2025 AMENDMENT

AETNA PRODUCER AGREEMENT

In accordance with the terms and conditions of the Aetna Producer Agreement (the "**Agreement**") by and between Aetna Health Management, LLC, a Delaware limited liability company, on behalf of itself and its affiliates ("**Aetna**") and Producer (as defined in the Agreement), Aetna hereby amends the Agreement, effective as of October 1, 2024 (this "**Amendment**"). Capitalized terms used herein but not defined shall have the meanings given to such terms in the Agreement.

1. **Section A(12) of the Producer Agreement is hereby amended by deleting the first sentence and replacing it with the following:**

   "Producer and subcontractors or other persons purporting to work on their behalf shall comply with all applicable laws regarding (i) the recording and/or monitoring of telephone calls, (ii) audible notice requirements regarding the recordation and/or monitoring of telephone calls (including notifying such individual or entity at the inception of the call that such calls will be recorded and monitored), (iii) obtaining consent at the inception of the recordation and/or monitoring of telephone calls, (iv) the storage, privacy, security and destruction of any recorded telephone calls; and/or (v) performing autodialed or prerecorded calls, sending text messages, and outreaching to individuals on internal or external do not call lists."

2. **Section A(12)(a) of the Producer Agreement is hereby amended by adding the following:**

   "Producer will ensure that any requests from a member to be placed on Company's "do not call" lists are shared with the Company within five (5) business days;"

3. **Section B(2)(C) of the Producer Agreement is hereby amended by adding the following**: "or Producer's failure to notify Company in writing regarding any such violation;"

4. **Section D(2) of the Producer Agreement is hereby amended by deleting** "Producer Guides"

5. **Section 1 of the Medicare Product Addendum is hereby amended by adding the following to the first sentence**: "COMPANY COMMUNICATIONS" **and further amended by adding the following last sentence:** "Contracted Producers, excluding LOAs, may be contacted by Company via e-mail, phone, text, or other electronic communication as part of their contractual relationship."

6. **Section 2(B) of the Medicare Product Addendum is hereby amended by deleting the second sentence and replacing it with the following**:

   "In its sole discretion, Company may refuse to appoint, refuse to grant Ready to Sell status, discontinue or terminate the appointment or otherwise limit the authority to sell of any Producer at any time."

7. **Section 5(A) of the Medicare Addendum is hereby amended by deleting the first sentence and replacing it with the following:** "Service programs may be available to Producers in participating markets (as determined by Company)."

8. **Section 7(C) of the Medicare Addendum is hereby amended by adding the following after the second sentence:** "In addition, Producer will comply with all applicable laws and regulations in contacting a Medicare Product enrollee, including but not limited to the Telephone Consumer Protection Act (TCPA) and implementing regulations. In particular, Producer agrees to comply with all applicable laws and regulations regarding the generation and use of consumer leads, including ensuring that the prior express written consent from the Medicare Product enrollee has been collected before performing any telemarketing or promotional outreach. Producer shall ensure that all messages are logically and topically related to the consumer's consent and maintain accurate records of all consents obtained. Producer shall also report back to Company any do not call requests received from a Medicare Product enrollee."

9. **New Jersey Fully Integrated Dual-Eligible Regulatory Compliance Addendum is hereby amended by deleting Sections A and B in their entirety and replacing them with the following:**

"A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

This provider contract/subcontract shall be subject to the applicable material terms and conditions of the contract between the Contractor and the State and shall also be governed by and construed in accordance with all laws, regulations and contractual obligations incumbent upon the Contractor. MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2024, dependent upon available appropriation. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2024. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers.

2. The Any Willing Plan status also expires June 30, 2024.

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

Contractor and the pharmacy.

4. Claims payment for services to MLTSS Members. The Contractor shall process (pay or deny) claims for assisted living providers, nursing facilities, special care nursing facility, CRS providers, adult/pediatric medical day care providers, PCA and self directed Vendor Fiscal/Employer Agent Financial Management Services (VF /EA FMS) claims within the following timeframes:
    1. HIPAA compliant electronically submitted clean claims shall be processed within fifteen (15) calendar days of receipt;
    2. Manually submitted clean claims shall be processed within thirty (30) calendar days of receipt.

5. Nursing Facility Quality Incentive Payment Program (NF QIPP). The NF QIPP leverages quality outcome performance rate add-ons to state set Medicaid NF rate payments and is dependent on budget appropriations. The NF QIPP uses selected quality measures that includes Minimum Data Set (MDS) measures that are collected by CMS as part of the federally mandated process for clinical assessment of all residents in Medicare and Medicaid certified nursing homes. DHS utilizes standard quarters that are both finalized (no further revisions by CMS) and publicly available. One annual resident and family satisfaction survey measure collected by NJ is also utilized. The CoreQ Long Stay Satisfaction Survey is the tool utilized to determine an overall composite satisfaction score.

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 NJFamilyCare State Plans, and in accordance with procedures and requirements as may from time to time be promulgated by the United States Department of Health and Human Services.

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

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

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

4. Electronic Visit Verification (EVV)
    a. The Contractor shall develop or purchase and implement an electronic visit verification system to monitor member receipt and utilization of personal care services including at a minimum, personal care assistance, home based supportive care and in-home respite. This includes all applicable self-directed personal care services.

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

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

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

d. The Contractor shall monitor all manual confirmations and take action to eliminate manual confirmations to ensure compliance with 21st Century Cures Act EVV system requirements by January 1, 2022.
    I. Contractor shall pay claims for visits recorded in an EVV system which may require manual intervention.
    II. The Contractor shall utilize an exceptions process as specified by DMAHS for visits recorded manually and outside the EVV system.

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

f. The Contractor shall select its own electronic visit verification vendor, as applicable, and shall ensure, in the development of its EVV system, the following minimal functionality:
    I. The ability to effectively connect with the state procured contracted EVV aggregator;
    II. The ability to receive and store service authorizations for individual members;
    III. The ability to log the arrival and departure of an individual provider staff person or worker, through the use of a mobile device, member landline telephone or a static GPS device, when mobile and landline service is not available;
    IV. Contractor shall maintain records of unique staff identifier to allow for auditing and reporting for program integrity;
    V. The ability to verify in accordance with business rules that services are being delivered in the correct location (e.g., the member's home);
    VI. The ability to match services provided to a member with services authorized in the plan of care;
    VII. The ability to ensure that the provider/worker delivering the service is authorized to deliver such services;
    VIII. The ability to create a schedule of services from the service authorizations entered for each member which identifies the amount, frequency, duration and scope of each service, and any schedule specified in which services are needed or preferred by the member;

IX. Ensure that workers are scheduled by providers in accordance with such authorization, including any schedule of services specified; and to ensure providers' adherence to the established schedule;
X. The ability to distinguish between electronic confirmation versus manual confirmation.

g. The EVV system shall have the ability to receive and store service authorizations and service schedules as required. Schedule data must be used to compare to visit verification.
   I. The ability to identify gaps in care and provide system-generated reporting regarding each provider's compliance with scheduling requirements, late and missed visits, and other data specified by DMAHS;
   II. The ability to allow more flexible scheduling options, including the option for open scheduling while still performing all remaining system functions;
   III. The ability to receive and store updated authorizations and provide timely notification to the provider of the updates
   IV. Outline the process for provider to update schedules based on changes in authorization information.
   V. The ability to capture worker notes per service provided and provide such notes to the provider, MCO and DMAHS as appropriate, upon request;
   VI. Access to the EVV system and a dashboard for DMAHS to conduct monitoring of the Contractor's performance with the requirements detailed above;

h. The Contractor shall establish business processes regarding EVV and ensure efficient operation of EVV. The Contractor must ensure the following:
   I. Timely as defined by 4.6.4B of this Contract.
   II. Consistency between MCO authorizations, and the authorizations reflected in the EVV system.
   III. Timely remediation of issues associated with claims rejections or denials in order to provide appropriate claims adjudication for services delivered
   IV. Ongoing monitoring of the total volume of rejected or denied claims due to issues with the EVV system.
      a. In instances where systems outages, breakdowns, etc. are identified, the Contractor shall notify DMAHS and providers immediately.
   V. Contractor shall collaborate with the Fiscal Intermediary for Self-Direction to determine root cause for rejections or denials.
   VI. Contractor shall perform monthly program integrity audits of rendering provider credentials (certified home health aide, registered nurse, licensed practical nurse, physical therapist, cognitive therapist, occupational therapist, speech therapist) to verify services were provided by the authorized provider for such service. If it is determined that the credentials are incorrect, expired, or missing the Contractor shall adhere to A.7.2.1A and 7.36.5 et al (RECOVERIES AND OVERPAYMENTS) of the MCO contract."

10. New Jersey Fully Integrated Dual-Eligible Regulatory Compliance Addendum is hereby amended by deleting Section M(5)(g)((ix) in its entirety and replacing it with the following:

"An offer of social service assistance; and, if requested, referral to County Social Service Agency."

11. New Jersey Fully Integrated Dual-Eligible Regulatory Compliance Addendum is hereby amended by deleting Section N in its entirety and replacing it with the following:

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

1. For acute care general, private psychiatric, specialty and comprehensive rehabilitation hospitals, the provider/contractor shall submit inpatient claims to the Contractor based on the medical record and services provided. The inpatient claim shall include, but not be limited to the following:
   a. Diagnosis Code
   b. Procedure Code
   c. Sex
   d. Discharge Status Code
   e. Date of Birth
   f. Newborn Birth Weight
   g. Admission Date
   h. Discharge Date
   i. Skilled level of Care (SNF) or Administrative Days and associated dates
   j. Residential level of Care (denied days) and associated dates

2. The resulting Contractor generated encounter record shall be subject to review by the New Jersey Utilization Review (NJUR) Vendor.
   a. In the event that the NJUR review results in an adverse determination, the provider/subcontractor shall adjust the claim pursuant to the adverse determination or appeal the decision utilizing the NJUR appeal process."

12. New Jersey Fully Integrated Dual-Eligible Regulatory Compliance Addendum is hereby amended by deleting Section T(7) in its entirety and replacing it with the following:

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

   a. State of New Jersey debarment list (mandatory): **https://nj .gov/comptroller/doc/nj debarment list.pdf**
   b. Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/
   c. N.J. Treasurer's exclusions database (mandatory): **http://www.state.nj.us/treasury/revenue/ debarment/ debarsearch.shtml**
   d. N.J. Division of Consumer Affairs licensure databases, including all licensed healthcare professionals (mandatory, if applicable): http://www.njconsumeraffairs.gov/Pages/verification.aspx
   e. N.J. Department of Health licensure and certification database, including: Nursing Home Administrators, Certified Assisted Living Administrators, Certified Nurse

Aides/Personal Care Assistants, and Certified Medication Aides (mandatory, if applicable):
https://njna.psiexams.com/

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

13. **Commencing with Sales relating to Medicare Products having effective dates in 2025, the compensation schedule(s) of the Agreement is hereby replaced with a new compensation schedule(s), which is attached hereto and incorporated into the Agreement by reference.**

14. To the extent of any conflict (as determined by Aetna) between this Amendment and the Agreement, this Amendment supersedes all prior agreements, addendums or exhibits relating to the subject matter hereof.

15. This Amendment shall be governed by the laws of the state of Connecticut without regard to its conflict of laws provisions. Venue for any action shall be in a court located.

MEDICARE PRODUCT ADDENDUM
TO THE PRODUCER AGREEMENT

The requirements set forth in this Medicare product addendum (the "Medicare Product Addendum") shall apply to the sales of Medicare Advantage and Medicare Part D plans (collectively, "Medicare Products") made by Producer on behalf of Company and, with respect to Medicare Products, its terms shall control in the event of a conflict with the terms of any other part of this Agreement. Capitalized terms not otherwise defined in this Medicare Product Addendum shall have the meanings ascribed to them elsewhere in this Agreement.

1. **PRODUCER DUTIES; LIMITATION OF AUTHORIZATION**. Producer agrees to sell Medicare Products on behalf of Company and, if applicable, perform administrative and other duties related to such sales in accordance with the terms of this Agreement. Producer agrees to be bound to this Agreement, agrees that it has the authority to bind its downline Producers, employees and principal, if applicable, to this Agreement, and further agrees that such parties are hereby bound to this Agreement. Producer shall not solicit or collect premiums from any Medicare member or prospective Medicare member. Except as permitted and/or required by this Agreement, Producer is not authorized to make any payment to any party in connection with this Agreement or any Medicare Products unless such payment is first authorized by Company.

2. **READY TO SELL REQUIREMENTS**

   A. Prior to selling Medicare Products, Producer must be "Ready to Sell." Producer shall be Ready to Sell only if Producer (i) has completed, and is currently compliant with, all applicable Company and Centers for Medicare and Medicaid Services ("CMS") requirements, including having the appropriate licenses and being appointed by the legal entity applicable to the Medicare Products being sold by Producer and (ii) has verified Ready to Sell status with Company. Producer shall cease all selling activities immediately and notify Company in the event Producer ceases to meet any of the Ready to Sell requirements. If Producer is an upline, Producer shall also be Ready to Sell in each state in which its agents are selling.

   B. Company may require Producer or its upline to be responsible for any fees associated with the appointment of the Producer by Company. In its sole discretion, Company may refuse to appoint, refuse to grant Ready to Sell status, or discontinue or terminate the appointment of any Producer at any time. Company may approve or deny contract with Producer in Company's sole discretion.

3. **UPLINE ADMINISTRATIVE SERVICES**

   A. If Producer is an upline, Producer shall also perform the following administrative services in consideration for the administrative fees included in the compensation schedules provided by Company: (i) upline shall, and shall require its Producers (including its principal), to comply with the terms and conditions of this Agreement; (ii) upline shall conduct periodic training programs for its Producers and other employees on marketing, sales, and the Medicare Products; (iii) upline must maintain records of its Producers' compliance with Company's and CMS' testing and training requirements, executed Producer Agreements between Company and Producer, as well as evidence of licensure, completion of Company-required forms and evidence of compliance with Company and CMS requirements; (iv) upline shall assist Company with communicating with upline's Producers and with the oversight and management of such Producers; (v) upline shall provide contracting and other support for its Producers, including providing assistance with data reporting and issue resolution and (vi) upline shall promptly notify Company upon becoming aware that upline, its principal or any of its Producers is no longer compliant with this Agreement and shall ensure that any such non-compliant selling activities ceases.

   B. If Producer is an upline, the upline may change its designation of the principal, upon notice to Company in accordance with Company's principal change guidelines.

C. If Producer is an upline, Producer represents that it is authorized to bind any LOA under upline to the terms and conditions of this Agreement and that it will ensure that LOAs meet Ready to Sell requirements. Upon notice to Upline, Company shall have the right to audit upline's payments to its LOAs, including any charge backs assessed against LOAs, for sales of Medicare Products.

D. Subject to Company's approval, upline may add or terminate any producer in upline's hierarchy, including, but not limited to, non-LOAs. Producers may leave an upline's hierarchy as set forth in the Medicare Producer guidebook made available to Producer by Company (the "Medicare Producer Guide").

4. **TELEPHONIC ENROLLMENT SERVICES**

The following shall apply to Producers that provide telephonic enrollment services:

A. Prior to providing telephonic enrollment services, Producer shall obtain all necessary approvals, and be in compliance with applicable laws and CMS requirements contained in the Medicare Enrollment and Disenrollment guidance (including CMS guidance on telephonic enrollment) and the requirements set forth in the Medicare Producer Guide. In addition, Producer shall also obtain separate and specific approval from Company before using telephonic enrollment services to sell Company's DSNP plans. With respect to calls which substantively relate to Medicare Products or involve the marketing of or enrollment in such Medicare Products, Producer must have Ready to Sell status. Customer service representatives may only be used to field clerical questions, such as inbound calls inquiring as to the status of an already submitted application. Licensed Producers shall only handle calls from Medicare Product enrollees and prospective Medicare Product enrollees residing in states where the Producer is licensed and appointed.

B. Producer shall have the ability to support calls from individuals who cannot speak or hear (including TDD services) and the ability to access translation services for individuals who do not speak English. Producer must inform callers that translation services are free. All telephone calls made or received by Producer during which an enrollment in a Medicare Product or a scope of appointment was completed must be recorded in their entirety and provided to Company in a format that allows for Company to retrieve any call by a specific caller, upon request. In addition, Producers are required to use a CMS or Company approved script. Producer shall maintain copies of recordings in accordance with the record retention requirements set forth Section 9. Producer shall provide Company with copies of recorded calls within forty-eight (48) hours of Company's request.

5. **ADDITIONAL SERVICE PROGRAMS.**

A. Services programs which includes, but is not limited to, Health Risk Assessment (HRA) is available to Producers in participating markets (as determined by Company). Producers will receive service fees as set forth in the compensation schedule provided by Company in Producer World ("Service Fees"). Company reserves the right to modify Service Fees from time to time under any service program upon notice to Producer. Company reserves the right to suspend or deny payments to any Producer who, in Company's sole discretion, does not meet the requirements for receipt of the Service Fees or does not perform the services in compliance with applicable laws, including CMS requirements, and this Agreement.

6. **COMPENSATION**.

A. Producer shall receive compensation as set forth in the compensation schedules provided by Company for services performed under this Medicare Product Addendum, if Producer, in Company's sole discretion, meets all applicable requirements for receipt of such compensation, including meeting CMS requirements for receipt of compensation. If Producer is an upline, Producer shall also receive the administrative fees included in the compensation schedules provided by Company. Company may recoup, by means of an offset or otherwise, any amounts paid which do not comply with this Agreement or applicable laws. Producer shall have no cause of action against Company for any

amounts that cannot be paid or that are recouped under the terms of this Agreement or in accordance with applicable laws. If Producer believes that Company has underpaid or failed to make a payment owed to Producer, Producer must notify Company within twenty-four (24) months of the date of Producer's receipt of the alleged underpayment or, with respect to a missing payment, within twenty-four (24) months of the applicable policy effective date. Company will only pay compensation for renewals to Producer if (i) this Medicare Product Addendum is in effect or (ii) the Producer has been terminated without cause and has ceased selling Medicare Products. To receive renewal compensation Producer must comply with licensing and compensation regulations at 42 CFR 422.2274 and 42 CFR 423.2274. Company may cease payment of renewals immediately and without notice in the event that Producer no longer meets the requirements listed in the foregoing sentence or commits any act or omission which would have been considered non-compliant under the terms of this Agreement if it were still in effect or which would have resulted in termination if such act or omission had been committed while this Agreement was still in effect.

B. If Producer discontinues its association with its upline and Producer is not an LOA of such upline, Company shall continue to pay compensation to Producer and upline with respect to sales made under this Medicare Product Addendum while Producer was contracted with upline, where Producer continues to be the Producer of record and the applicable Medicare member remains in the same plan; provided, however, Company shall cease all such payments to Producer and its upline, including administrative fees, if such Producer becomes an employee of Company. If Producer is an LOA of its upline and discontinues its association with upline, Company shall continue to pay compensation to upline with respect to sales made by Producer under this Medicare Product Addendum while Producer was an LOA of such upline, where the Producer, upline or another LOA of such upline continues to be Producer of record and the applicable Medicare member remains in the same plan; provided, however, Company shall cease all such payments, including administrative fees, if Producer becomes an employee of Company.

C. Unless otherwise permitted by CMS guidance, if a Medicare Product enrollee disenrolls or is disenrolled from a Medicare Product within three (3) months of his or her enrollment in a Medicare Product (a "Rapid Disenrollment"), no compensation shall be paid by Company to Producer for that sale. If compensation is paid by Company for a sale, and a Rapid Disenrollment occurs, then Producer shall refund such compensation paid by Company for such enrollee in accordance with the Rapid Disenrollment compensation recovery requirements set forth in the Medicare Communications and Marketing Guidelines ("MCMG") and Chapter 42 of the Code of Federal Regulations, Part 422 Subpart V -Medicare Advantage Communication Requirements & Part 423 Subpart V – Part D Communication Requirements. Company may deduct any compensation amounts paid to Producer from amounts Company otherwise owes to Producer.

7. **MARKETING**

A. Costs for Medicare Product marketing materials shall be allocated as follows: (i) Company shall furnish to Producer, at Company's expense, all standard Medicare Product forms, applications, and marketing materials that Company develops and utilizes for its own marketing of such products. Such materials shall be provided in reasonable amounts, as determined by Company in its sole discretion, upon a request by Producer; and (ii) any custom forms, applications, over-prints or marketing materials requested and submitted to Company by Producer, and approved by Company shall be printed and distributed at Producer's expense, unless otherwise agreed to by Company. If Producer intends to conduct a meeting or event for which Company is required to keep accurate records under the MCMG and Chapter 42 of the Code of Federal Regulations, Part 422 Subpart V -Medicare Advantage Communication Requirements & Part 423 Subpart V – Part D Communication Requirements. Producer shall provide Company with prior notice of any such meeting or event in accordance with the requirements set forth in the Medicare Producer Guide.

B. The parties may engage in various means of featuring the parties' products and/or services in print or other advertising/communications media (collectively, "co-branding activities") and agree to do so in accordance with applicable laws. Such co-branding activities may also include permissible promotion of co-marketed educational and wellness programs. The parties shall cooperate in the development of any campaign, event or activity designed to promote Company's products in any way, directly or indirectly. Producer shall obtain Company's advance written

approval for a campaign, event or activity. The parties acknowledge and agree that it is in the best interest of Company and Producer for Company to be involved in the early stages of campaign, event or activity development so that Company may conduct any analysis it deems necessary and approve or disapprove of a campaign, event or activity proposal before significant resources are expended by either party in its development.

C. Producer will be considered a Third Party Marketing Organization ("TPMO") to the extent Producer receives compensation for performing lead generation, marketing, sales and enrollment related functions as part of the chain of enrollment, which chain encompasses the steps taken by a Medicare Product enrollee from becoming aware of a Medicare plan or plans to making an enrollment decision. In its role as a TPMO, Producer shall have the following additional obligations: (i) disclose to Company any subcontracted relationships used for marketing, lead generation, and enrollment, (ii) record all marketing, sales and enrollment calls in their entirety with Medicare Product enrollees, including the enrollment process, and including the audio portion of calls via web-based technology (iii) report to Company any staff disciplinary actions or violations of any requirements that apply to Company associated with Medicare Product enrollee interaction on a monthly basis, and (iv) use the TPMO disclaimer as required under 42 CFR § 422.2267(e)(41). Violations by TPMOs must be reported to Company and shall be subject to disciplinary actions as determined by Company in its sole discretion. When conducting lead generating activities as a TPMO, Producer must, when applicable, (i) disclose to the Medicare Product enrollee that his or her information will be provided to a licensed agent for future contact, which disclosure must be provided as follows: (A) verbally when communicating with a beneficiary through telephone, (B) in writing when communicating with a Medicare Product enrollee through mail or other paper, (C) electronically when communicating with a Medicare Product enrollee through email, online chat, or other electronic messaging platform, and (ii) disclose to the Medicare Product enrollee that he or she is being transferred to a licensed agent who can enroll him or her into a new plan. In addition, Producer shall comply with any additional requirements specified by Company in the Medicare Producer Guide.

8. **COMPLAINTS**

A. Producer shall promptly report to Company any complaints against Producer related to the activities performed by Producer under this Agreement and provide any requested information and documentation promptly to Company related to such complaints. Producer shall cooperate with Company in the investigation of any such complaint and in the implementation of any corrective action plan developed as a result of such investigation. Producer shall reimburse Company for any fines or penalties awarded or assessed against Company as a result of Producer's actions. Company may recoup such fines or penalties by offsetting such amounts against any amounts due from Company to Producer.

B. Company may implement remedial actions or corrective action plans from time to time if Company determines in its sole discretion that such actions are necessary to ensure Producer's conduct is compliant with the terms of this Agreement. Corrective or remedial actions may include verbal warnings, written warnings, addition of Producer to Company's Producer oversight watch list, focused education of Producer, direct oversight (e.g., ride-along assessment), re-training and re-testing on relevant criteria, commission holds, probationary periods, suspension, or such other corrective or remedial actions deemed appropriate by Company in its sole discretion to address Producer's conduct. Company may also report Producer to any applicable state Departments of Insurance as appropriate in its sole discretion.

C. Pursuant to Section B(2) of the Producer Agreement, Company may terminate this Medicare Product Addendum for cause if Producer causes an unacceptable number of complaints (including, but not limited to, CTMs) as determined by Company in its sole discretion.

9. **REGULATORY REQUIREMENTS.**

A. **Compliance with Laws; Contracting; Delegation.** The term "applicable laws" as used in this Agreement shall include without limitation, as it relates to this Medicare Product Addendum, all applicable orders, directives, instructions, sub-regulatory guidance, and other requirements of any Official, including requirements for Medicare Advantage and Medicare Part D plans that pertain to participation as a First Tier or Downstream Entity. Producer acknowledges that

payments made to Producer by Company are made in whole or in part with federal funds and subject Producer to those laws applicable to individuals/entities receiving federal funds. [45 C.F.R. part 84 and 45 C.F.R. part 91]**.**

B. **Subcontractors.** Producer shall require all of its subcontractors, if any, to comply with all applicable laws. Producer shall include in Producer's contracts with subcontractors all contractual and legal obligations required to appear in such contracts under applicable laws. To the extent CMS requires additional provisions to be included in such subcontracts, Producer shall amend its contracts accordingly. If Producer delegates to a subcontractor a service required by this Agreement, and the service is required under the terms of Company's CMS Contract, Producer's subcontract shall be in writing and shall specify the delegated activities and reporting responsibilities, in addition to meeting the contract requirements described above. In the event that Company delegates a function to Producer, Company retains the right to approve, suspend or terminate such delegation.

C. **Compliance Obligations**

1. **Compliance with CMS Contract, Law.** Any services performed by Producer for Company's Medicare Products shall be consistent with Company's obligations under its CMS Contract and comply with applicable laws. [42 C.F.R. § 422.504(i)(3)(iii)] and [42 C.F.R. § 423.505(i)(3)(iii)] [42 C.F.R. §§ 422.504(i)(4)(v)] and [42 C.F.R. § 423.505(i)(4)(iv)].

2. **Compliance with Medicare Policies**. In addition to complying with the obligations set forth in this Agreement, Producer shall comply with policies applicable to Company's Medicare Products, including, but not limited to, those contained in the Medicare Producer Guide, as modified by Company from time to time. Producer understands that policy changes will automatically take effect on the date specified, unless an earlier date is required by applicable laws. Producer is encouraged to contact Company to discuss any questions or concerns with Company policies or policy changes. [42 C.F.R. § 422.503] and [42 C.F.R. § 422.504] and [Medicare Managed Care Manual, Chapter 11, Section 100.4].

3. **Grievances/Appeals.** Producer agrees to cooperate with Company in resolving Medicare complaints, appeals, and grievances in accordance with applicable laws. [42 C.F.R. §422.504(a)(7)].

4. **Offshore Services.** If Producer (or its subcontractors) provides services for Company's Medicare Products that involve the receipt, processing, transferring, handling, storing or accessing of Protected Health Information ("PHI") Offshore ("Offshore Services"), Producer agrees to complete Company's Offshore Services Attestation prior to the commencement of Offshore Services (where possible), within fifteen (15) days of a material change in scope or delivery of Offshore Services, and no less than annually.

5. **Excluded Entities.** Producer agrees that no person or entity that provides services, directly or indirectly, for Company's Medicare Products, may be an Excluded Entity under Section 1128 or 1128A of the Social Security Act. Producer shall screen the Exclusion Lists prior to initially hiring/contracting and monthly thereafter to ensure no employee or subcontractor appears on Exclusion Lists. If any employee or subcontractor appears on an Exclusion List or is otherwise prohibited from receiving payment under the Medicare program by federal law, Producer will remove such individual or entity from any direct or indirect work on Company's Medicare Products and promptly notify Company of the same.

6. **Compliance Program and Anti-Fraud Initiatives**. Producer shall maintain an effective compliance program to prevent, detect, and correct: (1) non-compliance with CMS's program requirements and (2) fraud waste and abuse ("FWA"). Such compliance program shall include dissemination to employees and Downstream Entities of (a) written policies and/or standards of conduct articulating the entity's commitment to compliance with applicable laws, initially within ninety (90) days of hire/contracting, and at least annually thereafter; (b) communications regarding the obligation to report potential non-compliance or FWA issues (internally and to payers, including Company, as applicable), and a no-tolerance policy for retaliation or retribution for good faith reporting, and reporting mechanisms to employees and Downstream Entities and (c) appropriate training and education to ensure familiarity with and compliance with the compliance program. Producer, through its compliance program shall

establish and maintain a process to: oversee and ensure that employees and Downstream Entities perform applicable services for Company's Medicare Products consistent with this Agreement and applicable laws and shall require implementation of disciplinary actions and corrective actions up to terminations where needed to ensure such compliance. Producer shall require that any Downstream Entity maintains an effective compliance program consistent with the requirements of this section.

7. **Marketing**. Producer shall comply with the MCMG and Chapter 42 of the Code of Federal Regulations, Part 422 Subpart V -Medicare Advantage Communication Requirements & Part 423 Subpart V – Part D Communication Requirements, as may be updated from time to time.

8. **Hold Harmless.** Producer shall not hold Medicare Members 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)].

D. **Records and Audit.**

1. **Maintenance of Records**. Producer shall preserve records applicable to Medicare Members and to Company's Medicare Products, including its compliance with applicable laws and this Agreement for the longer of: (i) the period of time required by state and federal law, or (ii) ten (10) years. In addition, to the extent applicable, Producer shall comply with 42 C.F.R. §422.2480(c) and maintain all records containing data used by Company to calculate Medicare medical loss ratios ("MLRs") for Company's Medicare Products and/or evidence needed by Company and/or Officials to validate MLRs (collectively, "MLR Records") for ten (10) years from the year in which such MLRs are filed by Company.

2. **Audit.** Producer agrees that Officials, including but not limited to HHS, the Comptroller General, or their designees have the right to directly or indirectly audit, evaluate, and inspect any pertinent information possessed by Producer or its Downstream Entities and relating to Company's Medicare Products and any CMS Contract for any particular contract period, including, but not limited to, any books, contracts, computer or other electronic systems (including medical records and documentation of First Tier and Downstream Entities) (collectively, "Records") through ten (10) years from the final date of the Final Contract Period of the CMS Contract or from the date of Completion of Audit, whichever is later. Producer shall notify Company within two (2) business days of any request by an Official, or their designees, to audit or evaluate Producer records, and to the extent feasible, shall provide Company the right to participate in any such evaluation of Producer. [42 C.F.R. §§ 422.504(i)(2)(i), (ii), and (iv)] and [42 C.F.R. § 423.505(i)(2)(i), (ii), and (iv)]

3. **Confidentiality and Accuracy of Records**. Producer will comply with the confidentiality and Medicare 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 only in accordance with applicable laws, or pursuant to valid court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by Medicare Members to the records and information that pertain to them. [42 C.F.R. §§ 422.504(a)(13) and 422.118] and [42 CFR § 423.136]

4. **Company Oversight/Information and Records.** Producer acknowledges and agrees that Company shall monitor, including, but not limited to, through field evaluations or other oversight activities, and shall have the right to audit, and remains accountable for, the functions and responsibilities performed by Producer for Company's Medicare Products. Producer agrees to promptly provide to Company any information and records, including without limit, MLR Records, if applicable, and information and records that are reasonably needed by Company: (1) for administration of Company's Medicare Products, (2) to monitor and audit performance of Producer and its subcontractors with this Agreement, applicable laws, and requirements of accreditation agencies, including information regarding Producer's oversight and monitoring of its Downstream Entities (including a summary of any results of such activities), and (3) to fulfill any reporting requirements Company may have to CMS or other Officials. Producer shall complete an attestation from Company to confirm its compliance with requirements of this

Agreement as it relates to Company's Medicare Products upon request and agrees that Company may require corrective actions in the event of non-compliance. Ultimately, should Company, in its sole discretion, determine such noncompliance has not been or is not capable of being corrected to Company's satisfaction, Company may terminate Producer in accordance with the terms of this Agreement.

E. **Definitions.** The following definitions shall apply to this Section 9 (Regulatory Requirements):

1. **CMS Contract**: The contract(s) with CMS governing Company's Medicare Products.

2. **Completion of Audit:** Completion of audit by the Department of Health and Human Services, the Government Accountability Office, or their designees of Company or of any First Tier, Downstream, or Related Entity.

3. **Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with Company's Medicare Plans, below the level of the arrangement between an MA organization and a First Tier Entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.

4. **Excluded Entity:** A person or entity listed on the Department of Health and Human Services ("HHS") Office of Inspector General ("OIG") List of Excluded Individuals and Entities and the General Services Administration System for Awards Management ("SAM"), or appearing on the Federal Preclusion List.

5. **Exclusion Lists:** Collectively, the HHS OIG List of Excluded Individuals and Entities and the SAM.

6. **Final Contract Period:** The final term of the applicable CMS Contract governing Company's Medicare Plan(s).

7. **First Tier Entity:** Any party that enters into a written arrangement, acceptable to CMS, with an MA organization to provide administrative services or health care services for Medicare Members.

8. **Medicare Member:** A Medicare eligible individual who has enrolled in a Company Medicare Product.

9. **Officials:** Federal and state regulatory agencies or officials with jurisdiction, including but not limited to CMS, HHS, the Comptroller General and their designee.

10. **Offshore:** Physically located outside of one of the fifty United States or one of the United States Territories (i.e., American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands).

10. **SURVIVAL**. Notwithstanding the termination provisions of the Agreement applicable to this Medicare Product Addendum, the provisions of this Medicare Product Addendum necessary to carry out the intention of the parties as expressed herein, including without limitation those in Sections 6, 9, and 10 of this Medicare Product Addendum, shall survive the termination or expiration of this Medicare Product Addendum.

BUSINESS ASSOCIATE AGREEMENT
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

This Business Associate Agreement (the "BAA") is made by and between Company (hereinafter the "Covered Entity") and Producer (hereinafter the "Business Associate"), and is effective as of the Agreement Effective Date). This BAA is attached to and incorporated into the Agreement. All capitalized terms used herein but not otherwise defined shall have the meanings given to such terms elsewhere in the Agreement. In conformity with the regulations at 45 C.F.R. Parts 160-164 (the "Privacy and Security Rules"), Covered Entity will provide Business Associate with access to, or have Business Associate create, maintain, transmit and/or receive certain Protected Health Information (as defined below), thus necessitating a written agreement that meets the applicable requirements of the Privacy and Security Rules. Covered Entity and Business Associate agree as follows:

1. **Definitions**. The following terms shall have the meaning set forth below:

    a. ARRA. "ARRA" means the American Recovery and Reinvestment Act of 2009
    b. Breach. "Breach" has the same meaning as the term "breach" in 45 C.F.R. 164.402.
    c. C. F. R. "C.F. R." means the Code of Federal Regulations.
    d. Designated Record Set. "Designated Record Set" has the meaning assigned to such term in 45 C. F. R. 160.501.
    e. Discovery. "Discovery" shall mean the first day on which a Breach is known to Business Associate (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of Business Associate), or should reasonably have been known to Business Associate, to have occurred.
    f. Electronic Protected Health Information. "Electronic Protected Health Information" means information that comes within paragraphs 1 (i) or 1 (ii) of the definition of "Protected Health Information", as defined in 45 C. F. R. 160.103.
    g. Individual. "Individual" shall have the same meaning as the term "individual" in 45 C. F. R. 160.103 and shall include a person who qualifies as personal representative in accordance with 45 C. F. R. 164.502 (g).
    h. Protected Health Information. "Protected Health Information" shall have the same meaning as the term "Protected Health Information", as defined by 45 C. F. R. 160.103, limited to the information created or received by Business Associate from or on behalf of Covered Entity.
    i. Required by Law. "Required by Law" shall have the same meaning as the term "required by law" in 45 C. F. R. 164.103.
    j. Secretary. "Secretary" shall mean the Secretary of the Department of Health and Human Services or his designee.
    k. Security Incident. "Security Incident" shall have the same meaning as the term "security incident" in 45 C.F.R. 164.304.
    l. Standard Transactions. "Standard Transactions" means the electronic health care transactions for which HIPAA standards have been established, as set forth in 45 C. F. R., Parts 160-162.
    m. Unsecured Protected Health Information. "Unsecured Protected Health Information" means Protected Health Information that is not secured through the use of a technology or methodology specified by guidance issued by the Secretary from time to time.

2. **Obligations and Activities of Business Associate.**

    a. Business Associate agrees to not use or further disclose Protected Health Information other than as permitted or required by this BAA or as Required by Law. Business Associate shall also comply with any further limitations on uses and disclosures agreed by Covered Entity in accordance with 45 C.F.R. 164.522 provided that such agreed upon limitations have been communicated to Business Associate in accordance with Section 4.1(c) of this BAA.
    b. Business Associate agrees to use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by this BAA, including but not limited to the safeguards described in Section 2(m) of this BAA.
    c. Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this BAA.
    d. Business Associate agrees to promptly report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this BAA of which it becomes aware.

e. Business Associate agrees to report to Covered Entity any Breach of Unsecured Protected Health Information without unreasonable delay and in no case later than five (5) Business days after Discovery of a Breach. Such notice shall include the identification of each Individual whose Unsecured Protected Health Information has been, or is reasonably believed by Business Associate, to have been, accessed, acquired, or disclosed in connection with such Breach. In addition, Business Associate shall provide any additional information reasonably requested by Covered Entity for purposes of investigating the Breach. Business Associate's notification of a Breach under this section shall comply in all respects with each applicable provision of Section 13400 of Subtitle D (Privacy) of ARRA, 45 CFR 164.410, and related guidance issued by the Secretary from time to time. Without limiting Covered Entity's remedies under Section 6 or any other provision of this BAA, in the event of a Breach involving Unsecured Protected Health Information maintained, used or disclosed by Business Associate, Business Associate shall reimburse Covered Entity for the cost of providing any legally required notice to affected Individuals and the cost of credit monitoring for such Individuals to extent deemed necessary by Covered Entity in its reasonable discretion.

f. In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, Business Associate agrees to ensure that any subcontractors that create, receive, maintain, or transmit Protected Health Information on behalf of Business Associate agree in writing to the same restrictions and conditions that apply through this BAA to Business Associate with respect to such information. In no event shall Business Associate, without Covered Entity's prior written approval, provide Protected Health Information received from, or created or received by Business Associate on behalf of Covered Entity, to any employee or agent, including a subcontractor, if such employee, agent or subcontractor receives, processes or otherwise has access to the Protected Health Information outside of the United States.

g. Business Associate agrees to provide access, at the request of Covered Entity, within ten (10) business days of the request from Covered Entity, to Protected Health Information in a Designated Record Set, to Covered Entity or, as directed by Covered Entity, to an Individual in order to meet the requirements under 45 C.F.R. 164.524. Covered Entity's determination of what constitutes "Protected Health Information" or a "Designated Record Set" shall be final and conclusive. If Business Associate provides copies or summaries of Protected Health Information to an Individual it may impose a reasonable, cost-based fee in accordance with 45 C.F.R. 164.524 (c)(4).

h. Business Associate agrees to make any amendment(s) to Protected Health Information in a Designated Record Set that the Covered Entity directs or agrees to pursuant to 45 C.F.R. 164.526 at the request of Covered Entity or an Individual, within ten (10) business days of a request by Covered Entity. Business Associate shall not charge any fee for fulfilling requests for amendments. Covered Entity's determination of what Protected Health Information is subject to amendment pursuant to 45 C.F.R. 164.526 shall be final and conclusive.

i. Business Associate agrees to make (i) internal practices, books, and records, including policies and procedures, relating to the use and disclosure of Protected Health Information received from, or created or received by Business Associate on behalf of, Covered Entity, and (ii) policies, procedures, and documentation relating to the safeguarding of Electronic Protected Health Information available to the Covered Entity, or at the request of the Covered Entity to the Secretary, in a time and manner designated by the Covered Entity or the Secretary, for purposes of the Secretary determining Covered Entity's or Business Associate's compliance with the Privacy and Security Rules.

j. Business Associate agrees to document such disclosures of Protected Health Information as would be required for Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528.

k. Business Associate agrees to provide to Covered Entity, in the time and manner described below, the information collected in accordance with Section 2(j) of this BAA, to permit Covered Entity to respond to a request by an Individual for an accounting of disclosures of Protected Health Information in accordance with 45 C.F.R. 164.528. Business Associate agrees to provide such information to Covered Entity within thirty (30) business days of receipt of a request from Covered Entity.

l. Business Associate acknowledges that it shall request from the Covered Entity and so disclose to its affiliates, agents and subcontractors or other third parties, (i) the information contained in a "limited data set," as such term is defined at 45 C.F.R. 164.514(e)(2), or, (ii) if needed by Business Associate, to the minimum necessary to accomplish the intended purpose of such requests or disclosures. In all cases, Business Associate shall request and disclose Protected Health Information only in a manner that is consistent with guidance issued by the Secretary from time to time.

m. With respect to Electronic Protected Health Information, Business Associate shall implement and comply with (and ensure that its subcontractors implement and comply with) the administrative safeguards set forth at 45 C.F.R. 164.308,

the physical safeguards set forth at 45 C.F.R. 310, the technical safeguards set forth at 45 C.F.R. 164.312, and the policies and procedures set forth at 45 C.F.R. 164.316 to reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity. Business Associate acknowledges that, (i) the foregoing safeguard, policies and procedures requirements shall apply to Business Associate in the same manner that such requirements apply to Covered Entity, and (ii) Business Associate shall be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with the safeguard, policies and procedures requirements and any guidance issued by the Secretary from time to time with respect to such requirements.

n. With respect to Electronic Protected Health Information, Business Associate shall ensure that any subcontractors that create, receive, maintain, or transmit Electronic Protected Health Information on behalf of Business Associate, agree to comply with the applicable requirements of Subpart C of 45 C.F.R. Part 164 by entering into a contract that complies with 45 C.F.R. Section 164.314.
o. Business Associate shall report to Covered Entity any Security Incident of which it becomes aware, including Breaches of Unsecured Protected Health Information as required by 45 C.F.R. Section 164.410.
p. If Business Associate conducts any Standard Transactions on behalf of Covered Entity, Business Associate shall comply with the applicable requirements of 45 C.F.R. Parts 160-162.
q. During the term of this BAA, Business Associate may be asked to complete a security survey and/or attestation document designed to assist Covered Entity in understanding and documenting Business Associate's security procedures and compliance with the requirements contained herein. Business Associate's failure to complete either of these documents within the reasonable timeframe specified by Covered Entity shall constitute a material breach of this BAA.
r. Business Associate acknowledges that, as of the Agreement Effective Date, it shall be liable under the civil and criminal enforcement provisions set forth at 42 U.S.C. 1320d-5 and 1320d-6, as amended from time to time, for failure to comply with any of the use and disclosure requirements of this BAA and any guidance issued by the Secretary from time to time with respect to such use and disclosure requirements.
s. To the extent Business Associate is to carry out one or more of Covered Entity's obligation(s) under Subpart E of 45 CFR Part 164, Business Associate shall comply with the requirements of Subpart E that apply to Covered Entity in the performance of such obligation(s).
t. To the extent that Business Associate provides services to Covered Entity relating to individuals enrolled in state or federal programs (e.g., Medicare or Medicaid), Business Associate shall comply with any additional restrictions or requirements related to the use, disclosure, maintenance, and protection of Protected Health Information of individuals enrolled in such programs through Covered Entity. With respect to the Protected Health Information of Medicare enrollees, Business Associate shall report privacy and security incidents and/or Breaches immediately, but not later than five (5) day, to Covered Entity and include the information required under this Section 2 of this Addendum.

3. **Permitted Uses and Disclosures by Business Associate**.

3.1 General Use and Disclosure. Except as otherwise limited in this BAA, Business Associate may use or disclose Protected Health Information to perform its obligations and services to Covered Entity, provided that such use or disclosure would not violate the Privacy and Security Rules if done by Covered Entity or the minimum necessary policies and procedures of the Covered Entity.

3.2 Specific Use and Disclosure Provisions.

a. Except as otherwise prohibited by this BAA, Business Associate may use Protected Health Information for the proper management and administration of the Business Associate or to carry out the legal responsibilities of the Business Associate.
b. Except as otherwise prohibited by this BAA, Business Associate may disclose Protected Health Information for the proper management and administration of the Business Associate, provided that disclosures are Required By Law, or Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and used or further disclosed only as Required By Law or for the purpose for which it was disclosed to the person, and the person notifies the Business Associate of any instances of which it is aware in

which the confidentiality of the information has been breached in accordance with the Breach and Security Incident notifications requirements of this BAA.

c. Business Associate shall not directly or indirectly receive remuneration in exchange for any Protected Health Information of an Individual without Covered Entity's prior written approval and notice from Covered Entity that it has obtained from the Individual, in accordance with 45 C.F.R. 164.508, a valid authorization that includes a specification of whether the Protected Health Information can be further exchanged for remuneration by Business Associate. The foregoing shall not apply to Covered Entity's payments to Business Associate for services delivered by Business Associate to Covered Entity.
d. Business Associate shall not de-identify any Protected Health Information except as authorized by Covered Entity to provide data aggregation services to Covered Entity as permitted by 42 C.F.R. 164.504(e)(2)(i)(B).
e. Business Associate may use Protected Health Information to report violation of law to appropriate Federal and State authorities, consistent with 164.502 (j)(1).

4. **Obligations of Covered Entity**.

4.1 Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions.

a. Covered Entity shall notify Business Associate of any limitation(s) in Covered Entity's notice of privacy practices that Covered Entity produces in accordance with 45 C.F.R. 164.520 (as well as any changes to that notice), to the extent that such limitation(s) may affect Business Associate's use or disclosure of Protected Health Information.
b. Covered Entity shall provide Business Associate with any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes affect Business Associate's use or disclosure of Protected Health Information.
c. Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 C.F.R. 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

4.2 Permissible Requests by Covered Entity. Except as may be set forth in Section 3.2, Covered Entity shall not request Business Associate to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy and Security Rules if done by Covered Entity.

5. **Term and Termination**.

a. Term. The provisions of this BAA shall take effect on the Agreement Effective Date and shall terminate as set forth in Section 5(b) below.
b. Termination. Termination shall be governed by Section B of the Agreement.
c. Effect of Termination.

i. Except as provided in Section 5(c), upon termination of this BAA, for any reason, Business Associate shall return or destroy all Protected Health Information received from Covered Entity, or created, maintained, transmitted or received by Business Associate on behalf of Covered Entity. This provision shall apply to Protected Health Information that is in the possession of subcontractors or agents of Business Associate. Business Associate shall retain no copies of the Protected Health Information.
ii. In the event the Business Associate determines that returning or destroying the Protected Health Information is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the Parties that return or destruction of Protected Health Information is infeasible, per Section 5(a) above, Business Associate shall continue to extend the protection of this BAA to such Protected Health Information and limit further uses and disclosures of such Protected Health Information for so long as Business Associate maintains such Protected Health Information.

6. **Indemnification.** Indemnification shall be governed by the indemnification provisions set forth in Section D(7) of the Agreement.

7. **Notices.** Any notices or communications to be given under this BAA shall be made to the address and/or fax numbers given below:

To Business Associate: **To the address provided by Aetna** **the Business Associate as part of the contracting process.**	**To Covered Entity:** **HIPAA Member Rights Team** **151 Farmington Avenue, RT65** **Hartford, CT 06156** **Fax: (859) 280-1272** **Email: HIPAAFulfillment@aetna.com**

Each Party named above may change its address from time to time with notice.

8. **Miscellaneous**.

   a. Regulatory References. A reference in this BAA to a section in the Privacy and Security Rules means the section as in effect or as amended, and for which compliance is required.
   b. Amendment. Any amendment of this BAA shall be governed by D(6) of the Agreement.
   c. Survival. The respective rights and obligations of Business Associate under Sections 5(c) and 6 of this BAA shall survive the termination of this BAA.
   d. Interpretation. Any ambiguity in this BAA shall be resolved in favor of a meaning that permits Covered Entity to comply with the Privacy and Security Rules. In the event of any inconsistency or conflict between this BAA and any other agreement between the Parties, the terms, provisions and conditions of this BAA shall govern and control.
   e. No third party beneficiary. Nothing express or implied in this BAA is intended to confer, nor shall anything herein confer, upon any person other than the Parties and the respective successors or assigns of the Parties, any rights, remedies, obligations, or liabilities whatsoever.
   f. Governing Law. This BAA shall be governed by and construed in accordance with the laws of the state of Connecticut.

APPENDIX B

Schedule B-1

Medicare Products and Markets

Aetna Medicare Advantage Plans are available in the following individual Medicare markets:

Local Market	State	In These Counties Only	Product
Arizona	Arizona	Cochise, Coconino, Gila, Maricopa, Mohave, Pima, Pinal, Santa Cruz, Yavapai	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Local Market	State	In These Counties Only	Product
California	California	Alameda, Alpine, Amador, Calaveras, Colusa, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern, Lake, Los Angeles, Madera, Marin, Mariposa, Mono, Napa, Orange, Placer, Plumas, Riverside, Sacramento, San Benito, San Bernardino, San Diego, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Trinity, Tuolumne, Ventura, Yolo	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Local Market	State	In These Counties Only	Product
	DC	District of Columbia	
	Maryland	Anne Arundel, Baltimore, Baltimore City, Carroll, Frederick, Hartford, Howard, Montgomery	

Capitol	Virginia	Accomack, Albemarle, Alexandria City, Alleghany, Amelia, Amherst, Appomattox, Arlington, Augusta, Bath, Bedford, Bland, Botetourt, Bristol City, Brunswick, Buchanan, Buckingham, Buena Vista City, Campbell, Caroline, Carroll, Charles City, Charlottesville City, Charlotte, Chesapeake City, Chesterfield, Clarke, Colonial Heights City, Covington City, Craig, Culpeper, Cumberland, Danville City, Dickenson, Dinwiddie, Emporia City, Essex, Fairfax, Fairfax City, Falls Church City, Fauquier, Floyd, Fluvanna, Franklin, Franklin City, Frederick, Fredericksburg City, Galax City, Giles, Gloucester, Goochland, Grayson, Greene, Greensville, Halifax, Hampton City, Hanover, Harrisonburg City, Henrico, Henry, Highland, Hopewell City, Isle of Wight, James City, King And Queen, King George, King William, Lancaster, Lee, Lexington City, Loudoun, Louisa, Lunenburg, Lynchburg City, Madison, Manassas City, Manassas Park City, Martinsville City, Mathews, Mecklenburg, Middlesex, Montgomery, Nelson, New Kent, Newport News City, Norfolk City, Northampton, Northumberland, Norton City, Nottoway, Orange, Page, Patrick, Petersburg City, Pittsylvania, Poquoson City, Portsmouth City, Powhatan, Prince Edward, Prince George, Prince William, Pulaski, Radford City, Rappahannock, Richmond, Richmond City, Roanoke, Roanoke City, Rockbridge, Rockingham, Russell, Salem City, Scott, Shenandoah, Smyth, Southampton, Spotsylvania, Stafford, Staunton City, Suffolk City, Surry, Sussex, Tazewell, Virginia Beach City, Warren, Washington, Waynesboro City, Westmoreland, Williamsburg City, Winchester City, Wise, Wythe, York	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Local Market	State	In These Counties Only	Product
Florida	Florida	Alachua, Baker, Brevard, Broward, Charlotte, Citrus, Clay, Collier, Columbia, Desoto, Duval, Escambia, Flagler, Hernando, Highlands, Hillsborough, Indian River, Lake, Lee, Levy, Manatee, Marion, Martin, Miami-Dade, Nassau, Okaloosa, Orange, Osceola, Palm Beach, Pasco, Pinellas, Polk, Putnam, Santa Rosa, Sarasota, Seminole, St. Johns, St. Lucie, Sumter, Volusia, Walton	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Local Market	State	In These Counties Only	Product
	Alabama	Autauga, Baldwin, Barbour, Bibb, Blount, Bullock, Butler, Calhoun, Chambers, Cherokee, Chilton, Choctaw, Clarke, Clay, Cleburne, Coffee, Colbert, Coosa, Covington, Crenshaw, Cullman, Dale, Dallas,	

		DeKalb, Elmore, Escambia, Etowah, Fayette, Franklin, Geneva, Greene, Hale, Henry, Houston, Jackson, Jefferson, Lamar, Lauderdale, Lawrence, Lee, Limestone, Lowndes, Macon, Madison, Marengo, Marion, Marshall, Mobile, Montgomery, Morgan, Perry, Pickens, Pike, Randolph, Russell, Shelby, St. Clair, Talladega, Tallapoosa, Tuscaloosa, Walker, Washington, Wilcox, Winston	
Georgia/Gulf States	Arkansas	Arkansas, Benton, Boone, Calhoun, Carroll, Clark, Cleburne, Columbia, Conway, Crawford, Crittenden, Cross, Dallas, Faulkner, Franklin, Garland, Grant, Greene, Hempstead, Hot Spring, Howard, Independence, Jackson, Jefferson, Johnson, Lafayette, Lawrence, Lee, Little River, Logan, Lonoke, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Nevada, Newton, Ouachita, Perry, Phillips, Pike, Poinsett, Polk, Pope, Prairie, Pulaski, Saline, Scott, Searcy, Sebastian, Sevier, St. Francis, Stone, Union, Van Buren, Washington, White, Woodruff, Yell	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Georgia	Appling, Atkinson, Bacon, Baker, Baldwin, Banks, Barrow, Bartow, Ben Hill, Berrien, Bibb, Bleckley, Brantley, Brooks, Bryan, Burke, Butts, Calhoun, Camden, Candler, Carroll, Catoosa, Charlton, Chatham, Chattahoochee, Chattooga, Cherokee, Clarke, Clay, Clayton, Clinch, Cobb, Coffee, Colquitt, Columbia, Cook, Coweta, Crawford, Crisp, Dade, Dawson, Decatur, DeKalb, Dodge, Dooly, Dougherty, Douglas, Early, Echols, Effingham, Elbert, Emanuel, Evans, Fannin, Fayette, Floyd, Forsyth, Franklin, Fulton, Gilmer, Glascock, Glynn, Gordon, Grady, Greene, Gwinnett, Habersham, Hall, Hancock, Haralson, Harris, Hart, Heard, Henry, Houston, Irwin, Jackson, Jasper, Jeff Davis, Jefferson, Jenkins, Johnson, Jones, Lamar, Lanier, Laurens, Lee, Liberty, Lincoln, Long, Lowndes, Lumpkin, Macon, Madison, Marion, McDuffie, McIntosh, Meriwether, Miller, Mitchell, Monroe, Montgomery, Morgan, Murray, Muscogee, Newton, Oconee, Oglethorpe, Paulding, Peach, Pickens, Pierce, Pike, Polk, Pulaski, Putnam, Quitman, Rabun, Randolph, Richmond, Rockdale, Schley, Screven, Seminole, Spalding, Stephens, Stewart, Sumter, Talbot, Taliaferro, Tattnall, Taylor, Telfair, Terrell, Thomas, Tift, Toombs, Towns, Treutlen, Troup, Turner, Twiggs, Union, Upson, Walker, Walton, Ware, Warren, Washington, Wayne, Webster, Wheeler, White, Whitfield, Wilcox, Wilkes, Wilkinson, Worth	

	Louisiana	Acadia, Allen, Ascension, Assumption, Avoyelles, Beauregard, Bienville, Bossier, Caddo, Calcasieu, Caldwell, Cameron, Catahoula, Claiborne, Concordia, De Soto, East Baton Rouge, East Carroll, East Feliciana, Evangeline, Franklin, Grant, Iberia, Iberville, Jackson, Jefferson, Jefferson Davis, La Salle, Lafayette, Lafourche, Lincoln, Livingston, Madison, Morehouse, Natchitoches, Orleans, Ouachita, Plaquemines, Pointe Coupee, Rapides, Red River, Richland, Sabine, St. Bernard, St. Charles, St. Helena, St. James, St. John the Baptist, St. Landry, St. Martin, St. Mary, St. Tammany, Tangipahoa, Tensas, Terrebonne, Union, Vermilion, Vernon, Washington, Webster, West Baton Rouge, West Carroll, West Feliciana, Winn	
	Mississippi	Adams, Alcorn, Amite, Attala, Benton, Bolivar, Calhoun, Carroll, Chickasaw, Choctaw, Claiborne, Clay, Coahoma, Copiah, Covington, DeSoto, Franklin, George, Greene, Grenada, Hancock, Harrison, Hinds, Holmes, Humphreys, Issaquena, Itawamba, Jackson, Jefferson, Jefferson Davis, Lafayette, Lawrence, Leake, Lee, Leflore, Lincoln, Lowndes, Madison, Marion, Marshall, Monroe, Montgomery, Noxubee, Oktibbeha, Panola, Pearl River, Perry, Pike, Pontotoc, Prentiss, Quitman, Rankin, Scott, Sharkey, Simpson, Smith, Stone, Sunflower, Tallahatchie, Tate, Tippah, Tishomingo, Tunica, Union, Walthall, Warren, Washington, Wayne, Webster, Wilkinson, Yalobusha, Yazoo	

Local Market	State	In These Counties Only	Product
	Illinois	Boone, Bureau, Carroll, Cook, DeKalb, DuPage, Grundy, Hancock, Henderson, Henry, Jo Daviess, Kane, Kankakee, Kendall, Lake, Lee, McHenry, Mercer, Ogle, Rock Island, Stephenson, Warren, Whiteside, Will, Winnebago	
	Indiana	Adams, Allen, Bartholomew, Benton, Blackford, Boone, Brown, Carroll, Cass, Clark, Clay, Clinton, Crawford, Daviess, DeKalb, Dearborn, Decatur, Delaware, Dubois, Elkhart, Fayette, Floyd, Fountain, Franklin, Fulton, Gibson, Grant, Greene, Hamilton, Hancock, Harrison, Hendricks, Henry, Howard, Huntington, Jackson, Jasper, Jay, Jefferson, Jennings, Johnson, Knox, Kosciusko, La Porte, Lagrange, Lake, Lawrence, Madison, Marion, Marshall, Martin, Miami, Monroe, Montgomery, Morgan, Newton, Noble, Ohio, Orange, Owen, Parke, Perry, Pike, Porter, Posey, Pulaski, Putnam, Randolph, Ripley,	

Great Lakes		Rush, Scott, Shelby, Spencer, Starke, Steuben, St. Joseph, Sullivan, Switzerland, Tippecanoe, Tipton, Union, Vanderburgh, Vermillion, Vigo, Wabash, Warren, Warrick, Washington, Wells, White, Whitley	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Michigan	Alger, Allegan, Antrim, Arenac, Baraga, Barry, Bay, Benzie, Berrien, Branch, Calhoun, Cass, Charlevoix, Clare, Clinton, Crawford, Delta, Dickinson, Eaton, Emmet, Genesee, Gladwin, Grand Traverse, Gratiot, Hillsdale, Houghton, Huron, Ingham, Ionia, Iosco, Iron, Jackson, Kalamazoo, Kalkaska, Kent, Keweenaw, Lake, Lapeer, Leelanau, Lenawee, Livingston, Luce, Macomb, Manistee, Marquette, Mason, Mecosta, Menominee, Missaukee, Monroe, Montcalm, Montmorency, Muskegon, Newaygo, Oakland, Oceana, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Ottawa, Roscommon, Saginaw, Sanilac, Shiawassee, St. Clair, St. Joseph, Tuscola, Van Buren, Washtenaw, Wayne, Wexford	
	Wisconsin	Adams, Brown, Columbia, Dane, Florence, Forest, Green, Iowa, Kenosha, Kewaunee, La Crosse, Lafayette, Langlade, Manitowoc, Marinette, Marquette, Milwaukee, Monroe, Oconto, Outagamie, Ozaukee, Portage, Racine, Rock, Shawano, Sheboygan, Trempealeau, Vernon, Walworth, Washington, Waukesha, Waushara, Winnebago	

Local Market	State	In These Counties Only	Product
Heartland	Kansas	Allen, Anderson, Atchison, Barber, Bourbon, Brown, Butler, Chase, Chautauqua, Cherokee, Clay, Cloud, Coffey, Cowley, Crawford, Dickinson, Doniphan, Douglas, Elk, Franklin, Geary, Greenwood, Harper, Harvey, Jackson, Jefferson, Jewell, Johnson, Kingman, Labette, Leavenworth, Linn, Lyon, Marion, Marshall, McPherson, Miami, Mitchell, Montgomery, Morris, Nemaha, Neosho, Osage, Osborne, Ottawa, Pottawatomie, Republic, Riley, Saline, Sedgwick, Shawnee, Sumner, Wabaunsee, Washington, Wilson, Woodson, Wyandotte	
	Missouri	Andrew, Atchison, Barry, Barton, Bates, Benton, Buchanan, Caldwell, Carroll, Cass, Cedar, Christian, Clay, Clinton, Dade, Dallas, Daviess, DeKalb, Douglas, Gentry, Greene, Grundy, Harrison, Henry, Hickory, Holt, Jackson, Jasper, Johnson, Laclede, Lafayette, Lawrence, Livingston, McDonald, Mercer, Newton,	

		Nodaway, Ozark, Pettis, Platte, Polk, Ray, Saline, St. Clair, Stone, Taney, Vernon, Webster, Worth, Wright	

Local Market	State	In These Counties Only	Product
Keystone	Delaware	Kent, New Castle, Sussex	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Pennsylvania	Adams, Allegheny, Armstrong, Beaver, Bedford, Berks, Blair, Bradford, Bucks, Butler, Cambria, Cameron, Carbon, Centre, Chester, Clarion, Clearfield, Clinton, Columbia, Crawford, Cumberland, Dauphin, Delaware, Elk, Erie, Fayette, Forest, Franklin, Fulton, Greene, Huntingdon, Indiana, Jefferson, Juniata, Lackawanna, Lancaster, Lawrence, Lebanon, Lehigh, Luzerne, Lycoming, McKean, Mercer, Mifflin, Monroe, Montgomery, Montour, Northampton, Northumberland, Perry, Philadelphia, Pike, Potter, Schuylkill, Snyder, Somerset, Sullivan, Susquehanna, Tioga, Union, Venango, Warren, Washington, Wayne, Westmoreland, Wyoming, York	
	West Virginia	Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Monroe, Morgan, Nicholas, Ohio, Pendleton, Pleasants, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood, Wyoming	

Local Market	State	In These Counties Only	Product
	North Carolina	Alamance, Alexander, Alleghany, Anson, Ashe, Avery, Beaufort, Bertie, Bladen, Brunswick, Buncombe, Burke, Cabarrus, Caldwell, Camden, Caswell, Catawba, Chatham, Cherokee, Chowan, Clay, Cleveland, Columbus, Cumberland, Currituck, Davidson, Davie, Duplin, Durham, Edgecombe, Forsyth, Franklin, Gaston, Gates, Graham, Granville, Greene, Guilford, Halifax, Harnett, Haywood, Henderson, Hertford, Hoke, Hyde, Iredell, Jackson, Johnston, Jones, Lee, Lenoir, Lincoln, Macon, Madison, Martin, McDowell, Mecklenburg, Mitchell, Montgomery, Moore, Nash, Northampton, Orange, Pamlico, Pasquotank, Pender, Perquimans, Person,	

Mid-South		Pitt, Polk, Randolph, Richmond, Robeson, Rockingham, Rowan, Rutherford, Sampson, Scotland, Stanly, Stokes, Surry, Swain, Transylvania, Tyrrell, Union, Vance, Wake, Warren, Washington, Watauga, Wayne, Wilkes, Wilson, Yadkin, Yancey	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	South Carolina	Abbeville, Aiken, Allendale, Anderson, Bamberg, Barnwell, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chester, Chesterfield, Clarendon, Colleton, Darlington, Dillon, Dorchester, Edgefield, Fairfield, Florence, Georgetown, Greenville, Greenwood, Hampton, Horry, Jasper, Kershaw, Lancaster, Laurens, Lee, Lexington, Marion, Marlboro, McCormick, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, Union, Williamsburg, York	
	Tennessee	Bedford, Benton, Bledsoe, Bradley, Cannon, Carroll, Cheatham, Chester, Clay, Coffee, Crockett, Cumberland, Davidson, Decatur, DeKalb, Dickson, Dyer, Fayette, Fentress, Franklin, Gibson, Giles, Grundy, Hamilton, Hardeman, Hardin, Haywood, Henry, Hickman, Houston, Humphreys, Jackson, Lake, Lauderdale, Lawrence, Lewis, Lincoln, Macon, Marion, Marshall, Maury, McNairy, Meigs, Montgomery, Moore, Obion, Overton, Perry, Pickett, Polk, Putnam, Rhea, Robertson, Rutherford, Sequatchie, Shelby, Smith, Stewart, Sumner, Tipton, Trousdale, Van Buren, Warren, Wayne, Weakley, White, Williamson, Wilson	

Local Market	State	In These Counties Only	Product
	Colorado	Adams, Arapahoe, Archuleta, Boulder, Broomfield, Clear Creek, Conejos, Crowley, Custer, Delta, Denver, Douglas, El Paso, Elbert, Fremont, Gilpin, Grand, Huerfano, Jackson, Jefferson, LaPlata, Larimer, Las Animas, Lincoln, Mesa, Montrose, Morgan Park, Pueblo, Saguache, Teller, Washington, Weld	

Midlands	Iowa	Adair, Adams, Allamakee, Appanoose, Audubon, Benton, Black Hawk, Boone, Bremer, Buchanan, Buena Vista, Butler, Calhoun, Carroll, Cass, Cedar, Cerro Gordo, Cherokee, Chickasaw, Clarke, Clay, Clayton, Clinton, Crawford, Dallas, Davis, Decatur, Delaware, Des Moines, Dickinson, Emmet, Fayette, Floyd, Franklin, Fremont, Greene, Grundy, Guthrie, Hamilton, Hancock, Hardin, Harrison, Henry, Howard, Humboldt, Ida, Iowa, Jackson, Jasper, Jefferson, Johnson, Jones, Keokuk, Kossuth, Lee, Linn, Louisa, Lucas, Lyon, Madison, Mahaska, Marion, Marshall, Mills, Mitchell, Monona, Monroe, Montgomery, Muscatine, O'Brien, Osceola, Page, Palo Alto, Plymouth, Pocahontas, Polk, Pottawattamie, Poweshiek, Ringgold, Sac, Scott, Shelby, Sioux, Story, Tama, Taylor, Union, Van Buren, Wapello, Warren, Washington, Wayne, Webster, Winnebago, Winneshiek, Woodbury, Worth, Wright	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Nebraska	Adams, Antelope, Banner, Boone, Boyd, Brown, Buffalo, Burt, Butler, Cass, Cedar, Cheyenne, Clay, Colfax, Cuming, Custer, Dakota, Dixon, Dodge, Douglas, Fillmore, Franklin, Frontier, Furnas, Gage, Garfield, Gosper, Greeley, Hall, Hamilton, Harlan, Holt, Howard, Jefferson, Johnson, Kearney, Kimball, Knox, Lancaster, Loup, Madison, Merrick, Morrill, Nance, Nemaha, Nuckolls, Otoe, Pawnee, Phelps, Pierce, Platte, Polk, Richardson, Rock, Saline, Sarpy, Saunders, Seward, Sherman, Stanton, Thayer, Thurston, Valley, Washington, Wayne, Webster, Wheeler, York	
	North Dakota	Barnes, Burleigh, Cass, Dickey, Eddy, Emmons, Foster, Grand Forks, Grant, Griggs, Kidder, LaMoure, Logan, McIntosh, McLean, Mercer, Morton, Nelson, Oliver, Ransom, Richland, Sargent, Sheridan, Sioux, Steele, Stutsman, Trail, Walsh, Wells	
	South Dakota	Aurora, Beadle, Bon Homme, Brookings, Brule, Buffalo, Campbell, Charles Mix, Clark, Clay, Corson, Davison, Day, Deuel, Douglas, Gregory, Hamlin, Hanson, Hutchinson, Jerauld, Kingsbury, Lake, Lincoln, Marshall, McCook, Miner, Minnehaha, Moody, Sanborn, Spink, Turner, Union, Walworth, Yankton	

Local Market	State	In These Counties Only	Product
Minnesota	Minnesota	Anoka, Blue Earth, Brown, Carver, Chisago, Dakota, Hennepin, Isanti, Kanabec, Le Sueur, McLeod, Meeker, Mille Lacs, Nicollet, Ramsey, Renville, Scott, Sibley, Steele, Waseca, Washington, Wright	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Local Market	State	In These Counties Only	Product
Mountain	Nevada	Carson City, Churchill, Clark, Douglas, Lyon, Nye, Storey, Washoe	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Utah	Box Elder, Cache, Carbon, Davis, Duchesne, Iron, Juab, Morgan, Rich, Salt Lake, Summit, Tooele, Uintah, Utah, Washington, Weber	
	Wyoming	Uinta	

Local Market	State	In These Counties Only	Product
New England	Connecticut	Fairfield, Hartford, Litchfield, Middlesex, New Haven, New London, Tolland, Windham	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Massachusetts	Bristol, Essex, Hampden, Hampshire, Middlesex, Norfolk, Plymouth, Suffolk, Worcester	
	Maine	Androscoggin, Aroostook, Cumberland, Franklin, Hancock, Kennebec, Knox, Lincoln, Oxford, Penobscot, Piscataquis, Sagadahoc, Somerset, Waldo, Washington, York	
	New Hampshire	Belknap, Carroll, , Grafton, Hillsborough, Merrimack, Rockingham, Strafford, Sullivan	
	Rhode Island	Bristol, Kent, Newport, Providence, Washington	

Local Market	State	In These Counties Only	Product
New Jersey	New Jersey	Atlantic, Bergen, Burlington, Camden, Cape May, Cumberland, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Monmouth, Morris, Ocean, Passaic, Salem, Somerset, Sussex, Union, Warren	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Local Market	State	In These Counties Only	Product
New York	New York	Albany, Allegany, Bronx, Broome, Cattaraugus, Cayuga, Chautauqua, Chemung, Chenango, Clinton, Columbia, Cortland, Delaware, Dutchess, Erie, Essex, Franklin, Fulton, Genesee, Greene, Hamilton, Herkimer, Jefferson, Kings, Lewis, Livingston, Madison, Monroe, Montgomery, Nassau, New York, Niagara, Oneida, Onondaga, Ontario, Orange, Orleans, Oswego, Otsego, Putnam, Queens, Rensselaer, Richmond, Rockland, St. Lawrence, Saratoga, Schenectady, Schoharie, Schuyler, Seneca, Steuben, Suffolk, Sullivan, Tioga, Tompkins, Ulster, Warren, Washington, Wayne, Westchester, Wyoming, Yates	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Local Market	State	In These Counties Only	Product
Northwest	Idaho	All Counties	PDP only, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Oregon	Clackamas, Columbia, Jackson, Josephine, Linn, Marion, Multnomah, Washington, Yamhill	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Washington	Cowlitz, King, Kitsap, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston	

Local Market	State	In These Counties Only	Product
Ohio/ Kentucky	Kentucky	Barren, Boone, Boyd, Bracken, Breckinridge, Bullitt, Butler, Calloway, Campbell, Carroll, Carter, Christian, Clark, Edmonson, Fayette, Floyd, Franklin, Gallatin, Grant, Graves, Grayson, Greenup, Hancock, Hardin, Harrison, Hart, Henderson, Henry, Hopkins, Jefferson, Jessamine, Kenton, Knott, Knox, Larue, Laurel, Letcher, Lewis, Logan, Madison, Marshall, Martin, Mason, McCracken, McCreary, McLean, Meade, Montgomery, Muhlenberg, Nelson, Nicholas, Ohio, Oldham, Owen, Pendleton, Pike, Pulaski, Robertson, Rowan, Russell, Scott, Shelby, Spencer, Taylor, Todd, Trimble, Warren, Wayne, Webster, Whitley, Woodford	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
		Adams, Allen, Ashland, Ashtabula, Athens, Auglaize, Belmont, Brown, Butler, Carroll, Champaign, Clark, Clermont, Clinton, Columbiana, Coshocton, Crawford, Cuyahoga, Darke, Defiance, Delaware,	

	Ohio	Erie, Fairfield, Fayette, Franklin, Fulton, Gallia, Geauga, Greene, Guernsey, Hamilton, Hancock, Hardin, Harrison, Henry, Highland, Hocking, Holmes, Huron, Jackson, Jefferson, Knox, Lake, Lawrence, Licking, Logan, Lorain, Lucas, Madison, Mahoning, Marion, Medina, Meigs, Mercer, Miami, Monroe, Montgomery, Morgan, Morrow, Muskingum, Noble, Ottawa, Paulding, Perry, Pickaway, Pike, Portage, Preble, Putnam, Richland, Ross, Sandusky, Scioto, Seneca, Shelby, Stark, Summit, Trumbull, Tuscarawas, Union, Van Wert, Vinton, Warren, Washington, Wayne, Williams, Wood, Wyandot	

Local Market	State	In These Counties Only	Product
South Central	New Mexico	All Counties	PDP only, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Oklahoma	Adair, Atoka, Blaine, Bryan, Caddo, Canadian, Carter, Cherokee, Cleveland, Coal, Cotton, Craig, Creek, Custer, Delaware, Garfield, Garvin, Grady, Grant, Haskell, Hughes, Jefferson, Johnston, Kay, Kingfisher, Latimer, Le Flore, Lincoln, Logan, Love, Major, Marshall, Mayes, McClain, McIntosh, Murray, Muskogee, Noble, Nowata, Okfuskee, Oklahoma, Okmulgee, Osage, Ottawa, Pawnee, Pittsburg, Pontotoc, Pottawatomie, Pushmataha, Rogers, Seminole, Sequoyah, Stephens, Tulsa, Wagoner	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Texas	Anderson, Aransas, Atascosa, Austin, Bandera, Bee, Bell, Bexar, Bosque, Bowie, Brazoria, Brazos, Brooks, Burleson, Burnet, Caldwell, Calhoun, Cameron, Cass, Chambers, Cherokee, Collin, Colorado, Comal, Comanche, Coryell, Dallas, Denton, DeWitt, Dimmit, Duval, Ector, Ellis, El Paso, Erath Falls, Fannin, Fayette, Fort Bend, Galveston, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hale, Hamilton, Hardin, Harris, Harrison, Hays, Henderson, Hidalgo, Hill, Hood, Houston, Hunt, Jackson, Jasper, Jefferson, Jim Hogg, Jim Wells, Johnson, Karnes, Kaufman, Kendall, Kenedy, Kerr, Kleberg, La Salle, Lamar, Lampasas, Lavaca, Lee, Leon, Liberty, Live Oak, Limestone, Lubbock, Madison, Marion, Matagorda, Maverick, McLennan, Medina, Midland, Milam, Montague, Montgomery, Morris, Nacogdoches, Navarro, Newton, Nueces, Panola, Parker, Polk, Potter, Rains, Randall, Red River, Refugio, Robertson, Rockwall, Rusk, San Augustine, San Jacinto, San Patricio, Smith,	

		Somervell, Starr, Tarrant, Titus, Tom Green, Travis, Tyler, Upshur, Van Zandt, Victoria, Walker, Waller, Washington, Webb, Wharton, Willacy, Williamson, Wilson, Wise, Wood	

Local Market	State	In These Counties Only	Product
St. Louis	Illinois	Adams, Alexander, Bond, Brown, Calhoun, Cass, Champaign, Christian, Clark, Clay, Clinton, Coles, Crawford, Cumberland, DeWitt, Douglas, Edgar, Edwards, Effingham, Fayette, Ford, Franklin, Fulton, Gallatin, Greene, Hamilton, Hardin, Iroquois, Jackson, Jasper, Jefferson, Jersey, Johnson, Knox, La Salle, Lawrence, Livingston, Logan, Macon, Macoupin, Madison, Marion, Marshall, Mason, Massac, McDonough, McLean, Menard, Monroe, Montgomery, Morgan, Moultrie, Peoria, Perry, Piatt, Pike, Pope, Pulaski, Putnam, Randolph, Richland, Saline, Sangamon, Schuyler, Scott, Shelby, St. Clair, Stark, Tazewell, Union, Vermilion, Wabash, Washington, Wayne, White, Williamson, Woodford	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)
	Missouri	Adair, Audrain, Bollinger, Boone, Butler, Callaway, Camden, Cape Girardeau, Carter, Chariton, Clark, Cole, Cooper, Crawford, Dent, Franklin, Gasconade, Howard, Howell, Iron, Jefferson, Knox, Lewis, Lincoln, Linn, Macon, Madison, Maries, Marion, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Oregon, Osage, Pemiscot, Perry, Phelps, Pike, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Schuyler, Scotland, Scott, Shannon, Shelby, St. Charles, St. Francois, St. Louis, St. Louis City, St. Genevieve, Stoddard, Sullivan, Texas, Warren, Washington, Wayne	

Local Market	State	In These Counties Only	Product
Alaska	Alaska	All Counties	PDP Only, excluding Non-Commissionable Medicare Products (per Schedule B-2)
Hawaii	Hawaii	All Counties	
Montana	Montana	All Counties	
Vermont	Vermont	All Counties	

Aetna Medicare Part D Plans are available in the following individual Medicare markets:

Region	Product
All CMS regions, except regions 35-39. (Regions 35-39 are the following U.S. territories*: American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands of the United States).	All, excluding Non-Commissionable Medicare Products (per Schedule B-2)

Schedule B-2

Non-Commissionable Individual Medicare Products

Neither Upline nor its agents are eligible to receive a Commission for the following Medicare Products:

Medicare Advantage HMO		
Product	**Contract/PBP**	**Plan Name**
HMO	H2663/065	Aetna Medicare SmartSaver Elite (HMO)
HMO	H1609/066*	Aetna Medicare FL Select (HMO)
HMO	H1609/067*	Aetna Medicare FL Select (HMO)
HMO-POS	H3312/062*	Aetna Medicare Value (HMO-POS)
HMO-POS	H3748/006*	Aetna Medicare Elite (HMO-POS)
HMO-POS	H3748/017*	Aetna Medicare Classic (HMO-POS)
HMO-POS	H3931/097*	Aetna Medicare Connect Plus (HMO-POS)
HMO-POS	H3931/162*	Aetna Medicare Value (HMO-POS)
HMO	H8332/004*	Aetna Medicare Value (HMO)
HMO-POS	H8649/003*	Aetna Medicare Advantra (HMO-POS)

*Application dates on or after November 1, 2024

Medicare Advantage PPO		
Product	**Contract/PBP**	**Plan Name**
PPO	H5521/482*	Aetna Medicare Value Plus (PPO)
PPO	H3288/007*	Aetna Medicare Choice (PPO)
PPO	H5521/084*	Aetna Medicare Value Plus (PPO)
PPO	H5521/101*	Aetna Medicare Choice (PPO)
PPO	H5521/110*	Aetna Medicare Premier (PPO)
PPO	H5521/370*	Aetna Medicare Choice (PPO)
PPO	H5521/425*	Aetna Medicare Core (PPO)
PPO	H5521/432*	Aetna Medicare FL Explorer Premier (PPO)
PPO	H5521/437*	Aetna Medicare FL Explorer Premier (PPO)
PPO	H5521/446*	Aetna Medicare Discover (PPO)
PPO	H5521/459*	Aetna Medicare Platinum (PPO)
PPO	H5521/480*	Aetna Medicare Eagle (PPO)
PPO	H5521/482*	Aetna Medicare Value Plus (PPO)
PPO	H5521/521*	Aetna Medicare Elite (PPO)
PPO	H5521/522*	Aetna Medicare Premier (PPO)

*Application dates on or after November 1, 2024

Medicare Advantage HMO/PPO SNP		
Product	**Contract/PBP**	**Plan Name**
HMO I-SNP	H0628/018	Aetna Medicare Longevity (HMO I-SNP)
HMO I-SNP	H3931/179	Aetna Medicare Supportive Care (HMO I-SNP)
HMO I-SNP	H3959/066	Aetna Medicare Longevity Plan (HMO I-SNP)
PPO I-SNP	H5521/461	Aetna Medicare Longevity (PPO I-SNP)
PPO I-SNP	H5521/506	Aetna Medicare Longevity (PPO I-SNP)
HMO D-SNP	H1609/056*	Aetna Medicare FL Dual Select (HMO D-SNP)
HMO D-SNP	H3312/087*	Aetna Medicare Assure (HMO D-SNP)

*Application dates on or after November 1, 2024

******Special note and reminder for 2025: All new sales for PDP plans are non-commissionable regardless of the state, county, or partner hierarchy level. Producers will be paid renewal commissions on previously placed business of commissionable PDP plans. ******

This New Jersey Fully Integrated Dual-Eligible Special Needs Plan ("FIDE") Compliance Addendum ("FIDE Addendum") is required by the State of New Jersey Department of Human Services ("DHS"), Division of Medical Assistance and Health Services ("DMAHS").

REQUIRED LANGUAGE – ALL PROVIDER CONTRACTS AND SUBCONTRACTS

The following text must be included verbatim in all provider contracts and subcontracts (to the extent applicable to the provider contract/subcontract). The language either may be included in the body of the provider contract/subcontract or as an amendment. For the most up to date version of the verbatim language that applies to this agreement, please refer to the Provider Manual. The provider/subcontractor agrees to serve enrollees in New Jersey's Fully Integrated Dual Eligible Special Needs Plan (FIDE) and/or New Jersey's managed care program and, in doing so, to comply with all of the following provisions:

DEFINITIONS

For the purposes of this addendum, the following terms shall have the following meanings:

- Contractor—means Company under the Agreement.

- Provider--means any physician, hospital, facility, health care professional, vendor, or other entity provider of enrollee services who is licensed or otherwise authorized to provide services in the state or jurisdiction in which they are furnished.

- Subcontract--any written contract between the Contractor and a third party to perform a specified part of the Contractor's obligations under this contract.

- Subcontractor--any third party who has a written contract with the Contractor to perform a specified part of the Contractor's obligations under this contract. This subcontractor 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.

A. SUBJECTION OF PROVIDER CONTRACT/SUBCONTRACT

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

MLTSS Any Willing Provider and Any Willing Plan. Any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury, or long term care pharmacy that applies to become a network provider and complies with the Contractor's provider network requirements shall be included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care

nursing facility (SCNF), assisted living provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form. This is known as Any Willing Plan. The Contractor must accept all NFs, SCNF, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies

which are Medicaid Providers, and network participation of these provider types cannot be denied based on the application of a subjective standard.

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

2. The Any Willing Plan status also expires on the date established by DMAHS.

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

4. Any Willing and Qualified Provider (AWQP): MLTSS. AWQP refers to any New Jersey Based nursing facility (NF) provider that meets the criteria defined below in Section N. In order to be an AWQP and in the Contractor's network, the New Jersey- Based NF must meet any four of the following seven quality performance measures in what is herein known as the NF Quality Improvement Initiative. The first five measures are part of the federally mandated process for clinical assessment of all residents in Medicare or Medicaid certified NFs as part of the Minimum Data Set (MDS):

a. The NF shall be at or above the statewide average of the percentage of long stay residents who are immunized against influenza. This measure is calculated annually during the influenza season.

b. The NF shall be at or below the statewide average of the percentage of long stay residents who receive an antipsychotic medication. The measure could be met with any four of the most recent six quarters examined.

c. The NF shall be at or below the statewide average of the percentage of long-stay, high risk residents with a pressure ulcer. The measure could be met with any four of the most recent six quarters examined.

d. The NF shall be at or below the statewide average of the percentage of long stay residents who are physically restrained. The measure could be met with any four of the most recent six quarters examined.

e. The NF shall be at or below the statewide average of the percentage of long stay residents who experience one or more falls with a major injury. The measure could be met with any four of the most recent six quarters examined.

f. These two additional measures are also included in the NF Quality Improvement Initiative:

i. The CoreQ Long-Stay Resident Experience Questionnaire and the CoreQ Long-Stay Family Questionnaire will measure NF resident and family satisfaction across all NFs. It will provide

the average CoreQ satisfaction rating for each NF, which combines the satisfaction scores of both the long-stay residents and their family members. There will be benchmarks of the average resident score and the CoreQ satisfaction rating that the NF shall meet or exceed.

ii. This performance measure will ask the NF whether the facility is using INTERACT, Advancing Excellence Tools, TrendTracker or another validated tool to measure 30-day re-hospitalizations and overall hospital utilization. The NF shall directly provide a response of yes or no.

5. While the following are general provisions in the AWQP policy, they will be outlined in guidance and procedures and issued by the State prior to the implementation of the NF Quality Improvement Initiative:

- In cooperation with the State, the Contractor shall be responsible for notifying NFs, which fail to meet any four out of seven performance quality measures, that no new MLTSS enrollments for their members will be forthcoming; and for MLTSS members currently residing in the NF, the Contractor will enter into single case agreements.
- The Contractor may not contract with a NF for new MLTSS admissions that does not meet any four out of seven performance quality measures.
- The Contractor shall focus their NF care management on working with the NFs to improve their performance quality measures.
- The NF shall be able to appeal to the State for reconsideration of network exclusion. Exceptions may be made by the State for NFs that have a population with disproportionate needs, etc.
    - To meet geographic access
    - To maintain family cohesion
    - Because of a NF appeals network exclusion due to the unique features and population of that NF
- The NF shall be able to enter into a corrective action plan with the State if it doesn't meet any four of the seven measures
-

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

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

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

B. COMPLIANCE WITH FEDERAL AND STATE LAWS AND REGULATIONS

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

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

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

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

C. APPROVAL OF PROVIDER CONTRACTS/SUBCONTRACTS AND AMENDMENTS

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

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

D. EFFECTIVE DATE

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

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

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

F. ENROLLEE-PROVIDER COMMUNICATIONS

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

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

a. To prohibit the enforcement, including termination, as part of a provider contract/subcontract or agreement to which a health care provider is a party, of any mutually agreed upon terms and conditions, including terms and conditions requiring a health care provider to participate in, and cooperate with, all programs, policies, and procedures developed or operated by the Contractor to assure, review, or improve the quality and effective utilization of health care services (if such utilization is according to guidelines or protocols that are based on clinical or scientific evidence and the professional judgment of the provider), but only if the guidelines or protocols under such utilization do not prohibit or restrict medical communications between providers/subcontractors and

their patients; or

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

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

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

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

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

H. TERMINATION OF PROVIDER CONTRACT/SUBCONTRACT – STATE

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

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

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

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

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

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

6. Materially breaches the provider contract/subcontract; or

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

I. NON-DISCRIMINATION

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

1. The provider/subcontractor shall accept assignment of an enrollee and not discriminate against eligible enrollees because of race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, Section 504 of the Rehabilitation Act of 1973, 29 USC Section 794, the Americans with Disabilities Act of 1990 (ADA), 42 USC Section 12132, and rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulation.

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

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

The provider/subcontractor shall submit to the Contractor 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 Contractor 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 CONTRACTOR'S INSOLVENCY AND TO HOLD ENROLLEES AND FORMER ENROLLEES HARMLESS

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

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

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

4. The provider/subcontractor agrees that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between the provider/subcontractor and enrollees, or persons acting on their behalf, insofar as such contrary agreement relates to liability for payment for or continuation of covered services provided under the terms and conditions of this continuation of benefits provisions.

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

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

K. INSPECTION

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

If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time. The DMAHS, the MFD, or its designee, and the MFCU, shall have the right to inspect, evaluate, and audit all of the following documents in whatever form they are kept, including but not limited to, all physical and computer or other electronic records and systems, originated or prepared pursuant to, or related to this contract:

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

Medicaid claims;

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

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

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

L. RECORD MAINTENANCE

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

M. RECORD RETENTION AND PROVIDER/SUBCONTRACTOR DOCUMENTATION REQUIREMENTS

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

Record Retention Requirements - Records must be retained for the later of ten (10) years from the date of service or after the final payment is made under the provider contract/subcontract and all pending matters are closed. If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, the records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later. Records shall be made accessible at a New Jersey site and on request to agencies of the State of New Jersey and the federal government. For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10a 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.

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

1) Medical supplies and DME:

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

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

ii) A detailed description of the specific supplies and/or equipment prescribed;
(1) For example, the phrase "wheelchair" or "patient needs wheelchair" is insufficient. The order shall describe the type and style of the wheelchair;
iii) The length of time the medical equipment items or supplies are required;
iv) A diagnosis and summary of the patient's physical condition to support the need for the item(s) prescribed; and
v) The prescriber's printed name, address and signature.

2) Orders for laboratory tests:

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

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

i) In the absence of a written order, the patient's chart or medical record may be used as the test requisition or authorization, but must be physically present at the laboratory at the time of testing and available to Federal or State representatives upon request;
ii) A test request also may be submitted to the laboratory electronically if the system used to generate and transmit the electronic order has adequate security and system safeguards to prevent and detect fraud and abuse and to protect patient confidentiality. The system shall be designed to prevent and detect unauthorized access and modification or manipulation of records, and shall include, at a minimum, electronic encryption; or
iii) Telephoned or other oral laboratory orders are also permissible, but shall be followed up with a written or electronic request within 30 days of the telephone or other oral request, which shall be maintained on file with the clinical laboratory. If the laboratory is unable to obtain the written or electronic request, it must maintain documentation of its efforts to obtain them.

c) Standing orders shall be:

i) Patient specific, and not blanket requests from the physician or licensed practitioner;
ii) Medically necessary and related to the diagnosis of the recipient; and
iii) Effective for no longer than a 12-month period from the date of the physician's/practitioner's order.

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

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

iii) The sex (if known) and date of birth of the patient;
iv) The specific test(s) to be performed;
v) The source of the specimen, when appropriate;
vi) The date and, if appropriate, time of specimen collection;
vii) For Pap smears, the patient's last menstrual period, and indication of whether the patient had a previous abnormal report, treatment or biopsy;
viii) For drug testing, the order shall indicate whether the test is for screening (presumptive) or confirmation (definitive) purposes and the specific drug classes to be tested as defined by the American Medical Association;

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

e) All orders and results of the tests billed shall be on file with the billing laboratory performing the tests. The results of the tests, clinical and billing records shall be available for review by Medicaid/NJ FamilyCare representatives.

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

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

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

3) Services Provided by a Psychologist

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

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

i) Date(s) of service rendered;
ii) Signature of the psychologist;
iii) Chief complaint(s);
iv) Pertinent historical, social, emotional, and additional data;
v) Reports of evaluation procedures undertaken or ordered;
vi) Diagnosis; and
vii) The intended course of treatment and tentative prognosis.

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

i) Date(s) and duration of service (for example, hour, half-hour);
ii) Signature of the psychologist;
iii) Name(s) of modality used, such as individual, group, or family therapy;
iv) Notations of progress, impediments, or treatment complications; and
v) Other components, such as dates or information not included in (c)1 through 4 above, which may be important to the clinical description and prognosis.
vi) One or more of the following components shall be recorded to delineate the visit and establish its uniqueness. (Not all of the components need be included):

(1) Symptoms and complaints;
(2) Affect;
(3) Behavior;
(4) Focus topics; and
(5) Significant incidents or historical events.

4) Mental Health Services Provided by an Independent Clinic

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

i) Evaluates the beneficiary's mental condition;
ii) Determines whether treatment in the program is appropriate, based on the beneficiary's diagnosis;
iii) Includes certification, in the form of a signed statement, by the evaluation team, that the program is appropriate to meet the beneficiary's treatment
needs; and
iv) Is made part of the beneficiary's records.
v) The evaluation for the intake process shall include a physician or advance practice nurse (APN) and an individual experienced in the diagnosis and treatment of mental illness. Both criteria may be satisfied by the same individual, if appropriately qualified.

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

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

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

ii) A projected schedule for service delivery which includes the frequency and duration of each type of planned therapeutic session or encounter;
iii) The type of personnel that will be furnishing the services; and
iv) A projected schedule for completing reevaluations of the beneficiary's condition and updating the plan of care.

c) The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.

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

(1) The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, etc.;
(2) the date and time that services were rendered;
(3) The duration of services provided;
(4) The signature of the practitioner or provider who rendered the services;
(5) The setting in which services were rendered; and
(6) A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

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

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

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

i) The periodic review shall determine:

(1) The beneficiary's progress toward the treatment objectives;
(2) The appropriateness of the services being furnished; and
(3) The need for the beneficiary's continued participation in the program

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

5) APN Services:

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

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

i) The date of service;
ii) The name of the beneficiary;
iii) The beneficiary's chief complaint(s), reason for visit;
iv) Review of systems;
v) Physical examination;
vi) Diagnosis;
vii) A plan of care, including diagnostic testing and treatment(s);
viii) The signature of the APN rendering the service; and
ix) Other documentation appropriate to the procedure code being billed. (See N.J.A.C. 10:58A-4, HCPCS Codes.)

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

i) Chief complaint(s);
ii) A complete history of the present illness, with current medications and review of systems, including recordings of pertinent negative findings;
iii) Pertinent medical history;
iv) Pertinent family and social history;
v) A complete physical examination;
vi) Diagnosis; and
vii) Plan of care, including diagnostic testing and treatment.

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

i) In an office or residential health care facility:

(1) The beneficiary's chief complaint(s), reason for visit;
(2) Pertinent medical, family and social history obtained;
(3) Pertinent physical findings;
(4) All diagnostic tests and/or procedures ordered and/or performed, if any, with results; and
(5) A diagnosis.

ii) In a hospital or nursing facility setting:

(1) An update of symptoms;
(2) An update of physical symptoms;
(3) A resume of findings of procedures, if any done;
(4) Pertinent positive and negative findings of lab, X-ray or any other test;
(5) Additional planned studies, if any, and the reason for the studies;
And

(6) Treatment changes, if any.

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

i) Reviewed the beneficiary's medical history with the beneficiary and/or his or her family, depending upon the medical situation;
ii) Performed a physical examination, as appropriate;
iii) Confirmed or revised the diagnosis; and
iv) Visited and examined the beneficiary on the days for which a claim for reimbursement is made.

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

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

i) A history (complete initial for new beneficiary, interval for established beneficiary) including past medical history, family history, social history, and systemic review.
ii) A developmental and nutritional assessment.
iii) A complete, unclothed, physical examination to also include the following:
(1) Measurements: height and weight; head circumference to 25 months; blood pressure for children age three or older; and

(2) Vision, dental and hearing screening;

iv) The assessment and administration of immunizations appropriate for age and need;
v) Provisions for further diagnosis, treatment and follow-up, by referral if necessary, of all correctable abnormalities uncovered or suspected;
vi) Mandatory referral to a dentist for children age twelve months or older;
vii) The laboratory procedures performed or referred if medically necessary per Bright Futures guidelines.
viii) Health education and anticipatory guidance; and
ix) An offer of social service assistance; and, if requested, referral to a county welfare agency.

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

i) The beneficiary's chief complaint(s), reason for visit;
ii) Pertinent medical, family and social history obtained;
iii) Pertinent physical findings;
iv) The procedures, if any performed, with results;
v) Lab, X-ray, ECG, etc., ordered with results; and
vi) Diagnosis(es) plus treatment plan status relative to present or pre-existing illness(es) plus pertinent recommendations and actions.

6) Physician Services
a) Physician Recordkeeping; general

i) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.
ii) The minimum recordkeeping requirements for services performed in the office, home, residential health care facility, nursing facility (NF), and the hospital setting shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

iii) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.
iv) Records of Residential Health Care Facility patients shall be maintained in the physician's office.
v) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid/NJ FamilyCare program or its agents.

b) Minimum documentation; initial visit; new patient

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

(1) Chief complaint(s);
(2) Complete history of the present illness and related systemic review, including recordings of pertinent negative findings;
(3) Pertinent past medical history;
(4) Pertinent family and social history;
(5) A record of a full physical examination pertaining to, but not limited to, the history of the present illness and including recordings of pertinent negative findings;
(6) Diagnosis(es) and the treatment plan, including ancillary services and medications ordered;
(7) Laboratory, X-Rays, electrocardiograms (ECGs), and any other diagnostic tests ordered, with the results; and
(8) The specific services rendered and/or modality used (for example, biopsies, injections, individual and/or group psychotherapy, and family therapy).

c) Minimum documentation; established patient

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

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

(a) The purpose of the visit;
(b) The pertinent physical, family and social history obtained;
(c) A record of pertinent physical findings, including pertinent negative findings based upon (a) and (b) above;
(d) Procedures performed, if any, with results
(e) Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests

ordered, with the results of the tests; and
(f) Prognosis and diagnosis.

d) Minimum documentation; home visits and house calls

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

e) Minimum documentation; hospital or nursing facility

i) In a hospital or nursing facility, documentation shall include:
(1) An update of symptoms;
(2) An update of physical findings;
(3) A resume of findings of procedures, if any are applicable;
(4) The pertinent positive and negative findings of laboratory, X-Ray, electrocardiograms (ECGs), or other tests or consultations;
(5) Any additional planned studies, if any, including the reasons for any studies; and
(6) Treatment changes, if any.

f) Minimum documentation; hospital discharge medical summary

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

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

g) Minimum documentation; mental health services

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

(1) The specific services rendered and modality used, for example, individual, group, and/or family therapy;
(2) The date and the time services were rendered;
(3) The duration of services provided, for example, one hour, or one half hour;
(4) The signature of the physician who rendered the service;
(5) The setting in which services were rendered;
(6) A notation of impediments, unusual occurrences or significant deviations from the treatment described in the Plan of Care;

(7) Notations of progress, impediments, treatment, or complications; and
(8) Other relevant information, which may include dates or information not included in above, yet important to the clinical picture and prognosis.

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

7) Pharmaceutical services

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

b) Invoices and documentation required by subsection (a) must substantiate that the prescription drugs or medical supplies dispensed were purchased from an authorized source regulated by the federal/state entities and National Association of Boards of Pharmacy - Verified Accredited Wholesaler Distributors (NABPVAWD). Pharmacies shall provide product tracing information (i.e. pedigree) to DMAHS and/or MFD upon request.

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

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

e) Pharmacies may transfer inventory to alleviate a temporary shortage, or for the sale, transfer, merger or consolidation of all or part of the business of a pharmacy from or with another pharmacy, whether accomplished as a purchase and sale of stock or business assets. The transfer or purchase of covered legend and nonlegend products or medical supplies from another licensed pharmacy must be verified and documented as originating from a NABP-VAWD and licensed drug wholesaler. All

records involved in the transfer must be maintained and accessible for ten (10) years. These records shall be contemporaneous with the transfer and shall include the name of the prescription drug or medical supply, dosage form, strength, NDC, lot number, quantity and date transferred. Additionally, records must indicate the supplier or manufacturer's name, address
and registration number.

N. DATA REPORTING

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

O. DISCLOSURE

1. The provider/subcontractor further agrees to comply with the Prohibition On Use Of Federal Funds For Lobbying provisions of the Contractor's agreement with the State. 2. The provider/subcontractor shall comply with financial disclosure provision of 42 CFR 434, 1903 (m) of the S.S.A., and N.J.A.C. 10:49-19.

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

P. LIMITATIONS ON COLLECTION OF COST-SHARING

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

Q. INDEMNIFICATION BY PROVIDER/SUBCONTRACTOR

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

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

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

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

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

R. CONFIDENTIALITY

1. General. The provider/subcontractor hereby agrees and understands that all information, records, data, and data elements collected and maintained for the operation of the provider/subcontractor and the Contractor and Department and pertaining to enrolled persons, shall be protected from unauthorized disclosure in accordance with the provisions of 42 U.S.C. 1396(a)(7)(Section 1902(a)(7) of the Social Security Act), 42 CFR Part 431, subpart F, 45 CFR Parts 160 and 164, subparts A & E, N.J.S.A. 30:4D-7 (g) and N.J.A.C. 10:49-9.7. Access to such information, records, data and data elements shall be physically secured and safeguarded and shall be limited to those who perform their duties in accordance with provisions of this provider contract/subcontract including the Department of Health and Human Services and to such others as may be authorized by DMAHS in accordance with applicable law. For enrollees covered by the Contractor's plan that are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10a and 9:6-8:40 and consistent with the need to protect the enrollee's confidentiality.

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

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

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

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

6. Notification in Case of Breach. Should there be a breach of confidentiality with respect to the data, information or records described in this section, the provider/subcontractor is responsible for complying, at a minimum, with the following statutes and regulations: (1) Section 13402 of the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009 (ARRA) (Pub. L. 111-5), 42 U>S>C> 17932 et. seq. and the implementing

regulations at 45 CFR Part 164, subpart D; and (2) the Identity Theft Prevention Act, N.J.S.A. 56:11-44 et. seq.

S. CLINICAL LABORATORY IMPROVEMENT

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

T. FRAUD, WASTE, AND ABUSE

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

2. If the State has withheld payment and/or initiated a recovery action against the provider/subcontractor, or withheld payments pursuant to 42 CFR 455.23 and NJAC 10:49-9.10(a), the Contractor shall have the right to withhold payments from the provider/subcontractor and/or forward those payments to the State.

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

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

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

6. The Contractor shall have a nationally recognized standard criteria for inpatient hospital admissions that shall substantially conform to the Milliman Care Guidelines (MCG). The Contractor shall inform and include in all provider contracts for network provider hospitals or clinical care review team subcontractors, that for purposes of audits of inpatient hospital admissions by DMAHS or MFD or its subcontractors, MCG criteria will be applied.

7. Hospital Acquired Conditions and Provider–Preventable Conditions. All Network hospitals agrees to comply with the Contractors no payment policy and quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions according to federal regulations at CFR 434,438, and 447. The ICD-10 Version 33

Hospital Acquired Condition (HAC) list may be accessed at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html. The Contractor's specific policies that have been prior approved by DMAHS are included in the Contractor's Provider Manual.

U. THIRD PARTY LIABILITY

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

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

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

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

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

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

d. The claim is for a child who is in a DCP&P supported out of home placement.

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

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

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

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

b. When the provider/subcontractor becomes aware that an enrollee has retained counsel, who either may institute or has instituted a legal cause of action for damages against a third party, the provider/subcontractor shall notify the Contractor in writing, including the enrollee's name and Medicaid identification number, date of accident/incident, nature of injury, name and address of enrollee's legal representative, copies of pleadings, and any other documents related to the action in the provider's/subcontractor's possession or control. This shall include, but not be limited to (for each service date on or subsequent to the date of the accident/incident), the enrollee's diagnosis and the nature of the service provided to the enrollee.

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

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

V. ENROLLEE PROTECTIONS AGAINST LIABILITY FOR PAYMENT

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

a. (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, N.J.S.A. 30:4D-6i or N.J.S.A. 30:4J-4.1 (as both of these provisions may be amended by State Appropriations Act language in effect at the time the service is rendered, as set forth in Section 4.2.1D.2 of the contract), or NJAC 10:74-9.1; and

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

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

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

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

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

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

participating provider in the Contractor's network; or

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

W. Off-Shore

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

X. Further delegation of any delegated activity is not permissible.