AETNA BETTER HEALTH OF NEWJERSEY MEDICAID FACILITY SERVICES AGREEMENT

The term of this Medicaid Facility Services Agreement (the "Agreement") by and between Aetna Better Health Inc., a New Jersey corporation on behalf of itself and its Affiliates (hereinafter "Company"), and Brandywine At Brandall Estates (hereinafter "Facility"), shall commence effective _____ [Date to be completed by Company] (the "Effective Date"). Company and Facility may be referred to individually as a "Party" and collectively as the "Parties." The Regulatory Compliance Addendum attached to this Agreement as Exhibit A, is expressly incorporated into this Agreement and is binding upon the Parties. In the event of any inconsistent or contrary language between the Regulatory Compliance Addendum and any other part of this Agreement, including but not limited to exhibits, attachments or amendments, the Parties agree that the provisions of the Regulatory Compliance Addendum shall prevail. The attached Exhibit D – Medicare Requirements (including Schedule 1) is incorporated into this Agreement and will apply to the provision of Medicare-covered services, as described therein.

WHEREAS, Company administers Plans for Government Sponsors that provide access to health care services to Members or arranges for the provision of health care services to Members of Government Programs; and

WHEREAS, Company contracts with certain health care providers and facilities to provide access to such health care services to Members; and

WHEREAS, Facility provides health care services to patients within the scope of its licensure or accreditation; and

WHEREAS, Company and Facility mutually desire to enter into an arrangement whereby Facility will become a Participating Provider and render health care services to Members; and

WHEREAS, in return for the provision of health care services by Facility, Company will pay Facility for Covered Services under the terms of this Agreement; and

WHEREAS, Facility understands and agrees that Government Sponsors or other government entities may require certain changes to the terms of this Agreement before Facility can provide services to Members under the terms of any Plans that are awarded, by the Government Sponsors, to Company.

NOW, THEREFORE, in consideration of the foregoing and of the mutual covenants, promises and undertakings herein, the sufficiency of which is hereby acknowledged, and intending to be legally bound hereby, the parties agree as follows:

1.0 DEFINITIONS

When used in this Agreement, all capitalized terms shall have the following meanings:

Affiliate. Any corporation, partnership or other legal entity (including any Plan) directly or indirectly owned or controlled by, or which owns or controls, or which is under common ownership or control with Company.

Clean Claim. A claim that can be processed without obtaining additional information from the Facility who provided the service or from a third party, except that it shall not mean a claim submitted by or on behalf of a Facility who is under investigation for fraud or abuse, or a claim that is under review for medical necessity; provided, further, unless otherwise required by law or regulation, a claim which (a) is submitted within the proper timeframe as set forth in this Agreement and (b) has (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9 (or successor standard), HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services), and (c) does not involve coordination of benefits, and (d) has no defect or error (including any new procedures with no CPT code,

experimental procedures or other circumstances not contemplated at the time of execution of this Agreement) that prevents timely adjudication.

Coinsurance. A payment a Member is required to make under a Plan which is determined as a percentage of the lesser of: (a) the rates established under this Agreement; or (b) Facility's usual, customary and reasonable billed charges.

Confidential Information. Any information that identifies a Member and is related to the Member's participation in a Plan, the Member's physical or mental health or condition, the provision of health care to the Member or payment for the provision of health care to the Member. Confidential Information includes, without limitation, "individually identifiable health information", as defined in 45 C.F.R. § 160.103 and "non-public personal information" as defined in laws or regulations promulgated under the Gramm-Leach-Bliley Act of 1999.

Copayment. A charge required under a Plan that must be paid by a Member at the time of the provision of Covered Services, or at such other time as determined by Facility and which is expressed as a specific dollar amount.

Covered Services. Those health care services for which a Member is entitled to receive coverage under the terms and conditions of a Plan. The Parties agree that Company is obligated to pay for only those Covered Services that are determined to be medically necessary, as determined in accordance with the Member's applicable Plan.

Deductible. An amount that a Member must pay for Covered Services during a specified coverage period in accordance with the Member's Plan before benefits will be paid.

Effective Date. Defined in first paragraph of this Agreement.

Emergency Medical Condition. 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: (a) placing the health of the individual (or, with respect to a pregnant woman, her pregnancy or health or the health of her fetus) in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part; or such other definition as may be required by applicable law.

Emergency Services. Covered Services furnished by a qualified provider and necessary to evaluate or stabilize an Emergency Medical Condition.

Facility. Defined in first paragraph of this Agreement.

Facility Services. Defined in Section 2.1 of this Agreement.

Government Programs. Plans operated and/or administered by Company pursuant to a State Contract.

Government Sponsor. A state agency or other governmental entity authorized to offer, issue and/or administer one or more Plans, and which, to the extent applicable, has contracted with Company to administer all or a portion of such Plan(s).

Material Change. Any change in Policies that could reasonably be expected, in Company's determination, to have a material adverse impact on (i) Facility's reimbursement for Facility Services or (ii) Facility administration.

Medically Necessary or Medical Necessity. Those Health care services that a physician or other applicable health care provider, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and (c) not primarily for the convenience of the patient, physician or other 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 patient's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical

literature generally recognized by the relevant medical community, or otherwise consistent with physician specialty society recommendation and the views of physicians practicing in relevant clinical areas and any other relevant factors.

Member. An individual covered by or enrolled in a Plan.

Participating Provider. Any physician, hospital, hospital-based physician, skilled nursing facility, mental health and/or substance abuse professional (which shall include psychiatrists, psychologists, social workers, psychiatric nurses, counselors, family or other therapists or other mental health/substance abuse professionals), or other individual or entity involved in the delivery of health care or ancillary services who or which has entered into and continues to have a current valid contract with Company to provide Covered Services to Members, and, where applicable, has been credentialed by Company or its designee consistent with the credentialing policies of Company or its designee, as applicable. Certain categories of Participating Providers may be referred to herein more specifically as, e.g., "Participating Physicians" or "Participating Hospitals."

Party. Company or Facility, as applicable. Company and Facility may be referred to collectively as the "Parties."

Plan. A Member's health care benefits as set forth in the State Contract. Such Plans are listed in the **Program Participation Schedule** attached hereto and made a part hereof.

Policies. The policies and procedures promulgated by Company which relate to the duties and obligations of the Parties under the terms of this Agreement, including, but not limited to: (a) quality improvement/management; (b) utilization management, including, but not limited to, precertification of elective admissions and procedures, concurrent review of services and referral processes or protocols; (c) pre-admission testing guidelines; (d) claims payment review; (e) member grievances; (f) provider credentialing; (g) electronic submission of claims and other data required by Company; and (h) any applicable participation criteria required by the State in connection with the Government Programs. Policies also include those policies and procedures set forth in the Company's and/or Government Sponsor's manuals (as modified from time to time) as Company determines appropriate in its sole discretion; clinical policy bulletins made available via Company's internet web site; and other policies and procedures, whether made available via a password-protected web site for Participating Providers (when available), by letter, newsletter, electronic mail or other media.

Post-Stabilization Care Services. Covered Services relating to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, under circumstances defined in federal regulations, to improve or resolve the Member's condition.

Proprietary Information. Any and all information, whether prepared by a Party, its advisors or otherwise, relating to such Party or the development, execution or performance of this Agreement whether furnished prior to or after the Effective Date. Proprietary Information includes but is not limited to, with respect to Company, the development of a pricing structure, (whether written or oral) all financial information, rate schedules and financial terms which relate to Facility and which are furnished or disclosed to Facility by Company. Notwithstanding the foregoing, the following shall not constitute Proprietary Information:

(a) information which was known to a receiving Party (a "Recipient") prior to receipt from the other Party (a "Disclosing Party") (as evidenced by the written records of a Recipient);

(b) information which was previously available to the public prior to a Recipient's receipt thereof from a Disclosing Party;

(c) information which subsequently became available to the public through no fault or omission on the part of a Recipient, including without limitation, the Recipient's officers, directors, trustees, employees, agents, contractors and other representatives;

(d) information which is furnished to a Recipient by a third party which a Recipient confirms, after due inquiry, has no confidentiality obligation, directly or indirectly, to a Disclosing Party; or

(e) information which is approved in writing in advance for disclosure or other use by a Disclosing Party.

Specialty Program. A program for a targeted group of Members with certain types of illnesses, conditions, cost or risk factors.

Specialty Program Providers. Those hospitals, physicians and other providers that have been identified or designated by Company or the Government Sponsor to provide Covered Services associated with a Specialty Program.

State Contract. Company's contract(s) with Government Sponsors to administer Plans or Government Programs identified in the **Program Participation Schedule**.

2.0 FACILITY SERVICES AND OBLIGATIONS

2.1 Provision of Services.

Facility will make available and provide to Members Covered Services, including facilities, equipment, personnel or other resources necessary to provide such Covered Services according to generally accepted standards of Facility's practice ("Facility Services"). Upon written notice from Facility, Company may agree to add new or relocating facilities and locations to this Agreement upon completion of applicable credentialing and satisfaction of all other requirements of Company. Other demographic information may be revised upon written notice from Facility.

2.2 Non-Discrimination and Equitable Treatment of Members.

Facility agrees to provide Facility Services to Members with the same degree of care and skill as customarily provided to Facility's patients who are not Members, according to generally accepted standards of Facility's practice. Facility and Company agree that Members and non-Members should be treated equitably. Facility agrees not to discriminate against Members on the basis of race, ethnicity, gender, creed, ancestry, lawful occupation, age, religion, marital status, sexual orientation, mental or physical disability, medical history, color, national origin, place of residence, health status, claims experience, evidence of insurability (including conditions arising out of acts of domestic violence), genetic information, source of payment for services, cost or extent of Facility Services required, or any other grounds prohibited by law or this Agreement and will abide by Company's cultural competency Policies. Facility shall deliver Covered Services in a culturally competent manner to Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds, and comply with Company's Policies on cultural competency.

2.3 Federal Law.

Company is a Federal contractor and an Equal Opportunity Employer which maintains an Affirmative Action Program. To the extent applicable to Facility, Facility, on behalf of itself and any subcontractors, agrees to comply with the following, as amended from time to time: Title XIX of the federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, Executive Order 11246, the Vietnam Era Veterans Readjustment Act of 1974, the Drug Free Workplace Act of 1988, Section 503 of the Rehabilitation Act of 1973, Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972 (regarding education programs and activities), the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") administrative simplification rules at 45 CFR parts 160, 162, and 164, the Americans with Disabilities Act of 1990, Federal laws, rules and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. seq.), and the anti-kickback statute (Section 1128B(b) of the Social Security Act), and any similar laws, regulations or other legal mandates applicable to recipients of federal funds and/or transactions under or otherwise subject to any government contract of Company.

2.4 Facility Representations.

2.4.1 General Representations. Facility represents, warrants, and covenants as applicable that: (a) it has and shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies; (b) it is and will remain throughout the term of this Agreement, in substantial compliance with all applicable Federal and state laws and regulations related to this Agreement and the services to be provided hereunder, including, without limitation statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims, and prohibition of kickbacks: (d) it has established an ongoing quality assurance/assessment program (e) all ancillary health care personnel employed by, associated or contracted with Facility who treat Members ("Ancillary Personnel": (e) are and will remain throughout the term of this Agreement appropriately licensed and/or certified (when and as required by state law) and supervised and qualified by education, training, and experience to perform their professional duties and (ii) will act within the scope of their licensure or certification, as the case may be (f) and executing this Agreement and performing it's obligations hereunder shall not cause Facility to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

2.4.2 Government Program Representations. Company has or shall seek contracts to serve beneficiaries of Government Programs. To the extent Company participates in such Government Programs, Facility agrees, on behalf of itself and any subcontractors of Facility acting on behalf of Facility, to be bound by all rules and regulations of, and all requirements applicable to, such Government Programs. Facility acknowledges and agrees that all provisions of this Agreement shall apply equally to any employees, independent contractors and subcontractors of Facility who provide or may provide Covered Services to Members of Government Programs, and Facility represents and warrants that Facility shall cause such employees, independent contractors and subcontractors to comply with this Agreement, the State Contract, and all applicable laws, rules and regulations and perform all requirements applicable to Government Programs. Any such subcontract or delegation shall be subject to prior written approval by Company. With respect to Members of Government Programs, Facility acknowledges that compensation under this Agreement for such Members constitutes receipt of Federal funds. Facility agrees that all services and other activities performed by Facility under this Agreement will be consistent and comply with the obligations of Company and/or Government Sponsor under its contract(s) with the Centers for Medicare and Medicaid Services ("CMS"), and any applicable state regulatory agency, to offer Government Program. Facility further agrees to allow Government Sponsor, CMS, any applicable state regulatory agency, and Company to monitor Facility's performance under this Agreement on an ongoing basis in accordance with applicable laws, rules and regulations. Facility acknowledges and agrees that Company may only delegate its activities and responsibilities under the State Contract or any Company contract(s) with Government Sponsor, CMS and any applicable regulatory agency, to offer Government Program in a manner consistent with applicable laws, rules and regulations, and that if any such activity or responsibility is delegated by Company to Facility, the activity or responsibility may be revoked if Government Sponsor, CMS or Company determine that Facility has not performed satisfactorily. Upon request, Facility shall immediately provide to Company any information that is required by Company to meet its reporting obligations to CMS, including without limitation, physician incentive plan information, if applicable. To the extent that Facility generates and/or compiles and provides any data to Company that Company, in turn, submits to CMS, Facility certifies, to the best of its knowledge and belief, that such data is accurate, complete and truthful.

2.4.3 Government Program Requirements. Facility, on behalf of itself and each Facility-based Physician, hereby agrees to perform its obligations under this Agreement in accordance with the terms and conditions set forth in Exhibits A & D, as applicable.

2.4.4 Qualified Providers. Facility shall exclude any physician or other provider from performing services in connection with this agreement if such provider has been suspended or terminated from participation in Government Programs or any other government-sponsored program, including Medicare or the Medicaid program in any state. Facility is prohibited from using any individual or entity ("Offshore Entity") (including, but not limited to, any employee, contractor, subcontractor,

agent, representative or other individual or entity) to perform any services for Plans if the individual or entity is physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands), unless Company, in its sole discretion and judgment, agrees in advance and in writing to the use of such Offshore Entity. Facility further agrees that Company has the right to audit any Offshore Entity prior to the provision of services for Plans.

2.4.5 Suspension or Debarment Facility represents, warrants and covenants, as applicable, that it and each Facility-based Physician:

a. Has not within a three year period preceding the proposal submission been convicted or had a civil judgment rendered against him/her/it for commission of fraud or criminal offense in performing a public transaction or contract (local, state or federal) or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements or receiving stolen property; and

b. Is not presently indicted for or otherwise criminally or civilly charged by a governmental entity with the commission of any of the above offenses; and

c. Has not within a five year period preceding execution of this Agreement had one or more public transactions terminated for cause or fault; and

d. Is not excluded, debarred or suspended from participation in any government-sponsored program including, but not limited to, Government Programs, Medicare or the Medicaid program in any state; and

e. Will immediately report any change in the above status to Company; and

f. Will maintain all appropriate licenses to perform its duties and obligations under the Agreement.

2.5 Facility's Insurance.

During the term of this Agreement, Facility agrees to procure and maintain such policies of general and professional liability and other insurance, or a comparable program of self-insurance, at minimum levels as required by state law or, in the absence of a state law specifying a minimum limit, an amount customarily maintained by Facility in the state or region in which the Facility operates. Such insurance coverage shall cover the acts and omissions of Facility as well as those Facility's agents and employees. Facility agrees to deliver certificates of insurance or other documentation as appropriate to show evidence of such coverage to Company upon request. Facility agrees to make best efforts to provide to Company at least thirty (30) days advance notice, and in any event will provide notice as soon as reasonably practicable, of any cancellation or material modification of said policies.

2.6 Product Participation.

Facility agrees to participate in the Plans and other health benefit programs listed on the **Program Participation Schedule.**, To the extent that Company establishes and/or participates in a provider Pay-for-Performance incentive program or Performance Improvement Programs, Facility agrees to comply with and participate in such program.

Nothing herein shall require that Company identify, designate or include Facility as a preferred participant in any specific Plan for which Company provides incentives based upon the use of selected participating facilities, Specialty Program or other program; provided, however, Facility shall accept compensation in accordance with this Agreement for the provision of any Covered Services to Members under a Plan, Specialty Program or other program in which Facility has agreed to participate hereunder.

2.7 Consents to Release Medical Information.

Facility covenants that it will obtain from Members to whom Facility Services are provided, any necessary consents or authorizations to the release of Information and Records to Company, Government Sponsors,

their agents and representatives in accordance with any applicable Federal or state law or regulation or this Agreement.

3.0 COMPANY OBLIGATIONS

3.1 Company's Covenants.
Company or Government Sponsors shall provide Members with a means to identify themselves to Facility (e.g., identification cards), explanation of provider payments, a general description of products (e.g. Quick Reference Card), a listing of Participating Providers, and timely notification of material changes in this information. Company shall provide Facility with a means to check eligibility. Company shall include Facility in the Participating Provider directory or directories for the Plans, Specialty Programs and products in which Facility is a Participating Provider, including when Facility is designated as preferred participant, and shall make said directories available to Members. Company reserves the right to determine the content of provider directories.

3.2 Company Representations.
Company represents and warrants that: (a) this Agreement has been executed by its duly authorized representative; and (b) executing this Agreement and performing its obligations hereunder shall not cause Company to violate any term or covenant of any other agreement or arrangement now existing or hereinafter executed.

The parties acknowledge that one or more state governmental authorities may recommend or require that various Company agreements, including this Agreement, be executed prior to the issuance to Company of one or more approvals, consents, licenses, permissions or other authorizations from governmental authorities with jurisdiction over the subject matter of this Agreement, or which Company deems to be necessary or desirable in its sole discretion (collectively, a "License"). Facility agrees that all Company obligations to perform, and all rights of Facility, under this Agreement are expressly conditioned upon the receipt of all Licenses. Failure of Company to obtain any License shall impose no liability on Company under this Agreement.

3.3 Company's Insurance.
Company at its sole cost and expense agrees to procure and maintain such policies of general and/or professional liability and other insurance (or maintain a self-insurance program) as shall be necessary to insure Company and its employees against any claim or claims for damages arising by reason of personal injuries or death occasioned directly or indirectly in connection with the performance of any service by Company under this Agreement and the administration of Plans.

4.0 CLAIMS SUBMISSIONS, COMPENSATION AND MEMBER BILLING

4.1 Claim Submission and Payment.

4.1.1 Facility Obligation to Submit Claims. Facility agrees to submit Clean Claims to Company for Facility Services rendered to Members. Facility agrees to submit claim and encounter data related to a Member enrolled in a Government Program in the form and manner as specified by Company, and, Facility certifies that any such data is accurate, complete and truthful. Facility will make best commercial efforts to submit a minimum of eighty-five percent (85%) of its Member claims electronically to Company. Facility represents that, where necessary, it has obtained signed assignments of benefits authorizing payment for Facility Services to be made directly to Facility. For claims Facility submits electronically, Facility shall not submit a claim to Company in paper form unless Company requests paper submissions or fails to pay or otherwise respond to electronic claims submission in accordance with the time frames required under this Agreement or applicable law or regulation. Facility agrees that Company, or the applicable Government

Sponsor, will not be obligated to make payments for billings received more than one hundred andeighty(180)) days (or such other period required by applicable state law or regulation)from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. Company may waive this requirement if Facility provides notice to Company, along with appropriate evidence, of other extraordinary circumstances outside the control of Facility that resulted in the delayed submission. In addition, unless Facility notifies Company of its payment disputes within one hundred eighty (180) days, or such other time as required by applicable state law or regulation, of receipt of payment from Company, such payment will be considered full and final payment for the related claims. If Facility does not timely bill Company or Government Sponsors, or dispute any payment, timely as provided in this Section 4.1.1, Facility's claim for payment will be deemed waived and Facility will not seek payment from Government Sponsors, Company or Members. Facility shall pay on a timely basis all Participating Providers, employees, independent contractors and subcontractors who render Covered Services to Members of Company's Plans for which Facility is financially responsible pursuant to this Agreement.

Facility agrees to permit claim editing to the primary procedure those services considered part of, incidental to, or inclusive of the primary procedure and make other adjustments for inappropriate billing or coding (e.g., rebundling, duplicative procedures or claim submissions, mutually exclusive procedures, gender/procedure mismatches, age/procedure mismatches). To the extent Facility is billing on a CMS 1500, as of the Effective Date, in performing adjustments for inappropriate billing or coding, Company utilizes a commercial software package (as modified by Company for all Participating Providers in the ordinary course of Company's business) which commercial software package relies upon Government Programs and other industry standards in the development of its rebundling logic.

Subject to applicable law: (i) Company may update internal payment systems in response to additions, deletions, and changes to Government Sponsor, CMS, or other industry source codes without obtaining any consent from Facility or any other party, and Company will provide, at the written request of Facility, a copy of the fee schedule in effect at the time of such request; (ii) Company shall not be responsible for communicating such routine changes of this nature, and will update any applicable payment schedules on a prospective basis within ninety (90) days from the date of publication or such longer period as Company determines appropriate in its sole discretion; and (iii) Company shall have no obligation to retroactively adjust claims.

4.1.2 Company Obligation to Pay for Covered Services. Company shall make payments to Facility for Covered Services on a timely basis consistent with the claims payment procedure described at 42 U.S.C. § 1396a(a)(37)(A). Company agrees to pay Facility for non-capitated Covered Services rendered to Members according to the lesser of (i) Facility's actual billed charges or (ii) the rates set forth in the Services and Compensation Schedule, attached hereto and made a part hereof. Company must pay all claims in accordance with State Contract and regulatory requirements. .. Facility will make best commercial efforts to utilize online explanation of benefits or electronic remittance of advice (or combination thereof) and electronic funds transfer in lieu of receiving paper equivalents to the extent such services are available from Company. Company reserves the right in accordance with State Contract and New Jersey Department of Banking and Insurance regulations, to recoup any overpayment or payment made in error (e.g., a duplicate payment or payment for services rendered by Facility to a patient who was not a Member and amounts identified through routine investigative reviews of records or audits) against any other monies due to Facility under this Agreement.

In the event that Facility identifies any overpayments by Company, Facility shall, as required under Section 6402(a) of the Patient Protection and Affordable Care Act, report and return any and all such overpayments to Company within sixty (60) days of Facility's identification of any and all such overpayments. In addition, when reporting and returning any such overpayments by Company, Facility must provide Company with a written reason for the overpayment (e.g., excess payment under coordination of benefits, etc.).

To the extent, if any, that the compensation under certain Plans is in the form of capitation payments or a case-based rate methodology, Facility acknowledges the financial risks to Facility of this arrangement and has made an independent analysis of the adequacy of this arrangement. Facility, therefore, agrees and covenants not to bring any action asserting the inadequacy of these arrangements or that Facility was in any way improperly induced by Company to accept the rate of payment, including, but not limited to, causes of actions for damages, rescission or termination alleging fraud or negligent misrepresentation or improper inducement. Notwithstanding anything in this Agreement to the contrary, subcontractors agree to seek compensation solely from Facility for those Covered Services provided to Members and for which Facility is compensated by Company. Subcontractor shall in no event bill Company, its Affiliates, Government Sponsor, or Members for any such Covered Services. Facility will provide Company with a Designation of Payment Schedule from all subcontractors, which will indemnify and hold harmless Company, Government Sponsor and its Members for payment of all compensation owed subcontractor under subcontractor's arrangement with Facility.

Complaints or disputes concerning payments for the provision of services as described in this Agreement shall be subject to the Company's grievance resolution system.

4.1.3 Eligibility Determinations. Company shall have the right to recover payments made to Facility if the payments are for services provided to an individual who is later determined to have been ineligible based upon information that is not available to Company at the time the service is rendered or authorization is provided.

4.1.4 Utilization Management. Company utilizes systems of utilization review/quality improvement/peer review to promote adherence to accepted medical treatment standards and to encourage Participating Providers to minimize unnecessary medical costs consistent with sound medical judgment and in accordance with applicable laws. To further this end, Provider agrees, consistent with sound judgment and in accordance with applicable law, (a) to participate, as requested, and to abide by Company's utilization review, patient management, quality improvement programs, and all other related programs (as modified from time to time) and decisions with respect to all Members; (b) to comply with Company's precertification and utilization management requirements for those Covered Services requiring such notice; (c) to regularly interact and cooperate with Company's nurse case managers; (d) to utilize Participating Providers to the fullest extent possible, consistent with sound medical judgment; (e) to abide by all Company's credentialing criteria and procedures bi-annually, annually, or otherwise, when applicable;(f) to obtain advance authorization from Company prior to any non-Emergency Service admission, or Post-stabilization Care Services and to comply with Company's notification policies in effect a the time services are provided. C. For those Members who require services under a Specialty Program, Provider agrees to work with Company to transfer the Member's care to a Specialty Program Provider.

4.2 Coordination of Benefits.

Except as otherwise required under applicable Federal, state law or regulation or a Plan, when Company or a Government Sponsor is secondary payer under applicable coordination of benefit principles, and payment from the primary payer is less than the compensation payable under this Agreement without coordination of benefits, then Company or Government Sponsor will pay Facility the lesser of (i) the copayment, coinsurance and deductible amount for the Covered Services as reported on the explanation of benefits of the primary payer, or (ii) the amount of the difference between the amount paid by the primary payer and the compensation payable under this Agreement, absent other sources of payment. Notwithstanding any other provision of this paragraph, if payment from the primary payer is greater than or equal to the compensation payable under this Agreement without coordination of benefits, neither Company, Government Sponsor nor the applicable Member (in accordance with Section 4.3.2 below) shall have any obligation to Facility. Notwithstanding anything to the contrary in this section, in no event shall Facility collect more than Medicare allows if Medicare is the primary payer. Medicaid is never the primary payer.

4.3 Member Billing.

4.3.1 Permitted Billing of Members. Facility may bill or charge Members only in the following circumstances: (a) applicable Copayments, Coinsurance and/or Deductibles, if any, not collected at the time that Covered Services are rendered; and (b) for services that are not Covered Services only if: (i) the Member's Plan provides and/or Company confirms that the specific services are not covered; (ii) the Member was advised in writing prior to the services being rendered that the specific services may not be Covered Services; and (iii) the Member agreed in writing to pay for such services after being so advised. Facility acknowledges that Company's denial or adjustment of payment to Facility based on Company's performance of utilization management as described in Section 4.1.3 or otherwise is not a denial of Covered Services under this Agreement or under the terms of a Plan, except if Company confirms otherwise under this Section 4.3. Facility may bill or charge individuals who were not Members at the time that services were rendered.

4.3.2 Holding Members Harmless. Facility hereby agrees that in no event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, shall Facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or persons acting on their behalf (other than Company) or (ii) any settlement fund or other res controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles made in accordance with the terms of the applicable Plan. Facility further agrees that this Section 4.3.2: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Facility and Members or persons acting on their behalf.

4.3.3 Dual Eligible Members. Facility acknowledges and agrees that Members who are also enrolled in a State Medicaid plan ("Dual Eligible Members") are not responsible for paying to Facility any Copayments, Coinsurance or Deductibles for Medicare Part A and Part B services ("Cost Sharing Amounts") when the State Medicaid plan is responsible for paying such Cost Sharing Amounts. Facility further agrees that they will not collect Cost Sharing Amounts from Dual Eligible Members when the State is responsible for paying such Cost Sharing Amounts, and will, instead, either accept the Company's payment for Covered Services as payment in full for Covered Services and applicable Cost Sharing Amounts, or, bill the applicable State source for the appropriate Cost Sharing Amounts owed by the State Medicaid plan. Dual Eligible Members in Capitated Financial Alignment Demonstration Plans are not responsible for Cost Sharing Amounts for Medicare Parts A and B services.

To protect Members, Facility agrees not to seek or accept or rely upon waivers of the Member protections provided by this Section 4.3.

5.0 COMPLIANCE WITH POLICIES

5.1 Policies

.Facility agrees to accept and comply with Policies of which Facility knows or reasonably should have known (e.g. clinical policy bulletins or other Policies made available to Facility). Facility will utilize the electronic real time HIPAA compliant transactions, including but not limited to, eligibility, pre-certification and claim status inquiry transactions to the extent such electronic real time features are utilized by Company. Company may at any time modify Policies. Company will provide notice by letter, newsletter, electronic mail, or other media, of Material Changes. Failure by Facility to object in writing to any Material Change within thirty (30) days following receipt thereof constitutes Facility's acceptance of such Material Change. In the event that Facility reasonably believes that a Material Change is likely to have a material adverse financial impact upon Facility's practice, Facility agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse financial impact. Notwithstanding the foregoing, at Company's discretion, Company may modify the Policies to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of the Facility, and the Policies

shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency having supervisory authority over this Agreement. Facility agrees that noncompliance with any requirements of this Section 5.1 or any Policies will relieve Company or Government Sponsors and Members from an financial liability for the applicable portion of the Facility Services.

5.2 Notices and Reporting

To the extent neither prohibited by law nor violative of applicable privilege, Facility agrees to provide notice to Company and shall provide all information reasonably requested by Company regarding the nature, circumstances, and disposition of (a) any action taken by Facility adversely affecting medical staff membership of Participating Physicians and other Participating Providers, (b) any litigation or administrative action brought against by Facility of any of its employees, medical staff members or affiliated providers which is related to the provision of health care services and could have a material impact on the Facility Services provided to Members; (c) any investigation initiated by any government agency or program except routine or initial surveys required by state or federal law against or involving Facility that does or could adversely affect Facility's accreditation status, licensure, or certification to participate in the Medicare or Medicaid programs; (d) any change in the ownership or management of Facility requiring approval of a state regulatory agency, which shall be governed by Section 9.6 below with respect to changes of the legal entity with legal control over Facility; and (e) any material change in services provided by Facility or licensure status related to such services, including without limitation in the closure of a service unit or material decrease in beds. Company and Facility agree to be mutually committed to promoting Member safety and quality. Facility therefore agrees to use best efforts to provide Company with prior notice of, and in any event will provide notice as soon as reasonably practicable notice of any actions taken by Facility described in this Section 5.2

5.3 Information and Records.

5.3.1 Maintenance of Information and Records. Facility agrees (a) to maintain Information and Records (as such terms are defined in Section 5.3.2) in a current, detailed, organized and comprehensive manner and in accordance with customary medical practice, Government Sponsor directives, applicable Federal and state laws, and accreditation standards; (b) that all Member medical records and Confidential Information shall be treated as confidential and in accordance with applicable laws; (c) to maintain such Information and Records for the longer of six (6) years after the last date Facility Services were provided to Member, or the period required by applicable law or Government Sponsor directives; and (d) to maintain Information and Records in accordance with the requirements of Exhibits A & D, as applicable. This Section 5.3.1 shall survive the termination of this Agreement, regardless of the cause of the termination.

5.3.2 Access to Information and Records. Facility agrees that (a) Company (including Company's authorized designee) and Government Sponsors shall have access to all data and information obtained, created or collected by Facility related to Members and necessary for payment of claims, including without limitation Confidential Information ("Information"); (b) Company (including Company's authorized designee), Government Sponsors and Federal, state, and local governmental authorities and their agents having jurisdiction, upon request, shall have access to all books, records and other papers (including, but not limited to, contracts, medical and financial records and physician incentive plan information) and information relating to this Agreement and to those services rendered by Facility to Members ("Records"); (c) consistent with the consents and authorizations required by Section 2.6 hereof, Company or its agents or designees shall have access to medical records for the purpose of assessing quality of care, conducting medical evaluations and audits, and performing utilization management functions; (d) applicable Federal and state authorities and their agents shall have access to medical records for assessing the quality of care or investigating Member grievances or complaints; and (e) Members shall have access to their health information as required by 45 C.F.R. § 164.524 and applicable state law, be provided with an accounting of disclosures of information when and as required by 45 C.F.R. § 164.528 and applicable state law, and have the opportunity to amend or correct the information as required by 45 C.F.R. § 164.526 and applicable state law. Facility agrees to supply copies of Information and Records within fourteen (14) days of the receipt of a request, where practicable, and in no event

later than the date required by Government Sponsor directives and any applicable law or regulatory authority. This Section 5.3.2 shall survive the termination of this Agreement, regardless of the cause of termination.

5.3.3 Government Requirements Regarding Records for Medicare Members In addition to the requirements of Sections 5.3.1 and 5.3.2, with respect to Medicare Plans, Facility agrees to maintain Information and Records (as those terms are defined in Section 5.3) for the longer of: (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date the U.S. Department of Health and Human Services ("HHS"), the U.S. Comptroller General, or their designees complete an audit, or (iii) the period required by applicable laws, rules or regulations. Facility further agrees that, with respect to Medicare Plans, Company and Federal, state and local government authorities having jurisdiction, or their designees, upon request, shall have access to all Information and Records, and that this right of inspection, evaluation and audit of Information and Records shall continue for the longer of (i) ten (10) years from the end of the final contract period of any government contract of Company, (ii) the date HHS, the U.S. Comptroller General, or their designee complete an audit, or (iii) the period required by applicable laws, rules or regulations. This Section 5.3.3 shall survive the termination of this Agreement, regardless of the cause of termination.

5.4 Quality, Accreditation and Review Activities.
Facility agrees to cooperate with any commercially reasonable Company quality activities or review of Company or a Plan conducted by the National Committee for Quality Assurance (NCQA) or a state or Federal agency with authority over Company and/or the Plan, as applicable

5.5 Proprietary Information.

5.5.1 Rights and Responsibilities. Each Party agrees that the Proprietary Information of the other Party is the exclusive property of such Party and that each Party has no right, title or interest in the same. Each Party agrees to keep the Proprietary Information and this Agreement strictly confidential and agrees not to disclose any Proprietary Information or the contents of this Agreement to any third party without the other Party's consent, except (i) to governmental authorities having jurisdiction, (ii) in the case of Company's disclosure to Members, Government Sponsors, consultants and vendors under contract with Company, and (iii) in the case of Facility's disclosure to Members for the limited purpose of advising Members of potential treatment options and costs consistent with applicable Federal and state laws. Except as otherwise required under applicable Federal or state law, each Party agrees to not use any Proprietary Information of the other Party, and at the request of the other Party hereto, return any Proprietary Information upon termination of this Agreement for whatever reason. Notwithstanding the foregoing, Facility through its staff is encouraged to discuss Company's provider payment methodology with patients, including descriptions of the methodology under which the Facility is paid. In addition, Facility through its staff may freely communicate with patients about their treatment options, regardless of benefit coverage limitations. This Section 5.5.1 shall survive the termination of this Agreement for one (1) year, regardless of the cause of termination.

6.0 TERM AND TERMINATION

6.1 Term.
This Agreement shall be effective for an initial term ("Initial Term") of one (1) year from the Effective Date, and thereafter shall automatically renew for additional terms of one (1) year each, unless and until terminated in accordance with this Article 6.0.

6.2 Termination without Cause.
This Agreement may be terminated by either party at any time following the conclusion of the Initial Term without cause with at least ninety (90) days prior written notice.

6.3 Termination for Breach.
This Agreement may be terminated at any time by either Party upon at least thirty (30) days prior written notice of such termination to the other Party upon material default or substantial breach by such Party of one or more of its obligations hereunder, unless such material default or substantial breach is cured within thirty (30) days of the notice of termination; provided, however, if such material default or substantial breach is incapable of being cured within such thirty (30) day period, any termination pursuant to this Section 6.3 will be ineffective for the period reasonably necessary to cure such breach if the breaching party has taken all steps reasonably capable of being performed within such thirty (30) day period. Notwithstanding the foregoing, the effective date of such termination may be extended pursuant to Section 6.6 herein.

6.4 Immediate Termination or Suspension.
Any of the following events shall result in the immediate termination or suspension of this Agreement by Company, upon notice to Facility, at Company's discretion at any time; (a) the revocation or non-renewal for cause of any mandatory Federal, state, or local license, certificate, approval, or authorization of Facility that is not under appeal (b) the bankruptcy or receivership of Facility, or an assignment by Facility for the benefit of creditors materially affecting its ability to operate in compliance with all applicable regulatory requirements (c) the loss or material limitation of Facility's insurance under Section 2.4 of this Agreement (d) a substantiated determination by Company that Facility's continued participation in provider networks could result in harm to Members (e) the exclusion, debarment or suspension of Facility from participation in any governmental sponsored program including, but not limited to, Government Programs, Medicare of the Medicaid program in any state: (f) the indictments or conviction of Facility for any crime (g) the listing of Facility in the HIPDB: or (h) the withdrawal, expiration, or termination of the State Contract. To protect the interests of the patients, including Members, Facility will provide immediate notice to Company of any of the aforesaid events described in clauses (a) through (h).

6.5 Obligations Following Termination.
Following the effective date of any expiration or termination of this Agreement or any Plan, Facility and Company will cooperate as provided in this Section 6.5 and in Exhibits A & D, as applicable. This Section 6.5 and Exhibits A & D, as applicable, shall survive the termination of this Agreement, regardless of the cause of termination.

6.5.1 Upon Termination. Upon expiration or termination of this Agreement for any reason, other than termination by Company in accordance with Section 6.4 above. Facility agrees to provide Services to: (a) any Member who is receiving services from Facility as of the effective date of termination until such Member's discharge or the Member's course of treatment is completed and (b) any Member, upon request of such Member or the applicable Plan Sponsor for one (1) calendar year. The terms of this Agreement, including the Services and Compensation Schedule, shall apply to all services under this Section/Agreement 6.5.1

6.5.2 Upon Insolvency or Cessation of Operations. If this Agreement terminates as a result of insolvency or cessation of operations of Company, and as to Members of HMOs that become insolvent or cease operations, then in addition to other obligations set forth in this section, Facility shall continue to provide Facility Services to: (a) all Members for the period for which premium has been paid; and (b) Members confined as inpatients in Facility on the date of insolvency or other cessation of operations until medically appropriate discharge. This provision shall be construed to be for the benefit of Members. No modification of this provision shall be effective without the prior written approval of the applicable regulatory agencies.

6.5.3 Obligation to Cooperate. Upon notice of expiration or termination of this Agreement or of a Plan, Facility shall cooperate with Company and comply with Policies, if any, in the transfer of Members to other providers.

6.5.4 Obligations During Dispute Resolution Proceedings.

In the event of any dispute between the Parties in which a Party has provided notice of termination under Section 6.3 and the dispute is required to be resolved or is submitted for resolution under Article 8.0 below, the termination of this Agreement shall be stayed and the Parties shall continue to perform under the terms of this Agreement until the final resolution of the dispute.

7.0 RELATIONSHIP OF THE PARTIES

7.1 Independent Contractor Status.

The relationship between Company and Facility, as well as their respective employees and agents, is that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Facility will each be solely liable for its own activities and those of its agents and employees, and neither Company nor Facility will be liable in any way for the activities of the other Party or the other Party's agents or employees arising out of or in connection with: (a) any failure to perform any of the agreements, terms, covenants or conditions of this Agreement; (b) any negligent act or omission or other misconduct; (c) the failure to comply with any applicable laws, rules or regulations; or (d) any accident, injury or damage. Facility acknowledges that all Member care and related decisions are the responsibility of Facility and its medical staff, and that Policies do not dictate or control Facility's clinical decisions with respect to the care of Members. Facility agrees to indemnify and hold harmless the Government Sponsor and Company from any and all claims, liabilities and third party causes of action arising out of the Facility's provision of care to Members. Company agrees to indemnify and hold harmless the Facility from any and all claims, liabilities and third party causes of action arising out of the Company's administration of health care services in connection with the Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the reason for termination.

7.2 Use of Name.

Facility consents to the use of Facility's name and other identifying and descriptive material in provider directories and in other materials and marketing literature of Company in all formats, including, but not limited to, electronic media. Facility may use Company's names, logos, trademarks or service marks in marketing materials or otherwise, upon receipt of Company's prior written consent, which shall not be unreasonably withheld.

7.3 Interference with Contractual Relations.

Facility shall not engage in activities that will cause Company to lose existing or potential Members, including but not limited to: (a) advising Company customers, Government Sponsors or other entities currently under contract with Company to cancel, or not renew said contracts; (b) impeding or otherwise interfering with negotiations which Company is conducting for the provision of health benefits or Plans; or (c) using or disclosing to any third party membership lists acquired during the term of this Agreement for the purpose of soliciting individuals who were or are Members or otherwise to compete with Company. Notwithstanding the foregoing, Company shall not prohibit, or otherwise restrict, Facility from advising or advocating on behalf of a Member who is its patient, for the following: (i) the Member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered; (ii) any information the Member needs in order to decide among all relevant treatment options; (iii) the risks, benefits, and consequences of treatment or nontreatment; and (iv) the Member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions. This section shall continue to be in effect for a period of one (1) year after the expiration or termination of this Agreement.

8.0 DISPUTE RESOLUTION

8.1 Member Grievance Dispute Resolution.
Facility agrees to (a) cooperate with and participate in Company's applicable appeal, grievance and external review procedures (including, but not limited to, Medicaid appeals and expedited appeals procedures), (b) provide Company with the information necessary to resolve same, and (c) abide by decisions of the applicable appeals, grievance and review committees. Company will make available to Facility information concerning the Member appeal, grievance and external review procedures at the time of entering into this Agreement.

8.2 Facility Dispute Resolution.
Company shall provide a mechanism whereby Facility may raise issues, concerns, controversies or claims regarding the obligations of the Parties under this Agreement. Facility shall exhaust this mechanism prior to instituting any arbitration or other permitted legal proceeding. The Parties agree that any dispute that may arise between the Parties shall not disrupt or interfere with the provision of services to Members. Discussions and negotiations held pursuant to this Section 8.2 shall be treated as inadmissible compromise and settlement negotiations for purposes of applicable rules of evidence.

8.3 Arbitration.

8.3.1 Submission of Claim or Controversy to Arbitration. Any controversy or claim arising out of or relating to this Agreement or the breach, termination, or validity thereof, except for temporary, preliminary, or permanent injunctive relief or any other form of equitable relief, shall be settled by binding arbitration administered by the American Arbitration Association ("AAA") and conducted by a sole Arbitrator ("Arbitrator") in accordance with the AAA's Commercial Arbitration Rules ("Rules"). The arbitration shall be governed by the Federal Arbitration Act, 9 U.S.C. §§ 1-16, to the exclusion of state laws inconsistent therewith or that would produce a different result, and judgment on the award rendered by the Arbitrator (the "Award") may be entered by any court having jurisdiction thereof. A stenographic record shall be made of all testimony in any arbitration in which any disclosed claim or counterclaim exceeds $250,000. An Award for $250,000 or more shall be accompanied by a short statement of the reasoning on which the Award rests.

8.3.2 Appeal of Arbitration Award. In the event a Party believes there is a clear error of law and within thirty (30) days of receipt of an Award of $250,000 or more (which shall not be binding if an appeal is taken), a Party may notify the AAA of its intention to appeal the Award to a second Arbitrator (the "Appeal Arbitrator"), designated in the same manner as the Arbitrator except that the Appeal Arbitrator must have at least twenty (20) years' experience in the active practice of law or as a judge. The Award, as confirmed, modified or replaced by the Appeal Arbitrator, shall be final and binding, and judgment thereon may be entered by any court having jurisdiction thereof. No other arbitration appeals may be made.

8.3.3 Confidentiality. Except as may be required by law or to the extent necessary in connection with a judicial challenge, permitted appeal, or enforcement of an Award, neither a Party nor an arbitrator may disclose the existence, content, record, status or results of a negotiation or arbitration. Any information, document, or record (in whatever form preserved) referring to, discussing, or otherwise related to a negotiation or arbitration, or reflecting the existence, content, record, status, or results of a negotiation ("Negotiation Record") or arbitration ("Arbitration Record"), is confidential. The arbitration hearing shall be closed to any person or entity other than the arbitrator, the parties, witnesses during their testimony, and attorneys of record. Upon the request of a Party, an arbitrator may take such actions as are necessary to enforce this Section 8.3.3, including the imposition of sanctions.

8.3.4 Pre-hearing Procedure for Arbitration. The Parties will cooperate in good faith in the voluntary, prompt and informal exchange of all documents and information (that are neither privileged nor proprietary) relevant to the dispute or claim, all documents in their possession or control on which they rely in support of their positions or which they intend to introduce as exhibits at the hearing, the identities of all individuals with knowledge about the dispute or claim and a brief description

of such knowledge, and the identities, qualifications and anticipated testimony of all experts who may be called upon to testify or whose report may be introduced at the hearing. The Parties and Arbitrator will make commercially reasonable efforts to conclude the document and information exchange process within sixty (60) calendar days after all pleadings or notices of claims have been received. At the request of a Party in any arbitration in which any disclosed claim or counterclaim exceeds $250,000, the Arbitrator may also order pre-hearing discovery by deposition upon good cause shown. Such depositions shall be limited to a maximum of three (3) per Party and shall be limited to a maximum of six (6) hours' duration each. As they become aware of new documents or information (including experts who may be called upon to testify), all Parties remain under a continuing obligation to provide relevant, non-privileged documents, to supplement their identification of witnesses and experts, and to honor any understandings between the Parties regarding documents or information to be exchanged. Documents that have not been previously exchanged, or witnesses and experts not previously identified, will not be considered by the Arbitrator at the hearing. Fourteen (14) calendar days before the hearing, the Parties will exchange and provide to the Arbitrator (a) a list of witnesses they intend to call (including any experts) with a short description of the anticipated direct testimony of each witness and an estimate of the length thereof, and (b) premarked copies of all exhibits they intend to use at the hearing.

8.3.5 Arbitration Award. The arbitrator may award only monetary relief and is not empowered to award damages other than as set forth in this Agreement. The Award shall be in satisfaction of all claims by all Parties. Arbitrator fees and expenses shall be borne equally by the Parties. Postponement and cancellation fees and expenses shall be borne by the Party causing the postponement or cancellation. Fees and expenses incurred by a Party in successfully enforcing an Award shall be borne by the other Party. Except as otherwise provided in this Agreement, each Party shall bear all other fees and expenses it incurs, including all filing, witness, expert witness, transcript, and attorneys' fees.

8.3.6 Survival. The provisions of Section 8.3 shall survive expiration or termination of this Agreement, regardless of the cause giving rise hereto.

8.4 Arbitration Solely Between Parties; No Consolidation or Class Action.
Company and Facility agree that any arbitration or other proceeding related to a dispute arising under this Agreement shall be conducted solely between them. Neither Party shall request, nor consent to any request, that their dispute be joined or consolidated for any purpose, including without limitation any class action or similar procedural device, with any other proceeding between such Party and any third party.

9.0 MISCELLANEOUS

9.1 Amendments.
This Agreement constitutes the entire understanding of the Parties hereto and no changes, amendments or alterations shall be effective unless signed by both Parties, except as expressly provided herein. Company may amend this Agreement upon thirty (30) days prior written notice, by letter, newsletter, electronic mail or other media (an "Amendment"). Failure by Facility to object in writing to any such Amendment within thirty (30) days following receipt thereof constitutes Facility's acceptance of such Amendment. In the event that Facility reasonably believes that an Amendment is likely to have a material adverse impact upon Facility, Facility agrees to notify Company in writing, specifying the specific bases demonstrating a likely material adverse impact, and the Parties will negotiate in good faith an appropriate revised Amendment, if any, to this Agreement. Notwithstanding the foregoing, at Company's discretion, Company may amend this Agreement to comply with applicable law or regulation, or any order or directive of any governmental agency, without the consent of Facility, and this Agreement shall be deemed to be automatically amended to conform with all laws and regulations promulgated at any time by any state or federal regulatory agency or authority having supervisory authority over this Agreement. Facility agrees that noncompliance with

any requirements of this Section 9.1 will relieve Company or Government Sponsors and Members from any financial liability for the applicable portion of the Facility Services. Changes to Policies are addressed by Section 5.1 hereto.

9.2 Waiver.
The waiver by either Party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof. To be effective, all waivers must be in writing and signed by an authorized officer of the Party to be charged. Facility waives any claims or cause of action for fraud in the inducement or execution related hereto.

9.3 Governing Law.
This Agreement and the rights and obligations of the parties hereunder shall be construed, interpreted, and enforced in accordance with, and governed by, the laws of the State where Facility is located.

9.4 Liability.
Notwithstanding Section 9.3, either Party's liability, if any, for damages to the other Party for any cause whatsoever arising out of or related to this Agreement, and regardless of the form of the action, shall be limited to the damaged Party's actual damages. Neither Party shall be liable for any indirect, incidental, punitive, exemplary, special or consequential damages of any kind whatsoever sustained as a result of a breach of this Agreement or any action, inaction, alleged tortious conduct, or delay by the other Party.

9.5 Severability.
Any determination that any provision of this Agreement or any application thereof is invalid, illegal or unenforceable in any respect in any instance shall not affect the validity, legality and enforceability of such provision in any other instance, or the validity, legality or enforceability of any other provision of this Agreement. Neither Party shall assert or claim that this Agreement or any provision hereof is void or voidable if such Party performs under this Agreement without prompt and timely written objection.

9.6 Successors; Assignment.
.Comapny agrees that Facility, if acquired, merged, or legal control is otherwise transferred to the extent requiring approval of the applicable New Jersey licensing agency, will not withhold it's consent of the assignment of this Agreement if such regulatory approval is properly obtained and submitted to Company by the successor to Facility. An application for assignment of this Agreement will not alone authorize Company's termination of this Agreement. Neither Party may assign its rights or its duties and obligations under this Agreement without the prior written consent of the other Party, which consent may not be unreasonably withheld; provided, however, that Company may assign its rights or its duties and obligations to an Affiliate or successor in interest so long as any such assignment or delegation will not have a material impact upon the rights, duties and obligations of Facility.

9.7 Headings.
The headings contained in this Agreement are included for purposes of convenience only, and shall not affect in any way the meaning or interpretation of any of the terms or provisions of this Agreement.

9.8 Notices.
Except for any notice required under Article 6, Term and Termination, or if otherwise specified, notices required pursuant to the terms and provisions hereof may be effective if sent by letter, electronic mail or other generally accepted media. With respect to notices required under Article 6, notice shall be effective only if given in writing and sent by overnight delivery service with proof of receipt, or by certified mail return receipt requested. Notices shall be sent to the addresses set forth on the signature page of this Agreement (which addresses may be changed by giving notice in conformity with this Section 9.8). Facility shall notify Company of any changes in the information provided by Facility related to Facility's address.

9.9 Remedies.
Notwithstanding Sections 8.3 and 9.4, the Parties agree that each has the right to seek any and all remedies at law or equity in the event of breach or threatened breach of Section(s) 5.5, 6.6 and 7.3.

9.10 Non-Exclusivity.
This Agreement is not exclusive, and nothing herein shall preclude either Party from contracting with any other person or entity for any purpose. Company makes no representation or guarantee as to the number of Members who may select or be assigned to Facility.

9.11 Force Majeure.
If either Party shall be delayed or interrupted in the performance or completion of its obligations hereunder by any act, neglect or default of the other Party, or by an embargo, war, act of terror, riot, incendiary, fire, flood, earthquake, epidemic or other calamity, act of God or of the public enemy, governmental act (including, but not restricted to, any government priority, preference, requisition, allocation, interference, restraint or seizure, or the necessity of complying with any governmental order, directive, ruling or request) then the time of completion specified herein shall be extended for a period equivalent to the time lost as a result thereof. This Section 9.11 shall not apply to either Party's obligations to pay any amounts owing to the other Party, nor to any strike or labor dispute involving such Party or the other Party.

9.12 Confidentiality.
It is further understood and agreed by and among the Parties that the terms and conditions of this Agreement, except as otherwise specified, are and shall remain confidential, and shall not be disclosed by either Party without express written consent of the other Party or as required by law or by governmental authorities or by express order by a court having jurisdiction over the Party from whom disclosure is sought.

9.13 Entire Agreement.
This Agreement (including any attached schedules, appendices and/or addenda) constitutes the complete and sole contract between the Parties regarding the subject matter described above and supersedes any and all prior or contemporaneous oral or written representations, communications, proposals or agreements not expressly included in this Agreement and may not be contradicted or varied by evidence of prior, contemporaneous or subsequent oral representations, communications, proposals, agreements, prior course of dealings or discussions of the Parties. The Parties understand and agree that this Agreement only applies to the Plans described in this Agreement and, likewise, this Agreement does not and will not supersede any agreement(s) between Company's affiliates and Provider that relates to Company's affiliates other lines of business that are not the subject of this Agreement (that are not the Plans described in this Agreement).

9.14 Signatures.
Facsimile and electronic signatures shall be deemed to be original signatures for all purposes of this Agreement.

9.15 Incorporation of Recitals.
The Parties incorporate the recitals into this Agreement as representations of fact to each other.

IN WITNESS WHEREOF, the undersigned parties have executed this Agreement by their duly authorized officers, intending to be legally bound hereby.

FACILITY	**COMPANY**
By:_____	By:_____
Printed Name:_____	Printed Name:_____
Title:_____	Title:_____
Date:_____	Date:_____

REIMBURSEMENT ADDRESS:

_____

_____

_____

MAIN TELEPHONE NUMBER:_____

CHIEF EXECUTIVE OFFICER:_____

CHIEF FINANCIAL OFFICER:_____

BUSINESS OFFICE MANAGER:_____

FEDERAL TAX I.D. NUMBER:_____

NPI NUMBER:_____

As required by Section 9.8 ("Notices") of this Agreement, notices shall be sent to each Party at the following addresses:

To Facility at:

_____

_____

_____

_____

_____

To Company at:

Aetna Better Health

3 Independence Way, Ste 400

Princeton, NJ 08540-6626

PROGRAM PARTICIPATION SCHEDULE

Facility agrees to participate in the Plans and other health benefit programs listed herein:

Those New Jersey Medicaid and CHIP Plans and programs offered by Company within the State of New Jersey (includes Managed Long Term Services and Supports).

Those Medicare plans for Medicaid enrollees offered by Company within the State of New Jersey (includes Medicare D-SNP and integrated Medicare-Medicaid Plans).

SERVICES AND COMPENSATION SCHEDULE

1.0 COMPENSATION

New Jersey Medicaid and CHIP Plans:	Aetna Medicaid Market Fee Schedule
New Jersey Medicare Plans:	Medicare Allowable Rate

2.0 SERVICES

Provider will be reimbursed for those Covered Services in accordance with the terms of this Agreement that are within the scope of and appropriate to the Provider's license and certification to practice.

3.0 GENERAL COMPENSATION TERMS AND CONDITIONS

Definitions

"Aetna Medicaid Market Fee Schedule (AMMFS)" – A fee schedule that is based upon the contracted location where service is performed and the State of New Jersey's Medicaid Fee Schedule.

"Medicare Allowable" - the current payment as of discharge date that a hospital will receive from Company, subject to the then current Medicare Inpatient Prospective Payments Systems and will be updated in accordance with CMS changes, provided, however, that exempt units for psychiatric, rehabilitation and skilled nursing facility services will be paid in accordance with the applicable Medicare Prospective Payment Systems. These payments are intended to mirror the payment a Medicare Fiscal Intermediary ("FI") would make to the hospital, less (with respect to DRG-based payments) the payments for Indirect Medical Education (IME), Direct Graduate Medical Education (DGME), bad debt, as appropriate and adjusted by CMS or Government Sponsor for sequestration, SGR or other items and Aetna payment and processing guidelines. For other provider types, the Medicare allowable rate is based upon CMS Geographic Pricing Cost Indices (GPCI) and Resource Based Relative Value Scale (RBRVS) Relative Value Units (RVU) including Outpatient Prospective Payment System (OPPS) cap rates; the Clinical Laboratory Fee Schedule (CLAB); the Durable Medical Equipment, Prosthetics, Orthotics and Supplies Fee Schedule; including PEN (DMEPOS) and 'Medicare Part B Drug Average Sales Price (ASP),' as appropriate. Coding and fees determined under this schedule will be updated as CMS releases code updates, changes in the MFS relative values, including OPPS cap payments, or the CMS conversion factors. Company plans to update the schedule within 90 days of the final rates and/or codes being published by CMS. However, the rates and coding sets for these services do not become effective until updates are completed by Company and payment is considered final and exclusive of any retroactive or retrospective CMS adjustments to the rate. Company payment policies apply to services paid based upon the Medicare allowable rate.

General

A. Member Cost Share. Rates are inclusive of any applicable Member Copayment, Coinsurance or Deductible.

B. Billing. When billing, Provider must designate applicable codes related to those Covered Services provided by Provider under the terms of this Agreement.

C. Coding. Company utilizes nationally recognized coding structures including, but not limited to, Revenue Codes as described by the Uniform Billing Code, AMA Current Procedural Terminology (CPT4), CMS Common Procedure Coding System (HCPCS), Diagnosis Related Groups (DRG), ICD-9 (or successor standard) Diagnosis and Procedure codes, and National Drug Codes (NDC). As changes are made to nationally-recognized codes,

Company will update internal systems to accommodate new codes. Such changes will only be made when there is no material change in the procedure itself. Until updates are complete, the procedure will be paid according to the standards and coding set for the prior period.

The use of ICD-10 coding shall not impact the aggregate rates and compensation intended by the Parties as set forth in this Services and Compensation Schedule. Consequently, in the event that use of ICD-10 codes result in aggregate payments that would differ from the aggregate payments that would have resulted based on ICD-9 coding (excluding utilization and validated case mix severity changes), the rates set forth in this Services and Compensation Schedule will be reviewed by Company periodically and adjusted at least annually in order to reflect what would have been paid had ICD-9 coding been utilized for determination of the payments.

Company will comply and utilize nationally recognized coding structures as directed under applicable Federal laws and regulations, including, without limitation, the Health Insurance Portability and Accountability Act (HIPAA).

D. Affordable Care Act Primary Care Enhancement. For those primary care Covered Services that the State of New Jersey has determined to reimburse at 100% of the Medicare allowable amount in accordance with Section 1902(a)(13)(C) of the Social Security Act, for so long as the rates are in effect and so long as Facility meets the requirements of applicable law for the rates, Company shall compensate Facility for the provision of such Covered Services to eligible Members delivered in accordance with the terms and conditions set forth in this Agreement at the lesser of Facility's billed charges or an amount equal to but not greater than the State's enhanced rates. Facility certifies that, to the extent required by law, such payments will insure to the benefit of the individual Participating Physicians, and will supply Company with any legally-required documentation of such. Company reserves the right i) to pay such enhanced compensation through monthly or quarterly adjustment; ii) to make payments directly to qualifying Participating Physicians; and/or iii) to require such Physicians or Facility to complete any agreements, forms, attestations or releases needed to effectuate such payments. Enhanced compensation is not available for Members of CHIP Plans.

E. Medicare-Medicaid Dual-Eligibles – Where Company is the responsible payor for Medicare and Medicaid Covered Services, rates for each service are determined by whether that service is regarded as a Medicare Covered Service or a Medicaid Covered Service by CMS and Government Sponsor, and with respect to a Member's benefit limits under each program. For Medicare Covered Services (inclusive of Member Copayment or Coinsurance), Company shall compensate provider at the specified Medicare rate. For Medicaid Covered Services, Company shall compensate provider according to the applicable Medicaid rate. When a service is covered under Medicare and Medicaid, Company will determine the rate (Medicare or Medicaid) according to applicable law, coordination of benefit principles and the terms of Member's Plan. Rates do not include, and Company is not responsible for, supplemental or wrap-around payments unless required by Company's contracts with Government Sponsor.

Exhibit A

New Jersey Regulatory Compliance Addendum

This Regulatory Compliance Addendum, including the attached Exhibit A-1, MacBride Principles Certification Form, is incorporated by reference in the Agreement.

If there is any conflict between the terms of this Exhibit A and any of the terms of this Agreement, the terms of this Exhibit A shall govern and control. For purposes of this Regulatory Compliance Addendum, the terms "Provider" and "Subcontractor" shall mean the health care executing this Agreement, as identified on the first page of the Agreement. The terms "Contractor" and "Company" shall mean Aetna Better Health Inc., a New Jersey Corporation.

1. DMAHS Mandatory Terms

The provider/subcontractor agrees to serve enrollees in New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

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

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 the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor 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. The Contractor 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 the Contractor 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 the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor 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. The Contractor shall pay long term care pharmacies the rate negotiated between the Contractor and the pharmacy.

Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facilkity, 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 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 Provider/Subcontractor shall submit claims within 180 calendar days from the date of service.

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

3. The Provider and 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 provider/subcontractor understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract/subcontract and any amendments thereto.

The contractor and AWP provider shall only amend this provider contract unilaterally for statutory and regulatory changes, and upon mutual consent of the parties with State approval.

D. EFFECTIVE DATE

This provider contract/subcontract shall become effective only when the contractor's agreement with the State takes effect.

E. NON-RENEWAL/TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT

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

F. ENROLLEE-PROVIDER COMMUNICATIONS

1. The contractor shall not prohibit or restrict the provider/subcontractor from engaging in medical communications with the 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 the provider/subcontractor and the provider's/subcontractor's patient. Providers/subcontractors 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 provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractors 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. Company, in making utilization review determinations agrees to define "medical necessity" in confirmance with New Jersey Medicaid and Department of Health licensing standards defining eligibility for admisison to or coverage of the applicable level of care.

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

a. To prohibit the enforcement, including termination, as part of a provider contract/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 the contractor 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 providers/subcontractors and their patients;

or

b. To permit a health care provider to misrepresent the scope of benefits covered under this provider contract/subcontractor or to otherwise require the contractor to reimburse providers/subcontractors for benefits not covered.

G. RESTRICTION ON TERMINATION OF PROVIDER CONTRACT/ SUBCONTRACT BY CONTRACTOR

Termination of AWP providers is limited to State ordered termination as indicated Section H below. The contractor shall not terminate this provider contract/subcontract for either of the following reasons:

1. Because the provider/subcontractor expresses disagreement with the contractor's decision to deny or limit benefits to a covered person or because the provider/subcontractor assists the covered person to seek reconsideration of the contractor's decision; or because the 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 the contractor or not, policy provisions of the contractor, or the provider/subcontractor's personal recommendation regarding selection of a health plan based on the provider/subcontractor's personal knowledge of the health needs of such patients.

2. Because the provider/subcontractor engaged in medical communications, either explicit or implied, with a patient about medically necessary treatment options, or because the 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 PROVIDER CONTRACT/SUBCONTRACT – STATE

The provider/subcontractor understands and agrees that the State may order the termination of this provider contract/subcontract if it is determined that the provider/subcontractor:

1. Takes any action or fails to prevent an action that threatens the health, safety or welfare of any enrollee, 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, DHSS, 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 provider contract/subcontract; or

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

I. NON-DISCRIMINATION

The provider/subcontractor shall comply with the following requirements regarding nondiscrimination:

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees 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 Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

2. ADA Compliance. The provider/subcontractor shall comply with the requirements of the Americans with Disabilities Act (ADA). In providing health care benefits, the provider/subcontractor shall not directly or indirectly, through contractual, licensing, or other arrangements, discriminate against Medicaid/NJ FamilyCare beneficiaries who are "qualified individuals with a disability" covered by the provisions of the ADA. The contractor shall supply a copy of its ADA compliance plan to the provider/subcontractor.

A "qualified individual with a disability" as defined pursuant to 42 U.S.C.§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.

The provider/subcontractor shall submit to Company a written certification that it is conversant with the requirements of the ADA, that it is in compliance with the law, and certifies that the provider/subcontractor meets ADA requirements to the best of the provider/subcontractor's knowledge. The 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 the provider/subcontractor to be in compliance with the ADA. Where applicable, the 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. The provider/subcontractor shall not discriminate against eligible persons or enrollees on the basis of their health or mental health history, health or mental health status, their need for health care services, amount payable to the provider/subcontractor on the basis of the eligible person's actuarial class, or pre-existing medical/health conditions.

4. The 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. The provider/subcontractor shall not discriminate against any employee engaged in the work required to produce the services covered by this provider/subcontractor contract, 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 PL 1975, Chapter 127.

6. Grievances. The provider/subcontractor agrees to forward to Company copies of all grievances alleging discrimination against enrollees 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 the provider/subcontractor.

J. OBLIGATION TO PROVIDE SERVICES AFTER THE PERIOD OF THE CONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

1. The provider/subcontractor shall remain obligated to provide all services for the duration of the period after the contractor's insolvency, should insolvency occur, for which capitation payments have been made and, for any hospitalized enrollee, until the enrollee has been discharged from the inpatient facility.

2. The provider/subcontractor agrees that under no circumstances, (including, but not limited to, nonpayment by the contractor or the state, insolvency of the contractor, or breach of agreement) will the provider/subcontractor bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees, or persons acting on their behalf, for covered services other than provided in section 2.P.

3. The provider/subcontractor agrees that this provision shall survive the termination of this provider contract/subcontract regardless of the reason for termination, including insolvency of the contractor, and shall be construed to be for the benefit of the contractor or enrollees.

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, 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 this continuation of benefits provisions.

5. The 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. The 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. 10:74-8.7.01.

K. INSPECTION

The provider/subcontractor shall allow the New Jersey Department of Human Services, the U.S. Department of Health and Human Services (DHHS), 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 provider contract/subcontract, and to inspect, evaluate, and audit any and all books, records, and facilities maintained by the 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.

The subcontractor shall also permit the State, at its sole discretion, to conduct onsite inspections of facilities maintained by the provider/subcontractor, prior to approval of their use for providing services to enrollees. Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/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 enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontractor shall furnish any such record, or copy thereof, to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

The DMAHS, the MFD, or its designee, and the 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 contractor, 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 NJAC 10:49-9.8(b) (1).

L. RECORD MAINTENANCE

The 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

The provider/subcontractor hereby agrees to maintain an appropriate recordkeeping system for services to enrollees. Such system shall collect all pertinent information relating to the medical management of each enrolled beneficiary and make that information readily available to appropriate health professionals and the Department. 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 the provider contract/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 enrollees who are eligible through the Division of Youth and Family Services, 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 enrollee's confidentiality.

If an enrollee disenrolls from the contractor, the provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department 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 enrollee.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the contractor 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. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the contractor's agreement with the State.

2. The 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. The 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 the Contractor.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

The provider/subcontractor shall not impose cost-sharing charges of any kind upon Medicaid or NJ FamilyCare A and B enrollees. Personal contributions to care for NJ FamilyCare C enrollees and copayments for NJ FamilyCare D enrollees shall be collected in accordance with the attached schedule.

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

1. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees 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 provider contract/subcontract.

2. The provider/subcontractor agrees to indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees 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 provider contract/subcontract.

3. The provider/subcontractor agrees further that it will indemnify and hold harmless the State, its officers, agents, and employees, and the enrollees and their eligible dependents from any and all claims for services for which the provider/subcontractor receives payment.

4. The provider/subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees 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 provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

5. The provider/subcontractor shall indemnify the State, its officers, agents and employees, and the enrollees 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 the provider/subcontractor, its officers, agents, and employees arising out of alleged violation of any State or federal law or regulation. The provider/subcontractor shall also indemnify and hold the State harmless from any claims of alleged violations of the Americans with Disabilities Act by the subcontractor/provider.

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 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 provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the contractor's plan that are eligible through the Division of Youth and Family Services, 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 enrollee's confidentiality.

2. Enrollee-Specific Information. With respect to any identifiable information concerning an enrollee that is obtained by the provider/subcontractor, it: (a) shall not use any such information for any purpose other than carrying out the express terms of this provider contract/subcontract; (b) shall promptly transmit to the Department all requests for disclosure of such information; (c) shall not disclose except as otherwise specifically permitted by the provider contract/subcontract, any such information to any party other than the Department without the Department'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 provider contract/subcontract, return all such information to the Department or maintain such information according to written procedures sent by the Department for this purpose.

3. Employees. The provider/subcontractor shall instruct its employees to keep confidential information concerning the business of the State, its financial affairs, its relations with its enrollees 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 enrollees shall be confidential and shall be disclosed to other persons within the 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 provider contract/subcontract.

5. The provisions of this article shall survive the termination of this provider contract/subcontract and shall bind the provider/subcontractor so long as the provider/subcontractor maintains any individually identifiable information relating to Medicaid/NJ FamilyCare beneficiaries.

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, the 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 U.S.C. 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

The provider/subcontractor shall ensure that all laboratory testing sites providing services under this provider contract/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. The provider/subcontractor agrees to assist the contractor 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 provider/subcontractor, or withheld payments pursuant to 42 CFR 456.23 and NJAC 10:49-9.10(a), the contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

3. The contractor 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, DHSS, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. The contractor 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 the contractor'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.

U. THIRD PARTY LIABILITY

1. The provider/subcontractor shall utilize, whenever available, and report any other public or private third party sources of payment for services rendered to enrollees.

2. Except as provided in subsection 3. below, if the provider/subcontractor is aware of third party coverage, it shall submit its claim first to the appropriate third party before submitting a claim to the contractor.

3. In the following situations, the provider/subcontractor may bill the contractor first and then coordinate with the liable third party, unless the contractor 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 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 DYFS 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 the provider/subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the provider/subcontractor may bill the contractor without having received a written denial from the third party.

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

a. The provider/subcontractor shall notify the contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.

b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the contractor in writing, including the enrollee's name and Medicaid identification number, date

of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the 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 enrollee's diagnosis and the nature of the service provided to the enrollee.

c. The provider/subcontractor shall notify the contractor on no less than a weekly basis when it becomes aware of the death of one of its Medicaid enrollees age 55 or older, utilizing the "Combined Notification of Death and Estate Referral Form" located in subsection B.5.1 of the Appendix.

d. The provider/subcontractor agrees to cooperate with the contractor's and the State's efforts to maximize the collection of third party payments by providing to the contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and /or third party liability, is the contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee'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 medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and

b. The enrollee 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 and/or NJAC 10:74-9.1; and

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

e. The protections afforded to enrollees under 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and

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

g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee 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 contract to the contrary, an enrollee 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 the contractor's network; or

b. The enrollee 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.

2. <u>Additional Terms Required by Law or State Contract</u>

A. DEFINITIONS

1. The definition of "Clean Claim" in the Agreement is stricken and replaced with:

   "A claim by Provider where 1) the claim is for a service or supply covered by the Member's Plan; 2) the claim is submitted with all the information requested by Company or in other instructions; 3) the person to whom the service or supply was provided was a Member on the date of service; 4) Company does not reasonably believe that the claim has been submitted fraudulently; and 5) the claim does not require special treatment. For the purposes of this definition, 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. In order to accept a claim, the information requested by Company is specified in its Policies, which include the requirements that a claim have (i) detailed and descriptive medical and patient data, (ii) a corresponding referral (whether in paper or electronic format), if required for the applicable claim, and (iii) whether submitted via an electronic transaction using permitted standard code sets (e.g., CPT-4, ICD-9 (or successor standard), HCPCS) as required by the applicable Federal or state regulatory authority (e.g., U.S. Dept. of Health & Human Services, U.S. Dept. of Labor, state law or regulation) or otherwise, all the data elements of the UB-04 or CMS-1500 (or successor standard) forms (including but not limited to Member identification number, national provider identifier ("NPI"), date(s) of service, complete and accurate breakdown of services). Further information on the type of information and documentation that must be submitted with a claim, including a standard claim form and any other claim submission requirements utilized by the carrier for both manually and electronically submitted claims, and a street address where claim submissions can be delivered by hand or registered/certified mail, is available in Company's Policies which are posted on its website."

2. The following is added to the end of the definition of Emergency Medical Condition:

   "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."

B. INSURANCE

Provider agrees to procure and maintain such policies of general and professional liability and other insurance or a comparable program of self-insurance, at minimum levels of $1,000,000 per claim/$3,000,000 annual aggregate as required by state law.

C. PAYMENT OF CLAIMS AND COMPENSATION

1. DMAHS Recoveries. Whenever DMAHS has initiated a recovery claim against Provider, whether that recovery claim arises out of Provider's fee-for-service or managed care participation, Company must comply with any written request from DMAHS to withhold all or part of any payments that are owed by the Company to Provider up to the amount of DMAHS's recovery claim, and Company must immediately remit those payments to DMAHS. Provider and any subcontractor of Provider shall fully cooperate with Company in Company's compliance with these procedures.

2. Encounter Data. Provider agrees to cooperate in the implementation of Company's Encounter Data submission incentive system. Pursuant to this system, Providers must timely submit all encounter data apropriate to the services provided under this Agreement. Timely submission of encounter data is a precondition for participation in any supplemental pay for performance or medical home iniative offered by Company. Failure to timely submit encounter data shall be a breach of this Agreement and may result in termination, in accordance with the Agreement's terms. Company may, but is not required to, offer additional incentives to Provider.

3. Financial Risk. Unless expressly set forth elsewhere in this Agreement, Provider is not subject to financial risk for the delivery of Covered Services by persons or entities other than Provider. Provider either a)

certifies that no such financial risk is imposed by Provider upon other persons or entities (such as subcontractors or employed physicians); or if such risk is imposed, b) will promptly disclose such to Company and cooperate to fulfill Company's obligations of disclosure to Government Sponsor, and fulfill all other requirements of applicable law and the State Contract.

4. No Prohibited Incentives. No compensation is payable under this Agreement as a financial incentive to provider for the withholding of Covered Services that are Medically Necessary.

5. Time for Submission of Claims. Notwithstanding the time periods stated in Section 4.1.1 of the Agreement, Provider agrees that Company, or the applicable Government Sponsor, will not be obligated to make payments for billings received more than one hundred and eighty (180) days from (a) the date of service or, (b) when Company is the secondary payer, from the date of receipt of the primary payer's explanation of benefits. Company may make payment for billings received outside of such time period, upon consideration of the factors set forth in N.J.A.C. 11:22-3.4(e), when addressed by Provider.

6. Time for Payment of Claims. Notwithstanding the time periods stated in Section 4.1.2 of the Agreement, Company will make payment for Clean Claims within the timeframe required by N.J.S.A. 26:2J-8.1.d.

7. Time for Requests for Refund of Overpayments. Notwithstanding anything in this Agreement to the contrary, Company shall not make a request for reimbursement of an overpayment, except during the 18-month period described in N.J.S.A. 26:2J-8.1.d(10) or as permitted therein.

D. INFORMATION AND RECORDS

Without limitation, the government agencies permitted access to Information under Section 5.3.2 of the Agreement include the New Jersey Departments of Banking and Insurance, Health and Senior Services and Human Services. In addition to the purposes stated in Section 5.3.2, such regulators may access Information for the purpose of assessing the quality of care or investigating Member grievances or complaints.

E. TERMINATION

1. Prohibited Terminations. Company shall not terminate this Agreement because Provider expresses disagreement with Company's decision to deny or limit benefits to a Member or because Provider assists the Member to seek reconsideration of the Company's decision; or because Provider 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 Company or not, policy provisions of a plan, or Provider's personal recommendation regarding selection of a health plan based on the Provider's personal knowledge of the health needs of such patients. Nor shall Company terminate this Agreement or penalize Provider because (a) Provider filed a complaint or appeal as permitted by the New Jersey regulations governing health maintenance organizations; or (b) for acting as an advocate for the Member for seeking benefits for appropriate, medically necessary health services. Nevertheless, Provider is prohibited from making, publishing, disseminating, or circulating directly or indirectly or aiding, abetting, or encouraging the making, publishing, disseminating, or circulating of any oral or written statement or any pamphlet, circular, article, or literature that is false or maliciously critical of Company and calculated to injure Company. A material misrepresentation by Provider of the provisions, terms, or requirements of Company shall be a breach of this Agreement for which Company may exercise its rights of termination.

2. Government Sponsor Termination. In addition to those grounds for termination set forth in Section 6.4 of the Agreement or elsewhere, Company may terminate this Agreement immediately upon direction from Government Sponsor if Provider's performance is not consistent with the State Contract.

3. Additional Terms for Transition. The parties agree that, regardless of which party terminates the Agreement, the parties shall abide by the terms of the Agreement, including the compensation terms, for four (4) months following the date of termination for cases in which it is medically necessary for a Member

to continue treatment with the terminated Provider, except a longer period shall apply in the following cases: i) for Members who are pregnant at the termination date, the Agreement shall continue through the post-partum evaluation of the Member, up to six (6) weeks after delivery; ii) for Members who are in post-operative care at the termination date, the Agreement shall continue for a period of up to six (6) months; iii) for Members who are receiving oncologic treatment at the termination date, the Agreement shall continue for a period of up to one (1) year; iv) for Members who are receiving psychiatric treatment at the termination date, the Agreement shall continue for up to one (1) year; v) to any Member who is an inpatient at Provider as of the effective date of termination until such Member's discharge or Company's orderly transition of such Member's care to another provider; and vii) at Company's request to any Member for up to one (1) calendar. Notwithstanding the foregoing, i) the Agreement shall not continue in force hereunder if the Provider has been terminated based upon the opinion of Company's Medical Director that the Provider is an imminent danger to a patient, public health, safety and welfare, a determination of fraud, breach of contract, termination in accordance with Section 6.4 of the Agreement (or section 2 above) or if the Provider is the subject of disciplinary action by the State Board of Medical Examiners.

4. Notice of Termination. If the Agreement between Company and Provider is terminated by Company on any date other than the designated renewal or anniversary date, Company shall give Provider at least ninety (90) days prior written notice of the termination and the opportunity to request a hearing in all instances except when the termination is based upon non-renewal of the contract, a determination of fraud, breach of contract by Provider, sanctions by a State or Federal agency, or the opinion of the Company's medical director that Provider represents an imminent danger to a Member or the public health, safety and welfare. The notice of termination shall specify: (a) that the Provider may request in writing from Company, within fifteen (15) days of receipt of the notice, a written reason for the termination unless such reason is already stated in the notice, (b) that the Provider may request a hearing, and; (c) the procedures for exercising Provider's right to a hearing.

F. RELATIONSHIP OF THE PARTIES

Section 7.1 of the Agreement, Independent Contractor Status, is deleted and replaced with the following:

"The relationship between Company and Provider, as well as their respective employees and other agents, is intended to be that of independent contractors, and neither shall be considered an agent or representative of the other Party for any purpose, nor shall either hold itself out to be an agent or representative of the other for any purpose. Company and Provider will each be solely liable for its own activities and those of its employees and other agents, and neither Company nor Provider will be liable in any way for the activities of the other Party or the other Party's employees or other agents. Provider acknowledges that all Member care and related decisions are the responsibility of Provider and its medical staff, and that Policies do not dictate or control Provider's clinical decisions with respect to the medical care or treatment of Members. Provider has the right to communicate openly with Company's Members regarding all appropriate diagnostic testing and treatment options.

"Nothing in this Agreement nor Company's Policies shall be construed to require Provider to violate the statutes or rules governing licensure of Provider. Moreover, nothing in this Agreement may be construed to prohibit or restrict Provider from engaging in medical communications with the provider's patient, either explicit or implied, nor shall any Policy, provider manual, newsletters, directives, letters, verbal instructions, or any other form of communication from Company prohibit medical communication between Provider and Provider's patient. Provider shall be free to communicate freely with patients about the health status of patients, medical care or treatment options including any alternative treatment that may be self-administered, the risks, benefits, and consequences of treatment or non-treatment regardless of whether benefits for that care or treatment are provided under the State Contract, if Provider is acting within the lawful scope of practice. Provider shall be free to practice its respective profession in providing the most appropriate treatment required by patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities. The foregoing does not prohibit the enforcement of the terms of this Agreement and Company's Policies requiring Provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by Company 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 providers and their patients; or to permit Provider to misrepresent the scope of benefits covered under the State Contract or to otherwise require Company to reimburse providers for benefits not covered.

"Provider agrees to indemnify and hold harmless the Company from any claims, liabilities or other and third party causes of action arising related to the Provider's provision of care to Members. Company agrees to indemnify and hold harmless the Provider from any and all claims, liabilities and third party causes of action arising out of the Company's administration of Plans. This provision shall survive the expiration or termination of this Agreement, regardless of the cause giving rise to termination. Nothing in the within this Agreement, including this Section and Section 9.4 shall waive, modify, delegate or shift the liability of either party under N.J.S.A 2A:53A-33a.

"Provider and Company are mutually responsible to assure 24 hour, seven-day a week emergency and urgent care coverage to Members."

G. DISPUTE RESOLUTION

1. Hearing Upon Termination. Hearings for Agreement termination, when permitted under this Agreement, shall be conducted in accordance with the following guidelines: (a) Provider shall have the right to make a written request for a hearing within ten (10) business days following the date of receipt of notice of termination; (b) the Agreement shall be deemed to have terminated, creating the right to a hearing, whenever Agreement terminates on any date other than a designated renewal or anniversary date of the Agreement, except that no such right shall exist with respect to termination described in Section 6.4.1 of this Agreement; (c) if no renewal of anniversary date is specified in the Agreement, then the renewal or anniversary date shall be deemed to be the month and day in each calendar year on which the Agreement was originally signed by both parties, or became effective, whichever date is latest; (d) Company shall hold a hearing before a panel appointed by the Company, within thirty (30) days following receipt of a written request for a hearing by Provider; (e) the panel shall consist of no less than three (3) people, at least one of whom shall be a clinical peer in the same or substantially similar discipline and specialty as the Provider requesting the hearing; (f) Company shall not preclude Provider from being present at the hearing or represented by counsel at the hearing; (g) the panel shall render a decision on the matter within thirty (30) days of the close of the hearing unless the panel provides notice to Company and Provider of the need for an extension for rendering its decision, prior to the date that the decision would otherwise be due; (h) the panel's decision shall set forth the relevant Agreement provisions and the facts upon which the Company and Provider have relied at the hearing; (i) the panel shall recommend that the Provider be terminated, reinstated or provisionally reinstated, and specify the reasons for its recommendations, including the reasons for any provisional reinstatement; (j) with regard to provisional reinstatements, the panel shall specify the conditions for provisional reinstatement, the duration of the conditions, and the consequences of the failure to meet the conditions; (k) in the event of reinstatement or provisional reinstatement, the panel shall specify the impact of the reinstatement upon the terms of duration of the Agreement at issue; (l) in the event that the panel recommends that Provider be terminated, Company shall provide notice of termination to Members in accordance with New Jersey law and Provider shall continue to provide services to Members at the contract price following termination, in accordance with New Jersey law pertaining to continuity of care; and (m) Provider's participation in the hearing shall not be deemed to be an abrogation of Provider's legal rights.
2. Provider Disputes.
   Company's internal provider dispute resolution mechanisms are more fully described in Company's Policies. Company's Member Appeal process for matters including utilization review and medical necessity provides under some circumstances for appeal by the Provider on the Member's behalf, including appeal to an Independent Utilization Review Organization or Medicaid Fair Hearing. Matters determined by these bodies are conclusive upon the parties and not subject to further appeal, arbitration or litigation between the parties (unless otherwise provided for under state and federal law).

Provider may file a payment dispute verbally or in writing direct to Aetna Better Health of New Jersey to resolve billing, payment and other administrative disputes for any reason including but not limited to: lost or incomplete claim forms or electronic submissions; requests for additional explanation as to services or treatment rendered by a health care provider; inappropriate or unapproved referrals initiated by the provider; or any other reason for billing disputes. Provider Payment Disputes do not include disputes related to medical necessity. Disputes must be filed on or before the 90th calendar day following Company's determination which forms the basis of the dispute. Provider can file a verbal payment dispute with Aetna Better Health of New Jersey by calling Provider Services Department, or in writing. Provider may be requested to complete and submit a Dispute Form with any appropriate supporting documentation. The Dispute Form, is accessible on Company's website, or upon request will be given to Provider via fax or by mail.

Provider may file a formal grievance in regard to policies, procedures or any aspect of our Company's administrative functions or other matters specified in Company's Policies, either in writing or by telephone. An acknowledgement letter will be sent within three (3) business days summarizing the grievance and will include instruction on how to revise the grievance within the timeframe specified in the acknowledgement letter and withdraw a grievance at any time until Grievance Committee review. Aetna Better Health of New Jersey will resolve all provider grievances within forty-five (45) calendar days of receipt of the grievance and will notify the Provider of the resolution within ten (10) calendar days of the decision.

H. AMENDMENTS

Any amendment to this Agreement requires the prior approval of the New Jersey Department of Banking and Insurance. Provider understands that the State reserves the right in its sole discretion to review and approve or disapprove this provider contract and any amendments thereto.

I. SECONDARY CONTRACTORS

To the extent Provider is or acts as a secondary contractor (as defined in Section 11:24-1.2 of the New Jersey Administrative Code), Company is a third party beneficiary of the secondary contractor's contract(s) with the health care providers, and Provider's contract(s) with health care providers shall provide that Company shall have privity of contract with the health care providers such that the Company shall have standing to enforce Provider's contract(s) with the health care providers in the absence of enforcement by Provider. All Provider's agreements with health care providers shall be consistent with laws regarding confidentiality of information and with professional licensing standards, including, but not limited to, New Jersey Statutes Sections 45:14B-31 et seq. and 11:24-15.2(b-e) of the New Jersey Administrative Code. Such contracts shall include a provision whereby the provider is required to hold Members harmless for the cost of any service or supply covered by Company, subject to Section 11:24-15.2(b)(7)(i & ii), whether or not the provider believes the compensation received is adequate. Secondary contractors shall maintain throughout the term of this Agreement all appropriate license(s) and certification(s) mandated by governmental regulatory agencies.

J. SERVICE STANDARDS

1. Critical Incident Reporting. Provider agrees that it and its employees will participate in Company's education efforts and abide by Company's policies concerning the reporting of Member critical incidents. Providers must report, respond to and document critical incidents affecting Members to Company by providing such reports made to state and federal agencies pursuant to applicable law or regulation .

2. Background Checks. Providers, as well as ll employees and/or agents of a provider or subcontractor and who provide direct care must have a criminal background check as required by federal and State law, including checks required of all persons with direct access to Managed Long Term Services and Supports Members, and checks required under N.J.S.A. 45:1-30 et seq..

3. Mandatory Requirements for Particular Provider Types

The following terms are incorporated into the Agreement only as applicable to Provider's specific provider type.

A. FEDERALLY QUALIFIED HEALTH CENTERS

1. Provider will deliver the following specific services under the terms of this Agreement:

[List services if applicable]

2. The credentialing requirements for individual practitioners are set forth in Company's Policies.

3. Continuation of this Agreement is contingent on Provider maintaining quality services and maintaining the Primary Care Evaluation Review (PCER) by the federal government at a good quality level. Provider must make available to Company its PCER results annually, which will be considered in the Provider's QM reviews for assessing quality of care.

B. HOSPITALS

1. Provider will deliver the following specific services under the terms of this Agreement:
[List services if applicable]

2. Company shall pay for all medical screening services rendered to Members by hospitals and emergency room physicians. The amount and method of reimbursement for medical screenings for Hospital is set forth in this Agreement, or in a separate agreement with non-hospital-salaried emergency room physicians. Such reimbursement includes reimbursement for urgent care and non-urgent care rates.

3. Prior authorization for medical screenings, emergency care, or urgent care situations at the hospital emergency room is not be required. The hospital emergency room physician may determine the necessity for contacting the PCP or the Company for information about a patient who presents with an urgent condition. Provider must notify Company of a hospital admission through the emergency room within 24 to 72 hours of the admission, and notify Company of all Members who present in the emergency room for non-emergent care who have been medically screened but not admitted as an inpatient within 24 to 72 hours of the rendered service.

C. PRIMARY CARE PHYSICIANS
In addition to those responsibilities of a PCP set forth in the agreement, all Providers who are PCP's shall:

1. Supervise, coordinate, and manage Members' care;

2. Maintain Members' medical records;

3. Provide 24 hour/7 day a week access; and

4. Make referrals for specialty care.

D. NURSING AND REHABILITATION FACILITIES

Provider must contact Company prior to or within 24 hours of admission of a Member for authorization of care.

E. ALL FACILITIES

Provider must follow clear procedures for granting of admitting and attending privileges to physicians, and notify Company when such procedures are no longer appropriate. The admission authorization procedures for Members;

the procedures for notifying Company when Members present at emergency rooms and the procedures for billing and payment, schedules, and negotiated arrangements, if not set forth herein, are contained in Company's Policies.

F. MLTSS Providers

All MLTSS providers must meet the Provider Specification Reqirements of the State Contract applicable to their provider type and the services rendered. The State Contract's MLTSS Services & Behavioral Health Services Directories conatin these requirements, as well as other service descriptions and limitations, billing codes and other terms applicable to the specific contracted MLTSS services.

Exhibit A-1

MacBride Principles Certification Form

Pursuant to Public Law 1995, c.134, Provider must complete the certification below by checking one of the two representations listed and signing where indicated.

I certify, pursuant to N.J.S.A. 52:34-12.2 that the entity for which I am authorized to contract:

____ has no ongoing business activities in Northern Ireland and does not maintain a physical presence therein through the operation of offices, plants, factories, or similar facilities, either directly or indirectly, through intermediaries, subsidiaries or affiliated companies over which it maintains effective control; or

____ will take lawful steps in good faith to conduct any business operations it has in Northern Ireland in accordance with the MacBride principles of nondiscrimination in employment as set forth in N.J.S.A. 52:18A-89.5 and in conformance with the United Kingdom's Fair Employment (Northern Ireland) Act of 1989, and permit independent monitoring of their compliance with those principles.

I certify that the foregoing statements made by me are true. I am aware that if any of the foregoing statements made by me are willfully false, I am subject to punishment.

PROVIDER

By:_____

Printed Name:_____

Title:_____

Date:_____

EXHIBIT D

MEDICARE REQUIREMENTS

Provider shall comply, and shall cause its Downstream Entities to comply, with the requirements set forth in this Exhibit D, *Medicare Requirements* with respect to the provision of Services under the Agreement, including the performance of delegated activities in connection with Company or its subsidiaries or Affiliates' Medicare Advantage and/or Part D Program (including D-SNP or MMP). Except as provided herein, all other provisions of the Agreement between Company and Provider not inconsistent herein shall remain in full force and effect. This Exhibit D shall supersede and replace any inconsistent provisions to the Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of the Agreement. Provider's obligations specifically include the following:

A. Medicare Required Provisions.

Provider agrees to comply with all of the provisions of Exhibit D, Schedule 1, attached hereto and incorporated into the Agreement.

B. Other Medicare Requirements – Provider Obligations.

1. **Maintenance of Records and Audits**

   (a) Company or its designee(s) shall have the right, but not the obligation, to audit, inspect and copy, during regular business hours at Company's cost and in a manner that does not unreasonably interfere with Provider's business, any books and records Provider maintains pursuant to the Agreement and the Services performed, upon ten (10) business days' written notice to Provider; but only to the extent that such inspection is not prohibited by applicable law. To the extent that Company uses a third-party to audit Provider, such third party may not be a competitor of Provider and shall execute a confidentiality agreement acceptable to Provider, such acceptance shall not be unreasonably denied, delayed or withheld.

   (b) Provider shall maintain (and shall cause Downstream Entities to maintain) operational, financial, administrative and medical records, contracts, books, files and other documents as required legally or as are reasonable in the industry in connection with Services performed under the Agreement ("Records"). Such Records shall be maintained in a timely and accurate manner and shall, at a minimum, be reasonably sufficient to allow Company to determine whether Provider and its Downstream Entities are performing their obligations under the Agreement consistent with the terms of the Agreement and in accordance with applicable law and to confirm that the data submitted by Provider and its Downstream Entities for reporting and other purposes is accurate.

   (c) The terms of this paragraph 4, including with respect to maintenance of Records by Provider and Downstream Entities, shall remain in effort for a period of ten (10) years following the termination of the agreement between CMS and Company.

2. **Compliance With Law.** Provider acknowledges that Company, directly or indirectly, receives federal funds and that as a contractor of Company, the payments to Provider under the Agreement are, in whole or in part, from federal funds. In carrying out its duties and obligations under the Agreement, Provider shall follow and adhere to all applicable laws, including, but not limited to Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d et. Seq.); sections 503 and 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§793 and 794); Title IX of the Education Amendments of 1972, as amended (20 U.S.C. § 1681 et. Seq.); section 654 of the Omnibus Budget Reconciliation Act of 1981, as amended (41 U.S.C. §9849); the Americans with Disabilities Act (42 U.S.C. §12101 et. Seq.); and the Age Discrimination Act of 1975, as amended (42 U.S.C. §6101 et. Seq.); the Vietnam Era Veterans Readjustment Assistance Act (38 U.S.C. § 4212); and applicable sections of the Medicare and Modernization Act of 2003, HIPAA and the HITECH Act of 2009, together with all applicable implementing regulations, rules guidelines and standards as from time to time are promulgated thereunder.

3. **Exclusion Screening and Related Requirements.** Provider shall not employ or contract with, and shall ensure that its Downstream Entities do not employ or contract with, individuals or entities that are excluded under the HHS Office of Inspector General's List of Excluded Individuals/Entities ("OIG List") or otherwise excluded from participation in Medicare or other Federal health care programs, or are debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency ("Excluded Individuals"). Provider shall, and shall cause its Downstream Entities to: (a) review the OIG List and the U.S. General Services Administration's Excluded Parties List System prior to the initial hiring of any employee or the engagement of any Downstream Entity to furnish services to Company's Medicare Program, and monthly thereafter, to ensure compliance with this paragraph; (b) provide documentation, upon written request by Company, of such Exclusion Screening and related requirements; (c) promptly notify Company upon discovering that it, or any of its employees or Downstream Entities, has furnished Medicare program related services to Company under the Agreement as or through an Excluded Individual or that a person or entity furnishing Services under the Agreement has been convicted of a criminal felony that could serve as the basis of Federal health care program exclusion; and (d) promptly remove an Excluded Individual from any work related, directly or indirectly, to Services furnished under the Agreement and use commercially reasonable efforts to take other appropriate corrective action reasonably requested by Company based on the above notification.

4. **Benefit Continuation**. If applicable to the Services, and to the extent required by applicable law, Provider agrees, and will require its Downstream Entities to agree, to provide for the continuation of Company's Members' health care benefits, for all such Members, for the duration of the contract period for which CMS payments have been made, and for such Members who are hospitalized on the date Company's contract with CMS terminates, or in the event of an insolvency of Company, through the date of the Member's discharge.

5. **Reporting and Disclosure; Submission of Encounter and Other Data.** Upon request by Company, Provider shall certify, and cause its Downstream Entities to certify, that any data and other information submitted to Company are accurate, complete and truthful based on best knowledge, information and belief. Provider shall provide reasonable cooperation and assistance with Company's requests for information and shall promptly submit encounter data, medical records and such other information as requested by Company to allow Company to respond in a timely manner to any data validation audits or requests for information by CMS, and to monitor and audit the obligation of Provider and Downstream Entities to provide accurate, complete and truthful data and other information. This paragraph 5 shall survive termination of the Agreement, regardless of the cause giving rise to termination.

6. **Offshore Services**. For purposes of this Exhibit, the term "offshore" shall mean any country or territory that is not the United States or one of the United States territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico and the Virgin Islands). Provider represents and warrants that it does not and will not use offshore subcontractors, or permit any Members' protected health information or other personal information to be accessible to any offshore employees, without prior written notice to Company and Company's prior written approval of such offshore subcontractors and/or offshore use of Member's PHI or personal information. Prior to Company's written approval, Company may review and approve Provider's or its subcontractor's policies and procedures applicable to such offshore use. In addition to the above, any offshore services shall be subject to all of the standards, terms and conditions set forth in this Amendment and the Agreement the same as if the services were provided within the U.S. This includes, but is not limited to, timely access to records created and/or related to such offshore services, such as customer service call records.

7. **Compliance Program and Anti-Fraud Initiatives.** Provider shall (and shall cause its Downstream Entities to) institute, operate, and maintain an effective compliance program to detect, correct and prevent the incidence of non-compliance with CMS requirements and the incidence of fraud, waste and abuse relating to the operation of Company's Medicare Program. Such compliance program shall be appropriate to Provider or Downstream Entity's organization and operations and shall include: (a) written policies, procedures and standards of conduct articulating the entity's commitment to comply with Federal and State laws; and (b) for all officers, directors, employees, contractors and agents of Provider or Downstream Entity, required participation in effective compliance and anti-fraud training

and education that is consistent with guidance that CMS has or may issue with respect to compliance and anti-fraud and abuse initiatives, unless exempt from such training under relevant CMS regulations.

8. **Marketing Non-Health Related Items**. Provider shall not: (1) engage in any marketing or sales activities that could mislead or confuse Medicare beneficiaries, or (2) market or advertise non-health care related products to Medicare Members or prospective Medicare Members. Further, Provider shall at all times comply with the then current Medicare Marketing Guidelines.

9. **Definitions:**

   (a) ***"Affiliate"*** means with respect to any person or entity, each of the persons and/or entities that directly or indirectly, through one or more intermediaries, owns or controls, is controlled by or is under common control with, such person or entity. For the purpose of the Agreement, "control" means the possession, directly or indirectly, of the power to direct or cause the direction of management and policies, whether through the ownership of voting securities, by contract or otherwise.

   (b) "***Centers for Medicare and Medicaid Services ("CMS")***" shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

   (c) "***Downstream Entity***" shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

   (d) "***Medicare Advantage ("MA***")" shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

   (e) "***Medicare Advantage Organization ("MA organization")***" shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

   (f) "***Member or Enrollee***" shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

   (g) "***Part D***" shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

   (h) "***Part D Organization***" shall have the meaning set forth in Exhibit D, Schedule 1 of this Exhibit D.

Exhibit D, Schedule 1
Medicare Advantage Contract Amendment

CMS requires that specific terms and conditions be incorporated into the Agreement between a Medicare Advantage Organization or First Tier Entity and a First Tier Entity or Downstream Entity to comply with the Medicare laws, regulations, and CMS instructions, including, but not limited to, the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2066 ("MMA"); and

Except as provided herein, all other provisions of the Agreement between Company and Provider not inconsistent herein shall remain in full force and effect. This Amendment shall supersede and replace any inconsistent provisions to the Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of the Agreement.

NOW, THEREFORE, the parties agree as follows:

A. **Definitions:**

1) Centers for Medicare and Medicaid Services ("CMS"): the agency within the Department of Health and Human Services that administers the Medicare program.

2) Completion of Audit: completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of a Medicare Advantage Organization, Medicare Advantage Organization contractor or related entity.

3) Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or applicant) and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4) Final Contract Period: the final term of the contract between CMS and the Medicare Advantage Organization.

5) First Tier Entity: any party that enters into a written arrangement, acceptable to CMS, with an MA organization or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.

6) Medicare Advantage ("MA"): an alternative to the traditional Medicare program in which private plans run by health insurance companies provide health care benefits that eligible beneficiaries would otherwise receive directly from the Medicare program.

7) Medicare Advantage Organization ("MA organization"): a public or private entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving waivers) that is certified by CMS as meeting the MA contract requirements.

8) Member or Enrollee: a Medicare Advantage eligible individual who has enrolled in or elected coverage through a Medicare Advantage Organization.

9) Provider: (1) any individual who is engaged in the delivery of health care services in a State and is licensed or certified by the State to engage in that activity in the State; and (2) any entity that is engaged in the delivery of health care services in a State and is licensed or certified to deliver those services if such licensing or certification is required by laws or regulations of the State.

10) Related entity: any entity that is related to the MA organization by common ownership or control and (1) performs some of the MA organization's management functions under contract or delegation; (2) furnishes services to Medicare enrollees under an oral or written agreement; or (3) leases real property or sells materials to the MA organization at a cost of more than $2,500 during a contract period.

B. **Required Provisions:**

Provider agrees to the following:

1) HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books,

contracts, computer or other electronic systems (including medical records and documentation of the First Tier Entity, Downstream Entity, and other entities related to CMS' contract with Company's Affiliates included in the Agreement) through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]

2) Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3) Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4) Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]

5) Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

6) If any of the MA organization's activities or responsibilities under its contract with CMS are delegated to any First Tier Entity, Downstream Entity or related entity:

[INFORMATIONAL NOTE: If there is no delegation of a specific activity or responsibility, please delete the related provision.]

(i) The delegated activities and reporting responsibilities are specified as follows:

[List activities and reporting responsibilities or enter the section and name of the delegation or applicable agreement].

(ii) CMS and the MA organization reserve the right to revoke the delegation activities and reporting requirements or to specify other remedies in instances where CMS or the MA organization determine that such parties have not performed satisfactorily.

(iii) The MA organization will monitor the performance of the parties on an ongoing basis.

[Enter any applicable section and name of the delegation or applicable agreement].

(iv) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA organization or the credentialing process will be reviewed and approved by the MA organization and the MA organization must audit the credentialing process on an ongoing basis.

[**Enter any applicable section and name of the delegation or applicable agreement].**

(v) If the MA organization delegates the selection of providers, contractors, or subcontractor, the MA organization retains the right to approve, suspend, or terminate any such arrangement.

[42 C.F.R. §§ 422.504(i)(4) and (5)]

In the event of a conflict between the terms and conditions above and the terms of a related agreement, the terms above control.