BRIGHTON health plan SOLUTIONS

Brighton Health Network Administrative Guidelines

UPDATED 2.24.2020

WHO WE ARE

Brighton Health Plan Solutions (BHPS) is an innovative health care enablement company on a mission to improve how health care is accessed and delivered in the self-funded health plan market. It offers several industry-leading brands, including MagnaCare and *Create*®, accessing the Brighton Health Network (BHN).

CONTENTS

CLAIM RECONSIDERATION AND DISPUTE RESOLUTION

Claim Reconsideration and Dispute Resolution Standards

ERISA appeal rights typically belong to the member and not providers unless specifically authorized by the member in accordance with the member's plan requirements.

BHN provider disputes regarding post-service claims will be resolved through the dispute resolution process as opposed to the member's plan's claims and appeals procedures. An exception to this standard is when the provider is specifically designated as the member's authorized representative in accordance with the member's plan's specific requirements for that purpose.

Note: An assignment for purposes of payment will usually not constitute a valid appointment of an authorized representative.

Dispute Resolution for Post-Service Claims

If a provider does not agree with how a post-service claim was processed (paid, corrected, denied, etc.), the claim can be submitted for reconsideration.

Claim reconsideration requests should be submitted within 60 days from the date of payment or denial of the original claim, unless the provider participation agreement states otherwise.

How to Submit for Reconsideration

Include these items in a submission:

- The reasons the decision is contested
- A copy of the denial letter, notice of adverse determination, Remittance Advice or Explanation of Benefits
- The original claim
- Documents that support the provider's position (e.g., medical records and office notes)

Reconsideration requests can be submitted by mail only at:

MagnaCare products:

MagnaCare
P.O. Box 8085
Garden City, NY 11530
Attention: Claim Reviews

***Create* products:**

Create® Claim Reviews
P.O. Box 8118
Garden City, NY 11530

For more information, call Provider Services:

MagnaCare products: 800-352-6465

***Create* products:** 844-427-3878

Decision Timeframe

If a proper submission is made, BHN will reach a decision on a post-service claim in sixty (60) days, and fifteen (15) days for a pre-service claim.

There are situations when additional documents are required to reach a decision. If requests for these documents are not satisfied, the reconsideration will be denied.

CLAIMS PROCESS

Submitting a Claim

Submit claims through BHN's clearinghouse Change HealthCare. The MagnaCare Payor ID is 11303 and the *Create* Payor ID is CREA8.

Payor ID, though, may diverge based on a member's specific plan. The correct Payor ID is usually found on a member's card, but a phone call or further research may be necessary in certain circumstances; using the correct Payor ID is essential to receiving timely, proper reimbursement.

Mail paper claims to:

MagnaCare products:

MagnaCare
P.O. Box 1001
Garden City, NY 11530

***Create* products:**

Create
P.O. Box 8116
Garden City, NY 11530

Claim Requirements for All Claims

BHN may pend or deny a claim if a claim form is incomplete. To avoid this, be sure to include:

- Patient name
- Patient address
- Patient gender
- Patient date of birth
- Patient policy number
- Patient relationship to subscriber (policy owner)
- Subscriber name (if different from patient)
- Subscriber address (if different from patient)
- Subscriber policy number (if different from patient)
- Rendering provider's name
- Rendering provider's signature (or authorized representative's)

- NPI
- TIN
- Address where services were rendered
- Remit to address
- Phone number
- Date of service
- Place of service
- Number of services included days/units rendered
- CPT code(s)
- HCPCS procedure codes with modifiers where appropriate
- Current ICD-10-CM diagnostic coded by specific service code to the highest level of specificity
- Charge per service and total charges
- Detailed information about other insurance coverage (if relevant)

Additional Claim Requirements for UB-04

- Date and hour of admission
- Date and hour of discharge
- Member status at discharge code
- Type of bill code
- Type of admission
- Current 4-digit revenue code
- Attending physician ID
- For outpatient services, the specific CPT or HCPCS codes, line item date of service and appropriate revenue code(s)
- Completed box 45 for physical, occupational or speech therapy services (rev codes: 0420-0449)
- Any special billing instructions contained in provider's Brighton agreement
- On an inpatient hospital bill type of 11x, use the actual time the member was admitted to inpatient status
- If charges are rolled to the first surgery revenue code line on hospital outpatient surgery claims, report a nominal monetary amount on all other surgical revenue code lines to ensure appropriate adjudication
- Include the condition code designated by the national uniform billing committee (NUBC) on claims for outpatient preadmission non-diagnostic services that occur within three calendar days of an inpatient admission and are not related to the admission

Unlisted Codes

Submission of unlisted medical or surgical codes should include a detailed description of the procedure or service.

Claim Edits

When claims are submitted using EDI, HIPAA edits are applied to help ensure claims contain specific information. Any claims not meeting BHN requirements are rejected and returned back to the provider for corrections.

BHN utilizes industry standard claim editing software to ensure appropriate and standardized claim processing and has the right to re-bundle services that are included in the primary procedure.

BHN's General Review of Claims

BHN has the right to review claims to confirm a provider is following appropriate and nationally accepted coding practices. BHN may adjust payment to the provider at a revised allowable amount if accepted practices are not being followed. Providers must cooperate by providing access to requested claims information, all supporting documentation and other related data.

BHN may pend or deny a claim and request medical records to determine whether the service rendered is covered and eligible for payment. BHN will send notification regarding what is needed. To help claim processing and avoid delays due to pended claims, please resubmit only what is required. Returning a copy of the notification with your additional documents is necessary for proper resubmission.

Checking the Status of a Claim

To check the status of a claim, log into the provider's account:

MagnaCare products

Create products

Claims are searchable using Member ID, Patient Account Number, Claim ID and other criteria.

Claim status can also be requested by performing an ANSI 276 transaction through Change Healthcare.

For more information, contact Provider Services:

MagnaCare products: 800-352-6465 or email customerserviceinquiries@magnacare.com

***Create* products:** 844-427-3878 or email providerassistance@createhealthplans.com

Claim Correction and Resubmission Standards

When correcting or submitting late charges on electronic 837 institutional claims, use bill type xx7, replacement of prior claim. If resubmitting via paper, submit a new bill indicating the correction made and mail it to the address on the EOB from the original claim.

CREDENTIALING

General Credentialing Rules

All individual providers seeking participation must be credentialed before becoming a participating provider and then re-credentialed every three years thereafter.

Credentialing updates can be sent to:

MagnaCare products: credentialingupdates@magnacare.com

***Create* products:** providerupdates@createhealthplans.com

For more information about credentialing, click here.

Joining the Network

If a provider wishes to join BHN network, email recruitmentrequests@magnacare.com to commence the enrollment process; a complete application from BHN will be e-mailed back in response.

If a provider has an updated and attested to CAQH profile, complete and submit the application attestation, W9 form and the executed provider participation agreement.

If no CAQH profile exists, the entire application must be completed and submitted with the executed provider participation agreement

ID CARDS

Reading an ID Card

See a sample MagnaCare ID card with explanations.
See a sample *Create* ID card with explanations.

MEDICAL MANAGEMENT/QUALITY ASSURANCE/UTILIZATION REVIEW

Medical Management/Quality Assurance/Utilization Review Standards

The goal of the program is to ensure that members receive appropriate, cost-effective care rendered by high quality providers. This goal is achieved through continual monitoring of treatment plans, provider credentials and provider performance.

The program is a URAC certified utilization review program and utilizes InterQual criteria for procedure review.

Medical Management/Quality Assurance/Utilization Review Examples

- Moving an outpatient procedure to a physician's office or free standing facility when clinically appropriate
- Outpatient surgery when feasible

- Alternative treatment services such as home care and home infusion therapy
- Relevance of health care services to the medical needs of the patient based on age and clinical diagnosis
- Services consistent with the clinical impression or working diagnosis
- Appropriateness of treatment frequency and demonstration of compliance with evaluation and management coding guidelines
- Use of other health care services consistent with the patient's medical needs
- Use of appropriate CPT codes and guidelines for visits, consultations, and treatment of the condition described
- Detection of duplication of diagnostic procedures
- Determination of provider compliance with managed care requirements
- Performance of procedures in a manner consistent with FDA or other guidelines and community standards
- Utilization of resources commensurate with burden of illness

Peer Review

Reviews of provider behavior will be performed by similarly boarded physicians, including both BHN medical directors and external practitioners.

PRECERTIFICATION/PRIOR AUTHORIZATION

Precertification/Prior Authorization Rules and Requirements

Most plan sponsors require precertification/prior authorization for certain services including all hospital admissions and many outpatient procedures.

Any elective procedure or service must be pre-certified at least five (5) days prior to the scheduled procedure or service date. Failure to pre-certify may result in a reduction of the member's benefits. BHN reserves the right to pend or deny a claim for additional information.

When verifying benefits and eligibility, always confirm whether prior authorization is required for the service being rendered. This should happen before the service is rendered. The telephone number for precertification can be found on the member's ID card.

Precertification/Prior Authorization Examples

The following services generally require precertification/prior authorization:

- Ambulatory Surgery (regardless of setting)
- Chiropractic Services
- Physical or Occupational Therapy
- Podiatric Services
- Speech Therapy

- Audiology Services
- High Tech Radiology Services
- Hyperbaric Oxygen

Submitting a Pre-certification/Prior Authorization Request

MagnaCare products:
If the plan sponsor has selected MagnaCare to administer their medical management benefits, prior authorization requests can be submitted within the provider portal.

Submit inpatient pre-certification requests by fax to 516-723-7399.
Submit outpatient pre-certification requests by fax to 516-723-7306.

Or, call Provider Services at 888-362-4624.

***Create* products:**
Submit pre-certification requests by fax at 1-516-723-7392.

Or, call our Provider Services team at 1-844-427-3878

Decision Timeframe

Pre-certification/prior authorization decisions will be provided within fifteen (15) days of receipt.

Decisions on urgent care requests will be provided within seventy two (72) hours.

PROVIDER RESPONSIBILITIES

Availability and Access to Care
Providers must ensure availability of health care services by a BHN participating provider twenty four (24) hours per day, seven (7) days per week, three hundred and sixty five (365) days per year including coverage for weekends, vacations and after office hours.

Referrals

BHN requires participating providers to use reasonable efforts to find in-network providers for our members. This includes surgical assistants or assistant surgeons.

MagnaCare in-network providers can be found here.

Create in-network providers can be found here.

Referrals to an emergency room should not occur for care that can be provided in an office setting.

Checking Eligibility

Providers should verify each patient's eligibility and benefits prior to rendering services. Verification requests shall be confirmed directly with BHN, unless otherwise indicated.

When a member presents with an emergency condition, eligibility verification must occur within two (2) business days of initial treatment if the individual is admitted to the hospital. The hospital shall notify BHN or payor's utilization department, as applicable, upon admission of any member within the standard requirement established by BHN or such payor, as applicable.

For a MagnaCare member, log into a provider's account here.
Use the Member ID to search for member eligibility or call Provider Services at 800-352-6465.

For a *Create* member, log into a provider's account here and navigate to ELIGIBILITY & BENEFITS. Use the Member ID to search for member eligibility or call our Provider Services team at 1-844-427-3878

Up-to-Date Information

Providers are responsible for ensuring BHN has a provider's most current information on file. This information includes name, address, phone number, billing information and provider status.

Please review information as reflected on MagnaCare's website and make sure to submit any changes to providerupdates@magnacare.com or within the provider portal.

Review information as reflected on *Create*'s website and make sure to submit any changes to providerupdates@createhealthplans.com.

Provision of Covered Services

Provider may only provide covered services:

- As ordinarily and customarily provided by a healthcare provider similar to provider.
- Within the scope of the provider's operating certificate or other applicable license or certificate.
- Consistent with these Administrative Guidelines and standard prevailing in the community.
- In accordance with all applicable laws, rules and regulations.

Utilization of Participating Providers

Provider shall make best efforts to use participating providers to coordinate delivery and site of service for covered services to a member. If provider does not have appropriate admitting privileges with participating hospitals or access to other participating providers, provider will appropriately coordinate through BHN to identify other healthcare providers or locations to perform such Covered Services.

Non-discrimination

A provider shall furnish covered services to BHN members in the same manner in which a provider provides services to all other patients. With the same availability, and shall not discriminate in the treatment of patients on the basis of race, sex, age, religion, place of residence, HIV status, sexual orientation, creed, color, national origin, source of payment (including Covered Persons status as a member of a Plan), type of illness or condition, or disability or other basis protected by state or federal law.

REIMBURSEMENT

Obtaining Reimbursement

Provider may not bill or seek payment from members or BHN for covered services with the exception of billing and seeking payment from members for applicable copayments, coinsurance, deductibles, and services in excess of benefit limits as specified in the member's benefit plan and as outlined in the provider agreement. In the event that the service is determined not to be a covered service, provider may bill the member, so long as the member received notice prior to the service being rendered that he/she would be responsible for such charges.

Remittance Advice

To view Remittance Advice (RA) login to provider's account and navigate to ERA Download.

Search claims using Member ID, Patient Account Number, BHN Claim ID and other such criteria.

MagnaCare products:
Log into the website or call Provider Services at 800-352-6465.

***Create* products:**
Log into the website or call Provider Services at 1-844-427-3878.

Expected Reimbursement Timeframe

BHN issues payments daily to providers based on client funding. Clean claims shall be paid by either BHN or payor, as applicable, per the terms of the Provider Agreement. In the event that BHN determines that a claim is incomplete, inaccurate, or subject to Coordination of Benefits, BHN or Payor shall remit payment within 45 days of receipt of all records and information necessary for proper claims adjudication. BHN nor payor shall be required to pay a claim where records and information have not been received within one hundred and eighty (180) days of service date.

Surgery Standard

Multiple ambulatory surgery procedures shall be reimbursed at one hundred percent (100%) of the contracted rate for the most expensive procedure, fifty percent (50%) of the contracted rate for the second most expensive procedure, and twenty-five percent (25%) of the contracted rate for each additional procedure. If all services run through the Grouper are ungroupable, then the total claim is paid at the ungroupable case rate. If one (1) or more services are matched to groups, then ungroupable services are to be denied as inclusive of the matched procedure(s).

The BHN ASC groupers can be found here.

Allied Professionals Standard

Allied Professionals, including, but not limited to, Nurse Practitioners, Physician Assistants, and PsyDs, will be paid at seventy percent (70%) of the BHN maximum default fee schedule.

Physical Therapy Standard

Physical therapy services will be bundled per standard methodology and reimbursed as a single episode of care regardless of the number of modalities billed.

Ceiling Provision Standard

For all covered services, reimbursement will be the lesser of the BHN allowed amount or one hundred percent (100%) of billed charges.

Urgent Care Standard

Urgent Care services are to treat non-life threatening conditions and minor medical conditions.
Global fee allowance for Urgent Care services includes all services rendered during that episode of care, including but not limited to the following services: professional, facility, laboratory, pathology, radiology, diagnostic, therapeutic, non-preventable vaccinations and all surgical dressings, drugs, splints, IV therapy, casts and other supplies.

All other non-urgent care, routine service, preventative care and/or immunization cannot be billed in conjunction with an urgent care visit.

Inpatient Transfers

BHN will reduce DRG allowances when an admitted member is transferred to a different hospital resulting in a subsequent admission. All transfers are subject to evaluation on a case-by-case basis by the BHN Medical Management Team.

Member transfers will not be predicated on arbitrary, capricious, or unreasonable discrimination because of race, color, religion, national origin, age, sex, physical condition, disability, sexual orientation, gender identity or expression, genetic information, veteran status, economic or insurance status, or ability to pay.

All transfers will be preceded by member (or personal representative) education regarding risks, need and benefits of the transfer. This information will be documented in the medical records.

Reimbursement to the Network hospital that transferred the patient will be reimbursed on a calculated per diem rate.

- For hospitals contracted at MS DRG groupers, the calculated per diem is equal to the outlier threshold for non-transfer cases, divided by the geometric mean length of stay for the DRG, multiplied by a number equal to the length of stay for the case and not to exceed the full DRG payment.
- Payment to hospitals excluded from DRG reimbursement are paid at the BHN contracted rate.

When a member is transferred to a different hospital within the same hospital system, BHN may pend or deny the initial admission and reimburse only the second admission. Emergency room and ambulance fees related to a transfer will be denied.

Never Events

Never Events, and all associated services related to the Never Event, will not be reimbursed.

Never Events are defined as adverse events or errors in medical care that are clearly identifiable, preventable and present serious consequences to patients. This includes, but may not be limited to, hospital-acquired conditions, incorrect procedures, procedures performed on an incorrect body part or wrong person.

Never Events are not considered medically necessary as they are not required to diagnose or treat an illness, injury, disease or its symptoms and are not consistent with generally accepted standards of medical practice.

Providers involved in follow-up care necessitated by the occurrence of a Never Event but were not responsible for the occurrence will be reimbursed.

Observation

Observation is a well-defined set of specific, clinically appropriate services, which include ongoing assessment, reassessment and short-term treatment interventions that are required to make a decision whether members will require further treatment as hospital inpatients, or if they can be discharged from the hospital for treatment as an outpatient in the community.

Claims submitted with charges for observation services are subject to medical necessity review and potential denial of payment.

Observation services billed at less than eight (8) units will be reduced to the next level and reimbursed at emergency room or ambulatory surgery rate. Observation services billed at greater than forty eight (48) units will be denied for review by BHN Medical Management team. This may require that the network hospital submit medical records or additional information.

When emergency department services precede an observation stay, the emergency department services are considered inclusive to the observation services.

All observation services within three (3) days of an inpatient stay are considered inclusive to that inpatient stay.

Readmission

BHN may pend or deny a claim and request medical records or additional information if a claim meets any of the following conditions: same day readmissions for a related condition, planned readmission, or unplanned readmission within thirty (30) days after a previous discharge.

BHN may deny both initial and subsequent claims if the readmission is deemed preventable and require that network hospital resubmit both admissions in a single claim to receive reimbursement.

SUBROGATION AND COORDINATION OF BENEFITS (COB)

Subrogation Standards

Brighton has the right to recover benefits paid for a member's health care services when a third party causes the member's injury or illness to the extent permitted under state and federal law and the member's benefit plan.

Coordination of Benefits (COB) Standards

COB is administered according to the member's benefit plan and in accordance with law. BHN accepts secondary claims electronically.

A provider's contracted rates will not be used to determine coordination of benefits responsibility for programs where a government unit is a primary payor. Total payment, by BHN or payor, as applicable, in addition to any primary coverage payment, will not exceed that of the BHN contracted rate or that allowed by the primary payor.

Provider shall determine whether a patient's illness or injury is covered by auto insurance, other primary health coverage, or otherwise gives rise to a claim by a payor by virtue of coordination of benefits or subrogation and shall seek compensation from those primary payors first if BHN or Payor, as applicable is secondarily liable.

CONTINUITY OF CARE

Continuity of Care Background

Transition of Care gives new members the option to request extended coverage from their current health care professional who will be out-of-network with the new plan. This is for a limited time due to a specific medical condition and may continue until the safe transfer to a network health care professional can be arranged. The provider must agree to accept network rates.

Continuity of Care gives existing members the option to request to extend care from their current health care professionals if they are or are soon to be out-of-network. Providers must notify members of the upcoming change in status prior to the effective date of such change and assist in the orderly transfer of members to another participating provider. Members with medical reasons preventing an immediate transfer to a network health care professional may request extended coverage for services at network rates for specific medical conditions for a defined period.

How Transition of Care/Continuity of Care Works

A member is eligible for a Transition of Care/Continuity of Care only when a member has a significant medical condition that requires continual care with a specific provider as determined in each individual situation. If a member's request is approved for the medical condition(s) listed in the application(s), the member will receive the in-network level of coverage for treatment of the specific condition(s) by the health care professional for a defined period, as determined by BHN. All other services or supplies must be provided by a participating network health care professional for the member to receive in-network coverage levels. If a member's plan includes out-of-network coverage and a member chooses to continue receiving care from the nonparticipating provider beyond the timeframe approved by BHN and agreed to by the provider, the member must follow the specific plan's out-of-network requirements. Depending on the actual request, a

medical necessity determination and a notification or prior authorization may still be required in order for service coverage.

Transition of Care/Continuity of Care Examples That Qualify

- Pregnancy in the second or third trimester through six (6) weeks post-delivery
  - Transition of Care for the mother does not apply to the newborn. If the care provider or facility is out-of-network for the newborn, a Transition of Care request must be submitted for the newborn also.
- Ongoing treatment for a life threatening condition.
- Newly diagnosed or relapsed cancer and currently receiving chemotherapy, radiation therapy or reconstruction.
- Ongoing treatment after a completed complex surgery or in the middle of a staged surgery.
- Treatment for end-stage kidney disease and on dialysis.
- Ongoing care after a recent organ transplant or on the waiting list for a transplant with a specific physician.
- Ongoing treatment for acute significant psychiatric problems or other significant behavioral health services.
- Ongoing treatment for a rare and complex medical condition requiring continuity with a specific specialist.

Transition of Care/Continuity of Care Examples That Do Not Qualify

- Routine exams and pediatric care.
- Care of chronic conditions like diabetes, arthritis, allergies, asthma, kidney disease and hypertension.
- Elective surgeries and procedures.

Transition of Care/Continuity of Care Timeframe and Application

A member must apply for transition of care no later than thirty (30) days after the date coverage begins.

Please complete this application.

GENERAL COMPLIANCE AND FRAUD, WASTE, AND ABUSE REQUIREMENTS

Providers are responsible for complying with all applicable laws, regulations and BHN's Administrative Guidelines. BHN 's general compliance and Fraud, W aste and Abuse ("FW A") requirements apply to all Providers, regardless of their participation in Medicare or Medicaid.

Fraud, Waste, and Abuse and General Compliance

Provider Requirements

- Provide FWA and General Compliance training for the required employees and contractors of the working on MA and Part D programs. You can access the materials available on the CMS Medicare Learning Network® at the CMS website. Additionally, Providers must check for mandatory training materials related to Fraud Waste and Abuse issued by the respective state's Medicaid control unit and comply with any required training.
- Maintain a record of completion (i.e., method, training materials, dated employee sign-in sheet(s), attestations or electronic certifications that include the date of the training) for ten (10) years. BHN and/or CMS may request documentation from you to verify compliance with this requirement.
- Assist BHN in identifying, investigating and taking appropriate corrective action against fraud, waste, and/or abuse (as defined in 42 CFR 455.2) in the provision of health care services.
- Providers, and any subcontractors, engaged by a Provider, whether or not they are enrolled as Medicare or Medicaid providers, shall cooperate fully with State and federal oversight and prosecutorial agencies, including but not limited to, DMAHS, MFD, DHSS, MFCU, HHS-OIG, FBI, DEA, FDA, and the U.S. Attorney's Office. Failure to cooperate shall be grounds for termination of the Provider agreement. Such cooperation shall include providing access to all necessary recipient information, medical and clinical information, correspondence, documents, computer files, and appropriate staff.

Immediate Notification by Provider of Certain Occurrences

Provider shall notify BHN in writing immediately upon, but in no event more than thirty (30) days after, the occurrence of any of the following:

- Arrest, indictment or conviction for any felony or criminal charge related to the practice of Provider's profession;
- Any charges of professional or ethical misconduct brought against Provider and/or any clinician employed by Provider;
- Any investigation of Provider for alleged fraud and abuse or false claims conducted by a Payor or government agency;
- The exclusion, debarment, suspension or any other limitation of Provider's right to participate in Medicare, any Medicaid program or any other federal or state health care program;
- Provider contracts with an individual or entity that Provider or its affiliates knew or should have known is excluded from participation in any federal health care program.

Exclusion Checks

Prior to hiring or contracting with employees, Providers must screen against state and federal government exclusion lists, including the Office of Inspector General ("OIG") list of Excluded Individuals and Entities and the General Services Administration ("GSA") Excluded Parties Lists System. Anyone listed on one or both of these lists is excluded and therefore not eligible to support any federal or state programs. The individual or entity must be removed immediately from providing services or support to BHN, and BHN must be notified upon such identification. The exclusion lists should be reviewed on a regular basis and any exclusion or any

other event that makes an individual ineligible to perform work directly or indirectly on state or federal health care programs must be disclosed to BHN within ten (10) days of such exclusion.

Records Access

Pursuant to appropriate consent/authorization by a patient, the Provider will make the patient's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements ("QARR")), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for analysis and recovery of overpayments due to fraud and abuse. The Provider shall provide copies of such records at no cost. The Provider expressly acknowledges that he/she/it shall also provide BHN, on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law.

Reporting Potential Fraud, Waste or Abuse to BHN

If you identify potential FWA and/or compliance issues, immediately report the information to BHN so that BHN can investigate and respond appropriately. BHN prohibits any form of retaliation against you if you make a report in good faith.

Report potential Fraud, Waste, or Abuse to BHN by calling 888-624-6218

STATE LAWS

New York IPA Participating Provider Agreement

New York IPA Participating Provider Agreement
Brighton Health Network IPA, LLC d/b/a MagnaCare
IPA PARTICIPATING PROVIDER AGREEMENT

THIS IPA PARTICIPATING PROVIDER AGREEMENT (the "IPA Agreement"), is made and entered into between Brighton Health Network IPA, LLC d/b/a MagnaCare ("IPA") on behalf of itself and its affiliates and the Provider ("Provider"), a group practice, allied health professional, equipment or supply vendor and/or facility, who has entered into the Agreement on behalf of itself and each of its/their health professionals and for all sites at which Provider is located and/or renders services. This IPA Agreement, which is fully incorporated into the Agreement, shall become effective for Provider on the Effective Date of the Agreement. IPA and Provider are hereinafter sometimes referred to individually as a "Party" and collectively as the "Parties."

WHEREAS, IPA is a New York Limited Liability Company;

WHEREAS, pursuant to one or more agreements with Payors ("Payor Agreements"), IPA arranges for the provision of Covered Services to Payors' Enrollees through its Network of Participating Providers; and

WHEREAS, Provider is approved under the laws of New York State to provide Covered Services, and desires to participate in the Network and to contract with IPA to provide Covered Services to Enrollees.

NOW, THEREFORE, in consideration of the premises and mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually agreed by and between the Parties as follows:

ARTICLE 1 - DEFINITIONS

For purposes of this IPA Agreement, the following definitions shall apply:

1.1 **"Affiliate"** shall mean with respect to any entity, shall mean any entity controlling or controlled by or under common control with such entity and shall also include any entity fifty percent (50%) or more of whose outstanding voting power is owned by the specified entity either directly or through subsidiaries.

1.2 **"Clean Claim"** shall mean any claim for payment received from a Provider in a timely manner on a properly completed HIPAA compliant electronic or paper claim form and which, for adjudication, does not require the submission by the Provider of medical records or supplemental information or the taking of any further action by IPA or Payor with respect to (i) Coordination of Benefits with any other Payor; or (ii) the determination of payment liability; or (iii) correcting any other defect or error.

1.3 **"Covered Services"** means those Medically Necessary services and/or supplies for which an Enrollee is entitled to receive coverage for under the terms of his or her Plan which affords them coverage.

1.4 **"Enrollee"** shall mean an individual who is eligible to receive Covered Services under a Plan.

1.5 **"Group Provider"** means a Provider, as defined herein, with two or more physicians or other professionals practicing together as a proprietorship, partnership, PC, PLLC, PLLP, PA or any combination of the foregoing. References herein to "Provider" shall mean the Group Provider and each physician or other professional now or hereafter practicing and billing as part of the group, and all practice sites now existing or hereafter added by Group Provider as permitted hereunder.

1.6 **"IPA Policies and Procedures"** shall mean those policies and procedures adopted by IPA to facilitate the provision of Covered Services by Participating Providers, which may be amended by IPA from time to time.

1.7 **"Network"** shall mean the Participating Providers with which IPA contracts to furnish Covered Services to Enrollees under a Plan issued by a Payor.

1.8 **"Non-Covered Services"** shall mean those health care services and supplies that are not Covered Services under the applicable Payor Agreement and Plan.

1.9 **"Participating Provider"** shall mean those providers who have executed a Participating Provider Agreement with IPA, each of whom meets (i) all federal, state and local legal and regulatory requirements to offer Covered Services; and (ii) all other requirements established by IPA to be a Participating Provider, including other accreditation or licensure as IPA may deem appropriate from time to time.

1.10 **"Payor"** shall mean one or more Managed Care Organizations or Workers' Compensation Preferred Provider Organizations.

1.11 **"Payor Agreement(s)"** means those agreements between IPA and Payors which exist on the Effective Date and which may exist during the term hereof, pursuant to which IPA has agreed to make

the Network available to a Payors' Enrollee. Provider agrees to participate under the terms of all such Payor Agreements.

1.12 **"Plan"** shall mean any health benefit plan offered by a Payor that has entered into a Payor Agreement with IPA.

1.13 **"Plan Participating Provider"** means an individual or entity that has entered into an agreement with Payor to provide Covered Services to Enrollees.

ARTICLE 2 - CONTRACTING AUTHORIZATIONS

2.1 **Representation with Payors.** Provider authorizes IPA to negotiate and enter into Payor Agreements on Provider's behalf, provided the terms of the Payor agreements do not violate federal or state antitrust or unfair competition laws.

ARTICLE 3 - RESPONSIBILITIES OF PROVIDER

Provider shall be responsible for the following duties and obligations:

3.1 **License.** Throughout the term of this IPA Agreement, Provider shall maintain all applicable federal and state and any and all other state or local licenses, permits, certificates or approvals as may be required to provide Covered Services.

3.2 **Participation in Plans.** Provider shall participate in each Plan offered by a Payor with which IPA has a Payor Agreement except to the extent that IPA has notified Provider in writing that it is excluded from participation in such Plan. Nothing contained in this IPA Agreement guarantees to Provider that it will be permitted to participate in any or all Plans offered by any Payor. Provider acknowledges and agrees that: (i) IPA may from time to time enter into an agreement with a Payor under which only a limited network is offered and in which not all Participating Providers may participate; (ii) certain Payors may impose more stringent or burdensome credentialing or other requirements than those imposed by IPA and which Provider does not meet; (iii) Payors may request that Provider no longer provide Covered Services to Enrollees in a Plan offered by that Payor; (iv) neither IPA nor Payors warrant or guarantee that Provider will be utilized by Enrollees or any number of Enrollees under any Payor Agreement; and/or (v) IPA may decide in its sole discretion to limit participation in a particular Plan or to exclude Provider from a particular Plan. If Provider is already participating in a Plan, IPA will give Provider written notice that they are excluded from participation in that Plan at least ninety (90) days before the effective date of such exclusion, except that such exclusion shall be effective immediately on Provider's receipt of the notice if the Payor requests that Provider no longer provide Covered Services to Enrollees or if Provider fails to meet the applicable credentialing requirements. If Provider is not already participating in the particular Plan, its exclusion from the particular Plan shall be effective upon receipt by Provider or IPA, as applicable, of the written notice. Upon the applicable effective date, Provider will no longer participate in the specified Plan(s) under this IPA Agreement and will not be entitled to reimbursement under this IPA Agreement for Covered Services rendered to Enrollees of that Plan. Notwithstanding the exclusion of Provider from one or more Plans, the remaining terms and conditions of this IPA Agreement shall remain in full force and effect with respect to all other Plans. Provider agrees to notify affected Enrollees of the termination of Provider's participation in a particular Plan prior to the effective date of such termination and will assist in the orderly transfer of Enrollees to another Provider. Provider shall provide continuity of care pursuant to applicable law and industry standards.

3.3 **Representations, Warranties and Covenants.**

(i) Provider represents and warrants that Provider has and will maintain throughout the term of this IPA Agreement all licenses, registrations, certifications, qualifications and/or permits required by local, state and federal authorities to furnish Covered Services including, without limitation, workers' compensation, Medicare and Medicaid certifications and/or DEA registrations, as applicable. Provider represents and warrants that neither Provider nor any of Provider's partners, shareholders, directors, officers, agents or employees is excluded or suspended from participation in the Medicare or Medicaid programs, or has been convicted, under federal or state law, of a criminal offense related to: (i) the neglect or abuse of an Enrollee; or (ii) the delivery of, or charging for, a supply or service, and that Provider shall monitor its employees and agents for any future offenses, exclusions or suspensions. Provider shall furnish to IPA evidence of such licensures, registrations or certifications upon IPA's request. Provider understands and acknowledges that Provider's representations and warranties are relied upon by IPA in contracting with Provider.

(ii) Provider shall provide to IPA immediate written notice of: (i) any modification, suspension or termination of any licensure certification and/or hospital privileges; (ii) conviction and/or program exclusion of himself/herself or any employee or agent of Provider rendering Covered Services hereunder; (iii) a material reduction in, or termination of, the amount or type of professional liability coverage required under this Agreement; (iv) any event which would impact Provider's ability to lawfully perform the obligations set forth herein; (v) any other event which might make Provider (or any Group Provider) unable to render Covered Services to Enrollees in a high quality manner or otherwise comply with all of the terms of this Agreement; and/or (vi) if Provider adds, closes and/or changes the address of an office site for Provider's practice or of any other change in Provider's credentialing and/or billing information. In the case of a group, Provider will also provide prompt written notice to IPA if any Group Provider discontinues participation in Provider's practice and/or if an additional billing professional joins Group Provider's practice.

3.4 **Liability Insurance.**

(i) During the term of this IPA Agreement Provider shall maintain, at Provider's sole cost and expense, comprehensive general liability insurance and professional liability insurance in the minimum amount of $1,300,000 per occurrence and $3,900,000 in the aggregate if Provider is a physician and $1,000,000 per occurrence and $3,000,000 aggregate, if Provider is not physician. However, if Provider is a Group Provider of more than six (6) full time practitioners or is otherwise not an individual provider, then Provider shall maintain insurance with limits of at least $2 million for each occurrence and $3 million in the annual aggregate, or in such higher amounts as IPA and/or a Payor may require, to insure Provider and Provider's employees, agents or representatives against any claim for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance of any service by Provider in connection with this IPA Agreement. Such insurance shall name IPA as an additional insured/certificate holder. If Provider has a "claims made" policy, upon or prior to the termination of this IPA Agreement for any reason, Provider shall purchase a "tail" policy or obtain replacement coverage which insures prior acts, including losses arising from occurrences during the term of this IPA Agreement, and shall maintain such tail for the applicable statute of limitations, or six (6) years, whichever is greater. This Section 3.4 shall survive the expiration or termination of this IPA Agreement.

(ii) All policies of insurance required by Section 3.4(i) shall require that IPA be provided with at least 30 days prior written notice of any modification, cancellation or non-renewal of such policies.

(iii) Upon the execution of this IPA Agreement, and at any other time upon the request of IPA, Provider shall provide IPA with proof that Provider has obtained and currently maintains adequate insurance in accordance with this Section 3.4.

3.5 **Immediate Notification by Provider of Certain Occurrences.** Provider shall notify IPA in writing immediately upon, but in no event more than 30 days after, the occurrence of any of the following:

(i) the filing of any claims against Provider for professional negligence or malpractice, or the institution of any action, litigation, or lawsuit in that regard, regardless of whether the claim involves an Enrollee;

(ii) cessation of business;

(iii) the appointment of a receiver or an assignee for the benefit of creditors of Provider, insolvency of Provider, inability of Provider to pay debts as they become due, or the commencement of any voluntary or involuntary bankruptcy proceedings by or against Provider or any similar proceedings;

(iv) arrest, indictment or conviction for any felony or criminal charge related to the practice of Provider's profession;

(v) any charges of professional or ethical misconduct brought against Provider and/or any clinician employed by Provider;

(vi) any investigation of Provider for alleged fraud and abuse or false claims conducted by a Payor or government agency;

(vii) the exclusion, debarment, suspension or any other limitation of Provider's right to participate in Medicare, any Medicaid program or any other federal or state health care program;

(viii) Provider contracts with an individual or entity that Provider or its affiliates knew or should have known is excluded from participation in any federal health care program;

(ix) any lapse of professional liability (malpractice) insurance maintained by Provider covering Provider, any denial, cancellation, or non-renewal of any such insurance, or any reduction in the amount of such insurance carried by or issued to Provider;

(x) Provider's termination from participating in any Plan;

(xi) any change in Provider's name, addresses, email addresses, telephone numbers, fax numbers or taxpayer identification numbers; and

(xii) any other occurrence or condition which might materially impair the ability of Provider to discharge its duties or obligations under this Agreement.

3.6 **Participating in Credentialing/Recredentialing.** Provider and any employee or contractor of Provider that will provide Covered Services under this IPA Agreement shall participate in IPA's and/or Payor's credentialing/recredentialing process, which shall include, without limitation, the submission of written proof of malpractice insurance and other information or documents, as requested by IPA and/or Payor. Provider shall submit all information requested by IPA and/or Payor on a timely basis and warrants and covenants that all such information will be current and accurate.

3.7 **IPA's and/or Payor's Policies and Procedures.** Provider shall abide by IPA Policies and Procedures or the policies and procedures as may be established or amended from time to time by a Payor with respect to Covered Services furnished to Enrollees and as may be set forth in the manuals (which may be solely web based), newsletters and other such correspondence from IPA and/or Payor. Such policies and procedures shall include, but are not limited to, IPA and/or Payor's standards and requirements for quality improvement, utilization management, credentialing, and Enrollee grievances.

3.8 **Grievances.** Consistent with applicable law, Provider agrees to cooperate with IPA and Payors in the execution of grievance procedures related to Provider's provision of Covered Services, shall assist IPA and Payors in taking appropriate corrective action, and shall comply with all final determinations made by IPA or Payor pursuant to such grievance procedures.

3.9 **Referrals.** Provider agrees to refer Enrollees, when necessary, to Plan Participating Providers, except in the case of an emergency or as otherwise required by law. In the event a referral is made to a non- Plan Participating Provider, it is the Provider's responsibility to advise the Enrollee that the provider is not participating with IPA and/or Payor and that the Enrollee may incur out of pocket costs for using a non-Plan Participating Provider.

3.10 **Inspection.** IPA or its designee shall have the right to inspect, audit and/or evaluate all medical, billing and financial records relating to the treatment of all Enrollees under or in connection with this IPA Agreement and to inspect Provider's locations and operations to ensure compliance with this IPA Agreement and the Payor Agreement, and to ensure that they are adequate to meet IPA or Payor's needs and requirements.

3.11 **Provider Fees.** Provider shall accept from Payors, as full compensation for Covered Services furnished to Enrollees in accordance with the terms hereof, payment at the applicable fee schedule rate, which may be changed from time to time, provided, however, that when treating an Enrollee in an insured workers compensation and/or PIP program, Provider agrees to accept the lesser of the applicable fee schedule then in effect or the state prescribed fee schedule, if any. Except as is otherwise provided herein, Provider shall accept such payments as complete and full discharge of the liability of Payor and Enrollee for the provision of Covered Services.

ARTICLE 4 - PROVISION OF COVERED SERVICES

4.1 **Provider Services.** Provider shall provide those Covered Services which Provider is licensed/certified to provide, which Provider routinely provides, and which are within the scope of Provider's practice on a twenty-four hour per day, seven (7) day per week basis, and to arrange for backup coverage to the extent possible with other Plan Participating Providers or non-Plan Participating Providers who have agreed to accept the rates paid to Provider by applicable Payor and utilization management protocols as if participating in the Network, including for emergencies and during periods of Provider's absence. Provider shall utilize only qualified personnel to perform or assist in the responsibility for supervising and compensating its personnel and for requiring that such personnel be qualified and adhere to the terms and conditions of this IPA Agreement and all Payor Agreements. Provider agrees to

provide Covered Services in accordance with this IPA Agreement, all IPA Policies and Procedures, and all applicable federal, state, and local laws, rules and regulations, as all of the foregoing may be amended from time to time.

4.2 **Provision of Provider Services To Medicare Enrollees.** In addition to the above, when rendering Covered Services to Medicare program Enrollees, Provider shall comply with all applicable CMS instructions and regulations, including the Medicare conditions of participation (as set forth in Title XVIII of the Social Security Act and 42 C.F.R. Part 422) and those referenced herein, and shall maintain such compliance throughout the term of this IPA Agreement, including the Medicare Addendum, attached as Exhibit F to the Agreement. When treating Medicare Enrollees, Provider shall provide information in a culturally appropriate manner to all Enrollees, including those with limited English proficiency or reading skills and diverse cultural and economic backgrounds.

4.3 **Admitting Privileges.** Provider will at all times during the term hereof maintain active admitting privileges with at least one Plan Participating Provider which is a hospital if admitting privileges are required for Provider's specialty. Provider will refer Enrollees to a hospital which is a Plan Participating Provider for all elective admissions and, to the extent possible, all emergency admissions.

4.4 **Cooperation With Coordination of Benefits.** Provider shall cooperate and assist IPA and, when applicable, a Payor to obtain payments from other third party Payors, when in accordance with the coordination of benefit provisions of a Plan, another party has primary responsibility for payment for Covered Services. Such cooperation shall include, but not be limited to, providing information regarding additional coverage which may be available, completing claims forms from other third party Payors and assigning the right to such payments to the applicable payors;

4.5 **Verification of Eligibility.** Provider shall verify the eligibility of each Enrollee in accordance with the procedures set forth by IPA and/or a Payor. Compliance with IPA's and/or Payor's enrollment verification policies and procedures, and eligibility verification does not ensure that a person is, in fact, an Enrollee and eligible to receive Covered Services (i.e., authorization is not a guarantee of payment). IPA and the applicable Payor will have no responsibility for Covered Services provided to patients who are not eligible Enrollees. Provider shall be responsible to bill ineligible patients directly for Covered Services.

4.6 **Non-exclusivity.** Nothing contained in this Agreement shall prevent Provider from participating in, or contracting with, any other independent practice association, preferred provider organization, managed care organization, insurer or other health delivery or insurance program. In addition, the Parties acknowledge and agree that the Network is intended to be non¬exclusive and that IPA shall have the right to enter into an agreement with any Payor or other provider.

4.7 **Communications with Enrollees.** Notwithstanding any other provision in this IPA Agreement and regardless of any benefit or coverage exclusions associated with an Enrollee's Plan, Provider shall not be prohibited from discussing fully with an Enrollee any issues related to the Enrollee's health including recommended diagnostic tests, treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by IPA and/or Payor or any other party. IPA and/or Payor shall not refuse to allow or to continue the participation of an eligible provider, or refuse to compensate Provider in connection with Covered Services rendered, solely because Provider has in good faith communicated with one or more of current, former or prospective Enrollees regarding the provisions, terms or requirements of a Plan as they relate to the health needs of such Enrollee.

4.8 **Compliance with Administrative Programs.** Provider agrees to comply with and be bound by all of Payors' (including governmental entities') and applicable regulatory policies and procedures as they

may be amended from time to time, including, but not limited to, payment, external peer review, quality assurance and utilization management policies and procedures. Provider further agrees to cooperate fully in the implementation and operation of credentialing, grievance, appeal and other policies and procedures of Payors, as they may exist or be amended from time to time during the term of this IPA Agreement. Copies of the policies described in this Section 4.8 may be solely web based, as described in Section 3.7 of the IPA Agreement.

ARTICLE 5 - BILLING AND COMPENSATION

5.1 **Submission of Claims.** Provider shall submit all claims for Covered Services rendered to Enrollees covered by a Plan to the applicable Payor in accordance with instructions provided by the Payor. Provider shall use best efforts to submit claims electronically using IPA's File Transfer Protocol ("FTP") site and/or Change Healthcare or other similar electronic claim transmission account. FTP and/or Change Healthcare or other similar electronic claim transmittal instructions shall be available from IPA upon Provider's request. Clean Claims must be submitted within the time frame applicable to each Payor accessing the IPA. Claims submitted after each Payor's applicable time frame shall be denied payment, unless a coordination of benefits issue is involved, in which case a one hundred eighty (180) day limit from the date of service applies. Provider's claims for payment shall be made using CMS 1500 format, UB 04 or such other forms approved for use by Payor and pursuant to HIPAA. If Provider submits claims electronically, Provider shall submit claims electronically to Payors hereunder and shall cooperate with Payor in implementing such electronic claim submission. Provider shall submit Clean Claims so as to enable Payor to determine whether the services are Covered Services. In certain circumstances, and unless otherwise agreed upon by IPA, Payor shall pay Provider in accordance with this IPA Agreement using an "EZ Pay Card," which is a single use VISA (or alternative credit card) number, the amount of which is redeemable for ninety (90) days using the Provider's point of sale card terminal. In the event that a Payor makes an incorrect payment, duplicate payment or an overpayment, Provider agrees to repay Payor within seven (7) days of the date of Payor's request for such repayment and that in the event Provider fails to issue a voluntary and timely refund to Payor, subsequent payments by the Payor shall be adjusted or offset by the amount of the refund requested, or, if no such payment exists, Payor shall pursue Provider using any and all available remedies within the timeframes allowed by law.

5.2 **Medicare Prompt Payment.** When a Provider is rendering Covered Services to Medicare Enrollees, the relevant Payor or its agent shall remit payment for each Clean Claim no later than the 30th calendar day following receipt of the claim, or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 CFR 422.520.

ARTICLE 6 - RESTRICTIVE COVENANTS

6.1 **Confidential Information.**

(i) **Covenants of Provider.** All information concerning the terms and conditions of this IPA Agreement or developed hereunder, including the rates of compensation hereunder, shall be kept confidential by Provider and shall not be disclosed, directly or indirectly, to a third party except as required by law (in which case the disclosing Party shall provide to the other Party prior notice of its intended disclosure which affords to the other Party reasonable time in which to attempt quash such disclosure) or to carry out such Party's respective obligations hereunder or, as to IPA, under a Payor Agreement. Provider shall maintain as confidential all non-public information relating to IPA ("IPA Proprietary Information"). For purposes of this Agreement, "IPA Proprietary Information" shall include, but shall not be limited to: (i) the terms and conditions of all Payor Agreements; (ii), the financial arrangements between any provider and IPA, or any Payor

and IPA; and (iii) confidential information relating to IPA's business operations, clients, strategic plans and/or finances. Except as expressly permitted by this Agreement, IPA covenants not to disclose to third parties any information relating to the business of Provider obtained by IPA in the course of the relationship contemplated under this Agreement ("Provider Proprietary Information"), or to use such information for any purpose except as required or permitted hereunder. This Section shall not apply to information which: (i) is provided to voluntary accreditation agencies, government agencies or Payors or which is required to be disclosed by law or is consented to be disclosed by Provider; (ii) is reasonably required by other health care providers involved in a particular patient's care or by Payors involved in payment therefore; (iii) IPA can show was lawfully made known to IPA prior to disclosure by Provider; (iv) IPA discloses in connection with marketing or supporting its affinity or related product or service offerings; or (v) is or becomes public knowledge through no fault of IPA.

(ii) The Parties agree that any remedy available at law for any breach or attempted breach of this section may be inadequate and that the damage to the non-breaching Party for such breach or attempted breach will be irreparable, and, accordingly, the Parties agree that in the event of a breach or attempted breach of this Section, the non-breaching Party shall be entitled to seek specific performance, injunctive or other equitable relief, in addition to any money damages or other remedies which may exist in law or equity.

ARTICLE 7 - TERM AND TERMINATION

7.1 **Term.** This IPA Agreement shall commence as of the date executed by the Parties and shall thereafter automatically renew for successive terms of one (1) year each unless terminated as provided below.

7.2 **Termination Without Cause.** IPA may terminate this IPA Agreement at any time for any reason or no reason upon 90 days prior notice to Provider.

7.3 **Termination With Cause.**

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

(ii) A notice of termination shall include the reasons for the termination and if Provider is an individual licensed pursuant to Article VIII of the New York Education Law, notice shall include that Provider has the right to request a hearing or review, at Provider's discretion, before a panel appointed by IPA and a time limit of not less than 30 days within which Provider may request a hearing. The Parties acknowledge that such rights do not extend to Provider if Provider is a professional corporation, professional association or partnership rather than an individual practitioner, physician or provider. In such a case Provider shall not have the right to request a hearing.

7.4 **Immediate Termination.** Subject to applicable law, IPA may terminate this IPA Agreement in its entirety upon immediate notice to IPA upon the occurrence of any of the following: (a) IPA is notified of a situation in which Provider may cause imminent harm to an Enrollee; (b) there has been a final determination of fraud by Provider; or (c) there has been a final determination by a State licensing board or other Governmental Authority that impairs Provider's ability to practice. Notwithstanding

anything contained in this Agreement to the contrary, if Provider is a Group Provider, IPA may, in its discretion, terminate or non-renew this IPA Agreement pursuant to this Article VII as to any individual Group Provider(s) without otherwise effecting the duties and obligations of the non-terminated/renewed individual Group Provider(s), as to whom this IPA Agreement shall, in the sole discretion of IPA, otherwise remain in full force and effect.

ARTICLE 8 - RECORDS AND DATA COLLECTION

8.1 **Maintenance of Records.** Provider shall maintain adequate and accurate records relating to all Covered Services provided to Enrollees by Provider and the cost thereof, in such form and containing such information as required by applicable Laws and in accordance with the standards of applicable accreditation agencies. All such records shall be the joint property of Provider and IPA, to the extent permitted by Law. Such records shall be retained by Provider for the length of time mandated by Law. The obligations created by this Section shall survive the termination of this IPA Agreement.

8.2 **Data.** Pursuant to appropriate consent/authorization by the Enrollee, the Provider will make the Enrollee's clinical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the IPA and/or Payor for purposes including preauthorization, concurrent review, quality assurance, provider claims processing and payment.

8.3 **Confidentiality of Enrollee's Clinical Records.** Provider shall comply with all applicable Laws and all applicable standards, policies and procedures implemented or adopted by entities and agencies with authority over IPA or Payor, and those implemented or adopted by IPA or applicable Payors regarding the confidentiality and security of health information of an Enrollee ("Enrollee Information"), including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended, and any regulations promulgated thereunder ("HIPAA") and shall use and disclose such information or records only in accordance with state and federal laws and Payor or IPA requirements, as applicable. If applicable, Provider agrees to abide by the Business Associate Agreement between the Parties. The obligations created by this Section 8.3 shall survive the termination of this IPA Agreement.

8.4 **Maintenance and Enrollee Access to Records.** Provider shall retain medical records of Enrollees for six (6) years after the date of service rendered or, in the case of minors, six (6) years after the age of majority, or for Covered Services rendered to a Medicare plan Enrollee, for ten (10) years following the termination of this IPA Agreement or the completion of a CMS audit, whichever is later. Provider shall document in an Enrollee's medical record whether the Enrollee has executed an advanced directive. This provision shall survive termination of this IPA Agreement for any reason. Copies of all such records shall be provided at no cost to IPA and/or Payors. Provider's obligations set forth in this Section 8.4 shall survive termination of this IPA Agreement.

8.5 **Government Access to Records.** In accordance with applicable laws and regulations, Provider shall release to any federal, state and/or local agency or accrediting organization all records or copies of such records within the possession of Provider related to the Covered Services provided to Enrollees under this IPA Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Provider.

8.6 **Audit.**

(i) Provider shall maintain and provide any other records related to the provision of Covered Services which IPA or a Payor may reasonably request for regulatory compliance and shall cooperate with IPA and Payors in all fiscal and medical audits, site inspections, peer reviews, utilization reviews, credentialing, recredentialing and any other monitoring required by a

regulatory or accreditation agency. Any such record shall be delivered to IPA and/or the applicable Plan within five (5) business days of a request for such record;

(ii) Provider shall promptly comply with all directives and recommendations issued as a result of any such inspection or audit; and

(iii) A Payor or IPA may use statistical samples and other appropriate external audit and fraud and abuse and detection devices in conducting audits of Provider's records, books, papers, information and documents.

8.7 **Disclosure of Provider Information and Records.** Subject to all applicable confidentiality laws, Provider hereby authorizes IPA and/or Payor to release any and all information specific to Provider, (including, but not limited to, utilization profiles, encounter data, treatment plans, outcome data and other information pertinent to Provider's performance of Covered Services and/or, the professional qualifications of its staff and/or other credentialing information), to applicable government authorities, Payors and other entities. This provision shall survive the termination of this IPA Agreement.

8.8 **Listings of Providers.** Provider agrees that IPA and Payors may list Plan Participating Provider's name(s), address, telephone number, description of its services, and such other information as deemed relevant, in IPA's and/or Payors' rosters of Participating Providers and such other listings, directories and publications as IPA or Payor may produce from time to time.

ARTICLE 9 - NOTICES

9.1 **Notices.** Any notice or other communication by either Party to the other shall be in writing and effective when delivered personally, by facsimile transmission (with confirmation), through private delivery services, by electronic means, or by Certified U.S. Mail to the applicable Party at its address set forth with its signature, or to such other address, and to the attention of such other person or officer, as either Party may designate in writing in accordance with this Section. Mailed notices shall be deemed received three (3) business days following mailing. Notices to IPA shall be sent to: Chief Legal Officer, Brighton Health Network, LLC, One Penn Plaza, Suite 5300, New York, New York 10199.

ARTICLE 10 - MISCELLANEOUS

10.1 This IPA Agreement and the exhibits attached hereto constitute the only agreement and the entire understanding between the Parties hereto relating to the matters herein contained. The terms and provisions of this IPA Agreement are hereby declared to be severable, so that if any terms or provisions or part thereof are held invalid or unenforceable, such validity or unenforceability shall not affect the validity or enforceability of the other provisions hereof.

10.2 No provision of this IPA Agreement is intended to create, nor shall be deemed or construed to create, any relationship between IPA and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effectuating the provisions of this IPA Agreement. Neither of the Parties hereto, nor any of their respective officers, directors or employees, shall be construed to be the agent, employee, or representative of the other, except as specifically provided herein. Neither Party may make any claim against the other for social security benefits, worker's compensation benefits, unemployment insurance benefits, vacation pay, sick leave or any other employee benefit of any kind. Provider is not authorized to speak or act on behalf of IPA for any purpose whatsoever without the prior written consent of IPA.

10.3 The waiver by any Party hereto of a breach of any provision of this IPA Agreement shall not operate or be construed as a waiver of any subsequent breach by any Party.

10.4 In the event that either Party brings legal action relating to this IPA Agreement, the prevailing Party shall be entitled to payment by the other of all reasonable attorneys' fees, costs and expenses incurred in such action.

10.5 This IPA Agreement and the rights and obligations hereunder shall not be assignable by either Party hereto except that IPA shall have the right to assign its rights and obligations hereunder to any corporation that is a subsidiary, parent, or affiliate of IPA. Provider may not assign Provider's rights and obligations to any person or entity without the prior written consent of IPA and any attempted assignment without such prior written consent shall be void. Subject to the foregoing, this IPA Agreement shall inure to the benefit of and be binding upon the Parties hereto and also their respective heirs, assigns, and successors in interest of any kind whatsoever.

10.6 Provider shall not have the right to subcontract this IPA Agreement or any of the rights or obligations thereunder without the prior, written consent of IPA.

10.7 All terms and words used in this IPA Agreement regardless of the number or gender in which they are used shall be deemed to include any number and any gender as context may require.

10.8 Any obligation of the Parties or provision of this IPA Agreement which by its nature is intended to survive the termination of this IPA Agreement shall survive such termination.

10.9 The "New York State Department of Health Standard Clauses for Managed Care Provider/IPA Contracts," attached to this IPA Agreement as Exhibit 1, are expressly incorporated into this IPA Agreement and are binding upon the Parties to this IPA Agreement and shall apply with respect to products governed under New York law. In the event of any inconsistent or contrary language between the terms of the Standard Clauses the terms of this IPA Agreement, the Parties agree that the provisions of the Standard Clauses shall prevail, except to the extent applicable law provides otherwise.

10.10 This IPA Agreement shall be interpreted and enforced in accordance with the laws of the State of New York, without giving effect to conflict of law principles. Each Party hereby agrees and consents to the in personam jurisdiction of, and venue in, the courts of the State of New York with respect to any dispute or controversy arising under or in connection with this IPA Agreement. The Parties shall meet in good faith negotiations in order to resolve any disputes arising hereunder.

10.11 Neither IPA nor any Payors by this IPA Agreement or otherwise, guarantees to Provider the opportunity to provide Covered Services to any minimum number of Enrollees.

10.12 IPA may amend this IPA Agreement at any time on thirty (30) days' prior written notice, or less, if reasonably required by a Payor. Changes in any IPA Policies and Procedures shall not be deemed amendments of this IPA Agreement. IPA may amend the IPA Agreement upon less than thirty (30) days' notice to comply with the requirements of state and federal regulatory authorities and shall provide Provider with a copy of any such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required for such an amendment. Written notice shall include by electronic means, as provided by Section 9.1 above. All material amendments are subject to the prior approval of the New York State Department of Health.

10.13 This IPA Agreement and all amendments and exhibits and hereto shall be subject to the prior approval of the New York Department of Health, and may not be effectuated without such approval.

10.14 This IPA Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which, together, shall constitute one and the same agreement.

10.15 IPA will act as agent for Provider with regard to the remittance of payment for claims by Payors, and in its capacity as agent will assist Provider in resolving any claims adjudication issues that Provider may have with Payors.

10.16 As applicable, if Payor is participating in the MMP program, the Parties shall be bound by the provisions of Exhibit 3 to this IPA Agreement, which exhibit is attached hereto and incorporated herein.

10.17 This IPA Agreement and any attachments, exhibits or any other documents incorporated and referred to herein, constitutes the entire IPA Agreement between the Parties with respect to the subject matter hereof and supersedes any and all other agreements, whether oral or written, regarding the same. To the extent there is a conflict between a provision in the body of the IPA Agreement and any other document attached hereto, the terms of the Agreement shall control, provided, however, that in the event of an inconsistency between any provision in the body of this IPA Agreement and any provision set forth in Exhibit 1 attached hereto, the provision set forth in such Exhibits shall control.

EXHIBIT 1 (of New York State IPA Participating Provider Agreement)
NEW YORK STATE DEPARTMENT OF HEALTH
STANDARD CLAUSES
FOR MANAGED CARE PROVIDER/IPA CONTRACTS
(April 1, 2017 Version)

Notwithstanding any other provision of this agreement, contract, or amendment (hereinafter "the Agreement" or "this Agreement") the Article 44 plans and providers (hereinafter "parties") that contract with such plans agree to be bound by the following clauses which are hereby made a part of the Agreement. Further, if this Agreement is between a Managed Care Organization and an IPA, or between an IPA and an IPA, such clauses must be included in IPA contracts with providers, and providers must agree to such clauses.

A. DEFINITIONS FOR PURPOSES OF THIS EXHIBIT

"Managed Care Organization" or "MCO" shall mean the person, natural or corporate, or any groups of such persons, certified under Public Health Law Article 44, who enter into an arrangement, agreement or plan or any combination of arrangements or plans which provide or offer, or which do provide or offer, a comprehensive health services plan, or a health and long term services plan.

"Independent Practice Association" or "IPA" shall mean an entity formed for the limited purpose of contracting for the delivery or provision of health services by individuals, entities and facilities licensed and/or certified to practice medicine and other health professions, and, as appropriate, ancillary medical services and equipment, by which arrangements such health care providers and suppliers will provide their services in accordance with and for such compensation as may be established by a contract between such entity and one or more MCOs. "IPA" may also include, for purposes of this Agreement, a pharmacy or laboratory with the legal authority to contract with other pharmacies or laboratories to arrange for or provide services to enrollees of a New York State MCO.

"Provider" shall mean physicians, dentists, nurses, pharmacists and other health care professionals, pharmacies, hospitals and other entities engaged in the delivery of health care services which are licensed, registered and/or certified as required by applicable federal and state law.

B. GENERAL TERMS AND CONDITIONS

1. This agreement is subject to the approval of the New York State Department of Health (DOH) and if implemented prior to such approval, the parties agree to incorporate into this Agreement any and all modifications required by DOH for approval or, alternatively, to terminate this Agreement if so directed by DOH, effective sixty (60) days subsequent to notice, subject to Public Health Law §4403 (6)(e). This Agreement is the sole agreement between the parties regarding the arrangement established herein.
2. Any material amendment to this Agreement is subject to the prior approval of DOH, and any such amendment shall be submitted for approval in accordance with the appropriate procedures and timelines described in Sections III and VII of the New York State Department of Health Provider Contract Guidelines for MCOs and IPA/ACOs. To the extent the MCO provides and arranges for the provision of comprehensive Health Care Services to enrollees served by the Medical Assistance Program, the MCO shall notify and/or submit a copy of such material amendment to DOH, as may be required by the Medicaid Managed Care contract between the MCO and DOH.
3. Assignment of an agreement between an MCO and (1) an IPA/ACO, (2) an institutional network Provider, or (3) a medical group Provider that serves five (5) percent or more of the enrolled population in a county, or the assignment of an agreement between an IPA/ACO and (1) an institutional Provider or (2) a medical group Provider that serves five (5) percent or more of the enrolled population in a county, requires the prior approval of the Commissioner of Health.
4. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA/ACO's Providers to agree, to comply fully and abide by the rules, policies and procedures that the MCO (a) has established or will establish to meet general or specific obligations placed on the MCO by statute, regulation, contract, or DOH or DFS guidelines or policies and (b) has provided to the Provider at least 30 days in advance of implementation, including but not limited to:
    a. quality improvement/management
    b. utilization management, including but not limited to precertification procedures, referral process or protocol, and reporting of clinical encounter data
    c. member grievances; and
    d. Provider credentialing
5. The Provider or, if the Agreement is between the MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees, and shall require its Providers to agree, to not discriminate against an enrollee based on color, race, creed, age, gender, sexual orientation, disability, place of origin, source of payment or type of illness or condition.
6. If the Provider is a primary care practitioner, the Provider agrees to provide twenty-four (24) hour coverage and back-up coverage when the Provider is unavailable. The Provider may use a twenty-four (24) hour back-up call service provided appropriate personnel receive and respond to calls in a manner consistent with the scope of their practice.
7. The MCO or IPA/ACO that is a party to this Agreement agrees that nothing within this Agreement is intended to, or shall be deemed to, transfer liability for the MCO's or IPA/ACO's own acts or omissions, by indemnification or otherwise, to a Provider.
8. Notwithstanding any other provision of this Agreement, the parties shall comply with the provisions of the Managed Care Reform Act of 1996 (Chapter 705 of the Laws of 1996) Chapter 551 of the Laws of 2006, Chapter 451 of the Laws of 2007, Chapter 237 of the Laws of 2009, Chapter 297 of the Laws of

2012, Chapter 199 of the Laws of 2014, Part H, Chapter 60, of the Laws of 2014 and Chapter 6 of the Laws of 2015 with all amendments thereto.

9. To the extent the MCO enrolls individuals covered by the Medical Assistance Program, this Agreement incorporates the pertinent MCO obligations under the Medicaid Managed Care contract between the MCO and DOH as set forth fully herein, including:
    a. The MCO will monitor the performance of the Provider or IPA/ACO under the Agreement and will terminate the Agreement and/or impose other sanctions if the Provider's or IPA/ACO's performance does not satisfy the standards set forth in the Medicaid Managed Care contract.
    b. The Provider or IPA/ACO agrees that the work it performs under the Agreement will conform to the terms of the Medicaid managed care contract between the MCO and DOH and that it will take corrective action if the MCO identifies deficiencies or areas of needed improvement in the Provider's or IPA/ACO's performance.
    c. The Provider or IPA/ACO agrees to be bound by the confidentiality requirements set forth in the Medicaid Managed Care contract between the MCO and DOH.
    d. The MCO and the Provider or IPA/ACO agree that a woman's enrollment in the MCO's Medicaid Managed Care product is sufficient to provide services to her newborn, unless the newborn is excluded from the enrollment in Medicaid Managed Care or the MCO does not offer a Medicaid Managed Care product in the mother's county of fiscal responsibility.
    e. The MCO shall not impose obligations and duties on the Provider or IPA/ACO that are inconsistent with the Medicaid Managed Care contract or that impair any rights accorded to DOH, the local Department of Social Services, or the United States Department of Health and Human Services.
    f. The Provider or IPA/ACO agrees to provide medical records to the MCO for purposes of determining newborn eligibility for Supplemental Security Income where the mother is a member of the MCO and for quality purposes at no cost to the MCO.
    g. The Provider or IPA/ACO agrees, pursuant to 31 U.S.C. §1352 and CFR Part 93, that no federally appropriated funds have been paid or will be paid to any person by or on behalf of the Provider/IPA/ACO for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of any Member of Congress in connection with the award of any federal loan, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement. The Provider or IPA/ACO agrees to complete and submit the "Certification Regarding Lobbying," Appendix attached hereto as Exhibit 2 and incorporated herein, if this Agreement exceeds $100,000. If any funds other than federally appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a member of Congress, in connection with the award of any federal contract, the making of any federal grant, the making of any federal loan, the entering of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant loan, or cooperative agreement, and the Agreement exceeds $100,000 the Provider or IPA/ACO shall complete and submit Standard Form-LLL "Disclosure Form to Report Lobbying," in accordance with its instructions.
    h. The Provider or IPA/ACO agrees to disclose to the MCO, on an ongoing basis, any managing employee who has been convicted of a misdemeanor or felony in relation to the employee's involvement in any program under Medicare, Medicaid or a Title XX services program (block grant programs).

i. The Provider or IPA/ACO agrees to monitor its employees and staff against the List of Excluded Individuals and Entities (LEIE), the Social Security Administration Death Master List, and the National Plan Provider Enumeration System (NPPES).
j. The Provider or IPA/ACO agrees to disclose to the MCO complete ownership, control, and relationship information
k. The Provider or IPA/ACO agrees to obtain for the MCO ownership information from any subcontractor with whom the Provider has had a business transaction totaling more than $25,000 during the 12-month period ending on the date of the request made by DOH, Office of the Medicaid Inspector General (OMIG) or the United States Department of Health and Human Services (DHHS). The information requested shall be provided to the MCO within 35 days of such request.
l. The Provider or IPA/ACO agrees to have an officer, director or partner of the Provider execute and deliver to DOH a certification, using a form provided by DOH through OMIG's website, within five (5) days of executing this agreement, stating that:
    i. The Provider or IPA/ACO is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the Provider. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
    ii. All claims submitted for payment by the Provider/IPA/ACO are for care, services or medical supplies that have been provided.
    iii. Payment requests are submitted in accordance with applicable law.
m. The Provider or IPA/ACO agrees to require that an officer, director or partner of all subcontractors if they are not natural persons, or the subcontractor itself if it is a natural person, execute a certification, using a form provided by DOH through OMIG's website, before the subcontractor requests payment under the subcontract, acknowledging that:
    i. The subcontractor is subject to the statutes, rules, regulations, and applicable Medicaid Updates of the Medicaid program and of DOH related to the furnishing of care, services or supplies provided directly by, or under the supervision of, or ordered, referred or prescribed by the subcontractor. This includes 18 NYCRR 515.2 except to the extent that any reference in the regulation establishing rates, fees, and claiming instructions will refer to the rates, fees and claiming instructions set by the MCO.
    ii. All claims submitted for payment by the subcontractor are for care, services or medical supplies that have been provided.
    iii. Payment requests are submitted in accordance with applicable law.

10. The parties to this Agreement agree to comply with all applicable requirements of the federal Americans with Disabilities Act.
11. The Provider agrees, or if the Agreement is between the MCO and an IPA/ACO or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees and shall require the IPA's Providers to agree, to comply with all applicable requirements of the Health Insurance Portability and Accountability Act, the HIV confidentiality requirements of Article 27-F of the Public Health Law, and Mental Hygiene Law § 33.13.
12. Compliance Program. The Provider agrees that if it claims, orders, or is paid $500,000 or more per year from the Medical Assistance Program, including, in the aggregate, claims submitted to or paid directly by the Medical Assistance Program and/or claims submitted to or paid by any MCO under the Medicaid Managed Care Program, that it shall adopt and implement a compliance program which meets the requirements of New York State Social Services Law § 363-d(2) and 18 NYCRR § 521.3.

13. Compliance Program Certification. The Provider agrees that if it is subject to the requirements of Section B (12) of this Appendix, it shall certify to DOH, using a form provided by OMIG on its website, within 30 days of entering into a Provider Agreement with the MCO, if they have not so certified within the past year that a compliance program meeting the requirements of 18 NYCRR §521.3 and Social Services Law § 363-d(2) is in place. The Provider shall recertify during the month of December each year thereafter using a form provided by OMIG on OMIG's website.

C. PAYMENT; RISK ARRANGEMENTS

1. Enrollee Non-liability. Provider agrees that in no event, including, but not limited to, nonpayment by the MCO or IPA/ACO, insolvency of the MCO or IPA/ACO, or breach of this Agreement, shall Provider bill; charge; collect a deposit from; seek compensation, remuneration or reimbursement from; or have any recourse against a subscriber, an enrollee or person (other than the MCO or IPA/ACO) acting on his/her/their behalf, for services provided pursuant to the subscriber contract or Medicaid Managed Care contract and this Agreement, for the period covered by the paid enrollee premium. In addition, in the case of Medicaid Managed Care, Provider agrees that, during the time an enrollee is enrolled in the MCO, Provider will not bill DOH or the City of New York for covered services within the Medicaid Managed Care benefit package as set forth in the Agreement between the MCO and DOH. This provision shall not prohibit the Provider, unless the MCO is a Managed Long Term Care plan designated as a Program of All-Inclusive Care for the Elderly (PACE), from collecting copayments, coinsurance amounts, or permitted deductibles, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a covered person, provided that Provider shall have advised the enrollee in writing that the service is uncovered and of the enrollee's liability therefore prior to providing the service. Where the Provider has not been given a list of services covered by the MCO, and/or Provider is uncertain as to whether a service is covered, the Provider shall make reasonable efforts to contact the MCO and obtain a coverage determination prior to advising an enrollee as to coverage and liability for payment and prior to providing the service. This provision shall survive termination of this Agreement for any reason and shall supersede any oral or written agreement now existing or hereafter entered into between Provider and enrollee or person acting on his or her behalf.
2. Coordination of Benefits (COB). To the extent otherwise permitted in this Agreement, the Provider may participate in collection of COB on behalf of the MCO, with COB collectibles accruing to the MCO or to the Provider. However, with respect to enrollees eligible for medical assistance or participating in Child Health Plus, the Provider shall maintain and make available to the MCO records reflecting COB proceeds collected by the Provider or paid directly to enrollees by third party payers, and amounts thereof, and the MCO shall maintain or have immediate access to records concerning collection of COB proceeds.
3. If the Provider is a health care professional licensed, registered or certified under Title 8 of the Education Law, the MCO or the IPA/ACO must provide notice to the Provider at least ninety (90) days prior to the effective date of any adverse reimbursement arrangement as required by Public Health Law §4406-c(5-c). Adverse reimbursement change shall mean a proposed change that could reasonably be expected to have a material adverse impact on the aggregate level of payment to a health care professional. This provision does not apply if the reimbursement change is required by law, regulation or applicable regulatory authority; is required as a result of changes in fee schedules, reimbursement methodology or payment policies established by the American Medical Association current procedural terminology (CPT) codes, reporting guidelines and conventions; or such change is expressly provided for under the terms of this Agreement by the inclusion or reference to a specific fee or fee schedule, reimbursement methodology, or payment policy indexing scheme.

4. The parties agree to comply with and incorporate the requirements of Physician Incentive Plan (PIP) Regulations contained in 42 CFR §438.6(h), 42 CFR §422.208, and 42 CFR §422.210 into any contracts between the contracting entity (Provider, IPA/ACO, hospital, etc.) and other persons/entities for the provision of services under this Agreement. No specific payment will be made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an enrollee.
5. The parties agree that, where required by Public Health Law §4903, a claim for certain continued, extended, or additional health care services cannot be denied on the basis of medical necessity or a lack of prior authorization while a utilization review determination is pending if all necessary information was provided within the required timeframes and under the circumstances described in Public Health Law §4903.
6. The parties agree to follow Section 3224-a of the Insurance Law providing timeframes for the submission and payment of Provider claims to the MCO.
7. The parties agree to follow Section 3224-b(a) of the Insurance Law requiring an MCO to accept and initiate the processing of all claims submitted by physicians that conform to the American Medical Association's Current Procedural Technology (CPT) codes, reporting guidelines and conventions, or to the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System (HCPCS).
8. The parties agree to follow Section 3224-b(b) of the Insurance Law prohibiting an MCO from initiating overpayment recovery efforts more than 24 months after the original payment was received by a health care Provider, except where: (1) the plan makes overpayment recovery efforts that are based on a reasonable belief of fraud or other intentional misconduct or abusive billing; (2) for the Medicaid Managed Care and Family Health Plus programs, the overpayment recovery period for such programs is six (6) years from date payment was received by the health care Provider with written notice 30 days prior to engaging in overpayment recovery efforts. Such notice must state the patient's name, service date, payment amount, proposed adjustment, and a reasonably specific explanation of the proposed adjustment.
9. The parties agree to follow Section 3224-c of the Insurance Law providing that claims cannot be denied solely on the basis that the MCO has not received from the member information concerning other insurance coverage.
10. The parties agree that this contract does not waive, limit, disclaim, or in any way diminish the rights that any Provider may have pursuant to Section 3238 of the Insurance Law to the receipt of claims payment for services where preauthorization was required and received from the appropriate person or entity prior to the rendering of the service.
11. The parties agree that for a contract involving Tier 2 or 3 arrangements as described in Section VII.B of the Guidelines, the contract must:
    a. Provide for the MCO's ongoing monitoring of Provider financial capacity and/or periodic Provider financial reporting to the MCO to support the transfer of risk to the Provider; and
    b. Include a provision to address circumstance where the Provider's financial condition indicates an inability to continue accepting such risk; and
    c. Address MCO monitoring of the financial security deposit, describing the method and frequency of monitoring and recourse for correcting underfunding of the deposit to be maintained by the MCO; and
    d. Include a provision that the Provider will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH.
12. The parties agree that for any contract involving an MCO and IPA/ACO, the contract must include provisions whereby:
    a. The parties expressly agree to amend or terminate the contract at the direction of DOH (applies to Tier 1, Tier 2, and Tier 3);

b. The IPA/ACO will submit annual financial statements to the MCO, as well as any additional documents required by the MCO as necessary to assess the IPA/ACO's progress towards achieving value based payment goals as specified in the Roadmap, and the MCO will notify DOH of any substantial change in the financial condition of the IPA/ACO (applies to Tier 2 and Tier 3); and
c. The IPA/ACO will submit any additional documents or information related to its financial condition to the MCO, if requested by DOH (applies to Tier 2 and Tier 3); and
d. The parties agree that all Provider contracts will contain provision prohibiting Providers, in the event of a default by the IPA/ACO, from demanding payment from the MCO for any covered services rendered to the MCO's enrollees for which payment was made by the MCO to the IPA/ACO pursuant to the risk agreement (applies to Tier 2 and Tier 3).

D. RECORDS; ACCESS

1. Pursuant to appropriate consent/authorization by the enrollee, the Provider will make the enrollee's medical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the MCO (and IPA/ACO if applicable) for purposes including preauthorization, concurrent review, quality assurance, (including Quality Assurance Reporting Requirements (QARR)), payment processing, and qualification for government programs, including but not limited to newborn eligibility for Supplemental Security Income (SSI) and for MCO/Manager analysis and recovery of overpayments due to fraud and abuse. The Provider will also make enrollee's medical records available to the State for management audits, financial audits, program monitoring and evaluation, licensure or certification of facilities or individuals, and as otherwise required by state law. The Provider shall provide copies of such records to DOH at no cost. The Provider (or IPA/ACO if applicable) expressly acknowledges that the Provider shall also provide to the MCO and the State (at no expense to the State), on request, all financial data and reports, and information concerning the appropriateness and quality of services provided, as required by law. These provisions shall survive termination of the contract for any reason.
2. When such records pertain to Medicaid reimbursable services, the Provider agrees to disclose the nature and extent of services provided and to furnish records to DOH and/or the United States Department of Health and Human Services, the County Department of Social Services, the Comptroller of the State of New York, the Office of the Medicaid Inspector General, the New York State Attorney General, and the Comptroller General of the United States and their authorized representatives upon request. This provision shall survive the termination of this Agreement regardless of the reason.
3. The parties agree that medical records shall be retained for a period of six years after the date of service, and in the case of a minor, for three (3) years after majority or six (6) years after the date of service, whichever is later, or for such longer period as specified elsewhere within this Agreement. This provision shall survive the termination of this Agreement regardless of the reason.
4. The MCO and the Provider agree that the MCO will obtain consent directly from enrollees at the time of enrollment or at the earliest opportunity, or that the Provider will obtain consent from enrollees at the time of service is rendered or at the earliest opportunity, for disclosure of medical records to the MCO, to an IPA/ACO or to third parties. If the Agreement is between an MCO and an IPA/ACO, or between an IPA/ACO and an IPA/ACO, the IPA/ACO agrees to require the Providers with which it contracts to agree as provided above. If the Agreement is between an IPA/ACO and a Provider, the Provider agrees to obtain consent from the enrollee if the enrollee has not previously signed consent for disclosure of medical records.

E. TERMINATION AND TRANSITION

1. Termination or non-renewal of an agreement between an MCO and an IPA/ACO, institutional network Provider, or medical group Provider that serves five (5) percent or more of the enrolled population in a county, or the termination or non-renewal of an agreement between an IPA/ACO

and an institutional Provider or medical group Provider that serves five (5) percent or more of the enrolled population in a county, requires notice to the Commissioner of Health. Unless otherwise provided by statute or regulation, the effective date of termination shall not be less than 45 days after receipt of notice by either party, provided, however, that termination by the MCO may be effected on less than 45 days' notice provided the MCO demonstrates to the satisfaction of DOH, prior to termination, that circumstances exist which threaten imminent harm to enrollees or which result in Provider being legally unable to deliver the covered services and, therefore, justify or require immediate termination.

2. If this Agreement is between the MCO and a health care professional, the MCO shall provide to such health care professional a written explanation of the reasons for the proposed contract termination, other than non-renewal, and an opportunity for a review as required by state law. The MCO shall provide the health care professional 60 days' notice of its decision to not renew this Agreement.
3. If this Agreement is between an MCO and an IPA/ACO, and the Agreement does not provide for automatic assignment of the IPA/ACO's Provider contracts to the MCO upon termination of the MCO/IPA/ACO contract, in the event either party gives notice of termination of the Agreement, the parties agree, and the IPA/ACO's Providers agree, that the IPA/ACO Providers shall continue to provide care to the MCO's enrollees pursuant to the terms of this Agreement for 180 days following the effective date of termination, or until such time as the MCO makes other arrangements, whichever occurs first. This provision shall survive termination of this Agreement regardless of the reason for the termination.
4. Continuation of Treatment. The Provider agrees that in the event of MCO or IPA/ACO insolvency or termination of this contract for any reason, the Provider shall continue, until medically appropriate discharge or transfer, or completion of a course of treatment, whichever occurs first, to provide services pursuant to the subscriber contract or Medicaid Managed Care contract, to an enrollee confined in an inpatient facility, provided the confinement or course of treatment was commenced during the paid premium period. For purposes of this clause, the term "Provider" shall include the IPA/ACO and the IPA/ACO's contracted Providers if this Agreement is between the MCO and an IPA/ACO. This provision shall survive termination of this Agreement.
5. Notwithstanding any other provision herein, to the extent that the Provider is providing Health Care Services to enrollees under the Medicaid Program, the MCO or IPA/ACO retains the option to immediately terminate the Agreement when the Provider has been terminated or suspended from the Medicaid Program.
6. In the event of termination of this Agreement, the Provider agrees, and, where applicable, the IPA/ACO agrees to require all participating Providers of its network to assist in the orderly transfer of enrollees to another Provider.

F. ARBITRATION

To the extent that arbitration or alternative dispute resolution is authorized elsewhere in this Agreement, the parties to this Agreement acknowledge that the Commissioner of Health is not bound by arbitration or mediation decisions. Arbitration or mediation shall occur within New York State, and the Commissioner of Health will be given notice of all issues going to arbitration or mediation and copies of all decisions.

G. IPA/ACO-SPECIFIC PROVISIONS

1. Any reference to IPA/ACO Quality Assurance (QA) activities within this Agreement is limited to the IPA/ACO's analysis of utilization patterns and quality of care on its own behalf and as a service to its contract providers.

EXHIBIT 2 (of New York IPA Participating Provider Agreement)

CERTIFICATION REGARDING LOBBYING

Provider certifies, to the best of his or her knowledge, that:

2. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the IPA Provider for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
3.
4. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of any Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, the IPA Provider shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

EXHIBIT 3 (of New York State IPA Participating Provider Agreement)
MMP REQUIREMENTS

Payors which are Health Plans that participate in CMS' MMP duals program ("Health Plan") and Provider, which for the purposes of this Exhibit shall mean an IPA, ODS provider or an individual provider including a hospital, physician, or other contracted healthcare practitioner, including any first tier, downstream or related entities (as defined by CMS) that is participating in CMS' MMP duals program ("Provider") agree to comply with the following requirements under the MMP duals program:

1. HHS, the Comptroller General or their designees shall have the right to audit, evaluate and inspect any pertinent information including books, contracts, records, including medical records, and documentation related to CMS' contract with Health Plan for a period of 10 years from the final date of the contract period or the completion of any audit, whichever is later. [42 C.F.R. § 422.504(i)(2)(i) and (ii)].
2. The Parties will comply with confidentiality and Member record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Members to the records and information that pertain to them. [42 C.F.R. §§ 422.118 and 422.504(a)(13)].
3. Members may not be held liable for payment of any fees that are the legal obligation of Health Plan. [42 C.F.R. §§ 422.504(g)(1)(i) and 422.504(i)(3)(i)].
4. Members eligible for both Medicare and Medicaid will not be held liable for Medicare Part A and B cost sharing. Medicare Parts A and B services must be provided at zero cost-sharing as part of the integrated package of benefits. [Guidance issued by CMS on March 29, 2012].

5. Any services or other activities performed by the Parties must be consistent and comply with Health Plan's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)].
6. Health Plan or first tier entity is obligated to pay Provider under the terms of this Agreement. Section 5.2 of this Agreement contains a prompt payment provision, the terms of which have been developed and agreed to by both Health Plan and Provider. [42 C.F.R. § 422.520(b)].
7. Services must be provided in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. [42 C.F.R. § 422.112(a)(8)].
8. If Health Plan has delegated the selection of providers, Health Plan retains the right to approve, suspend, or terminate such arrangement. [42 C.F.R. § 422.504(i)(5)].
9. If applicable, delegated activities and reporting responsibilities delegated hereunder, if any, are set forth in this Agreement. [42 C.F.R. § 422.504(i)(4)(i)].
10. If applicable, any delegated activities and reporting requirements may be revoked in instances when CMS or Health Plan determines that the Parties have not performed satisfactorily. [42 C.F.R. § 422.504(i)(4)(ii)].
11. If any activities have been delegated, the performance of the Parties shall be monitored by Health Plan on an ongoing basis. [42 C.F.R. § 422.504(i)(4)(iii)].
12. If any activities have been delegated, the credentials of medical professionals affiliated with the Parties will either be reviewed by Health Plan or the credentialing process will be reviewed and approved by Health Plan and Health Plan will audit the credentialing process on an ongoing basis. [42 C.F.R. § 422.504(i)(4)(iv)].
13. The Parties must comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. § 422.504(i)(4)(v)].
14. The scope of this Agreement incorporates both the Medicare and the Medicaid population.
15. This Agreement is Effective either from January 1, 2014 –December 31, 2014, or contains an automatic renewal provision.

EXHIBIT 4 (of New York State IPA Participating Provider Agreement)
PROVISIONS APPLICABLE TO MEDICARE ENROLLEES

Except as provided herein, all other provisions of the Agreement between Brighton Health Network, LLC d/b/a MagnaCare and Provider not inconsistent herein shall remain in full force and effect. This amendment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the Parties agree as follows:

Definitions:

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

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

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

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

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

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

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

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

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

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

Required Provisions:

Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with [Entity Name], (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]
3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]

4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. First Tier or Downstream Entity may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
5. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the IPA and/or ODS and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]
7. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

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

NEW JERSEY ODS PARTICIPATING PROVIDER AGREEMENT

NEW JERSEY ODS PARTICIPATING PROVIDER AGREEMENT
Brighton Health Network, LLC d/b/a MagnaCare

THIS PARTICPATING PROVIDER AGREEMENT (the "ODS Agreement"), is made and entered into between Brighton Health Network, LLC d/b/a MagnaCare in its capacity as a New Jersey certified Organized Delivery System ("ODS"), on behalf of itself and its affiliates, and Provider ("Provider"), a group practice, physician, allied health professional, equipment or supply vendor, facility and/or other health professional who has entered into the Agreement. This Attachment, which is fully incorporated into the Agreement, shall become effective for Provider on the Effective Date of the Agreement. ODS and Provider are hereinafter sometimes referred to individually as a "Party" and collectively as the "Parties."

WHEREAS, ODS is a New York Limited Liability Company;

WHEREAS, pursuant to one or more agreements with Payors ("Payor Agreements"), ODS arranges for the provision of Covered Services to Payors' Enrollees through its Network of Participating Providers; and

WHEREAS, Provider is approved under the laws of the State of New Jersey to provide Covered Services, and desires to participate in the Network and to contract with ODS to provide Covered Services to Enrollees.

NOW, THEREFORE, in consideration of the premises and mutual covenants contained herein and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, it is mutually agreed by and between the Parties as follows:

ARTICLE 1 - DEFINITIONS

For purposes of this ODS Agreement, the following definitions shall apply:

1.1 **"Affiliate"** shall mean with respect to any entity, any entity controlling or controlled by or under common control with such entity and shall also include any entity fifty percent (50%) or more of whose outstanding voting power is owned by the specified entity either directly or through subsidiaries.

1.2 **"Clean Claim"** means a claim: (a) regarding services or supplies provided by Provider, subject to this ODS Agreement; (b) in regard to which the individual receiving the service or supply was an Enrollee on the date of service; (c) in regard to which the service or supply provided was a Covered Service on the date of service; (d) submitted with all the information requested by the payer on the claim form or other instructions that were distributed in advance to the Provider or Enrollee; and (e) that the Payer has no reason to believe has been submitted fraudulently.

1.3 **"Covered Services"** means those Medically Necessary services and/or supplies for which an Enrollee is entitled to receive coverage for under the terms of his or her Plan or other healthcare reimbursement in which they are enrolled to participate.

1.4 **"Enrollee"** shall mean an individual who is eligible to receive Covered Services under a Plan.

1.5 **"Emergency"** means a medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, psychiatric disturbances and/or symptoms of substance abuse such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of a bodily organ or part. In addition, with respect to a pregnant woman who is having contractions, an Emergency exists where there is inadequate time to effect a safe transfer to another hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or her unborn child.

1.6 **"Group Provider"** means a Provider, as defined herein, with two or more physicians or other professionals practicing together as a proprietorship, partnership, PC, PLLC, PLLP, PA or any combination of the foregoing. References herein to "Provider" shall mean the Group Provider and each physician or other professional now or hereafter practicing and billing as part of the group, and all practice sites now existing or hereafter added by Group Provider as permitted hereunder.

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

1.8 **"Network"** shall mean the Participating Providers with which ODS contracts to furnish Covered Services to Enrollees under a Plan issued by a Payor.

1.9 **"Non-Covered Services"** shall mean those health care services and supplies that are not Covered Services under the applicable Payor Agreement and Plan.

1.10 **"ODS Policies and Procedures"** shall mean those policies and procedures adopted by ODS to facilitate the provision of Covered Services by Participating Providers, which may be amended by ODS from time to time.

1.11 **"Participating Provider"** shall mean those providers who have executed a Participating Provider Agreement with ODS, each of whom meets (1) all federal, state and local legal and regulatory requirements to offer Covered Services; and (2) all other requirements established by ODS to be a Participating Provider, including other accreditation or licensure as ODS may deem appropriate from time to time.

1.12 **"Payor"** shall mean one or more managed care organizations or Workers' Compensation Preferred Provider Organizations.

1.13 **"Payor Agreement(s)"** means those agreements between ODS and Payors which exist on the Effective Date and which may exist during the term hereof, pursuant to which ODS has agreed to make the Network available to a Payors' Enrollee. Provider agrees to participate under the terms of all such Payor Agreements.

1.14 **"Plan"** shall mean any health benefit plan offered by a Payor that has entered into a Payor Agreement with ODS.

1.15 **"Plan Participating Provider"** means an individual or entity that has entered into an agreement with Payor to provide Covered Services to Enrollees.

ARTICLE 2 - CONTRACTING AUTHORIZATIONS

2.1 **Representation with Payors.** Provider authorizes ODS to negotiate and enter into Payor agreements on Provider's behalf, provided the terms of the Payor agreements do not violate federal or state antitrust or unfair competition laws.

ARTICLE 3 - RESPONSIBILITIES OF PROVIDER

Provider shall be responsible for the following duties and obligations:

3.1 **License.** Throughout the term of this ODS Agreement, Provider shall maintain all applicable federal and state and any and all other state or local licenses, permits, certificates or approvals as may be required to provide Covered Services.

3.2 **Participation in Plans.** Provider shall participate in each Plan offered by a Payor with which ODS has a Payor Agreement except to the extent that ODS has notified Provider in writing that it is excluded from participating in such Plan. Nothing contained in this ODS Agreement guarantees to Provider that it will be permitted to participate in any or all Plans offered by any Payor. Provider acknowledges and agrees that: (i) ODS may from time to time enter into an agreement with a Payor under which only a limited network is offered and in which not all Participating Providers may participate; (ii) certain Payors may impose more stringent or burdensome credentialing or other requirements than those imposed by ODS and which Provider does not meet; (iii) Payors may request that Provider no longer provide Covered Services to Enrollees in a Plan offered by that Payor; (iv) neither ODS nor Payors warrant or guarantee that Provider will be utilized by Enrollees or any number of Enrollees under any Payor Agreement; and/or (v) ODS may decide in its sole discretion to limit participation in a particular Plan or to exclude Provider from a particular Plan. If Provider is already participating in a Plan, ODS will give Provider written notice

that they are excluded from participation in that Plan at least ninety (90) days before the effective date of such exclusion, except that such exclusion shall be effective immediately on Provider's receipt of the notice if the Payor requests that Provider no longer provide Covered Services to Enrollees or if Provider fails to meet the applicable credentialing requirements. If Provider is not already participating in the particular Plan, its exclusion from the particular Plan shall be effective upon receipt by Provider or ODS, as applicable, of the written notice. Upon the applicable effective date, Provider will no longer participate in the specified Plan(s) under this ODS Agreement and will not be entitled to reimbursement under this ODS Agreement for Covered Services rendered to Enrollees of that Plan. Notwithstanding the exclusion of Provider from one or more Plans, the remaining terms and conditions of this ODS Agreement shall remain in full force and effect with respect to all other Plans. Provider agrees to notify affected Enrollees of the termination of Provider's participation in a particular Plan prior to the effective date of such termination and will assist in the orderly transfer of Enrollees to another Provider. Provider shall provide continuity of care pursuant to applicable law and industry standards.

3.3 **Representations, Warranties and Covenants.** Provider represents, warrants and covenants to ODS that:

(i) Provider represents and warrants that Provider has and will maintain throughout the term of this ODS Agreement all licenses, registrations, certifications, qualifications and/or permits required by local, state and federal authorities to furnish Covered Services including, without limitation, workers' compensation, Medicare and Medicaid certifications and/or DEA registrations, as applicable. Provider represents and warrants that neither Provider nor any of Provider's partners, shareholders, directors, officers, agents or employees is excluded or suspended from participation in the Medicare or Medicaid programs, or has been convicted, under federal or state law, of a criminal offense related to: (i) the neglect or abuse of an Enrollee; or (ii) the delivery of, or charging for, a supply or service, and that Provider shall monitor its employees and agents for any future offenses, exclusions or suspensions. Provider shall furnish to IPA evidence of such licensures, registrations or certifications upon ODS's request. Provider understands and acknowledges that Provider's representations and warranties are relied upon by ODS in contracting with Provider.

(ii) Provider shall provide to IPA immediate written notice of: (i) any modification, suspension or termination of any licensure, certification and/or hospital privileges; (ii) conviction and/or program exclusion of himself/herself or any employee or agent of Provider rendering Covered Services hereunder; (iii) a material reduction in, or termination of, the amount or type of professional liability coverage required under this Agreement; (iv) any event which would impact Provider's ability to lawfully perform the obligations set forth herein; (v) any other event which might make Provider (or any Group Provider) unable to render Covered Services to Enrollees in a high quality manner or otherwise comply with all of the terms of this Agreement; and/or (vi) if Provider adds, closes and/or changes the address of an office site for Provider's practice or of any other change in Provider's credentialing and/or billing information. In the case of a group, Provider will also provide prompt written notice to IPA if any Group Provider discontinues participation in Provider's practice and/or if an additional billing professional joins Group Provider's practice.

3.4 **Liability Insurance.**

(i) During the term of this ODS Agreement Provider shall maintain, at Provider's sole cost and expense, comprehensive general liability insurance and professional liability insurance in the minimum amount of $1,000,000 per occurrence and $3,000,000 aggregate, or in such higher amounts as ODS and/or a Payor may require, to insure Provider and Provider's employees,

agents or representatives against any claim for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance of any service by Provider in connection with this ODS Agreement. However, if Provider is a Group Provider of more than six (6) full time practitioners or is otherwise not an individual provider, then Provider shall maintain insurance with limits of at least $2 million for each occurrence and $3 million in the annual aggregate, or in such higher amounts as ODS and/or a Payor may require, to insure Provider and Provider's employees, agents or representatives against any claim for damages arising by reason of personal injury or death occasioned, directly or indirectly, in connection with the performance of any service by Provider in connection with this ODS Agreement. Such insurance shall name ODS as an additional insured/certificate holder. If Provider has a "claims made" policy, upon or prior to the termination of this ODS Agreement for any reason, Provider shall purchase a "tail" policy or obtain replacement coverage which insures prior acts, including losses arising from occurrences during the term of this ODS Agreement, and shall maintain such tail for the applicable statute of limitations, or six years, whichever is greater. This Section 3.4 shall survive the expiration or termination of this IPA Agreement.

(ii) All policies of insurance required by Section 3.4(i) shall require that ODS be provided with at least thirty (30) days prior written notice of any modification, cancellation or non-renewal of such policies.

(iii) Upon the execution of this ODS Agreement, and at any other time upon the request of ODS, Provider shall provide ODS with proof that Provider has obtained and currently maintains adequate insurance in accordance with this Section 3.4.

3.5 **Immediate Notification by Provider of Certain Occurrences.** Provider shall notify ODS in writing immediately upon, but in no event more than thirty (30) days after, the occurrence of any of the following:

(i) the filing of any claims against Provider for professional negligence or malpractice, or the institution of any action, litigation, or lawsuit in that regard, regardless of whether the claim involves an Enrollee;

(ii) cessation of business;

(iii) the appointment of a receiver or an assignee for the benefit of creditors of Provider, insolvency of Provider, inability of Provider to pay debts as they become due, or the commencement of any voluntary or involuntary bankruptcy proceedings by or against Provider or any similar proceedings;

(iv) arrest, indictment or conviction for any felony or criminal charge related to the practice of Provider's profession;

(v) any charges of professional or ethical misconduct brought against Provider and/or any clinician employed by Provider;

(vi) any investigation of Provider for alleged fraud and abuse or false claims conducted by a Payor or government agency;

(vii) the exclusion, debarment, suspension or any other limitation of Provider's right to participate in Medicare, any Medicaid program or any other federal or state health care program;

(viii) Provider contracts with an individual or entity that Provider or its affiliates knew or should have known is excluded from participation in any federal health care program;

(ix) any lapse of professional liability (malpractice) insurance maintained by Provider covering Provider, any denial, cancellation, or non-renewal of any such insurance, or any reduction in the amount of such insurance carried by or issued to Provider;

(x) Provider's termination from participating in any Plan;

(xi) any change in Provider's name, addresses, email addresses, telephone numbers, fax numbers or taxpayer identification numbers; and

(xii) any other occurrence or condition which might materially impair the ability of Provider to discharge its duties or obligations under this Agreement.

3.6 **Participating in Credentialing/Recredentialing.** Provider and any employee or contractor of Provider that will provide Covered Services under this ODS Agreement shall participate in ODS's and/or Payor's credentialing/recredentialing process, which shall include, without limitation, the submission of written proof of malpractice insurance and other information or documents, as requested by ODS and/or Payor. Provider shall submit all information requested by ODS and/or Payor on a timely basis and warrants and covenants that all such information will be current and accurate.

3.7 **ODS's and/or Payor's Policies and Procedures.** Provider shall abide by ODS Policies and Procedures or the policies and procedures as may be established or amended from time to time by a Payor with respect to Covered Services furnished to Enrollees and as may be set forth in the manuals (which may be solely web based), newsletters and other such correspondence from ODS and/or Payor. Such policies and procedures shall include, but are not limited to, ODS and/or Payor's standards and requirements for quality improvement, utilization management, credentialing, and Enrollee grievances.

3.8 **Grievances.** Consistent with applicable law, Provider agrees to cooperate with ODS and Payors in the execution of grievance procedures related to Provider's provision of Covered Services, shall assist ODS and Payors in taking appropriate corrective action, and shall comply with all final determinations made by ODS or Payor pursuant to such grievance procedures.

3.9 **Referrals.** Provider agrees to refer Enrollees, when necessary, to Plan Participating Providers, except in the case of an emergency or as otherwise required by law. In the event a referral is made to a non-Plan Participating Provider, it is the Provider's responsibility to advise the Enrollee that the provider is not participating with ODS and/or Payor and that the Enrollee may incur out of pocket costs for using a non-Plan Participating Provider.

3.10 **Inspection.** ODS or its designee, or any Payor shall have the right to inspect, audit and/or evaluate all medical, billing and financial records relating to the treatment of all Enrollees under or in connection with this ODS Agreement and to inspect Provider's locations and operations to ensure compliance with this ODS Agreement and the Payor Agreement, and to ensure that they are adequate to meet ODS or Payor's needs and requirements or in order to perform quality assurance functions.

3.11 **Provider Fees.** Provider shall accept from Payors, as full compensation for Covered Services furnished to Enrollees in accordance with the terms hereof, payment at the applicable fee schedule rate, which may be changed from time to time by ODS, provided, however, that when treating an

Enrollee in workers' compensation, Provider agrees to accept the lesser of the applicable fee schedule then in effect or the state prescribed workers' compensation fee schedule. Except as is otherwise provided herein, Provider shall accept such payments as complete and full discharge of the liability of Payor and Enrollee for the provision of Covered Services.

3.12 **Non-discrimination.** Provider shall furnish Provider Services to Enrollee in the same manner in which Provider provides services to Provider's other patients, and shall not discriminate in the treatment of Enrollees on the basis of race, sex, age, religion, place of residence, HIV status, sexual orientation, creed, color, national origin, source of payment, (including Enrollees status as a member of a Plan), type of illness or condition, or disability or other basis protected by state or federal law. Further, Provider shall comply with all other laws applicable to recipients of federal funds.

3.13 **Provider Rights.** Provider has the right and the obligation to communicate openly with all Enrollees regarding diagnostic tests and treatment options. Provider shall not be terminated or otherwise penalized because of complaints or appeals that the Provider files on his or her own behalf, or on behalf of an Enrollee, or for otherwise acting as an advocate for Enrollees in seeking Covered Services.

ARTICLE 4 - PROVISION OF COVERED SERVICES

4.1 **Provider Services.** Provider shall provide those Covered Services which Provider is licensed/certified to provide, which Provider routinely provides, and which are within the scope of Provider's practice on a twenty-four (24) hour per day, seven (7) day per week basis, and to arrange for backup coverage to the extent possible with other Plan Participating Providers or non-Plan Participating Providers who have agreed to accept the rates paid to Provider by applicable Payor and utilization management protocols as if participating in the Network for ODS business, including for Emergencies and during periods of Provider's absence. Provider shall utilize only qualified personnel to perform or assist in the responsibility for supervising and compensating its personnel and for requiring that such personnel be qualified and adhere to the terms and conditions of this ODS Agreement and all Payor Agreements. Provider agrees to provide Covered Services in accordance with this ODS Agreement, all Policies and Procedures, and all applicable federal, state, and local laws, rules and regulations, as all of the foregoing may be amended from time to time.

4.2 **Provision of Provider Services To Medicare Enrollees.** In addition to the above, when rendering Covered to Medicare program Enrollees, Provider shall comply with all applicable CMS instructions and regulations, including the Medicare conditions of participation (as set forth in Title XVIII of the Social Security Act and 42 C.F.R. Part 422) and those referenced herein, and shall maintain such compliance throughout the term of this ODS Agreement, including the Medicare Addendum, attached as Exhibit F to the Agreement. When treating Medicare Enrollees, Provider shall provide information in a culturally appropriate manner to all Enrollees, including those with limited English proficiency or reading skills and diverse cultural and economic backgrounds.

4.3 **Admitting Privileges.** Provider will at all times during the term hereof maintain active admitting privileges with at least one Plan Participating Provider which is a hospital if admitting privileges are required for Provider's specialty. Provider will refer Enrollees to a hospital which is a Plan Participating Provider for all elective admissions and, to the extent possible, all emergency admissions.

4.4 **Cooperation With Coordination of Benefits.** Cooperate and assist ODS and, when applicable, a Payor to obtain payments from other third party Payors, when in accordance with the coordination of benefit provisions of a Plan, another party has primary responsibility for payment for Covered Services. Such cooperation shall include, but not be limited to, providing information regarding additional

coverage which may be available, completing claims forms from other third party Payors and assigning the right to such payments to the applicable payors.

4.5 **Verification of Eligibility.** Verify the eligibility of each Enrollee in accordance with the procedures set forth by ODS and/or a Payor. Compliance with ODS's and/or Payor's enrollment verification policies and procedures, and eligibility verification does not ensure that a person is, in fact, an Enrollee and eligible to receive Covered Services (i.e., authorization is not a guarantee of payment). ODS and the applicable Payor will have no responsibility for Covered Services provided to patients who are not eligible Enrollees. Provider shall be responsible to bill ineligible patients directly for Covered Services

4.6 **Non-exclusivity.** Nothing contained in this ODS Agreement shall prevent Provider from participating in, or contracting with, any other independent practice association, preferred provider organization, managed care organization, organized delivery system insurer or other health delivery or insurance program. In addition, the Parties acknowledge and agree that the Network is intended to be non¬exclusive and that ODS shall have the right to enter into an agreement with any Payor or other provider.

4.7 **Communications with Enrollees.** Notwithstanding any other provision in this ODS Agreement and regardless of any benefit or coverage exclusions associated with an Enrollee's Plan, Provider shall not be prohibited from discussing fully with an Enrollee any issues related to the Enrollee's health including recommended diagnostic tests, treatments, treatment alternatives, treatment risks and the consequences of any benefit coverage or payment decisions made by ODS and/or Payor or any other party. ODS and/or Payor shall not refuse to allow or to continue the participation of an eligible provider, or refuse to compensate Provider in connection with Covered Services rendered, solely because Provider has in good faith communicated with one or more of current, former or prospective Enrollees regarding the provisions, terms or requirements of a Plan as they relate to the health needs of such Enrollee.

4.8 **Compliance with Administrative Programs.** Provider agrees to comply with and be bound by all of Payors' (including governmental entities') and applicable regulatory policies and procedures as they may be amended from time to time, including, but not limited to, payment, external peer review, quality assurance and utilization management policies and procedures. Provider further agrees to cooperate fully in the implementation and operation of credentialing, grievance, appeal and other policies and procedures of Payors, as they may exist or be amended from time to time during the term of this ODS Agreement. Copies of the policies described in this Section 4.4 may be solely web based, as described in Section 3.7 of the ODS Agreement.

4.9 **Quality Assurance.** All services rendered to Enrollees pursuant to this ODS Agreement are subject to the ODS' Quality Assurance Program (the "ODS Quality Assurance Program"), as set forth in ODS's Provider Manual as modified from time to time, with respect to ODS's provider network.

(i) ODS is responsible for day-to-day administration of the ODS Quality Assurance Program.

(ii) Provider may submit questions or complaints regarding the ODS Quality Assurance Program, and otherwise submit feedback regarding the operations of ODS and its provider network, to ODS Provider Services by telephone at 800-352-6465 or in writing to the Provider Services Department c/o MagnaCare, 1600 Stewart Avenue, Suite 700, Westbury, NY 11590.

(iii) Any quality assurance issues involving any Payor's Plan, contract or policy are subject to the quality assurance program of that Payor. Each Payor is responsible for day-to-day administration

of its quality assurance program. Provider may submit questions or complaints regarding any Payor's quality assurance program, and otherwise submit feedback regarding the operations of that Payor, to the Payor.

5.0 **Utilization Management.** Services rendered to each Enrollee pursuant to this ODS Agreement are subject to the relevant Payor's utilization management program (the "Utilization Management Program"), as set forth in utilization management materials provided to Provider by or on behalf of that Payor from time to time (the "Utilization Management Materials").

(i) With regard to each Enrollee, the relevant Payor or its delegate is responsible for day-to-day administration of the Utilization Management Program.

(ii) Provider is to comply with standards and other elements of each applicable Utilization Management Program, as set forth in the relevant Utilization Management Materials, and may obtain written copies of and appeal utilization management decisions as set forth in the relevant Utilization Management Materials.

(iii) Upon the request of Provider, Provider shall be supplied with the name and telephone number of the physician or other professional responsible for a decision to deny or limit any admission, service, procedure or length of stay.

(iv) Provider may receive information regarding utilization management protocols, and any parameters that may be placed on the use of one or more protocols, by contacting the relevant Payor or its delegate as instructed in the Utilization Management Materials.

(v) Provider may review utilization management protocols in Provider's practice area, and provide comments on those protocols by contacting any Payor or its delegate as instructed in that Payor's Utilization Management Materials.

(vi) Provider has the right to rely upon the written or oral authorization of a service by a Payor or its delegate, and any such service will not be retroactively denied as not being Medically Necessary except in cases where there was material misrepresentation of facts to the Payor or its delegate, or fraud.

(vii) Provider acknowledges that any appeal lodged on behalf of an Enrollee regarding a utilization management decision will not be eligible for the Independent Health Care Appeals Program established pursuant to N.J.S.A. 26:2S-11 until specific consent of the Enrollee is obtained.

ARTICLE 5 - BILLING AND COMPENSATION

5.1 **Submission of Claims.** Provider shall submit all claims for Covered Services rendered to Enrollees covered by a Plan to the applicable Payor in accordance with instructions provided by the Payor. Provider shall use best efforts to submit claims electronically using ODS' File Transfer Protocol ("FTP") site and/or Change Healthcare or other similar electronic claim transmission account. FTP and/or Change Healthcare or other similar electronic claim transmittal instructions shall be available from ODS upon Provider's request. Clean Claims must be submitted within the time frame applicable to each Payor accessing the ODS. Claims submitted after each Payor's applicable time frame shall be denied payment, unless a coordination of benefits issue is involved, in which case a one hundred eighty (180) day limit from the date of service applies. Provider's claims for payment shall be made using CMS 1500

format, UB 04 or such other forms approved for use by Payor and pursuant to HIPAA. If Provider submits claims electronically, Provider shall submit claims electronically to Payors hereunder and shall cooperate with Payor in implementing such electronic claim submission. Provider shall submit Clean Claims so as to enable Payor to determine whether the services are Covered Services. In certain circumstances, and unless otherwise agreed upon by MagnaCare , Payor shall pay Provider in accordance with this ODS Agreement using an "EZ Pay Card," which is a single use VISA (or alternative credit card) number, the amount of which is redeemable for ninety (90) days using the Provider's point of sale card terminal. In the event Provider fails to issue a voluntary and timely refund to Payor, subsequent payments by the Payor shall be adjusted or offset by the amount of the refund requested, or if no such payment exists, Payor shall pursue Provider using any and all available remedies within the timeframes allowed by law.

5.2 **Payment of Claims.** The relevant Payor or its agent shall remit payment for each Clean Claim no later than the 30th calendar day following receipt of the claim, or no later than the time limit established for the payment of claims in the Medicare program pursuant to 42 U.S.C. § 1395u(c)(2)(B), whichever is earlier, if the claim is submitted by electronic means, and no later than the 40th calendar day following receipt if the claim is submitted by other than electronic means. Any payment that is not remitted within the time limits set forth herein shall bear simple interest at the rate of 12% per annum. Such interest shall be calculated and paid pursuant to the policies and procedures (as amended from time to time) of the Payor responsible for the payment.

5.3 **Overpayment.** Provider shall remain bound to repay or otherwise offset the full amount of any overpayment or duplicate payment, subject to statutory provisions regarding disposition of such overpayments or duplicate payments, and to other general laws and principles of commercial conduct. Applicable statutory provisions mandate, without limitation, the following:

(i) Except in regard to claims that were submitted (i) fraudulently, (ii) by providers with a pattern of inappropriate billing, or (iii) subject to coordination of benefits, neither ODS nor Payor shall seek reimbursement for overpayment of a claim later than 18 months after the date the first payment on the claim was made;

(ii) Neither ODS nor any Payor shall collect or attempt to collect reimbursement for any overpayment before 45 calendar days have passed after the submission of a reimbursement request to Provider, except that in certain cases following a determination that the overpayment was the result of fraud by Provider, ODS or the Payor may sooner collect an overpayment by assessing it against payment of any future claim submitted by Provider; and

(iii) If Provider disputes a reimbursement request and initiates an appeal on or before the 45th calendar day following the submission of the reimbursement request to provider, neither ODS nor any Payor shall collect or attempt to collect reimbursement for any overpayment until Provider's rights to appeal set forth in Section 5.5 below are exhausted.

5.4 **Coordination of Benefits.** ODS or any Payor may coordinate benefits with any other coverage that any Enrollee is eligible to receive, subject to N.J.A.C. 11:4-28.7(e).

5.5 **Appeals.** Provider may appeal a decision denying Provider compensation to which Provider believes he or she is entitled under the terms of this ODS Agreement, and solely in connection with one or more claims, pursuant to the terms and procedures set forth below.

(i)Provider may appeal a determination of a Payor regarding payment of a claim, other than a Utilization Management determination, by submitting the matter, on or before the 90th

calendar day following Provider's receipt of notice of such determination, for internal review by the Payor. The Payor shall then conduct the internal review as follows:

(A) The review shall be carried out by employees of the Payor other than those responsible for claims payment on a day-to-day basis, at no cost to Provider;

(B) The review shall be concluded, and its results communicated to Provider in a written decision, within 30 days of receipt of the appeal; and

(C) The written decision shall include: (a) the names, titles and qualifying credentials of the persons participating in the review; (b) a statement of Provider's grievance; the decision of the reviewers, including a detailed explanation of the contractual and/or medical basis for such decision; (c) a description of the evidence or documentation that supports the decision; and (d) if the decision is adverse to Provider, a description of the method by which Provider may obtain an external review of the decision.

(ii) Any dispute regarding the determination of an internal appeal conducted pursuant to paragraph a above may be referred to state supervised binding arbitration, to be conducted by the arbitrator retained for that purpose by the New Jersey Commissioner of Banking and Insurance. Any Party may initiate such arbitration on or before the 90th calendar day following receipt of the determination which is the basis of the appeal, on a form prescribed by the New Jersey Commissioner of Banking and Insurance. Notwithstanding the foregoing, no dispute shall be accepted for arbitration unless the amount in dispute is $1,000 or more, but Provider may aggregate his or her disputed claim amounts for purposes of meeting this threshold.

(iii) Provider shall submit any complaint or grievance concerning ODS 's performance of its obligations under this ODS Agreement, other than an appeal regarding payment of claims or a Utilization Management determination, to ODS Provider Services at 800-352-6465 or by submitting the issue in writing to the Appeals Department c/o MagnaCare , 1600 Stewart Avenue, Suite 700, Westbury, NY 11590. ODS shall then conduct an internal review of the complaint or grievance, and shall determine a resolution within 30 days. If Provider is not satisfied with the resolution determined by ODS , Provider may then submit the matter to the New Jersey Department of Banking and Insurance.

(iv) To the extent that either Party is free to bring a suit against the other Party in connection with this ODS Agreement, instead of or in addition to addressing any disputes pursuant to the other dispute resolution provisions set forth in this Article 5, there is no limitation on the time period during which such suit may be brought, other than any relevant New Jersey or federal statute of limitation.

ARTICLE 6 - RESTRICTIVE COVENANTS

6.1 **Confidential Information.**

(i) **Covenants of Provider.** All information concerning the terms and conditions of this ODS Agreement or developed hereunder, including the rates of compensation hereunder, shall be kept confidential by Provider and shall not be disclosed, directly or indirectly, to a third party except as required by law (in which case the disclosing Party shall provide to the other Party prior notice of its intended disclosure which affords to the other Party reasonable time in which to attempt quash such disclosure) or to carry out such Party's respective obligations hereunder or, as to ODS , under a Payor Agreement. Provider shall maintain as confidential all non-public information relating to ODS ("ODS Proprietary Information"). For purposes of this Agreement,

"ODS Proprietary Information" shall include, but shall not be limited to: (i) the terms and conditions of all Payor Agreements; (ii), the financial arrangements between any provider and ODS, or any Payor and ODS; and (iii) confidential information relating to ODS' business operations, clients, strategic plans and/or finances. Except as expressly permitted by this Agreement, ODS covenants not to disclose to third parties any information relating to the business of Provider obtained by ODS in the course of the relationship contemplated under this Agreement ("Provider Proprietary Information"), or to use such information for any purpose except as required or permitted hereunder. This Section shall not apply to information which: (i) is provided to voluntary accreditation agencies, government agencies or Payors or which is required to be disclosed by law or is consented to be disclosed by Provider; (ii) is reasonably required by other health care providers involved in a particular patient's care or by Payors involved in payment therefore; (iii) ODS can show was lawfully made known to ODS prior to disclosure by Provider; (iv) ODS discloses in connection with marketing or supporting its affinity or related product or service offerings; or (v) is or becomes public knowledge through no fault of ODS.

(ii) The Parties agree that any remedy available at law for any breach or attempted breach of this section may be inadequate and that the damage to the non-breaching Party for such breach or attempted breach will be irreparable, and, accordingly, the Parties agree that in the event of a breach or attempted breach of this Section, the non-breaching Party shall be entitled to seek specific performance, injunctive or other equitable relief, in addition to any money damages or other remedies which may exist in law or equity.

ARTICLE 7 - TERM AND TERMINATION

7.1 **Term.** This ODS Agreement shall commence as of the Effective Date as defined herein and shall thereafter automatically renew for successive terms of one (1) year each unless terminated as provided below.

7.2 **Termination.** ODS Agreement may be terminated by either Party, with or without cause, upon at least 90 days advance written notice.

7.3 **Explanation of Termination.** If ODS terminates this ODS Agreement for any reason, other than as provided herein, and Provider so requests, ODS shall provide a written explanation for the termination, and shall conduct a hearing pursuant to the requirements of N.J.S. § 26:2S-8 within 30 days of the date of Provider's request. Notwithstanding the foregoing, ODS will not be obliged to provide a written explanation or conduct a hearing if:

(i) The termination is for breach of contract;

(ii) In the opinion of ODS's Medical Director, Provider represents an imminent danger to an individual patient or the public health, safety or welfare;

(iii) There is a determination of fraud; or

(iv) If ODS determines that Provider represents an imminent danger to an individual patient or the public health, safety or welfare, then ODS shall terminate this ODS Agreement immediately, and shall promptly notify the appropriate professional licensing board or boards. Notwithstanding anything contained in this Agreement to the contrary, if Provider is a Group Provider, ODS may, in its discretion, terminate or non-renew this ODS Agreement pursuant to this Article VII as to any

individual Group Provider(s) without otherwise effecting the duties and obligations of the non-terminated/renewed individual Group Provider(s), as to whom this ODS Agreement shall, in the sole discretion of ODS, otherwise remain in full force and effect.

7.4 **Rights and Obligations Upon Termination.** Upon the termination of this ODS Agreement, for any reason other than those reason specified in this Article 7, Provider shall remain obligated to provide services for Enrollees as follows:

(i) For up to four (4) months following the effective date of the termination in cases where it is Medically Necessary for the Enrollee to continue treatment with the Provider, except as provided in (ii) through (v) below;

(ii) In cases of pregnancy, through the postpartum evaluation of the Enrollee, up to six weeks after delivery;

(iii) In the case of post-operative care, up to six (6) months following the effective date of the termination;

(iv) In the case of oncological treatment, up to one (1) year following the effective date of the termination; and

(v) In the case of psychiatric treatment, up to one (1) year following the effective date of the termination.

(vi) Notwithstanding the above, Provider shall not be required to continue providing services, and neither ODS nor any Payer shall be obliged to pay Provider for services rendered after the effective date of the termination when the termination is based on breach or alleged fraud, or because, in the opinion of the Medical Director of ODS or the Payer, Provider presents an imminent danger to one or more Enrollees, or the public health, safety or welfare.

ARTICLE 8 - RECORDS AND DATA COLLECTION

8.1 **Maintenance of Records.** Provider shall maintain adequate and accurate records relating to all Covered Services provided to Enrollees by Provider and the cost thereof, in such form and containing such information as required by applicable Laws and in accordance with the standards of applicable accreditation agencies. All such records shall be the joint property of Provider and ODS, to the extent permitted by Law. Such records shall be retained by Provider for the length of time mandated by Law. The obligations created by this Section shall survive the termination of this ODS Agreement.

8.2 **Data.** Pursuant to appropriate consent/authorization by the Enrollee, the Provider will make the Enrollee's clinical records and other personally identifiable information (including encounter data for government-sponsored programs) available to the ODS and/or Payor for purposes including preauthorization, concurrent review, quality assurance, provider claims processing and payment.

8.3 **Confidentiality of Enrollee's Clinical Records.** Provider shall comply with all applicable Laws and all applicable standards, policies and procedures implemented or adopted by entities and agencies with authority over ODS or Payor, and those implemented or adopted by ODS or applicable Payors regarding the confidentiality and security of health information of an Enrollee ("Enrollee Information"), including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended, and any regulations promulgated thereunder ("HIPAA") and shall use and disclose such

information or records only in accordance with state and federal laws and Payor or ODS requirements, as applicable. If applicable, Provider agrees to abide by the Business Associate Agreement between the Parties. The obligations created by this Section 8.3 shall survive the termination of this ODS Agreement.

8.4 **Maintenance and Enrollee Access to Records.** Provider shall retain medical records of Enrollees for seven (7) years after the date of service rendered or, in the case of minors, seven (7) years after the age of majority, or for Covered Services rendered to a Medicare plan Enrollee, for ten (10) years following the termination of this ODS Agreement or the completion of a CMS audit, whichever is later. Provider shall document in an Enrollee's medical record whether the Enrollee has executed an advanced directive. This provision shall survive termination of this ODS Agreement for any reason. Copies of all such records shall be provided at no cost to ODS and/or Payors. Provider's obligations set forth in this Section shall survive termination of this ODS Agreement.

8.5 **Government Access to Records.** In accordance with applicable laws and regulations, Provider shall release to any federal, state and/or local agency or accrediting organization all records or copies of such records within the possession of Provider related to the Covered Services provided to Enrollees under this ODS Agreement if such access is necessary to comply with accreditation standards, statutes or regulations applicable to Provider.

8.6 **Audit.**

(i) Provider shall maintain and provide any other records related to the provision of Covered Services which ODS or a Payor may reasonably request for regulatory compliance and shall cooperate with ODS and Payors in all fiscal and medical audits, site inspections, peer reviews, utilization reviews, credentialing, recredentialing and any other monitoring required by a regulatory or accreditation agency. Any such record shall be delivered to ODS and/or the applicable Plan within five (5) business days of a request for such record;

(ii) Provider shall promptly comply with all directives and recommendations issued as a result of any such inspection or audit; and

(iii) A Payor or ODS may use statistical samples and other appropriate external audit and fraud and abuse and detection devices in conducting audits of Provider's records, books, papers, information and documents.

8.7 **Disclosure of Provider Information and Records.** Subject to all applicable confidentiality laws, Provider hereby authorizes ODS and/or Payor to release any and all information specific to Provider, (including, but not limited to, utilization profiles, encounter data, treatment plans, outcome data and other information pertinent to Provider's performance of Covered Services and/or, the professional qualifications of its staff and/or other credentialing information), to applicable government authorities, Payors and other entities. This provision shall survive the termination of this ODS Agreement.

8.8 **Listings of Providers.** Provider agrees that ODS and Payors may list Plan Participating Provider's name(s), address, telephone number, description of its services, and such other information as deemed relevant, in ODS's and/or Payors' rosters of Participating Providers and such other listings, directories and publications as ODS or Payor may produce from time to time.

ARTICLE 9 - NOTICES

9.1 **Notices.** Any notice or other communication by either Party to the other shall be in writing and effective when delivered personally, by facsimile transmission (with confirmation), through private delivery services, by electronic means agreed upon by the Parties, or by Certified U.S. Mail to the applicable Party at its address set forth with its signature, or to such other address, and to the attention of such other person or officer, as either Party may designate in writing in accordance with this Section. Mailed notices shall be deemed received three (3) business days following mailing. Notices to ODS shall be sent to: Chief Legal Officer, Brighton Health Network, LLC, One Penn Plaza, Suite 5300, New York, New York 10199.

ARTICLE 10 - MISCELLANEOUS

10.1 This ODS Agreement and the exhibits attached hereto constitute the only agreement and the entire understanding between the Parties hereto relating to the matters herein contained. The terms and provisions of this ODS Agreement are hereby declared to be severable, so that if any terms or provisions or part thereof are held invalid or unenforceable, such validity or unenforceability shall not affect the validity or enforceability of the other provisions hereof.

10.2 No provision of this ODS Agreement is intended to create, nor shall be deemed or construed to create, any relationship between ODS and Provider other than that of independent entities contracting with each other hereunder solely for the purpose of effectuating the provisions of this ODS Agreement. Neither of the Parties hereto, nor any of their respective officers, directors or employees, shall be construed to be the agent, employee, or representative of the other, except as specifically provided herein. Neither Party may make any claim against the other for social security benefits, worker's compensation benefits, unemployment insurance benefits, vacation pay, sick leave or any other employee benefit of any kind. Provider is not authorized to speak or act on behalf of ODS for any purpose whatsoever without the prior written consent of ODS.

10.3 The waiver by any Party hereto of a breach of any provision of this ODS Agreement shall not operate or be construed as a waiver of any subsequent breach by any Party.

10.4 In the event that either Party brings legal action relating to this ODS Agreement, the prevailing Party shall be entitled to payment by the other of all reasonable attorneys' fees, costs and expenses incurred in such action.

10.5 This ODS Agreement and the rights and obligations hereunder shall not be assignable by either Party hereto except that ODS shall have the right to assign its rights and obligations hereunder to any corporation that is a subsidiary, parent, or affiliate of ODS. Provider may not assign Provider's rights and obligations to any person or entity without the prior written consent of ODS and any attempted assignment without such prior written consent shall be void. Subject to the foregoing, this ODS Agreement shall inure to the benefit of and be binding upon the Parties hereto and also their respective heirs, assigns, and successors in interest of any kind whatsoever.

10.6 Provider shall not have the right to subcontract this ODS Agreement or any of the rights or obligations thereunder without the prior, written consent of ODS.

10.7 All terms and words used in this ODS Agreement regardless of the number or gender in which they are used shall be deemed to include any number and any gender as context may require.

10.8 Any obligation of the Parties or provision of this ODS Agreement which by its nature is intended to survive the termination of this ODS Agreement shall survive such termination.

10.9 This ODS Agreement shall be interpreted and enforced in accordance with the laws of the State of New Jersey, without giving effect to conflict of law principles. Each Party hereby agrees and consents to the in personam jurisdiction of and venue in the courts of the State of New Jersey with respect to any dispute or controversy arising under or in connection with this ODS Agreement. The Parties shall meet in good faith negotiations in order to resolve any disputes arising hereunder.

10.10 Neither ODS nor any Payors by this ODS Agreement or otherwise, guarantees to Provider the opportunity to provide Covered Services to any minimum number of Enrollees.

10.11 ODS may amend this ODS Agreement at any time on thirty (30) days' prior written notice, or less, if reasonably required by a Payor. Changes in any ODS Policies and Procedures shall not be deemed amendments of this ODS Agreement. ODS may amend the ODS Agreement upon less than thirty (30) days' notice to comply with the requirements of state and federal regulatory authorities and shall provide Provider with a copy of any such amendment and its effective date. Unless such regulatory authorities direct otherwise, the signature of Provider will not be required for such an amendment. Written notice shall include by electronic means, as provided by Section 9.1 above. All amendments, excluding those excepted by N.J.A.C. 11:24B-5.2, are subject to the prior approval of the New Jersey Department of Banking and Insurance ("DOBI").

10.12 This ODS Agreement may be executed in any number of counterparts, each of which shall be an original, but all of which, together, shall constitute one and the same agreement.

10.13 This ODS Agreement and all amendments and exhibits and hereto shall be subject to the prior approval of the New Jersey Department of Banking and Insurance, and may not be effectuated without such approval.

10.14 Exhibit 1, which is applicable in cases where Provider is providing Covered Services paid for by New Jersey Medicaid, is incorporated herein.

10.15 ODS will act as agent for Provider with regard to the remittance of payment for claims by Payors, and in its capacity as agent will assist Provider in resolving any claims adjudication issues that Provider may have with Payors.

10.16 This ODS Agreement and any attachments, exhibits or any other documents incorporated and referred to herein, constitutes the entire ODS Agreement between the Parties with respect to the subject matter hereof and supersedes any and all other agreements, whether oral or written, regarding the same. To the extent there is a conflict between a provision in the body of the ODS Agreement and any other document attached hereto, the terms of the Agreement shall control, provided, however, that in the event of an inconsistency between any provision in the body of this ODS Agreement and any provision set forth in Exhibit 1 attached hereto, the provision set forth in such Exhibits shall control.

EXHIBIT 1 (of New Jersey ODS Participating Provider Agreement)
New Jersey Standard Medicaid Clauses

Notwithstanding anything to the contrary contained in the ODS Agreement, when rendering services to New Jersey Medicaid Members, Provider agrees to abide by the terms of this Exhibit, which is incorporated by reference into the ODS Agreement its entirety.

The provisions of this Exhibit apply to health care services rendered by Provider (also referred to herein as "Provider/Sub-contractor") to Medicaid/NJ FamilyCare eligible enrollees. ("Medicaid Member(s)"). This Exhibit constitutes an amendment to the ODS Agreement, and also referred to herein as "contract/subcontract") and hereby expands the scope of the ODS Agreement, including the definition of Benefit Plan to include Medicaid Members. This Exhibit also shall be deemed to incorporate herein the pertinent provisions of the contract between the applicable Payor (also referred to herein as "contractor") and the New Jersey Department of Human Services, Division of Medical Assistance and Health Services ("DMAHS"). In the event of any conflict between the provisions of the ODS Agreement, the applicable Payor's Policies and Procedures, and this Exhibit, the provisions of this Exhibit control as related to services rendered to Medicaid Members.

Whenever in this Exhibit the term "Provider" is used to describe an obligation or duty, such obligation or duty shall also be the responsibility of each individual licensed health care practitioner, facility and provider employed or owned by or under contract with the Provider, as the context may require.

a. This Exhibit is subject to the following laws and all amendments thereof: Title XIX and Title XXI of the Social Security Act, 42 U.S.C. 1396 et. seq., 42 U.S.C. 1397aa et seq., the New Jersey Medical Assistance Act and the Medicaid, and NJ KidCare and NJ FamilyCare State Plans approved by CMS (N.J.S.A. 30:4D-1 et seq.; 30:4J-8 et seq.); federal and state Medicaid and Children's Health Insurance Program, and NJ FamilyCare regulations, other applicable federal and state statutes, and all applicable local laws and ordinances.
b. Provider agrees to fully cooperate with the applicable Payor in fulfilling its responsibilities under its contract with DMAHS. This shall include, but not be limited to, compliance with a written request from DMAHS to withhold all or part of any payments that are owed by the applicable Payor to Provider in connection with any recovery claim initiated by DMAHS against Provider, whether or not that recovery claim arises out of Provider's fee-for-service or managed care participation. In such case, the applicable Payor shall withhold all or part of any payments that are owed to Provider up to the amount of DMAHS's recovery claim, and the applicable Payor shall remit those payments to DMAHS as required by law.
c. Provider acknowledges that the responsibilities performed by Provider shall be monitored on an ongoing basis and the applicable Payor is ultimately responsible to the Department for the performance of all services performed under the Provider Participation ODS Agreement. Provider agrees to cooperate and comply with all performance monitoring activities employed by the applicable Payor to ensure that performance is consistent with the contract between the applicable Payor and the Department. The applicable Payor retains the right to revoke the Provider Participation Agreement if Provider does not perform satisfactorily.
d. 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.

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.

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.

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," the contractor's notice to DMAHS shall include the reasons for the termination. Provider resource consumption patterns shall not constitute "cause" unless the contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers.

F. ENROLLEE-PROVIDER COMMUNICATIONS

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

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

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 BY THE STATE OF NEW JERSEY

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

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

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

3. Has its certification suspended or revoked by DOBI, DHSS, and/or any federal agency or is federally debarred or excluded from federal procurement and non-procurement contracts;

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

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

6. Materially breaches the provider contract/subcontract; or

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

I. NON-DISCRIMINATION

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

1. The Provider/Subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation,

national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

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

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 the applicable Payor 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 the applicable Payor 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 balance billing as described within the payment in-full provision of N.J.S.A. 30:4D-6(c).

K. INSPECTION

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

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

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this provider contract/subcontract, including working papers, reports, financial records and books of account, medical records, dental records, prescription files, provider contracts and

subcontracts, credentialing files, and any other documentation pertaining to medical, dental, and nonmedical services to enrollees. Upon request, at any time during the period of this provider contract/subcontract, the provider/subcontractor shall furnish any such record, or copy thereof, to the Department or the Department's External Review Organization within 30 days of the request. If the Department determines, however, that there is an urgent need to obtain a record, the Department shall have the right to demand the record in less than 30 days, but no less than 24 hours.

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

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

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

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

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

L. RECORD MAINTENANCE

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

M. RECORD RETENTION

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

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

2. Three (3) years after final payment is made under the provider contract/subcontract and all pending matters are closed.

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

If an enrollee disenrolls from the contractor, the provider/subcontractor shall release medical records of the enrollee as may be directed by the enrollee, authorized representatives of the Department and appropriate agencies of the State of New Jersey and of the federal government. Release of records shall be consistent with the provision of confidentiality expressed in Section 2.R., Confidentiality, and at no cost to the enrollee.

N. DATA REPORTING

The provider/subcontractor agrees to provide all necessary information to enable the contractor to meet its reporting requirements, including specifically with respect to encounter reporting. The encounter data shall be in a form acceptable to the State.

O. DISCLOSURE

1. The Provider/Subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the contractor's agreement with the State.

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

3. The Provider/Subcontractor shall comply with the disclosure requirements concerning ownership and control, related business transactions and persons convicted of a crime pursuant to 42 CFR 455.100-106.

P. LIMITATIONS ON COLLECTION OF COST-SHARING

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

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

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

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

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

4. The Provider/Subcontractor agrees further to indemnify and hold harmless the State, its officers, agents and employees, and the enrollees and their eligible dependents, from all claims, damages, and liability, including costs and expenses, for violation of any proprietary rights, copyrights, or rights of privacy arising out of the publication, translation, reproduction, delivery, performance, use, or disposition of any data

furnished to it under this provider contract/subcontract, or for any libelous or otherwise unlawful matter contained in such data that the provider/subcontractor inserts.

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

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the Provider/Subcontractor and the contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.4. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the contractor's plan that are eligible through the Division of Youth and Family Services, records shall be kept in accordance with the provisions under N.J.S.A. 9:6-8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

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

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

4. Medical Records and management information data concerning enrollees shall be confidential and shall be disclosed to other persons within the provider's/subcontractor's organization only as necessary to provide medical care and quality, peer, or grievance review of medical care under the terms of this provider contract/subcontract.

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

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

S. CLINICAL LABORATORY IMPROVEMENT

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

T. FRAUD, WASTE, AND ABUSE

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

2. If the State has withheld payment and/or initiated a recovery action against the Provider/Subcontractor, or withheld payments pursuant to 42 CFR 456.23 and NJAC 10:49-9.10(a), the contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

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

U. THIRD PARTY LIABILITY

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

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

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

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

b. The claim is for prenatal care for a pregnant woman or for preventive pediatric services (including EPSDT services) that are covered by the Medicaid program.
c. The claim is for labor, delivery, and post-partum care and does not involve hospital costs associated with the inpatient hospital stay.

d. The claim is for a child who is in a DYFS supported out of home placement.

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

4. If the Provider/Subcontractor knows that the third party will neither pay for nor provide the covered service, and the service is medically necessary, the Provider/Subcontractor may bill the contractor without having received a written denial from the third party.

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

a. The Provider/Subcontractor shall notify the contractor within thirty (30) days after it learns that an enrollee has health insurance coverage not reflected in the health insurance provided by the contractor, or casualty insurance coverage, or of any change in an enrollee's health insurance coverage.
b. When the Provider/Subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the Provider/Subcontractor shall notify the contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the Provider's/Subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.
c. The Provider/Subcontractor shall notify the contractor within thirty (30) days of the date it becomes aware of the death of one of its Medicaid enrollees age 55 or older, giving the enrollee's full name, Social Security Number, Medicaid identification number, and date of death.
d. The Provider/Subcontractor agrees to cooperate with the contractor's and the State's efforts to maximize the collection of third party payments by providing to the contractor updates to the information required by this section.

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

1. As a general rule, if a participating or non-participating provider renders a covered service to a managed care enrollee, the provider's sole recourse for payment, other than collection of any authorized cost-sharing and /or third party liability, is the contractor, not the enrollee. A provider may not seek payment from, and may not institute or cause the initiation of collection proceedings or litigation against, an enrollee, an enrollee's family member, any legal representative of the enrollee, or anyone else acting on the enrollee's behalf unless subsections (a) through and including (f) or subsection (g) below apply:

a. (1) The service is not a covered service; or (2) the service is determined to be medically unnecessary before it is rendered; or (3) the provider does not participate in the program either generally or for that service; and
b. The enrollee is informed in writing before the service is rendered that one or more of the conditions listed in subsection (a) above exist, and voluntarily agrees in writing before the service is rendered to pay for all or part of the provider's charges; and
c. The service is not an emergency or related service covered by the provisions of 42 USC 1396u-2(b)(2)(A)(i), 42 CFR 438.114 and/or NJAC 10:74-9.1; and
d. The service is not a trauma service covered by the provisions of NJAC 11:24-6.3(a)3.i; and
e. The protections afforded to enrollees under 42 USC 1396u-2(b)(6), 42 CFR 438.106, NJAC 11:24-9.1(d)9, and/or NJAC 11:24-15.2(b)7.ii do not apply; and
f. The provider has received no program payments from either DMAHS or the contractor for the service; or
g. The enrollee has been paid for the service by a health insurance company or other third party (as defined in NJSA 30:4D-3.m), and the enrollee has failed or refused to remit to the provider that portion of the third party's payment to which the provider is entitled by law.

2. Notwithstanding any provision in this contract to the contrary, an enrollee shall not be responsible for the cost of care, except for any authorized cost-sharing, under the following circumstances:

a. The services are provided in association with an emergency department visit or inpatient stay at a participating network hospital, whether or not the servicing provider(s) or the admitting physician is a participating provider in the contractor's network; or
b. The enrollee obtains a referral/authorization for services by, and schedules an appointment with, a participating specialist, but a non-participating specialist affiliated with the same practice as the participating specialist renders the services because the participating specialist is not available.

EXHIBIT 2 (of New Jersey ODS Participating Provider Agreement)
PROVISIONS APPLICABLE TO MEDICARE ENROLLEES

Except as provided herein, all other provisions of the Agreement between Brighton Health Network, LLC d/b/a MagnaCare and Provider not inconsistent herein shall remain in full force and effect. This amendment shall supersede and replace any inconsistent provisions to such Agreement; to ensure compliance with required CMS provisions, and shall continue concurrently with the term of such Agreement.

NOW, THEREFORE, the Parties agree as follows:

Definitions:

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

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

Downstream Entity: any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between an MA organization (or

applicant) and a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

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

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

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

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

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

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

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

Required Provisions:

Provider agrees to the following:

1. HHS, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any pertinent information for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of the first tier, downstream, and entities related to CMS' contract with [Entity Name], (hereinafter, "MA organization") through 10 years from the final date of the final contract period of the contract entered into between CMS and the MA organization or from the date of completion of any audit, whichever is later. [42 C.F.R. §§ 422.504(i)(2)(i) and (ii)]
2. Provider will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118]

3. Enrollees will not be held liable for payment of any fees that are the legal obligation of the MA organization. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
4. For all enrollees eligible for both Medicare and Medicaid, enrollees will not be held liable for Medicare Part A and B cost sharing when the State is responsible for paying such amounts. Providers will be informed of Medicare and Medicaid benefits and rules for enrollees eligible for Medicare and Medicaid. First Tier or Downstream Entity may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such a plan. Providers will: (1) accept the MA plan payment as payment in full, or (2) bill the appropriate State source. [42 C.F.R. §§ 422.504(i)(3)(i) and 422.504(g)(1)(i)]
5. Any services or other activity performed in accordance with a contract or written agreement by Provider are consistent and comply with the MA organization's contractual obligations. [42 C.F.R. § 422.504(i)(3)(iii)]
6. Contracts or other written agreements between the MA organization and providers or between first tier and downstream entities must contain a prompt payment provision, the terms of which are developed and agreed to by the contracting parties. The MA organization is obligated to pay contracted providers under the terms of the contract between the IPA and/or ODS and the provider. [42 C.F.R. §§ 422.520(b)(1) and (2)]
7. Provider and any related entity, contractor or subcontractor will comply with all applicable Medicare laws, regulations, and CMS instructions. [42 C.F.R. §§ 422.504(i)(4)(v)]

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