-Specific Information. With respect to any identifiable information concerning a Member that is obtained by Contracted Provider/Subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this Agreement/Subcontract; (b) shall promptly transmit to DHS all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the Agreement/Subcontract, any such information to any party other than DHS without DHS's prior written authorization specifying that the information is releasable under 42 CFR, Section 431.300 et seq., and (d) shall, at the expiration or termination of the Agreement/Subcontract, return all such information to DHS or maintain such information according to written procedures sent by DHS for this purpose.

3. Employees. Contracted Provider/Subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its Members and its employees, as well as any other information which may be specifically classified as confidential by law.

4. Medical Records and management information data concerning Members shall be confidential and shall be disclosed to other persons within Contracted Provider's/Subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this Agreement/Subcontract.

5. The provisions of this article shall survive the termination of this Agreement/Subcontract and shall bind the Contracted Provider/Subcontractor so long as the Contracted Provider/Subcontractor maintains any individually identifiable information relating to Members.

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, Contracted Provider/Subcontractor is responsible for complying, at a minimum, with the following statues and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 USC 17932 et. seq. and the implementing regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

Contracted Provider/Subcontractor shall ensure that all laboratory testing sites providing services under this Agreement/Subcontract have either a Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver or a certificate of registration along with a CLIA identification number. Those laboratory service providers with a certificate of waiver shall provide only those tests permitted under the terms of their waiver. Laboratories with certificates of registration may perform a full range of laboratory tests.

T. FRAUD, WASTE, AND ABUSE

1. Contracted Provider/Subcontractor agrees to assist Health Plan as necessary in meeting its obligations under its contract with the State to identify, investigate, and take appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR § 455.2) in the provision of health care services.

2. If the State has withheld payment and/or initiated a recovery action against the Contracted Provider/Subcontractor, or withheld payments pursuant to 42 CFR § 456.23 and N.J.A.C. 10:49-9.10(a), Health Plan shall have the right to withhold payments from Contracted Provider/Subcontractor and/or forward those payments to the State.

3. Health Plan and its providers, and subcontractors, whether or not they are enrolled Medicaid providers, shall cooperate fully with state and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DOH, MFCU, DHHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. Health Plan shall include language in its contracts with its providers and subcontractors, requiring cooperation, and stating that a failure to cooperate shall be grounds for termination of Health Plan's agreement with the provider or subcontractor. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

4. MFD shall have the right to recover directly from providers and Members in Health Plan's network for the audits and investigations MFD solely conducts. Such money that MFD recovers directly shall not be shared with Health Plan, but reported to DMAHS in the format that Health Plan reports its recoveries to DMAHS. In addition, as a part of its recovery process, MFD shall have the right to request Health Plan to withhold payment to a provider in its network as a result of an MFD audit or investigation of managed care claims. Money withheld from a provider by Health Plan shall be sent to MFD from Health Plan and reported to DMAHS in the format that Health Plan reports its recoveries to DMAHS.

5. Health Plan shall have the right to recover directly from providers and Members in Health Plan's network for the audits and investigations Health Plan solely conducts.

U. THIRD PARTY LIABILITY

1. Contracted Provider/Subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to Members.

2. Except as provided in Subsection 3. below, if Contracted Provider/Subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to Health Plan.

3. In the following situations, Contracted Provider/Subcontractor may bill Health Plan first and then coordinate with the liable third party, unless Health Plan has received prior approval from the State to take other action.

    a. The coverage is derived from a parent whose obligation to pay support is being enforced by the Department of Human Services.

    b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid/FamilyCare Program.

    c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

    d. The claim is for a child who is in a Division of Child Protection and Permanency supported out of home placement.

    e. The claim involves coverage or services mentioned in 3.a, 3.b, 3.c, or 3.d, above in combination with another service.

4. If Contracted Provider/Subcontractor knows that the third party will neither pay for nor provide the Covered Service, and the service is Medically Necessary, Contracted Provider/Subcontractor may bill Health Plan without having received a written denial from the third party.

5. Sharing of TPL Information by Contracted Provider/Subcontractor.

    a. Contracted Provider/Subcontractor shall notify Health Plan within thirty (30) days after it learns that a Member has health insurance coverage not reflected in the health insurance provided by Health Plan, or casualty insurance coverage, or of any change in a Member's health insurance coverage.

    b. When Contracted Provider/Subcontractor becomes aware that a Member has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, Contracted Provider/Subcontractor shall notify Health Plan in writing, including the Member's name and Medicaid identification number, date of

accident/incident, nature of injury, name and address of Member's legal representative, copies of pleadings, and any other documents related to the action in the Contracted Provider's/Subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the Member's diagnosis and the nature of the service provided to the Member.

c. Contracted Provider/Subcontractor shall notify Health Plan within thirty (30) days of the date it becomes aware of the death of one of its Members age 55 or older, giving the Member's full name, Social Security Number, Medicaid identification number, and date of death.

d. Contracted Provider/Subcontractor agrees to cooperate with Health Plan's and the State's efforts to maximize the collection of third party payments by providing to Health Plan updates to the information required by this section.

V. MEMBER PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a Covered Service to a Member, the provider's sole recourse for payment, other than collection of any authorized cost-sharing, patient payment liability and /or third party liability, is Health Plan, not the Member. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, a Member, a Member's family member, any legal representative of the Member, or anyone else acting on the Member's behalf unless Subsections (a) through and including (f) or Subsection (g) below apply:

   a. (1) The service is not a Covered Service; or (2) the service is determined to be not Medically Necessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

   b. The Member is informed in writing before the service is rendered that one or more of the conditions listed in Subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and

   c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i), 42 CFR 438.114, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract between Health Plan and the State), or N.J.A.C. 10:74-9.1; and

   d. The service is not a trauma service covered by the provisions of N.J.A.C. 11:24-6.3(a)3.i; and

e. The protections afforded to Members under 42 USC 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, N.J.A.C. 11:24-9.1(d)9, and/or N.J.A.C. 11:24-15.2(b)7.ii do not apply; and

f. The provider has received no program payments from either DMAHS or Health Plan for the service; or

g. The Member has been paid for the service by a health insurance company or other third party (as defined in N.J.S.A. 30:4D-3.m), and the Member has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this Agreement/Subcontract to the contrary, a Member shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

   a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in Health Plan's network; or

   b. The Member obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

ATTACHMENT C
NEW JERSEY MEDICARE COMPENSATION
Skilled Nursing Facility
FEE FOR SERVICE

1. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Facility agrees to accept as payment in full for Covered Services rendered to MA Members within the State of New Jersey, and Health Plan will process and pay or deny Claims submitted for Covered Services rendered to MA Members under this Agreement and shall make payments to Facility within thirty (30) calendar days of receipt of such Claims at the lesser of the rates set out below and subject to adjustment pursuant to paragraph's 5-10, or Facility billed charges, less any MA Member Expenses and subject to any coordination of benefits or subrogation activities, or adjustments.

3. **Eighty Five Percent (80%) of the Health Plan's Medicare fee Schedule based on the applicable CMS Medicare Resource Utilization Group (RUG) rates published on the CMS website on the date the Covered Service is rendered, as adjusted per Paragraph (2) below for Locality <u>001</u>**

4. Health Plan will include in the Health Plan's Medicare fee schedule such Covered Services and corresponding rates not otherwise included in the CMS published Medicare fee schedule(s);
5. Health Plan will apply changes made by the CMS, or CMS' successor, to the Medicare fee schedule(s) loaded into the Health Plan systems on the effective date, if such CMS changes are published at least forty-five (45) days prior to such effective date, or if such CMS changes are published less than forty-five (45) days prior to such effective date, the CMS changes will be applied prospectively to Claims with dates of service no later than forty-five (45) days following CMS publication;
6. Payment rates are inclusive, including without limitation, facility, supplies, materials, drugs, equipment, x-ray, laboratory (technical, facility and professional) and other diagnostic fees, semi-private room and board, operating room, nurses and other Facility employees and permitted contracted entities and individuals;
7. If an MA Member is in Facility at the time a new rate becomes effective under this Agreement, payment for Covered Services to Facility for such stay will be based on the rates in effect on the date of admission;
8. In the event an MA Member is transferred to or from Facility to or from another medical facility not affiliated with Facility, the payment for Covered Services rendered by Facility and such other sending/receiving facility will be adjusted consistent with the payment rules and guidelines used by the CMS for traditional Medicare (Transfers to or from affiliated hospitals and/or medical facilities within the same system and related to the same admission are considered a single inpatient admission.); and/or
9. If an MA Member becomes ineligible or disenrolls from coverage under a Health Plan Benefit Contract during a stay at Facility, payment for Covered Services to Facility will be prorated based upon the total number of days the individual was an MA Member.

ATTACHMENT C2
NEW JERSEY MEDICAID/FAMILYCARE COMPENSATION
Skilled Nursing Facility

1. The compensation rates set forth in this Attachment apply for Benefit Plans under the New Jersey Medicaid/FamilyCare program. Compensation shall be subject to and in accordance with the terms and conditions of the Agreement, including this Attachment.

2. Provider shall be paid the lesser of provider's billed charges or the amount set forth in the fee schedule below. Reimbursement to provider shall be subject to the billing requirements, exclusions and limitations set forth in the Provider Manual.

Skilled Nursing Facility

Inclusive Rate: The contracted rates established by this exhibit are all-inclusive, including without limitation applicable taxes, for the provision of all Plan Contract (s) to the enrollee that are in the service category that corresponds to the contract rate and which are generally provided as a part of the service category. All items and non-physician services provided to enrollees must be directly furnished by Provider or billed by Provider when services are provided by another entity. No additional payments will be made for any services or items covered under the Enrollee's Plan Contract (s) and billed for separately by Provider.

REV CODES	Description	*Per Diem Contracted Rate*
191	Level1- Skilled Nursing Care	$250.00
192	Level 2- Rehabilitation Therapy	$300.00
193	Level 3- Sub-ACUTE Skilled Care Non-Weanable Ventilator	$375.00
194	Level 4- Weanable Ventilator Management	$563.00
199	Level 5-Other Sub-acute Care	$700.00
100	Custodial Care	$230.00
663	Daily Respite Care in a Nursing Facility	$186/100% NJ Medicaid Rate

3. Health Plan shall process claims and pay or deny a Clean Claim within 30 calendar days of its receipt of the Clean Claim if the Clean Claim was submitted by electronic means, or within 40 calendar days of its receipt of the Clean Claim if the Clean Claim was submitted by other than electronic means. The date of receipt of a Clean Claim shall be the date Health Plan receives the Clean Claim electronically, or for paper claims as indicated by Health Plan's date stamp on the Clean Claim. The date of payment shall be the date of the electronic funds transfer, check or other form of payment.

4. Payment of compensation is subject to the following:

    a. Health Plan may adjust claim payments due to coordination of benefits or subrogation.

    b. Health Plan prospectively applies DMAHS's changes to Medicaid/FamilyCare fee schedules as of the later of (i) the effective date of the change, or (ii) 45 days from the date DMAHS publishes the change on its website. Health Plan shall not retrospectively apply rate changes to claims that have already been paid.

    c. Health Plan uses claims editing software programs to assist it in determining proper coding for provider claim reimbursement. Such software programs use industry standard coding criteria and incorporate guidelines established by CMS such as the National Correct Coding Initiative and the National Physician Fee Schedule Database, the AMA and Specialty Society correct coding guidelines, and state specific regulations. These software programs may result in claim edits for specific procedure code combinations.

    d. Health Plan may update code numbers or delete retired codes, as such are revised or implemented by DMAHS or CMS from time to time. Where applicable, such as for value added benefits covered by a Benefit Plan, Health Plan will determine rates for items and services that are not included in DMAHS's payment system or rate schedule published on the DMAHS website.