HORIZON GOVERNMENT PROGRAMS
INDIVIDUAL PROVIDER AGREEMENT

This Individual Provider Agreement ("Agreement") is entered into by and between Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health and its Affiliates (collectively "Horizon") and ("Provider") Gina Kontos, OT (Horizon and Provider are each a "Party" and collectively the "Parties"). This Agreement is effective on the first day of the month of _____, 2023 (the "Effective Date").

WHEREAS, Horizon has established networks of participating providers to provide health care services to Members of Horizon's Health Benefit Plans; and

WHEREAS, Provider wishes to participate in one or more of Horizon's networks, as identified in each Appendix hereto, in accordance with the terms and conditions of this Agreement.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, for other good and valuable consideration, the sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties hereby agree as follows:

1. DEFINITIONS

1.1. "**Affiliates**," with respect to Horizon, means any parent, subsidiary, joint venture, or partner of Horizon, as well as any entity, as previously identified or as identified in the future by Horizon as an affiliate, which owns or is owned by Horizon, directly or indirectly, in whole or in part, and any entity, as previously identified or as identified in the future by Horizon as an affiliate, which is under common ownership, directly or indirectly, in whole or in part, with Horizon, including but not limited to Horizon Insurance Company and Horizon Healthcare Services, Inc. d/b/a Horizon Blue Cross Blue Shield of New Jersey.

1.2. "**Confidential Information**" means trade secrets and other confidential and proprietary information, including but not limited to policies, procedures, processes, systems, rates, pricing, claims processes, membership information, financial information, sales information, strategies, methodologies, contracts, business agreements and arrangements, plans, reports, specifications, designs, inventions, know-how, techniques, scripts, flowcharts, research, business development information, product information, and other non-public business information.

1.3. "**Covered Service**" means those medically necessary health care services for which Horizon is obligated to provide coverage under a Health Benefit Plan.

1.4. "**Governmental Authority**" means any and all federal, state, local, territorial, and other governmental, legislative, administrative, judicial (including arbitration tribunals and other similar bodies), and regulatory agencies, commissions, boards, bureaus, departments, bodies, instrumentalities, and other authorities, including but not limited to the New Jersey Department of Human Services Division of Medical Assistance and Health Services ("**DMAHS**"), the New Jersey Department of Banking and Insurance ("**DOBI**"), and the Centers for Medicare and

Medicaid Services ("**CMS**").

1.5. "**Health Benefit Plan**" means all Horizon Health Benefit Plans as separately defined in each Appendix hereto.

1.6. "**Law**" means any and all federal, state, and local statutes, regulations, codes, ordinances, rules, licensing requirements, standards of professional ethics and practice, regulatory guidance, instructions, constitutions, orders, injunctions, writs, decisions, judgments, decrees, or awards of any Governmental Authority, and the terms and conditions of any applicable contract between Horizon and a Governmental Authority.

1.7. "**Member**" means a person eligible to receive benefits under a Health Benefit Plan.

1.8. "**Primary Care Provider**" means a licensed medical doctor, doctor of osteopathy, or other licensed, certified, or otherwise qualified health care practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required primary care services to Members, including periodic examinations, ambulatory care visits and routine office procedures, preventive health care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, initiation of referrals to Specialty Providers, and for maintaining continuity of patient care.

1.9. "**Provider Associate**" means Provider's employees; employed or affiliated physicians, practitioners, and health care professionals; and Subcontractors.

1.10. "**Provider Manual**" means the prevailing Horizon Provider Administrative Manual and/or any other Horizon provider manual applicable to Provider, as amended from time to time in Horizon's sole discretion.

1.11. "**Provider Services**" means those Covered Services identified in Attachment A of each Appendix hereto that are provided by Provider to a Member.

1.12. "**Specialty Provider**" means a duly licensed medical doctor, doctor of osteopathy, or other licensed, certified, or otherwise qualified health care practitioner other than a Primary Care Provider.

1.13. "**Subcontractor**" means a subcontractor, of any tier, of Provider that is involved in the provision of Provider Services under this Agreement.

2. PROVIDER'S OBLIGATIONS AND REPRESENTATIONS

2.1. **Provider Services**

Provider shall provide Provider Services, in accordance with this Agreement, the Provider Manual, Horizon's policies and procedures, and applicable Law, to all Members who seek Provider Services from Provider.

2.2. **Provider Payment and Member Hold Harmless**

For all Provider Services, Provider agrees to accept payment from Horizon in accordance with this Agreement as payment in full and agrees to hold Members harmless from any payment or liability

for Provider Services, and shall not balance bill Members, regardless of Horizon's financial solvency, contractual breach, or whether Provider believes its compensation for the Provider Services from Horizon is made in accordance with this Agreement or is otherwise inadequate, except that Provider may collect a Member's cost-sharing amount(s), if any, in accordance with the Member's Health Benefits Plan. The terms of this paragraph shall survive any termination or expiration of this Agreement.

2.3. Claims and Encounters

Provider shall submit claims and accurate and complete encounter data to Horizon for all Provider Services in accordance with applicable Law, the Provider Manual, and applicable Horizon policies and procedures. Upon Horizon's request, Provider will, at no cost to Horizon, provide Horizon with an electronic, itemized bill for Provider Services rendered under this Agreement.

2.4. Provider Compliance

2.4.1. Law and Non-Discrimination

Provider and all Provider Associates shall comply with all applicable Law, including but not limited to Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d; Title IX of the Education Amendments of 1972 (regarding education programs and activities); Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794, the regulations (45 C.F.R. Parts 80 & 84) pursuant to that Act, and the provisions of Executive Order 11246, Equal Opportunity, dated September 24, 1965; the Americans with Disabilities Act of 1990 (ADA), including 42 U.S.C. § 12131 *et seq*. and 42 U.S.C. § 12182 *et seq*.; the Age Discrimination Act of 1975 as implemented by regulations at 45 C.F.R. Part 91; Section 1557 of the Patient Protection and Affordable Care Act, 42 U.S.C. § 18116; the New Jersey Law Against Discrimination, N.J.S.A. 10:5-12; and any rules and regulations promulgated pursuant to any of the statutes referenced above, and any other applicable Law prohibiting discrimination on grounds of age, race, ethnicity, mental or physical disability, sexual or affectional orientation or preference, gender identity, marital status, genetic information, source of payment, sex, color, creed, religion, or national origin or ancestry. As such, Provider shall not discriminate against Members because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap or disability, health or mental health history, health or mental health status, their need for health care services, amount payable to Horizon on the basis of the Member's actuarial class, or pre-existing medical/health conditions.

2.4.2. Provider Manual

Provider acknowledges and agrees that it has access to and has reviewed the Provider Manual and agrees to comply with all of the Provider Manual's terms and conditions, which are incorporated herein by reference and made part of this Agreement. Any conflict between the terms of the Provider Manual and the terms of this Agreement shall be governed by the terms of this Agreement.

2.4.3. Horizon Credentialing Standards

Provider acknowledges and agrees that it has access to all applicable Horizon credentialing and recredentialing standards and agrees to comply with all of their terms and conditions. Provider understands and agrees that Horizon is not obligated to pay

Provider or any Provider Associate for any Provider Services rendered by Provider and/or any Provider Associate to the extent Provider and/or the Provider Associate is not fully credentialed on the date of service in accordance with Horizon's credentialing and recredentialing standards.

2.4.4. Horizon Quality Assurance/Improvement and Utilization Management

Provider acknowledges and agrees that it has access to all applicable Horizon quality assurance/improvement and utilization management programs, policies, and procedures and agrees to participate in and comply with all of their terms and conditions. In support of such quality assurance/improvement programs, at Horizon's request Provider shall timely provide Horizon with copies of Member medical records at no cost to Horizon, and Provider understands that any failure to timely provide such records shall constitute a material breach of this Agreement. Provider agrees to cooperate with Horizon's quality improvement activities to improve the quality of care and services and Member experience, including collection and evaluation of data and participation in Horizon's quality improvement programs. Provider further agrees that Horizon may use Provider's performance data for quality improvement activities.

2.4.5. Horizon Policies and Procedures

Provider acknowledges and agrees that it has access to all applicable Horizon policies and procedures and agrees to comply with all of their terms and conditions.

2.4.6. Accreditation Programs

Provider shall participate and assist Horizon in accreditation programs, reviews, audits, and activities, including but not limited to those of the National Committee for Quality Assurance ("NCQA"), and shall comply with all applicable accreditation standards and requirements.

2.4.7. Appeals, Complaints, and Grievances

Provider shall participate in and comply with Horizon's processes and procedures for the resolution of Provider and Member appeals, complaints, and grievances in accordance with the Provider Manual, applicable Horizon policies and procedures, and applicable Law. Provider shall be deemed to have waived its right to pursue, in any forum, any appealable dispute for which Provider fails to timely appeal and exhaust its administrative remedies in accordance with this paragraph.

2.4.8. Revisions and Notice.

Horizon may from time to time, in its sole discretion, in accordance with Law and subject to any required approval of a Governmental Authority, make additions, deletions, or changes to the Provider Manual and Horizon's policies and procedures, including but not limited to its credentialing standards and quality assurance/improvement and utilization management policies and procedures. Provider shall keep apprised of all such additions, deletions, and changes, and shall comply with them within 30 days of Horizon providing notice, except that Provider shall immediately comply with any additions, deletions, or changes required by applicable Law. For the purposes of this Section, Horizon may provide such notice to Provider in accordance with the Notice provision of this Agreement or via Horizon's provider portal, Horizon's website, or other means of electronic communication or publication.

2.5. Provider Representations and Warranties

2.5.1. Valid License

Provider represents and warrants that it and each of its applicable Provider Associates (a) has a current, valid, and unrestricted license, certification, or other applicable qualification in the State of New Jersey and such license, certification, or other applicable qualification is not withdrawn, suspended, or restricted for any reason; and (b) meets all applicable federal and state participation requirements, allowing it to provide Provider Services in accordance with applicable Law.

2.5.2. Authority to Conduct Business

Provider represents and warrants that it has authority to conduct business in New Jersey as evidenced by a New Jersey Tax Certification or Trade Name Registration or Business Registration.

2.5.3. Government Programs Exclusion

Provider represents and warrants that neither it nor any Provider Associate is, has been, or is under threat, formal allegation, government investigation, or prosecution of being (a) excluded, debarred, or suspended from Medicare, Medicaid, NJ FamilyCare, or any other federal or state health care program; (b) discharged or suspended from doing business with or in the State of New Jersey; (c) convicted of certain crimes as described in Section 1128(b)(8) of the Social Security Act or has a contractual relationship with an individual convicted of such crimes; (d) knowingly or willfully engaged in any conduct prohibited under the False Claims Act (31 U.S.C. § 3729 *et seq*.) or the Anti-Kickback Statute (42 U.S.C. § 1320a-7b); or (e) debarred or suspended from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order. Provider shall, on at least a monthly basis, review (a) the U.S. Department of Health & Human Services, Office of Inspector General's List of Excluded Individuals/Entities; (b) the General Services Administration Excluded Parties List System and System for Award Management; and (c) the State of New Jersey Medicaid Fraud Division Debarment List to determine whether Provider or any Provider Associate has been excluded, debarred, or suspended from Medicare, Medicaid, NJ FamilyCare, or other federal or state health care program. If Provider determines that it or any Provider Associate has been so excluded, debarred, or suspended, it shall notify Horizon in writing immediately and in no event later than 48 hours after it learns of such exclusion, debarment, or suspension. Additionally, and unless medical necessity dictates otherwise, Provider and any excluded, debarred, or suspended Provider Associate shall immediately cease from directly or indirectly providing Provider Services and from directly or indirectly performing any other activities under this Agreement.

2.5.4. No Allegations or Investigations

Provider represents and warrants that, to Provider's knowledge, neither it nor any Provider Associate is the subject of any pending allegation, investigation, prosecution, or disciplinary action by a Governmental Authority, licensing body, hospital committee, or peer review organization regarding alleged fraud, waste, or abuse, violation of applicable Law, or otherwise related to Provider Services or relevant to Provider's obligations,

representations, or warranties under this Agreement. If Provider learns that it or any Provider Associate becomes the subject of such an allegation, investigation, prosecution, or disciplinary action, it shall notify Horizon in writing immediately and in no event later than 48 hours after it learns of such allegation, investigation, prosecution, or disciplinary action.

2.5.5. Notification and Materiality

Provider agrees that all representations and warranties set forth in this Section 2.5 are true and accurate and shall remain true and accurate throughout the term of his Agreement. Provider agrees to notify Horizon in writing within 48 hours upon learning that any of the representations and warranties in this Section 2.5 are false or inaccurate or become false or inaccurate during the term of this Agreement. Provider acknowledges and agrees that the representations and warranties in this Section 2.5 are a material part of this Agreement, that Horizon would not have entered into this Agreement with Provider but for Provider's representations and warranties in this Section 2.5, and that to the extent any of Provider's representations or warranties in this Section 2.5 are false or inaccurate or become false or inaccurate it shall constitute a material breach of this Agreement and any Appendix hereto and shall entitle Horizon to immediately terminate this Agreement and/or any Appendix hereto. In addition, Provider shall notify Horizon in writing within 30 days of any changes in its financial status that could reasonably be expected to materially impact Provider's ability to render Provider Services.

2.6. Insurance

At minimum, Provider shall maintain: (a) professional liability insurance in an amount the Parties determine is appropriate for Provider's anticipated risk, but in any event not less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year; (b) general liability insurance of not less than $1,000,000 combined single-limit coverage; and (c) an umbrella policy in excess of the professional and general liability policies of not less than $5,000,000 per occurrence and in the aggregate, combined single limit coverage. Provider shall make such policies available to Horizon for review upon request.

2.7. Subrogation

Provider shall cooperate with Horizon in its efforts to pursue claims against third parties where applicable Law or contractual standards indicate that a third party has primary responsibility for payment for Provider Services. The terms of this paragraph shall survive any termination or expiration of this Agreement.

2.8. Overpayments and Adjustments

If Provider receives an overpayment, Provider shall notify Horizon of the overpayment, including the reason for the overpayment, and shall return the overpayment to Horizon within 60 days from the date on which Provider identified the overpayment. Additionally, subject to Provider's applicable appeal rights, if any, and in accordance with applicable Law, Horizon shall be permitted to recover overpayments made to Provider by deducting such overpayments from future payments to Provider. The terms of this paragraph shall survive any termination or expiration of this Agreement.

2.9. Withholds

Provider agrees to fully cooperate with Horizon in complying with any request by a Governmental

Authority to recover amounts from Provider, which may include withholding all or part of any payments otherwise due to Provider. The terms of this paragraph shall survive any termination or expiration of this Agreement.

2.10. Provider Directory

Provider acknowledges and agrees that, during the term of this Agreement, Horizon shall list Provider in Horizon's provider directories with respect to each Health Benefit Plan in which Provider participates pursuant to this Agreement. Provider acknowledges that Horizon has the right to provide information to Members regarding alternative settings based on certain criteria, including, but not limited to, quality of care, scope of services, geographic considerations, and cost effectiveness. Provider shall notify Horizon in writing at least 30 days prior to any changes to Provider's contact information, business hours, business locations, NPI number(s), tax identification number(s), or other information contained in Horizon's provider directories. Provider shall regularly review Horizon's provider directories to ensure that the information regarding Provider in such directories is accurate, and Provider shall immediately notify Horizon in writing if Provider discovers any inaccurate information regarding Provider in Horizon's provider directories. Provider shall timely and accurately respond to any requests by Horizon that Provider confirm and/or update Provider's directory information, and Provider further understands and agrees that any failure by Provider to do so shall constitute a material breach of this Agreement.

2.11. Referrals

Provider shall refer Members in accordance with the Provider Manual and Horizon's policies and procedures. Except in the case of emergency or urgently needed services, or as otherwise permitted by Horizon, the Provider Manual, and/or Horizon's policies and procedures, Provider shall refer Members only to providers who participate in the Horizon Health Benefit Plan of the Member being referred. To the extent Provider refers a Member to a non-participating provider in violation of this paragraph, Provider shall be responsible for any additional cost (in excess of the in-network rate) incurred by Horizon in connection with such referral.

2.12. Privileges

Provider must maintain hospital admitting privileges as may be required by the Provider Manual and/or Horizon's policies and procedures.

2.13. Emergency and Urgent Care Coverage

To the extent required by applicable Law, the Provider Manual, or Horizon's policies or procedures, Provider shall ensure 24-hours-per-day, seven-days-per-week emergency and urgent care coverage to Members.

2.14. Practice Coverage

To the extent required by applicable Law, the Provider Manual, or Horizon's policies or procedures, Provider shall maintain appropriate office hours and on-call coverage for Provider's practice to ensure the availability of Provider Services on a 24-hours-per-day, seven-days-per-week basis. Provider shall arrange for such coverage in accordance with the Provider Manual and Horizon's policies and procedures. Provider shall use best efforts to make coverage arrangements with a provider that participates in all Horizon Health Benefit Plans in which Provider participates. To the extent Provider makes coverage arrangements with a non-participating provider, Provider shall ensure that the non-participating provider complies with all terms and conditions of this

Agreement, including all Member hold harmless provisions.

2.15. Additional Primary Care Provider Requirements

The following provisions of this Section 2.15 apply to Primary Care Providers only.

2.15.1. Servicing Members

Provider agrees to provide Provider Services to all Members in Provider's panel and to other Members who are eligible to receive services from Provider. Provider shall not refuse to provide or arrange for the provision of care to a Member solely because of the cost or volume of services required or because of the physical condition of the Member.

2.15.2. Member Panel

Provider agrees to accept Members into Provider's panel until such time as Provider's panel reaches a maximum membership threshold determined by Horizon. In the event Provider wishes to close his or her panel, Provider shall provide Horizon with at least 90 days advance written notice of such panel closure, and Horizon shall then either approve or deny Provider's request to close the panel. Provider acknowledges and agrees that Horizon, in its sole discretion, reserves the right to limit the number of Members in Provider's panel.

2.15.3. Member Transfers

Provider acknowledges that a Member may request to be transferred, and/or Horizon may direct a Member be transferred, to another Primary Care Provider. In addition, Provider may, in accordance with Horizon's policies and procedures, request a Member be transferred to another Primary Care Provider. Provider shall not seek to have a Member transferred because of the amount of professional services required or because of the Member's physical condition. Provider shall fully cooperate with Horizon in the transfer of medical records for Members who have transferred to another Primary Care Provider.

2.15.4. Office Hours

Provider shall be available to Members for office hours, or shall provide appropriate coverage for office hours, at least 20 hours per week.

2.16. Additional Specialty Provider Requirements

To the extent Provider is a Specialty Provider, Provider shall render Provider Services, in accordance with the Provider Manual and Horizon's policies and procedures, to all Members referred to Provider. Provider further agrees to timely provide the Members' Primary Care Provider with a written report of treatment and findings at no charge to the Member, Horizon, or the Primary Care Provider.

2.17. Group Affiliation

To the extent Provider is affiliated with a provider group that has a network participation agreement ("Group Agreement") or other reimbursement arrangement with Horizon, and to the extent the group submits a claim for reimbursement for any Provider Service rendered by Provider to a Member, Horizon will reimburse the group for such Provider Service in accordance with the Group Agreement or the group's other reimbursement arrangement and will not reimburse Provider directly in accordance with this Agreement.

3. HORIZON'S OBLIGATIONS

3.1. Payment

Horizon shall pay Provider for Provider Services in accordance with Attachment B of each Appendix hereto, applicable Law, and the Provider Manual. Such payments shall be subject to a Member's enrollment and eligibility; coordination of benefits with Member's primary insurance, if any, in accordance with applicable Law; Horizon's policies, procedures, processes, guidelines, and claim processing determinations; any cost sharing under a Member's applicable Health Benefit Plan; and any applicable prompt payment requirement.

3.2. Compliance with Law

Horizon shall perform its obligations under this Agreement in accordance with applicable Law, including applicable Law prohibiting discrimination.

4. TERM AND TERMINATION

4.1. Term

The term of this Agreement shall begin on the Effective Date and shall continue through and until the termination and/or expiration of all Appendices hereto. This Agreement shall terminate automatically upon the termination and/or expiration of all Appendices hereto.

4.2. Termination

This Agreement may be terminated only by terminating all Appendices in accordance with their terms and conditions. To the extent Provider attempts to terminate fewer than all Appendices, Horizon shall have the right, in its sole discretion, to immediately terminate any remaining Appendices.

5. MISCELLANEOUS

5.1. Blue Cross and Blue Shield Association

Provider expressly acknowledges its understanding that this Agreement constitutes an Agreement between Provider and Horizon, and that Horizon is an independent entity operating under a license with the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting Horizon to use the Blue Cross and/or Blue Shield service marks in the State of New Jersey, and that Horizon is not contracting as the agent of the Association. Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Horizon, and that the Association shall not be held accountable or liable to Provider for any of Horizon's obligations to Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Horizon other than those obligations created under other provisions of this Agreement.

5.2. Entire Agreement

This Agreement, together with all Appendices hereto, contains all of the terms and conditions of, and represents the entire understanding of the Parties regarding, the subject matter of this Agreement. The Parties agree that any prior or contemporaneous agreements, promises, representations, negotiations, or communications regarding the subject matter of this Agreement are superseded by and excluded from this Agreement and are not to be employed to construe this Agreement.

5.3. Amendments

5.3.1. Non-Regulatory Amendments

The Parties may amend this Agreement and/or any Appendix at any time by mutual, written agreement. Horizon may amend this Agreement and/or any Appendix hereto unilaterally upon written notice to Provider, which amendment shall be effective on the 31st day following such written notice. If Provider objects to the amendment, Provider may elect to terminate this Agreement or the applicable Appendix by written notice to Horizon prior to the effective date of the amendment, which termination shall be effective 90 days after Horizon receives Provider's notice of termination. If Provider timely terminates this Agreement or the applicable Appendix in accordance with this paragraph, the amendment shall not become effective unless the amendment is applied generally to other similarly situated providers, in which case the amendment shall become effective regardless of Provider's termination.

5.3.2. Regulatory Amendments

Notwithstanding anything in this Agreement to the contrary, Horizon may amend this Agreement and/or any Appendix hereto unilaterally at any time, upon written notice to Provider, where such amendment is mandated or necessitated by Law or by a Governmental Authority. Any such amendment shall be effective on the earlier of (a) the 31st day following such written notice, (b) the date specified in the amendment, or (c) the date required by Law and/or by the Governmental Authority. If Provider objects to such an amendment, Provider may elect to terminate this Agreement or the applicable Appendix by written notice to Horizon prior to the effective date of the amendment, which termination shall be effective 90 days after Horizon receives Provider's notice of termination. The amendment, however, shall become effective on the amendment effective date notwithstanding any termination by Provider.

5.4. Confidentiality

The Parties understand and agree that the terms and conditions of this Agreement, including but not limited to all payment rates and terms herein, are confidential, and that neither Party, nor anyone acting on either Party's behalf, shall disclose the terms or conditions of this Agreement without the other Party's written consent. Notwithstanding the foregoing, each Party is permitted to disclose this Agreement, and its terms and conditions, in the following circumstances: (a) to the Party's respective officers, directors, employees, accountants, attorneys, tax preparers, and auditors who have a need to know of the terms and conditions of this Agreement, but only to the extent that they agree to keep this Agreement and its terms and conditions confidential; (b) as required by valid subpoena or court order or as required by a Governmental Authority; or (c) as otherwise required by Law. In addition, Horizon may disclose this Agreement and its terms and conditions in connection with the administration and sale of Health Benefit Plans, including but not limited to disclosure to Horizon's vendors and subcontractors, and Horizon may disclose cost-of-care data regarding Provider in connection with Horizon's value-based care programs and arrangements. The terms of this paragraph shall survive any termination or expiration of this Agreement.

5.5. Confidential Information

Provider acknowledges that it may become privy to Confidential Information of Horizon. Provider shall not use the Confidential Information of Horizon for Provider's own competitive, business, or pecuniary interests. Moreover, Provider shall take commercially reasonable efforts to protect the

secrecy of, and prevent the disclosure and unauthorized use of, the Confidential Information of Horizon. The terms of this paragraph shall survive any termination or expiration of this Agreement.

5.6. Non-Exclusivity

This Agreement is non-exclusive and shall not prevent Provider or Horizon from participating in or contracting with any provider, preferred provider organization, health maintenance organization, or any other health care delivery or insurance program. Horizon shall have the right to create additional networks, subnetworks, plans, and products, including, but not limited to, tiered or narrowed products ("New Products"). Horizon shall notify Provider of any New Product and shall determine, in Horizon's sole discretion, whether to allow Provider to participate in the New Product.

5.7. Trademarks and Marketing

Provider agrees that Horizon has the right to identify Provider as a participating provider and to use Provider's name, address, telephone number, website, description, and other publicly available information in Horizon's provider directories, websites, marketing materials, advertisements, and communications. Horizon reserves the right to control the use of its name(s), symbol(s), trademark(s), and service mark(s), and Provider shall not use Horizon's and/or the Association's name(s), symbol(s), trademark(s), or service mark(s) in advertising, marketing, promotional materials, written communications, or otherwise without Horizon's prior, written consent, and Provider shall immediately cease and desist from any such use upon written notice from Horizon and upon termination of this Agreement. The terms of this paragraph shall survive any termination or expiration of this Agreement.

5.8. Notice

5.8.1. By Provider

For any notice required pursuant to this Agreement, Provider shall provide such notice to Horizon in writing via Certified Mail or overnight carrier (*e.g.*, Federal Express), with delivery confirmation, to the address below and/or to such other address(es) as Horizon may designate in writing, which notice shall be effective upon Horizon's receipt:

Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health
1700 American Blvd.
Pennington, NJ 08534
Attn: Director of Provider Contracting

With a copy (which shall itself not constitute notice) to:

Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health
1700 American Blvd.
Pennington, NJ 08534
Attn: Legal Counsel

5.8.2. By Horizon

For any notice required pursuant to this Agreement, Horizon shall provide such notice to Provider in writing via mail, email, or fax to the address below and/or to such other address(es) as Provider may designate in writing, which notice shall be effective upon Provider's receipt:

Name: Pedz Theraplay Spot LLC

Address: 231 Hutton Street, Jersey City, NJ 07307-4261

Email: info@pedztheraplayspot.com

Fax: 973-328-3210

The terms of this Section 5.8 shall survive any termination or expiration of this Agreement.

5.9. Assignment and Delegation

5.9.1. By Provider

Provider shall not assign or transfer this Agreement to any individual or entity without Horizon's prior, written consent, and any attempted assignment or transfer of this Agreement by Provider to any individual or entity without Horizon's prior, written consent shall be null and void. For the purposes of this paragraph, any change in control of Provider resulting from any merger, consolidation, stock transfer, other change in majority ownership, or sale or transfer of all or substantially all of Provider's assets, regardless of which entity survives, shall be deemed an assignment or transfer for purposes of this Agreement, including when such assignment or transfer occurs through operation of Law. Provider shall not delegate or subcontract for Provider Services or Provider's other obligations under this Agreement without Horizon's prior, written consent. Provider acknowledges and agrees that Horizon and any applicable Governmental Authority shall have the right to suspend or terminate any delegation or subcontract by Provider regarding Provider Services or Provider's other obligations hereunder, including but not limited to where it is determined that the subcontractor fails to perform delegated services satisfactorily. Provider further agrees that any delegation or subcontract regarding Provider Services or Provider's other obligations hereunder shall be in writing signed by the parties to be bound, and that such contract shall be consistent with, and shall require the subcontractor to comply with, all applicable Law, Provider's obligations under this Agreement and all Appendices hereto, and Horizon's applicable contractual obligations to Governmental Authorities, including but not limited to CMS and/or DMAHS as applicable.

5.9.2. By Horizon

Provider acknowledges and agrees that Horizon may, at its sole discretion and consistent with applicable Law, assign or transfer this Agreement to any individual or entity. Provider further acknowledges and agrees that Horizon may, at its sole discretion and consistent with applicable Law and accreditation standards, delegate to third parties its obligations under, and certain functions, programs, and activities related to, this Agreement.

5.10. Notice of Change in Ownership

Provider shall notify Horizon in writing at least 30 days prior to any material change in Provider's ownership, including but not limited to any asset purchase, merger, consolidation, stock transfer, or other change in majority ownership.

5.11. Indemnification

Each Party shall indemnify, defend, and hold harmless the other Party from all third-party claims, damages, penalties, fines, sanctions, and liability, including costs and attorneys' fees, arising out of or related to the negligence, gross negligence, willful misconduct, or breach of this Agreement by the indemnifying Party (each a "Claim"). Each Party agrees to promptly notify the other Party in writing of any Claim for which it may request indemnification hereunder, provided that any delay in providing such written notice shall not serve as a bar to indemnification except to the extent that that the indemnifying Party's ability to defend against or avoid the Claim has been prejudiced by such delay. Nothing herein shall be construed to require Provider to indemnify Horizon against any civil liability for damage caused to a Member as a result of Horizon's denial of medically necessary care. The terms of this paragraph shall survive any termination or expiration of this Agreement with respect to any third-party claims that arise from acts or omissions that occurred during the term of this Agreement.

5.12. Force Majeure

Each Party shall be excused, discharged, and released from performance under this Agreement to the extent such performance is limited or prevented, in whole or in part, by a Force Majeure Event. For purposes of this Agreement, a "Force Majeure Event," with respect to a given Party, is any event or circumstance, regardless of whether it was foreseeable, that was not caused by that Party and that prevents the Party from complying with any of its obligations under this Agreement, so long as the non-performing Party (a) promptly notifies the other Party of the occurrence of the Force Majeure Event and its effect on performance; and (b) uses reasonable efforts to resume its performance under this Agreement.

5.13. Severability

If any provision of this Agreement is deemed invalid, void, or unenforceable for any reason, all remaining provisions of this Agreement shall remain in full force and effect.

5.14. No Waiver

The waiver of any breach or violation of any provision of this Agreement must be set forth specifically in writing and signed by the waiving Party, and any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future breach or violation. The failure or delay of a Party to exercise any right or remedy under this Agreement shall not operate as, or be deemed to be, a waiver of such right or remedy.

5.15. Headings

All headings in this Agreement are for the convenience of the Parties only and shall not be construed to define, limit, or extend the substantive terms of this Agreement.

5.16. Relationship of the Parties

The provisions of this Agreement are not intended to create, and shall not be deemed or construed to create, any relationship between the Parties other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither of the

Parties, nor any of their respective employees, shall be construed to be the agent, employer, or representative of the other, nor will either Party have an expressed or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other Party.

5.17. Choice of Law and Venue

This Agreement shall be governed by and construed in accordance with the laws of the State of New Jersey and/or federal law, as applicable, without regard to conflict of law principles, and any claim arising out of or relating to this Agreement shall be brought in the State or Federal courts of New Jersey. The terms of this paragraph shall survive any termination or expiration of this Agreement.

5.18. Counterparts

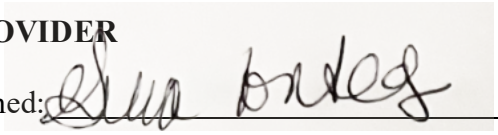
This Agreement may be executed in counterparts and transmitted by mail, email, or facsimile, and a scanned, electronic, or facsimile signature shall have the same force and effect as an original.

5.19. Binding Effect

Each Party has reviewed and understands all of the terms of this Agreement and has had a reasonable opportunity to review this Agreement with legal counsel of its own choosing. Each Party has executed this Agreement voluntarily, knowingly, of its own free will, without any duress or undue influence, in exchange for valuable consideration, and intending to be legally bound.

Each of the undersigned represents and warrants that each has the authority to execute this Agreement on behalf of each respective Party.

PROVIDER

Signed: 

Name: Gina Kontos

Title: OT

Address: 231 Hutton Street, Jersey City, NJ 07307-4261

Date: 05/15/2024

NPI: 1194350553

HORIZON HEALTHCARE OF NEW JERSEY, INC. D/B/A HORIZON NJ HEALTH

Signed: _____

Name: _____

Title: _____

Address: 1700 American Boulevard, Pennington, NJ 08534

Date: _____

HORIZON GOVERNMENT PROGRAMS APPENDIX FOR MEDICAID AND NJ FAMILYCARE

This Medicaid and NJ FamilyCare Appendix ("Appendix") to the Individual Provider Agreement (the "Agreement") between Horizon and Provider is incorporated into and governed by the Agreement. This Appendix is effective on the Effective Date of the Agreement (the "Appendix Effective Date"). All capitalized terms used in this Appendix shall have the meanings set forth in the Agreement unless expressly stated otherwise herein.

WHEREAS, Horizon and Provider are parties to the Agreement; and

WHEREAS, Provider wishes to participate in the network for Horizon's Managed Medicaid and NJ FamilyCare plan(s) in accordance with the terms and conditions of the Agreement and this Appendix.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, for other good and valuable consideration, the sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties hereby agree as follows:

The terms of this Appendix apply only with respect to those Provider Services rendered by Provider to Members enrolled in a "Health Benefit Plan" as defined in this Appendix.

1. DEFINITIONS

1.1. "**Critical Incident**" shall have the meaning defined in the contract between Horizon and DMAHS (the "State Contract") and applicable Law.

1.2. "**Health Benefit Plan**," for the purpose of this Appendix, means any of Horizon's Managed Medicaid and NJ FamilyCare plans.

1.3. "**Managed Long Term Services and Supports ('MLTSS')**" are those Provider Services defined as Managed Long Term Services and Supports in the State Contract when rendered to a Member who meets MLTSS eligibility requirements and who has been accepted into Horizon's MLTSS program (an "MLTSS Member").

2. PROVIDER'S OBLIGATIONS

2.1. Records

2.1.1. Record Maintenance

Provider shall maintain complete and accurate medical, financial, and administrative records regarding Provider Services and/or otherwise related to this Appendix, including as a condition of Provider's right to payment for Provider Services under this Appendix, medical records sufficient to substantiate all Provider Services and to demonstrate their medical necessity in accordance with applicable Law, the Provider Manual, applicable Horizon policies and procedures, and prevailing medical standards. Provider shall maintain such records for the longer of:

(i) 10 years from the date of service or 10 years from the date final payment is made under this Appendix and all pending matters are closed;

(ii) 10 years from the final date of this Appendix or 10 years from the date of completion of any audit, whichever is longer; or

(iii) For medical records, 10 years following the Member's most recent service or until the Member reaches the age of 23 years.

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 applicable retention period above, whichever is later.

2.1.2. Confidentiality and Member Access

Provider shall comply with all applicable Law, the Provider Manual, and applicable Horizon policies and procedures regarding confidentiality and disclosure of, and Member access to, medical records and Member health information. Horizon and Provider shall have a mutual right to a Member's medical records, as well as to timely and appropriate communication of patient information, so that both Horizon and Provider may perform their respective duties efficiently and effectively for the benefit of the Member. Upon a Member's disenrollment from a Health Benefit Plan, transition from Provider to another provider, or otherwise upon a Member's request, Provider shall release the Member's medical records free of charge and in accordance with applicable Law, including all applicable confidentiality requirements.

2.1.3. Inspection and Audit Rights

During the term of this Appendix and for 10 years from the final date of this Appendix or 10 years from the completion of any audit, whichever is longer, Provider agrees that Horizon, Governmental Authorities, and accrediting organizations, and each of their respective designees, have the right to (a) inspect, audit, evaluate, collect, make copies of, and receive from Provider, free of charge, timely copies of all Provider's and Provider's Subcontractors' medical, financial, administrative, and other hardcopy and electronic books, records, contracts, data, computer and other electronic systems, and other information regarding Provider Services and/or otherwise related to this Appendix and/or otherwise relevant to assessing quality, appropriateness, and timeliness of Provider Services rendered under this Appendix; and (b) inspect the facilities of Provider and Provider's Subcontractors. Provider agrees to cooperate and comply with such inspections, audits, evaluations, and collections in good faith in accordance with this Appendix, the Agreement, and applicable Law, and Provider acknowledges that inspections by a Governmental Authority may be unannounced.

2.1.4. Offshore Records

Provider shall not transmit or use, or allow to be transmitted or used, outside of the United States any medical records or other protected health information regarding Members.

2.1.5. Survival

The terms of this Section 2.1 shall survive any termination or expiration of the Agreement or this Appendix.

2.2. Monitoring

Provider acknowledges and understands that Horizon is ultimately responsible to DMAHS for Provider's performance of Provider Services and that Horizon therefore monitors Provider's performance on an ongoing basis to ensure that it is consistent with applicable Law and the State Contract. Provider understands and agrees that Horizon shall have the right to terminate this Appendix if Provider does not perform satisfactorily and that DMAHS may require Horizon to terminate this Appendix if Provider's performance is not consistent with the State Contract.

2.3. Notice

Provider shall notify Horizon in writing within 48 hours of any change in Provider's licensing or hospital admitting status.

2.4. Insolvency

In the event Horizon becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State of New Jersey, its officers, agents, or employees, or any Members or their eligible dependents. The terms of this paragraph shall survive any termination or expiration of the Agreement or this Appendix.

2.5. Equal Treatment

Provider shall provide the same level of medical care and health services to Members as it does to patients who are not Medicaid or NJ FamilyCare enrollees.

2.6. Reporting

Provider shall provide to Horizon, at no cost, all information and records necessary for Horizon to meet its reporting obligations, including, but not limited to, risk adjustment data and any other information necessary to characterize the context and purpose of each Provider Service furnished to a Member. Provider shall ensure, and certifies to, the accuracy, completeness, and truthfulness of all data, including but not limited to encounter data, and all reports generated by Provider regarding Provider Services to Members. The terms of this paragraph shall survive any termination or expiration of the Agreement or this Appendix.

2.7. Provider Protections

2.7.1. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon because Provider acts as an advocate for a Member in seeking appropriate, medically necessary health care services.

2.7.2. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon because Provider files a complaint or appeal as permitted by applicable Law.

2.7.3. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon because Provider expresses disagreement with Horizon's decision to deny or limit benefits to a Member or because Provider assists a Member to seek reconsideration of Horizon's decision.

2.7.4. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon 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 Horizon or not, policy provisions of a plan, or Provider's personal

recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

2.7.5. Nothing in the Agreement or this Appendix constitutes a financial incentive for Provider to withhold medically necessary Covered Services.

2.7.6. Nothing in the Agreement or this Appendix shall impair or limit the right of Provider to communicate openly with a Member about (a) the Member's health status, medical care, and all appropriate diagnostic testing and treatment options (including alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Member to decide among all relevant treatment options; (b) the risks, benefits, and consequences of treatment or non-treatment; and (c) the opportunity for the Member to refuse treatment and to express preferences about future treatment decisions.

2.7.7. Nothing in the Agreement or this Appendix shall be construed to impose obligations or responsibilities upon Provider which require Provider to violate the statutes or rules governing Provider's licensure.

2.8. Mandatory Verbatim Language

Provider shall comply with all provisions of the mandatory verbatim language for provider contracts and subcontracts as set forth in the State Contract. A copy of such verbatim language is attached as an Appendix to the Agreement.

2.9. Offshore Services

Provider shall not perform Provider Services, or any other services under this Agreement, outside of the United States.

2.10. Background Checks

Provider represents and warrants that it and all of its Provider Associates have completed a criminal background check as required by applicable Law, included but not limited to Provider Associates that perform direct services to MLTSS Members.

2.11. Critical Incidents

The following terms of this Section apply to the extent Provider renders MLTSS Provider Services to MLTSS Members:

2.11.1. Generally

Provider shall report, respond to, and document all Critical Incidents involving Members as required by applicable Law and the State Contract and in accordance with the process detailed in the Provider Manual.

2.11.2. Reporting to Horizon

Provider must report all Critical Incidents to Horizon within one business day from the date of the Critical Incident. Provider may make an initial report to Horizon verbally, but any verbal report must be followed with a written report within two business days from the date of the Critical Incident.

2.11.3. Abuse and Neglect

Provider shall report any suspected abuse, neglect, or exploitation of a Horizon MLTSS Member immediately in accordance with applicable Law.

2.11.4. Preventing Harm
In the event of a Critical Incident involving a Member, Provider shall immediately take steps to prevent any further harm to the Member and to respond to the Member's emergency needs, if any.

2.11.5. Investigation
Provider shall promptly investigate all Critical Incidents involving Members and shall submit a report of the investigation to Horizon within 15 calendar days (or, in the event of extenuating circumstances, within 30 calendar days) from the date of the Critical Incident. Provider shall cooperate with any investigation of a Critical Incident by Horizon, a Governmental Authority, or their designee.

2.11.6. Compliance
Provider shall fully comply with all mandatory training and reporting requirements set forth in the State Contract and those applicable to Adult Protective Services, Office of Institutionalized Elderly, Department of Health, the Department of Children and Families, and the Division of Disability Services including, but not limited to: N.J.A.C. 8:39-9.4; N.J.A.C. 8:36-5.10(a); N.J.A.C. 8:43F-3.3; N.J.A.C. 8:43J-3.4; N.J.S.A. 52:27D-409; and N.J.A.C. 8:57.

2.11.7. Survival
The terms of this Section 2.11 shall survive any termination or expiration of the Agreement or this Appendix.

3. TERM AND TERMINATION

3.1. Term

The initial term of this Appendix shall begin on the Appendix Effective Date and continue for three years thereafter (the "Initial Term"). At the end of the Initial Term, this Appendix shall automatically renew for successive one-year renewal terms (each a "Renewal Term") unless earlier terminated by either Party in accordance with the terms of the Agreement and/or this Appendix.

3.2. Termination

3.2.1. Termination by Horizon
Horizon may terminate this Appendix as follows:

3.2.1.1. Termination by Horizon with Cause
Horizon may terminate this Appendix for cause immediately upon written notice to Provider, without affording Provider the opportunity for a hearing, for the following reasons:

(i) Provider's breach of the Agreement or this Appendix as determined by Horizon in its sole discretion;

(ii) Fraud by Provider as determined by Horizon in its sole discretion;

(iii) If, in the opinion of Horizon's medical director, Provider represents an imminent danger to a Member or to the public health, safety, or welfare.

In addition, this Appendix shall terminate immediately upon termination of Horizon's contract with DMAHS or upon Horizon's discontinuance of all Health Benefit Plans to which this Appendix is applicable.

3.2.1.2. Termination by Horizon without Cause

Horizon may terminate this Appendix for any reason or no reason by providing Provider with at least 90 days written notice. In the event Horizon terminates this Appendix without cause in accordance with this Section, Provider shall have the right to request the reason for the termination in writing, to the extent not already stated in the termination notice, and/or to request a hearing, in accordance with the Provider Manual, to the extent such hearing right is afforded under applicable Law.

3.2.2. Termination by Provider

Provider may terminate this Appendix as follows:

(i) Upon written notice to Horizon at least 90 days prior to the end of the then existing Initial Term or Renewal Term, in which event the termination shall become effective upon the end of the then existing Initial Term or Renewal Term;

(ii) Upon 90 days written notice in the event of a material breach by Horizon, except that such termination will not take effect if Horizon cures the material breach within 90 days after receiving such notice or if Horizon disputes in good faith the allegation of material breach; or

(iii) In accordance with Section 5.3, "Amendments," of the Agreement.

3.3. Parties' Obligations Upon Termination or Expiration.

3.3.1. Continuation of Appendix and Agreement.

In the event this Appendix expires or is terminated by either Party, or by mutual agreement of both Parties, for any reason, the Parties shall continue to abide by the terms of this Appendix and the Agreement, including reimbursement terms, for four months following the date of expiration or termination, except that, to the extent Provider is not a hospital, Provider is not obligated to provide, and Horizon is not obligated to reimburse Provider for, services which are not medically necessary to be provided by Provider on and after the 31st day following the date of termination.

3.3.2. Continuation of Treatment by Non-Hospital Providers.

If, as of the effective date of termination or expiration of this Appendix, a Member is receiving from Provider post-operative follow-up care, oncological treatment, psychiatric treatment, obstetrical care, or other treatment for which it is medically necessary for the Member to continue treatment with Provider, then Provider may continue to provide such treatment to the Member under the terms of this Agreement as follows:

(i) For a period not to exceed six months in the case of post-operative follow-up care;

(ii) For a period not to exceed one year in the case of oncological treatment and psychiatric treatment;

(iii) Through the duration of a pregnancy and up to six weeks after delivery in the case of obstetrical care; and

(iv) For up to 120 calendar days in cases where it is medically necessary for the Member to continue treatment with Provider.

Provider shall provide such continued treatment to the same extent as it did prior to termination or expiration of the Agreement or this Appendix, and Horizon shall reimburse Provider for such continued treatment under the same terms and at the same fee schedule used to reimburse Provider for the services at the time of termination or expiration of the Agreement or this Appendix. Provider shall not be eligible to provide continued treatment to a Member under this Section if Provider is the subject of disciplinary action by the State Board of Medical Examiners or if this Appendix has been terminated based on Provider's fraud, breach of contract, or imminent danger to a patient or to the public health, safety, or welfare.

3.3.3. Survival

The terms of this Section 3.3 shall survive any termination or expiration of the Agreement or this Appendix.

ATTACHMENT A
TO HORIZON GOVERNMENT PROGRAMS
INDIVIDUAL PROVIDER AGREEMENT

APPENDIX FOR MEDICAID AND NJ FAMILYCARE

PROVIDER SERVICES

Provider shall provide the following Covered Services to Members:

1. Occupational Therapist
2. Click the arrow to the right, scroll, and select your specialty ...

ATTACHMENT B
TO HORIZON GOVERNMENT PROGRAMS
INDIVIDUAL PROVIDER AGREEMENT

APPENDIX FOR MEDICAID AND NJ FAMILYCARE

RATES

1. RATES

For Provider Services rendered by Provider to Members pursuant to this Appendix and the Agreement, Horizon shall reimburse Provider at the lesser of (a) billed charges or (b) 100% of the Horizon NJ Health standard fee schedule.

2. MISCELLANEOUS

2.1. Health Care Acquired Conditions and Serious Adverse Events.

Horizon will not pay Provider for any Provider Services arising out of or related to a Health Care Acquired Condition, Other Provider Preventable Condition, or Serious Adverse Event as defined under applicable Law and/or Horizon's applicable policies and procedures.

2.2. Standard Fee Schedule.

For any rates set forth in this Appendix that are based on the Horizon NJ Health standard fee schedule, such fee schedule is the standard, prevailing fee schedule maintained by Horizon for its Managed Medicaid and NJ FamilyCare plan(s). Upon Provider's written request, Horizon will send Provider a copy of the Horizon NJ Health standard fee schedule for those services applicable to Provider.

2.3. EPSDT Incentive Payment.

For any Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") screening examination, the rates set forth herein are inclusive of any and all incentive payments from DMAHS.

HORIZON GOVERNMENT PROGRAMS APPENDIX FOR MEDICARE

This Medicare Appendix ("**Appendix**") to the Individual Provider Agreement (the "**Agreement**") between Horizon and Provider is incorporated into and governed by the Agreement. This Appendix is effective on the Effective Date of the Agreement (the "**Appendix Effective Date**"). All capitalized terms used in this Appendix shall have the meanings set forth in the Agreement unless expressly stated otherwise herein.

WHEREAS, Horizon and Provider are parties to the Agreement; and

WHEREAS, Provider wishes to participate in the network for Horizon's Fully Integrated Dual Eligible Special Needs ("FIDE-SNP") plan(s) in accordance with the terms and conditions of the Agreement and this Appendix.

NOW, THEREFORE, in consideration of the mutual promises set forth herein, for other good and valuable consideration, the sufficiency of which is hereby acknowledged, and intending to be legally bound, the Parties hereby agree as follows:

The terms of this Appendix apply only with respect to those Provider Services rendered by Provider to Members enrolled in a "Health Benefit Plan" as defined in this Appendix.

1. DEFINITIONS

1.1. "**Critical Incident**" shall have the meaning defined in the contract between Horizon and DMAHS (the "State Contract") and applicable Law.

1.2. "**Health Benefit Plan**," for the purpose of this Appendix, means Horizon's FIDE-SNP plan(s) and any other Medicare Advantage plan(s) established by Horizon of which Provider has received or will receive written notice that this Appendix applies.

1.3. "**Managed Long Term Services and Supports ('MLTSS')**" are those Provider Services defined as Managed Long Term Services and Supports in the State Contract when rendered to a Member who meets MLTSS eligibility requirements and who has been accepted into Horizon's MLTSS program (an "MLTSS Member").

2. PROVIDER'S OBLIGATIONS

2.1. Records

2.1.1. Record Maintenance

Provider shall maintain complete and accurate medical, financial, and administrative records regarding Provider Services and/or otherwise related to this Appendix, including as a condition of Provider's right to payment for Provider Services under this Appendix, medical records sufficient to substantiate all Provider Services and to demonstrate their medical necessity in accordance with applicable Law, the Provider Manual, applicable Horizon policies and procedures, and prevailing medical standards. Provider shall maintain such records for the longer of:

(i) 10 years from the date of service or 10 years from the date final payment is made under this Appendix and all pending matters are closed;

(ii) 10 years from the final date of this Appendix or 10 years from the date of completion of any audit, whichever is longer; or

(iii) For medical records, 10 years following the Member's most recent service or until the Member reaches the age of 23 years.

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 applicable retention period above, whichever is later.

2.1.2. Confidentiality and Member Access

Provider shall comply with all applicable Law, the Provider Manual, and applicable Horizon policies and procedures regarding confidentiality and disclosure of, and Member access to, medical records and Member health information. Horizon and Provider shall have a mutual right to a Member's medical records, as well as to timely and appropriate communication of patient information, so that both Horizon and Provider may perform their respective duties efficiently and effectively for the benefit of the Member. Upon a Member's disenrollment from a Health Benefit Plan, transition from Provider to another provider, or otherwise upon a Member's request, Provider shall release the Member's medical records free of charge and in accordance with applicable Law, including all applicable confidentiality requirements.

2.1.3. Inspection and Audit Rights

During the term of this Appendix and for 10 years from the final date of this Appendix or 10 years from the completion of any audit, whichever is longer, Provider agrees that Horizon, Governmental Authorities, and accrediting organizations, and each of their respective designees, have the right to (a) inspect, audit, evaluate, collect, make copies of, and receive from Provider, free of charge, timely copies of all Provider's and Provider's Subcontractors' medical, financial, administrative, and other hardcopy and electronic books, records, contracts, data, computer and other electronic systems, and other information regarding Provider Services, otherwise related to this Appendix or Horizon's contract with CMS, and/or otherwise relevant to assessing quality, appropriateness, and timeliness of Provider Services rendered under this Appendix and (b) inspect the facilities of Provider and Provider's Subcontractors. Provider acknowledges that inspections by a Governmental Authority may be unannounced. Provider agrees to cooperate and comply with such inspections, audits, evaluations, and collections in good faith in accordance with this Appendix, the Agreement, and applicable Law, and Provider acknowledges that inspections by a Governmental Authority may be unannounced.

2.1.4. Offshore Records

Provider shall not transmit or use, or allow to be transmitted or used, outside of the United States any medical records or other protected health information regarding Members.

2.1.5. Survival

The terms of this Section 2.1 shall survive any termination or expiration of the Agreement or this Appendix.

2.2. Monitoring

Provider acknowledges and understands that Horizon is ultimately responsible to DMAHS and to CMS for Provider's performance of Provider Services and that Horizon therefore monitors Provider's performance on an ongoing basis to ensure that it is consistent with applicable Law and the State Contract. Provider understands and agrees that Horizon and CMS shall have the right to terminate this Appendix if Provider does not perform satisfactorily and that DMAHS may require Horizon to terminate this Appendix if Provider's performance is not consistent with the State Contract.

2.3. Notice

Provider shall notify Horizon in writing within 48 hours of any change in Provider's licensing or hospital admitting status.

2.4. Insolvency

In the event Horizon becomes insolvent or unable to pay Provider, Provider shall not seek compensation for services rendered from the State of New Jersey, its officers, agents, or employees, or any Members or their eligible dependents. The terms of this paragraph shall survive any termination or expiration of the Agreement or this Appendix.

2.5. Equal Treatment

Provider shall provide the same level of medical care and health services to Members as it does to patients who are not Medicaid, NJ FamilyCare, or Medicare enrollees.

2.6. Reporting

Provider shall provide to Horizon, at no cost, all information and records necessary for Horizon to meet its reporting obligations, including, but not limited to, risk adjustment data and any other information necessary to characterize the context and purpose of each Provider Service furnished to a Member. Provider shall ensure, and certifies to, the accuracy, completeness, and truthfulness of all data, including but not limited to encounter data, and all reports generated by Provider regarding Provider Services to Members. The terms of this paragraph shall survive any termination or expiration of the Agreement or this Appendix.

2.7. Provider Protections

2.7.1. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon because Provider acts as an advocate for a Member in seeking appropriate, medically necessary health care services.

2.7.2. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon because Provider files a complaint or appeal as permitted by applicable Law.

2.7.3. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon because Provider expresses disagreement with Horizon's decision to deny or limit benefits to a Member or because Provider assists a Member to seek reconsideration of Horizon's decision.

2.7.4. Provider shall not be penalized or the Agreement or this Appendix terminated by Horizon 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 Horizon or not, policy provisions of a plan, or Provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

2.7.5. Nothing in the Agreement or this Appendix constitutes a financial incentive for Provider to withhold medically necessary Covered Services.

2.7.6. Nothing in the Agreement or this Appendix shall impair or limit the right of Provider to communicate openly with a Member about (a) the Member's health status, medical care, and all appropriate diagnostic testing and treatment options (including alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the Member to decide among all relevant treatment options; (b) the risks, benefits, and consequences of treatment or non-treatment; and (c) the opportunity for the Member to refuse treatment and to express preferences about future treatment decisions.

2.7.7. Nothing in the Agreement or this Appendix shall be construed to impose obligations or responsibilities upon Provider which require Provider to violate the statutes or rules governing Provider's licensure.

2.8. Mandatory Verbatim Language

Provider shall comply with all provisions of the mandatory verbatim language for provider contracts and subcontracts as set forth in the State Contract. A copy of such verbatim language is attached as an Appendix to the Agreement.

2.9. Offshore Services

Provider shall not perform Provider Services, or any other services under this Agreement, outside of the United States.

2.10. Background Checks

Provider represents and warrants that it and all of its Provider Associates have completed a criminal background check as required by applicable Law, included but not limited to Provider Associates that perform direct services to MLTSS Members.

2.11. Critical Incidents

The following terms of this Section apply to the extent Provider renders MLTSS Provider Services to MLTSS Members:

2.11.1. Generally

Provider shall report, respond to, and document all Critical Incidents involving Members as required by applicable Law and the State Contract and in accordance with the process detailed in the Provider Manual.

2.11.2. Reporting to Horizon

Provider must report all Critical Incidents to Horizon within one business day from the date of the Critical Incident. Provider may make an initial report to Horizon verbally, but any verbal report must be followed with a written report within two business days from the date of the Critical Incident.

2.11.3. Abuse and Neglect
Provider shall report any suspected abuse, neglect, or exploitation of a Horizon MLTSS Member immediately in accordance with applicable Law.

2.11.4. Preventing Harm
In the event of a Critical Incident involving a Member, Provider shall immediately take steps to prevent any further harm to the Member and to respond to the Member's emergency needs, if any.

2.11.5. Investigation
Provider shall promptly investigate all Critical Incidents involving Members and shall submit a report of the investigation to Horizon within 15 calendar days (or, in the event of extenuating circumstances, within 30 calendar days) from the date of the Critical Incident. Provider shall cooperate with any investigation of a Critical Incident by Horizon, a Governmental Authority, or their designee.

2.11.6. Compliance
Provider shall fully comply with all mandatory training and reporting requirements set forth in the State Contract and those applicable to Adult Protective Services, Office of Institutionalized Elderly, Department of Health, the Department of Children and Families, and the Division of Disability Services including, but not limited to: N.J.A.C. 8:39-9.4; N.J.A.C. 8:36-5.10(a); N.J.A.C. 8:43F-3.3; N.J.A.C. 8:43J-3.4; N.J.S.A. 52:27D-409; and N.J.A.C. 8:57.

2.11.7. Survival
The terms of this Section 2.11 shall survive any termination or expiration of the Agreement or this Appendix.

2.12. Credentialing and Recredentialing
In Horizon's sole discretion, either (a) the credentials of Provider and/or any medical professionals affiliated with Provider will be reviewed by Horizon; or (b) Provider's credentialing process, if any, will be reviewed and approved by Horizon and Horizon will audit the credentialing process on an ongoing basis.

2.13. Delegation
Horizon delegates to Provider and Provider shall perform the services described in the Agreement and this Appendix. Provider acknowledges and agrees that Horizon may only delegate activities or functions to Provider in a manner consistent with the requirements set forth at 42 C.F.R. § 422.504(i)(4).

2.14. Compliance
In addition to Provider's compliance obligations set forth in the Agreement and this Appendix, Provider shall provide Provider Services in a manner consistent and in compliance with:

2.14.1. Applicable Law relating to advance directives;

2.14.2. All applicable Medicare laws, regulations, and CMS instructions; and

2.14.3. Horizon's contractual obligations to CMS.

3. TERM AND TERMINATION

3.1. Term

The initial term of this Appendix shall begin on the Appendix Effective Date and shall end on December 31 of the third calendar year following the Appendix Effective Date (the "Initial Term"). At the end of the Initial Term, this Appendix shall automatically renew for successive one-year renewal terms (each a "Renewal Term") unless earlier terminated by either Party in accordance with the terms of the Agreement and/or this Appendix.

3.2. Termination

3.2.1. Termination by Horizon

Horizon may terminate this Appendix as follows

3.2.1.1. Termination by Horizon for Cause

Horizon may terminate this Appendix for cause immediately upon written notice to Provider for the following reasons:

(i) Provider's breach of the Agreement or this Appendix as determined by Horizon in its sole discretion;

(ii) Fraud by Provider as determined by Horizon in its sole discretion;

(iii) If, in the opinion of Horizon's medical director, Provider represents an imminent danger to a Member or to the public health, safety, or welfare;

(iv) In instances where Horizon or CMS determine that Provider has not performed satisfactorily.

In addition, this Appendix shall terminate immediately upon termination of Horizon's contract with CMS or upon Horizon's discontinuance of all Health Benefit Plans to which this Appendix is applicable.

3.2.1.2. Termination by Horizon without Cause

Horizon may terminate this Appendix for any reason or no reason by providing Provider with at least 90 days written notice. In the event Horizon terminates this Appendix without cause in accordance with this Section, Provider shall have the right to request the reason for the termination in writing to the extent not already stated in the termination notice.

3.2.1.3. Hearing

In the event that Horizon terminates this Appendix, Provider, in accordance with the Provider Manual, may be entitled to a hearing to the extent such hearing right is afforded under applicable Law.

3.2.2. Termination by Provider

Provider may terminate this Appendix as follows:

(i) Upon written notice to Horizon at least 90 days prior to the end of the then existing Initial Term or Renewal Term, in which event the termination shall

become effective upon the end of the then existing Initial Term or Renewal Term;

(ii) Upon 90 days written notice in the event of a material breach by Horizon, except that such termination will not take effect if Horizon cures the material breach within 90 days after receiving such notice or if Horizon disputes in good faith the allegation of material breach; or

(iii) In accordance with Section 5.3, "Amendments," of the Agreement.

3.3. Parties' Obligations Upon Termination or Expiration.

3.3.1. Continuation of Appendix and Agreement

In the event this Appendix expires or is terminated by either Party, or by mutual agreement of both Parties, for any reason, the Parties shall continue to abide by the terms of this Appendix and the Agreement, including reimbursement terms, for four months following the date of expiration or termination, except that, to the extent Provider is not a hospital, Provider is not obligated to provide, and Horizon is not obligated to reimburse Provider for, services which are not medically necessary to be provided by Provider on and after the 31st day following the date of termination.

3.3.2. Continuation of Treatment by Non-Hospital Providers

If, as of the effective date of termination or expiration of this Appendix, a Member is receiving from Provider post-operative follow-up care, oncological treatment, psychiatric treatment, obstetrical care, or other treatment for which it is medically necessary for the Member to continue treatment with Provider, then Provider may continue to provide such treatment to the Member under the terms of this Agreement as follows:

(i) For a period not to exceed six months in the case of post-operative follow-up care;

(ii) For a period not to exceed one year in the case of oncological treatment and psychiatric treatment;

(iii) Through the duration of a pregnancy and up to six weeks after delivery in the case of obstetrical care; and

(iv) For up to 120 calendar days in cases where it is medically necessary for the Member to continue treatment with Provider.

Provider shall provide such continued treatment to the same extent as it did prior to termination or expiration of the Agreement or this Appendix, and Horizon shall reimburse Provider for such continued treatment under the same terms and at the same fee schedule used to reimburse Provider for the services at the time of termination or expiration of the Agreement or this Appendix. Provider shall not be eligible to provide continued treatment to a Member under this Section if Provider is the subject of disciplinary action by the State Board of Medical Examiners or if this Appendix has been terminated based on Provider's fraud, breach of contract, or imminent danger to a patient or to the public health, safety, or welfare.

3.3.3. Survival

The terms of this Section 3.3 shall survive any termination or expiration of the Agreement or this Appendix.

ATTACHMENT A
TO HORIZON GOVERNMENT PROGRAMS
INDIVIDUAL PROVIDER AGREEMENT

APPENDIX FOR MEDICARE

PROVIDER SERVICES

Provider shall provide the following Covered Services to Members:

1. Occupational Therapist

2. Click the arrow to the right, scroll, and select your specialty ...

ATTACHMENT B
TO HORIZON GOVERNMENT PROGRAMS
INDIVIDUAL PROVIDER AGREEMENT

APPENDIX FOR MEDICARE

RATES

1. RATES

1.1. For Provider Services rendered by Provider to Members pursuant to this Appendix and the Agreement, Horizon shall reimburse Provider at the lesser of (a) billed charges or (b) 85% of the amount Provider would have received had the Member been covered under original Medicare, less Medicare fee-for-service cost sharing amounts or applicable Health Benefit Plan copayment, coinsurance, or deductible, whichever is applicable. Changes to CMS rates and reimbursement guidelines will be made to Provider's rate(s) within 90 days following Horizon's receipt of such notification from CMS. All CMS updates will be implemented on a prospective basis only. Payments will remain at the existing rate(s) until such time as Horizon's payment system is updated with CMS's changes.

1.2. For any Provider Services that are not covered by Medicare but are covered by Medicaid under the Health Benefit Plan, then either (a) if Provider participates in the network for Horizon's Managed Medicaid and NJ FamilyCare plan(s), Horizon shall pay Provider at the lesser of (i) billed charges or (ii) Provider's contracted rate for Medicaid services as set forth in the Medicaid and NJ FamilyCare Appendix; or (b) if Provider does not participate in the network for Horizon's Managed Medicaid and NJ FamilyCare plan(s), or if Provider's Medicaid and NJ FamilyCare Appendix does not include a rate for the Provider Service at issue, then Horizon shall pay Provider at the lesser of (i) billed charges or (ii) 100% of the applicable Horizon NJ Health standard fee schedule. The provisions of this paragraph are subject to coordination of benefits.

2. COORDINATION OF BENEFITS

Provider acknowledges and agrees that it is prohibited by Law from collecting any Medicare Part A and B cost sharing (including coinsurance or deductibles) from Members who are also eligible for and enrolled in New Jersey Medicaid ("Dual Eligible" Members) when the State is responsible for paying the Medicare cost sharing amounts for such individuals under the Medicaid program. Provider agrees to accept the amounts paid by Horizon (if any), pursuant to its delegated authority from the State, as payment in full for Member cost sharing. Provider will be informed of Medicare and Medicaid benefits and rules for Dual Eligible Members. Horizon may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the Member under Title XIX if the Member were not enrolled in a Health Benefit Plan.

3. MISCELLANEOUS

3.1. <u>Health Care Acquired Conditions and Serious Adverse Events</u>

Horizon will not pay Provider for any Provider Services arising out of or related to a Health Care Acquired Condition, Other Provider Preventable Condition, or Serious Adverse Event as defined under applicable Law and/or Horizon's applicable policies and procedures.

3.2. Standard Fee Schedule

For any rates set forth in this Appendix that are based on the Horizon NJ Health standard fee schedule, such fee schedule is the standard, prevailing fee schedule maintained by Horizon for its Managed Medicaid and NJ FamilyCare plan(s). Upon Provider's written request, Horizon will send Provider a copy of the Horizon NJ Health standard fee schedule for those services applicable to Provider.

HORIZON GOVERNMENT PROGRAMS

NEW JERSEY VERBATIM LANGUAGE APPENDIX

The State of New Jersey requires that any provider/subcontractor who agrees to serve Medicaid/NJ FamilyCare members comply with all the following provisions. Any changes made to the required verbatim language by the State of New Jersey shall be deemed to be incorporated herein by reference without amendment, and provider/subcontractor shall remain apprised of, and comply with, any such changes.

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 from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2023, dependent upon available appropriation. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2023. 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, 2023.

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.

4. Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS

providers, adult/pediatric medical day care providers, PCA and participant directed Vendor Fiscal/Employer Agent Financial management Services (VF/EA FMS) claims within the following timeframes:

a. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;

b. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

5. Nursing Facility Quality Incentive Payment Program (NF QIPP) replaces Any Willing Qualified Provider (AWQP): MLTSS.

6. The AWQP initiative quality measures were utilized to provide rate enhancements and the program was replaced by the Nursing Facility Quality Incentive Payment Program (NF QIPP).

7. The NF QIPP leverages quality outcome performance rate add-ons to state set Medicaid NF rate payments and is dependent on budget appropriations. The NF QIPP focuses on long-stay Medicaid residents, includes SCNFs, and excludes low volume Medicaid facilities with low Medicaid member census.

8. The NF QIPP currently uses six quality measures that includes five Minimum Data Set (MDS) measures that are collected by CMS under its Medicare Nursing Home Compare program and one resident and family satisfaction survey measure collected by NJ. The CoreQ Long Stay Satisfaction Survey is the tool utilized to determine a resident and family overall satisfaction score. These five core MDS measures are a part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes collected by CMS. DHS utilizes four standard quarters that are both finalized (no further revisions by CMS) and publicly available.

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 from 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.

4. Electronic Visit Verification (EVV)

a. The Contractor shall develop or purchase and implement an electronic visit verification

system to monitor member receipt and utilization of personal care services including at a minimum, personal care assistance, home based supportive care and in-home respite. This includes all applicable self-directed personal care services.

b. The Contractor shall oversee its selected EVV vendor to ensure the EVV system operates in compliance with this Contract, with policies and protocols established by DMAHS, and with the requirements of the 21st Century Cures Act.

The 21st Century Cures Act requires electronic (not manual) verification of the type of service performed, the individual receiving the service, the date of the service, location of service delivery, the individual providing the service, and time the service begins and ends. The Contractor shall notify DMAHS within five (5) business days of the identification of any issue affecting EVV system operation which impacts the Contractor's performance of this Contract, including actions that will be taken by the Contractor to resolve the issue and the specific timeframes within which such actions shall be completed.

c. At a minimum, recredentialing of providers shall include verification of continued licensure and/or certification (as applicable); compliance with policies and procedures identified during credentialing, including background checks and training requirements, use of the EVV; and compliance with the HCBS Settings Rule detailed in 42 C.F.R. § 441.301(c)(4)-(5).

d. The Contractor shall monitor all manual confirmations and take action to eliminate manual confirmations to ensure compliance with 21st Century Cures Act EVV system requirements by January 1, 2022.

   i. Contractor shall pay claims for visits recorded in an EVV system which may require manual intervention.

   ii. The Contractor shall utilize an exceptions process as specified by DMAHS for visits recorded manually and outside the EVV system.

e. The Contractor shall generate reports and conduct audits according to DMAHS specification to ensure members are receiving necessary services. The Contractor shall take appropriate remedial action against providers and workers who repeatedly fail to use the EVV system as required.

f. The Contractor shall select its own electronic visit verification vendor, as applicable, and shall ensure, in the development of its EVV system, the following minimal functionality:

   i. The ability to effectively connect with the state procured contracted EVV aggregator;

   ii. The ability to receive and store service authorizations for individual members;

   iii. The ability to log the arrival and departure of an individual provider staff person or worker, through the use of a mobile device, member landline telephone or a static GPS device, when mobile and landline service is not available

   iv. Contractor shall maintain records of unique staff identifier to allow for auditing and reporting for program integrity

v. The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's home);

vi. The ability to match services provided to a member with services authorized in the plan of care;

vii. The ability to ensure that the provider/worker delivering the service is authorized to deliver such services;

viii. The ability to create a schedule of services from the service authorizations entered for each member which identifies the amount, frequency, duration and scope of each service, and any schedule specified in which services are needed or preferred by the member;

ix. Ensure that workers are scheduled by providers in accordance with such authorization, including any schedule of services specified; and to ensure providers' adherence to the established schedule;

x. The ability to distinguish between electronic confirmation versus manual confirmation.

g. The EVV system shall have the ability to receive and store service authorizations and service schedules as required. Schedule data must be used to compare to visit verification.

i. The ability to identify gaps in care and provide system-generated reporting regarding each provider's compliance with scheduling requirements, late and missed visits, and other data specified by DMAHS;

ii. The ability to allow more flexible scheduling options, including the option for open scheduling while still performing all remaining system functions;

iii. The ability to receive and store updated authorizations and provide timely notification to the provider of the updates

iv. Outline the process for provider to update schedules based on changes in authorization information.

v. The ability to capture worker notes per service provided and provide such notes to the provider, MCO and DMAHS as appropriate, upon request;

vi. Access to the EVV system and a dashboard for DMAHS to conduct monitoring of the Contractor's performance with the requirements detailed above;

h. The Contractor shall establish business processes regarding EVV and ensure efficient operation of EVV. The Contractor must ensure the following:

i. Timely as defined by 4.6.4B of this Contract.

ii. Consistency between MCO authorizations, and the authorizations reflected in the EVV system.

iii. Timely remediation of issues associated with claims rejections or denials in order to provide appropriate claims adjudication for services delivered

a. Ongoing monitoring of the total volume of rejected or denied claims due to issues with the EVV system.

iv. In instances where systems outages, breakdowns, etc. are identified, the Contractor shall notify DMAHS and providers immediately.

v. Contractor shall collaborate with the Fiscal Intermediary for Self-Direction to determine root cause for rejections or denials.

vi. Contractor shall perform monthly program integrity audits of rendering provider credentials (certified home health aide, registered nurse, licensed practical nurse, physical therapist, cognitive therapist, occupational therapist, speech therapist) to verify services were provided by the authorized provider for such service. If it is determined that the credentials are incorrect, expired, or missing the Contractor shall recoup payment from the provider.

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.

1. 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/subcontractor shall be free to communicate freely with their patients about the health status of their patients, medical care or treatment options regardless of whether benefits for that care or treatment are provided under the provider contract/subcontract, if the professional is acting within the lawful scope of practice. Providers/subcontractor s shall be free to practice their respective professions in providing the most appropriate treatment required by their patients and shall provide informed consent within the guidelines of the law including possible positive and negative outcomes of the various treatment modalities.

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

a. To prohibit the enforcement, including termination, as part of 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, DOH, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;
4. Becomes insolvent or falls below minimum net worth requirements;

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

6. Materially breaches the 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, gender identity, 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 Horizon 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 Horizon 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.

K. INSPECTION

The State, CMS, the Office of the Inspector General, the Comptroller General, and their designees may, at any time, inspect and audit any record or document of the MCO or its subcontractors, and may, at any time inspect the premises, physical facilities, and equipment where Medicaid-related activities or work is conducted. The right to audit under this section exists for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. 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, including but not limited to, all physical and computer or other electronic records and systems, originated or prepared pursuant to, or 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 AND PROVIDER/SUBCONTRACTOR DOCUMENTATION REQUIREMENTS

Provider/Subcontractor Documentation Requirements - The provider/subcontractor shall, at a minimum, maintain such records as are necessary to fully disclose the nature and extent of services provided, in accordance with N.J.S.A. 30:4D-12(d) and N.J.A.C. 10:49-9.8. The provider/subcontractor shall also comply with the documentation requirements set forth in this Section M, as applicable. To the extent that the Contractor has imposed more stringent requirements than those imposed by law, regulation or this Section M, the more stringent requirements shall prevail. The provisions of N.J.S.A 30:4D-12(e) and N.J.A.C. 10:49-5.5(a)(13)(i) through (iv) may apply to these documentation requirements.

Record Retention Requirements - Records must be retained for the later of ten (10) years from the date of service or after the 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 Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10(a) 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.

Compliance with Specific Requirements - Providers/subcontractors must comply with the following requirements:

1. Medical supplies and DME:

    a. Medical supplies and equipment require a legible, dated prescription or a dated Certificate of Medical Necessity (CMN) personally or electronically signed by the prescribing practitioner. Either document shall contain the following information:

        i. The beneficiary's name, address, gender and Medicaid/NJ FamilyCare eligibility identification number;

        ii. A detailed description of the specific supplies and/or equipment prescribed;

            (1) For example, the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order shall describe the type and style of the wheelchair;

        iii. The length of time the medical equipment items or supplies are required;

        iv. A diagnosis and summary of the patient's physical condition to support the need for the item(s) prescribed; and

        v. The prescriber's printed name, address and signature.

2. Orders for laboratory tests:

    a. All orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other practitioner whose license permits them to request the services, or be in an alternative form of order specifically authorized in (b) (i) through (iii) below. All orders shall be patient specific, contain the specific clinical laboratory test(s) requested, seek only medically necessary tests, shall be on file with the billing laboratory, and shall be available for review by Medicaid/NJ FamilyCare representatives upon request.

    b. If a signed order is not utilized, then clinical laboratory services shall be ordered in one of the following ways:

        i. In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at

the time of testing and available to Federal or State representatives upon request;

ii. A test request also may be submitted to the laboratory electronically if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or manipulation of records, and shall include, at a minimum, electronic encryption; or

iii. Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.

c. Standing orders shall be:

i. Patient specific, and not blanket requests from the physician or licensed practitioner;

ii. Medically necessary and related to the diagnosis of the recipient; and

iii. Effective for no longer than a 12-month period from the date of the physician's/practitioner's order.

d. The laboratory must ensure that all orders described in (a) through (c) above contain the following information:

i. The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;

ii. The patient's name or unique patient identifier;

iii. The sex (if known) and date of birth of the patient;

iv. The specific test(s) to be performed;

v. The source of the specimen, when appropriate;

vi. The date and, if appropriate, time of specimen collection;

vii. For Pap smears, the patient's last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy;

viii. For drug testing, the order shall indicate whether the test is for screening (presumptive) or confirmation (definitive) purposes and the specific drug classes to be tested as defined by the American Medical Association;

ix. Any additional information relevant and necessary for a specific test to ensure accurate and timely testing and reporting of results, including interpretation, if applicable.

e. All orders and results of the tests billed shall be on file with the billing laboratory performing

the tests. The results of the tests, clinical and billing records shall be available for review by Medicaid/NJ FamilyCare representatives.

f. The Medicaid/NJ FamilyCare program shall have the right to inspect all records, files and documents of in-State and out-of-State service and reference clinical laboratories which provide laboratory tests and services for Medicaid/NJ FamilyCare beneficiaries.

g. All laboratory test orders shall be supported by documentation in the referring physician's/practitioner's medical records.

h. If the laboratory uploads, transcribes or enters test requisition or authorization information into a record system or a laboratory information system, the laboratory must ensure that the information is transcribed or entered accurately.

3. Services Provided by a Psychologist

a. Psychologists shall keep such individual records as may be necessary to disclose fully the kind and extent of services provided and shall make such information available when requested by the New Jersey Medicaid/NJ FamilyCare program or its agents. The recordkeeping shall document the services provided as they relate to the procedure code(s) used for reimbursement purposes (see N.J.A.C. 10:67-3, Healthcare Common Procedure Coding System).

b. For the initial examination, the record shall include, as a minimum, the following:

i. Date(s) of service rendered;

ii. Signature of the psychologist;

iii. Chief complaint(s);

iv. Pertinent historical, social, emotional, and additional data;

v. Reports of evaluation procedures undertaken or ordered;

vi. Diagnosis; and

vii. The intended course of treatment and tentative prognosis.

c. For subsequent progress notes made for each Medicaid/ NJ FamilyCare patient contact, the following shall be included on the psychotherapeutic progress note:

i. Date(s) and duration of service (for example, hour, half-hour);

ii. Signature of the psychologist;

iii. Name(s) of modality used, such as individual, group, or family therapy;

iv. Notations of progress, impediments, or treatment complications; and

v. Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.

vi. One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):

(1) Symptoms and complaints;

(2) Affect;

(3) Behavior;

(4) Focus topics; and

(5) Significant incidents or historical events.

4. Mental Health Services Provided by an Independent Clinic

a. An intake evaluation shall be performed within 14 days of the first encounter or by the third clinic visit, whichever is later, for each beneficiary being considered for continued treatment. This evaluation shall consist of a written assessment that:

i. Evaluates the beneficiary's mental condition;

ii. Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;

iii. Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary's treatment needs; and

iv. Is made part of the beneficiary's records.

v. The evaluation for the intake process shall include a physician or advance practice nurse (APN) and an individual experienced in the diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

b. A written, individualized plan of care shall be developed for each beneficiary who receives continued treatment. The plan of care shall be designed to improve the beneficiary's condition to the point where continued participation in the program, beyond occasional maintenance visits, is no longer necessary. The plan of care shall be included in the beneficiary's records and shall consist of:

i. A written description of the treatment objectives including the treatment regimen and the specific medical/remedial services, therapies, and activities that shall be used to meet the objectives.

(1) Due to the nature of mental illness and the provision of program services, there may be instances in which a temporary deviation from the services written in the treatment plan occurs. In this event, the client may participate in alternate programming. The reason for the deviation should be clearly explained in the daily or weekly documentation. Deviations that do not resolve shall require a written change in the treatment plan;

ii. A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;

iii. The type of personnel that will be furnishing the services; and

iv. A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.

c. The mental health clinic shall develop and maintain legibly written documentation to support

each medical/remedial therapy service, activity, or session for which billing is made.

i. This documentation, at a minimum, shall consist of:

(1) The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;

(2) the date and time that services were rendered;

(3) The duration of services provided;

(4) The signature of the practitioner or provider who rendered the services;

(5) The setting in which services were rendered; and

(6) A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

d. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the beneficiary's medical record at least once a week, as well as any other information important to the clinical picture, therapy, and prognosis.

e. The individual services under partial care shall be documented on a daily basis. More substantive documentation, including progress notes and any other information important to the clinical picture, are required at least once a week.

f. Periodic review of the beneficiary's plan of care shall take place at least every 90 days during the first year and every six months thereafter.

i. The periodic review shall determine:

(1) The beneficiary's progress toward the treatment objectives;

(2) The appropriateness of the services being furnished; and

(3) The need for the beneficiary's continued participation in the program

ii. Periodic reviews shall be documented in detail in the beneficiary's records and made available upon request to the New Jersey Medicaid or NJ FamilyCare program or its agents.

5. APN Services:

a. The APN, in any and all settings, shall keep such legible individual written records and/or electronic medical records (EMR) as are necessary to fully disclose the kind and extent of service(s) provided, the procedure code being billed and the medical necessity for those services.

b. Documentation of services performed by the APN shall include, as a minimum:

i. The date of service;

ii. The name of the beneficiary;

iii. The beneficiary's chief complaint(s), reason for visit;

iv. Review of systems;

v. Physical examination;

vi. Diagnosis;

vii. A plan of care, including diagnostic testing and treatment(s);

viii. The signature of the APN rendering the service; and

ix. Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

c. In order to receive reimbursement for an initial visit, the following documentation, at a minimum, shall be placed on the medical record by the APN, regardless of the setting where the examination was performed:

i. Chief complaint(s);

ii. A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;

iii. Pertinent medical history;

iv. Pertinent family and social history;

v. A complete physical examination;

vi. Diagnosis; and

vii. Plan of care, including diagnostic testing and treatment.

d. In order to document the record for reimbursement purposes, the progress note for routine office visits or follow up care visits shall include the following:

i. In an office or residential health care facility:

(1) The beneficiary's chief complaint(s), reason for visit;

(2) Pertinent medical, family and social history obtained;

(3) Pertinent physical findings;

(4) All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and

(5) A diagnosis.

ii. In a hospital or nursing facility setting:

(1) An update of symptoms;

(2) An update of physical symptoms;

(3) A resume of findings of procedures, if any done;

(4) Pertinent positive and negative findings of lab, X-ray or any other test;

(5) Additional planned studies, if any, and the reason for the studies; and

(6) Treatment changes, if any.

e. To qualify as documentation that the service was rendered by the APN during an inpatient stay, the medical record shall contain the APN's notes indicating that the APN personally:

i. Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;

ii. Performed a physical examination, as appropriate;

iii. Confirmed or revised the diagnosis; and

iv. Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

f. The APN's involvement shall be clearly demonstrated in notes reflecting the APN's personal involvement with, or participation in, the service rendered.

g. For all EPSDT examinations for individuals under 21 years of age, the following shall be documented in the beneficiary's medical record and shall include:

i. A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.

ii. A developmental and nutritional assessment.

iii. A complete, unclothed, physical examination to also include the following:

(1) Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and

(2) Vision, dental and hearing screening;

iv. The assessment and administration of immunizations appropriate for age and need;

v. Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;

vi. Mandatory referral to a dentist for children age twelve months or older;

vii. The laboratory procedures performed or referred if medically necessary per Bright Futures guidelines;

viii. Health education and anticipatory guidance; and

ix. An offer of social service assistance; and, if requested, referral to a county welfare agency.

h. The record and documentation of a home visit or house call shall become part of the office progress notes and shall include, as appropriate, the following information:

i. The beneficiary's chief complaint(s), reason for visit;

ii. Pertinent medical, family and social history obtained;

iii. Pertinent physical findings;

iv. The procedures, if any performed, with results;

v. Lab, X-ray, ECG, etc., ordered with results; and

vi. Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es)

plus pertinent recommendations and actions.

6. Physician Services

a. Physician Recordkeeping; general

i. All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

ii. The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

iii. The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

iv. Records of Residential Health Care Facility patients shall be maintained in the physician's office.

v. The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.

b. Minimum documentation; initial visit; new patient

i. The following minimum documentation shall be entered on the medical record, regardless of the setting where the examination is performed, for the service claimed by use of the procedure codes for Initial visit--New patient:

(1) Chief complaint(s);

(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;

(3) Pertinent past medical history;

(4) Pertinent family and social history;

(5) A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;

(6) Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;

(7) Laboratory, X-Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and

(8) The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).

c. Minimum documentation; established patient

i. The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED

PATIENT:

(1) In an office or Residential Health Care Facility:

(a) The purpose of the visit;

(b) The pertinent physical, family and social history obtained;

(c) A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;

(d) Procedures performed, if any, with results;

(e) Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and

(f) Prognosis and diagnosis.

d. Minimum documentation; home visits and house calls

i. For HOME VISIT and HOUSE CALL codes, in addition to the components listed in N.J.A.C. 10:54-2.8, the office progress notes shall include treatment plan status relative to present or pre-existing illness(es), plus pertinent recommendations and actions.

e. Minimum documentation; hospital or nursing facility

i. In a hospital or nursing facility, documentation shall include:

(1) An update of symptoms;

(2) An update of physical findings;

(3) A resume of findings of procedures, if any are applicable;

(4) The pertinent positive and negative findings of laboratory, X-Ray, electrocardiograms (ECGs), or other tests or consultations;

(5) Any additional planned studies, if any, including the reasons for any studies; and

(6) Treatment changes, if any.

f. Minimum documentation; hospital discharge medical summary

i. When an inpatient is discharged from the hospital to the care of another medical facility (such as a nursing facility or a community home care agency), a legible discharge and medical summary shall be prepared and signed by the attending physician.

ii. The summary should cover the pertinent findings of the history, physical examination, diagnostic and therapeutic modalities, consultations, plan of care or therapy, medications, recommendations for follow-up care and final diagnosis related to the patient's hospitalization. Recommendations should also be made for further medical care and should be forwarded to the institution or agency to which the patient has been referred or discharged.

g. Minimum documentation; mental health services

i. For each patient contact made by a physician for psychiatric therapy, written documentation shall be developed and maintained to support each medical or remedial therapy, service, activity, or session for which billing is made. The documentation, at a minimum, shall consist of the following:

(1) The specific services rendered and modality used, for example, individual, group, and/or family therapy;

(2) The date and the time services were rendered;

(3) The duration of services provided, for example, one hour, or one- half hour;

(4) The signature of the physician who rendered the service;

(5) The setting in which services were rendered;

(6) A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;

(7) Notations of progress, impediments, treatment, or complications; and

(8) Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.

ii. Clinical progress, complications and treatment which affect prognosis and/or progress shall be documented in the patient's medical record, as well as any other information important to the clinical picture, therapy, and prognosis. For mental health services that are not specifically included in the patient's treatment regime, a detailed explanation shall be submitted with the claim form, addressed to the Office of Managed Behavioral Services, Mail Code #25, PO Box 712, Trenton, New Jersey 08625-0712, indicating how these services relate to the treatment regime and objectives in the patient's plan of care. Similarly, a detailed explanation should accompany bills for medical and remedial therapy, session or encounter that departs from the Plan of Care in terms of need, scheduling, frequency or duration of services furnished (for example, unscheduled emergency services furnished during an acute psychotic episode) explaining why this departure from the established treatment regime is necessary in order to achieve the treatment objectives.

7. Pharmaceutical services

a. Pharmacies shall keep and maintain wholesaler, manufacturer, and distributor invoices and other purchase invoices and documents for prescription drugs and medical supplies for a minimum of ten (10) years. Purchase records must indicate price, drug name, dosage form, strength, NDC, lot number and quantity. Pharmacies shall also maintain adequate records to validate purchases from wholesalers including but not limited to canceled-check information. Pharmacies must promptly comply with any requests to produce such documentation to DMAHS and/or MFD.

b. Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy - Verified

Accredited Wholesaler Distributors (NABP- VAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.

c. Pharmacies are required to have a product in stock at the pharmacy prior to submitting a claim for the product. All claims submissions shall contain the National Drug Code (NDC) of the product dispensed. Only the NDC of the actual product dispensed shall be submitted on the claim. Use of a similar NDC of a product not dispensed is not permissible.

d. Pharmacies shall keep and maintain any compound recipe worksheets identifying ingredients used in a compounded prescription drug. Pharmacies must submit claims with all ingredients included in each compound and may only submit claims with the NDC associated with the actual ingredients filled/dispensed. Pharmacies must promptly comply with any requests to produce such electronic or paper documentation to the Medicaid/NJ FamilyCare program and/or its agents.

e. Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and non- legend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer's name, address and registration number.

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.

1. For acute care general, private psychiatric, specialty and comprehensive rehabilitation hospitals, the provider/contractor shall submit inpatient claims to the Contractor based on the medical record and services provided. The inpatient claim shall include, but not be limited to the following:

    a. Diagnosis Code
    b. Procedure Code
    c. Sex
    d. Discharge Status Code
    e. Date of Birth
    f. Newborn Birth Weight
    g. Admission Date
    h. Discharge Date
    i. Skilled level of Care (SNF) or Administrative Days and associated dates
    j. Residential level of Care (denied days) and associated dates

2. The resulting Contractor generated encounter record shall be subject to review by the New Jersey Utilization Review (NJUR) Vendor.

    a. In the event that the NJUR review results in an adverse determination, the

provider/subcontractor shall adjust the claim pursuant to the adverse determination or appeal the decision utilizing the NJUR appeal process.

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, B and ABP 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 and N.J.A.C. 10:49-9.7. 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 Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10a and 9:6-8:40 and consistent with the need to protect the 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 statutes 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 455.23 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, DOH, 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.

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

5. The Contractor shall have the right to recover directly from providers and enrollees in the Contractor's network for the audits and investigations the Contractor solely conducts.

6. The Contractor shall have a nationally recognized standard criteria for inpatient hospital admissions that shall substantially conform to the Milliman Care Guidelines (MCG). The

Contractor shall inform and include in all provider contracts for network provider hospitals or clinical care review team subcontractors - that for purposes of audits of inpatient hospital admissions by DMAHS or MFD or its subcontractors - MCG criteria will be applied.

7. The provider/subcontractor shall comply with the provisions of Section 6032 of the federal Deficit Reduction Act of 2005. The provider/subcontractor and its employees, contractors, subcontractors and vendors, shall agree to abide by the Contractor's policies and procedures regarding Section 6032 of the federal Deficit Reduction Act of 2005. As part of these policies and procedures, the provider/subcontractor shall perform monthly exclusions, certification, and licensure checks of its employees, contractors, subcontractors and vendors, who directly or indirectly will be furnishing, ordering, directing, managing or prescribing Medicaid items or services in whole or in part, using the following databases:

   a. State of New Jersey debarment list (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf

   b. Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/

   c. N.J. Treasurer's exclusions database (mandatory): http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml

   d. N.J. Division of Consumer Affairs licensure databases, including all licensed healthcare professionals (mandatory, if applicable): http://www.njconsumeraffairs.gov/Pages/verification.aspx

   e. N.J. Department of Health licensure and certification database, including:, Nursing Home Administrators, Certified Assisted Living Administrators, Certified Nurse Aides/Personal Care Assistants, and Certified Medication Aides (mandatory, if applicable): https://njna.psiexams.com/.

   f. Federal exclusions and licensure database (optional and fee-based): https://www.npdb.hrsa.gov/hcorg/pds.jsp. Please note that only certain provider types may access this database. See www.npdb.hrsa.gov/hcorg/register.jsp for more information.

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 DCP&P 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, patient payment liability 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. 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, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), 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 1395w-4(g)(3)(A), 42 USC 1395cc(a)(1)(A), 42 USC 1396a(n)(3), 42 USC 1396u-2(b)(6), 42 CFR 438.106, 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.

W. OFF-SHORE

All services pursuant to any provider agreement or subcontract shall be performed within the United States.

X. FURTHER DELEGATION OF ANY DELEGATED ACTIVITY IS NOT PERMISSIBLE.