ADDENDUM FOR THE STATE OF ALABAMA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Alabama regarding provider contracts with providers rendering health care services in the State of Alabama. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health service corporation, health maintenance organization, or health benefit plan, as those terms are defined in applicable Alabama law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement in accordance with the requirements of applicable law and regulation:

    a. As specified by Ala. Admin. Code r. 420-5-6-.10(2)(q)(1), the following "hold harmless" clause shall be incorporated into the Agreement:

        "Provider hereby agrees that in no event, including but not limited to, non-payment by the health maintenance organization or CARECENTRIX, insolvency of the health maintenance organization or CARECENTRIX, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member, or persons other than the health maintenance organization acting on behalf of the Member for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, deductibles, and coinsurances on the health maintenance organization's behalf made in accordance with the terms of the applicable coverage agreement between the health maintenance organization and the Member.

        "Provider further agrees that (a) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the health maintenance organization Member, and that (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the Member, or persons on the Member's behalf."

        Ala. Code § 27-21A-3(b)(4); Ala. Admin. Code r. 482-1-080-.05(2)(c).

    b. Provider may not change, amend, or waive any provision of the Agreement without the prior written consent of CARECENTRIX. Any such attempts to change, amend, or waive the Agreement are void. Ala. Admin. Code r. 420-5-6-.10(2)(q).

    c. Provider shall cooperate with Payor and CARECENTRIX in complying with applicable laws relating to health maintenance organizations, and Provider shall comply with applicable laws regulating Provider. Ala. Admin. Code r. 420-5-6-.10(2)(r).

2. a. As used in this section of this Addendum, the defined terms "ACH electronic funds transfer," "covered health care provider," "health insurance plan," "health insurer," and "regional care organization" shall have the same meanings as set forth in Ala. Code § 27-1-17.1(a).

b. To the extent required by Ala. Code § 27-1-17.1(b), the following provision shall be added to the Agreement:

"IF A COVERED HEALTH CARE PROVIDER REQUESTS PAYMENT UNDER A HEALTH INSURANCE PLAN FROM A HEALTH INSURER OR ITS CONTRACTED VENDOR OR A REGIONAL CARE ORGANIZATION BE MADE USING ACH ELECTRONIC FUNDS TRANSFER, THAT REQUEST MUST BE HONORED. FURTHERMORE, SUCH A REQUEST MAY NOT BE USED TO DELAY OR REJECT A TRANSACTION, OR ATTEMPT TO ADVERSELY AFFECT THE COVERED HEALTH CARE PROVIDER."

c. Nothing in Ala. Code § 27-1-17.1 prohibits or adopts any standards for other methods of electronic funds transfers outside of the Automated Clearing House network. Alternative electronic funds transfer methods, including wire transfer and payment by card or otherwise through a private card network, are expressly permitted to pay a covered health care provider. Ala. Code § 27-1-17.1(c).

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ADDENDUM FOR THE STATE OF ALASKA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Alaska regarding provider contracts with providers rendering health care services in the State of Alaska. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health care insurer or health maintenance organization, as those terms are defined in applicable Alaska law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. The Covered Services to be provided by Provider under the terms of the Agreement are set forth in "Schedule A" to the Agreement, and any other applicable addendums, exhibits, or attachments to the Agreement. Alaska Stat. § 21.07.010(a)(1).

2. The rates of compensation for Covered Services rendered by Provider under the terms of the Agreement are set forth in "Schedule A" to the Agreement. Alaska Stat. § 21.07.010(a)(2).

3. The Agreement may be terminated in accordance with the termination provisions of the Agreement, including but not limited to any applicable addendums, exhibits, or attachments to the Agreement, and the Provider Manual. If the Agreement contains a provision that provides for discretionary termination of the Agreement without cause or with notice, such provision shall apply equitably to both parties, unless otherwise required by applicable law. Alaska Stat. § 21.07.010(a)(3).

4. To the extent required by Alaska Stat. § 21.07.010(a)(4) and applicable to Provider, notwithstanding anything to the contrary in the Agreement, in the event of a dispute between Provider and CARECENTRIX, a fair, prompt, and mutual dispute resolution process shall be used; at a minimum, such process shall provide for the following:

    a. The parties shall hold an initial meeting at which all parties are present or represented by individuals with authority regarding the matters in dispute. The meeting shall be held within ten (10) working days after CARECENTRIX receives written notice of the dispute from Provider, or gives written notice of the dispute to Provider, unless the parties otherwise agree in writing to a different schedule;

    b. If, within thirty (30) days following the initial meeting, the parties have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to the parties and who is not regularly under contract to or employed by either of the parties. Each party shall bear its proportionate share of the cost of mediation, including the mediator's fees;

    c. If, after a period of sixty (60) days following commencement of mediation, the parties are unable to resolve the dispute, either party may seek other relief allowed by law;

    d. The parties shall negotiate in good faith in the initial meeting and in mediation.

5. Provider shall not be penalized, nor shall the Agreement be terminated by CARECENTRIX, because Provider acts as an advocate for a Member in seeking appropriate, medically necessary health care services. Alaska Stat. § 21.07.010(a)(5).

6. Nothing in the Agreement shall be construed to impede Provider's ability to communicate openly with a Member about all appropriate diagnostic testing and treatment options. Alaska Stat. § 21.07.010(a)(6).

7. Terms used in the Agreement that require definition shall be defined in a clear and concise manner. Alaska Stat. § 21.07.010(a)(7).

8. No provision in the Agreement shall have as its predominant purpose the creation of direct financial incentives to Provider for withholding Covered Services that are medically necessary. This section shall not be construed to prohibit the Agreement from containing incentives for efficient management of the utilization and cost of Covered Services. Alaska Stat. § 21.07.010(b)(1).

9. Nothing in the Agreement shall require Provider to contract for all products that are currently offered or that may be offered in the future by Payor or CARECENTRIX. Alaska Stat. § 21.07.010(b)(2).

10. Nothing in the Agreement shall require Provider to be compensated for Covered Services provided under the Agreement at the same rate as Provider has contracted with another payor under a different agreement. Alaska Stat. § 21.07.010(b)(3).

11. To the extent required by Alaska Stat. § 21.07.010(c) and applicable to Provider, notwithstanding anything in the Agreement to the contrary, Provider shall not be required to indemnify or hold harmless CARECENTRIX for CARECENTRIX's acts or conduct, or Payor for Payor's acts or conduct. Furthermore, nothing in the Agreement shall be construed to require CARECENTRIX or Payor to indemnify or hold harmless Provider for Provider's acts or conduct.

12. In accordance with Alaska Stat. § 21.86.150(i), with respect to Members enrolled in a health maintenance organization (HMO) plan, CARECENTRIX or Payor may not cause, request, or knowingly permit:

    a. The imposition of limits regarding: (i) criticism by Provider of health care services covered by Payor's plan, or (ii) written or oral communications between Provider and a Member regarding health care services; or

    b. Financial incentives to be given or offered to Provider for denying or delaying health care services.

13. To the extent required by Alaska Stat. § 21.07.030(f) and applicable to Provider, in the event that the Agreement is terminated, a Member who is being actively treated by Provider on the date of the termination may continue to receive Covered Services from Provider for the period of time specified in subsection a. or b. of this section; provided, that the terms and conditions of the Agreement shall remain in force with respect to such continuing treatment; and, further provided, that the Member's health care insurance policy (as defined in applicable Alaska law) remains in force during such period:

    a. For the period that is the longest of the following:

        i. The end of the current policy or plan year;

        ii. Up to ninety (90) days after the termination date of the Agreement, if the event triggering the right to continuing treatment is part of an ongoing course of treatment;

        iii. Through completion of postpartum care, if the Member is pregnant on the date of termination of the Agreement; or

    b. Until the end of the medically necessary treatment for the condition, disease, illness, or injury if the Member has a terminal condition, disease, illness, or injury; in this subsection, "terminal" means a life expectancy of less than one (1) year.

    Consistent with the patient protection provisions of Chapter 21.07 of Alaska Statutes, nothing in this section shall be construed to require CARECENTRIX or Payor to arrange for continuing treatment of a Member by Provider after termination of the Agreement, if the termination was for reasons related to professional misconduct, quality of care, fraud, or any other reason that jeopardizes the health or safety of patients.

ADDENDUM FOR THE STATE OF ARIZONA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Arizona regarding provider contracts with providers rendering health care services in the State of Arizona. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health care insurer or health care services organization, as those terms are defined in applicable Arizona law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Covered Services are rendered to Members enrolled in a health care services organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

    a. Nothing in the Agreement shall be construed to restrict or prohibit Provider's good faith communication with a Member concerning the Member's health care or medical needs, treatment options, health care risks, or benefits. Ariz. Rev. Stat. § 20-1061(B)(1).

    b. CARECENTRIX shall not terminate or refuse to renew the Agreement solely because Provider in good faith (i) advocates in private or in public on behalf of a Member, (ii) assists a Member in seeking reconsideration of a decision to deny coverage for a health care service, or (iii) reports a violation of law to an appropriate authority. Ariz. Rev. Stat. § 20-1061(B)(2).

    c. The Agreement shall not contain a financial incentive plan that includes a specific payment made to or withheld from Provider as an inducement to deny, reduce, limit, or delay medically necessary care that is covered by a Member's evidence of coverage for a specific disease or condition. This provision does not prohibit per diem or per case payments, diagnostic related grouping payments, or financial incentive plans, including capitation payments or shared risk arrangements, that are not connected to specific medical decisions relating to a Member for a specific disease or condition. Ariz. Rev. Stat. § 20-1061(C).

    d. In the event that Payor is declared insolvent, Provider shall provide services to Members at the same rates of reimbursement and subject to the same terms and conditions established in the Agreement for the duration of the period after Payor is declared insolvent, until the earliest of the following:

        i. A determination by the court that Payor cannot provide adequate assurance that it will be able to pay Provider's claims for Covered Services that were rendered after Payor is declared insolvent.

        ii. A determination by the court that the insolvent Payor is unable to pay Provider's claims for Covered Services that were rendered after Payor is declared insolvent.

        iii. A determination by the court that continuation of the Agreement would constitute undue hardship to Provider.

        iv. A determination by the court that Payor has satisfied its obligations to all Members under its health care plans. Ariz. Rev. Stat. §§ 20-1074(B).

    e. In the event that Payor or CARECENTRIX fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any amounts owed by Payor or CARECENTRIX, and Provider shall not bill or otherwise attempt to collect from the Member any amount owed by Payor or CARECENTRIX. Neither Provider nor any agent, trustee, or assignee of

Provider shall maintain an action at law against a Member to collect any amounts owed by Payor or CARECENTRIX. Ariz. Rev. Stat. § 20-1072.

2. To the extent required by law, except in cases of fraud: (i) Payor or its designee shall not adjust the payment of a claim more than one (1) year after the date that Payor or its designee paid the claim; and (ii) Provider shall not request adjustment of the denial of a claim more than one (1) year after the date that Payor or its designee denied the claim. If the Agreement provides for a longer period of time to adjust or request adjustment of the payment or denial of a claim, that period shall be the same length of time for Payor or its designee and Provider. Ariz. Rev. Stat. § 20-3102(I).

ADDENDUM FOR THE STATE OF ARKANSAS

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Arkansas regarding provider contracts with providers rendering health care services in the State of Arkansas. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health care insurer or health maintenance organization, as those terms are defined in applicable Arkansas law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to prohibit, restrict, or penalize Provider in any way from disclosing to a Member any health care information that Provider deems appropriate regarding the nature of treatment, risks, or alternatives thereto; the availability of alternate therapies, consultations, or tests; the decision of utilization reviewers or similar persons to authorize or deny services; the process that is used to authorize or deny health care services or benefits; or information on applicable financial incentives and structures. Ark. Code § 23-99-407.

2. Upon termination of the Agreement, Provider may, at the option of a Member who is under Provider's care at the time of termination, continue to render Covered Services to the Member until the earlier of (i) the completion of a current episode of treatment for an acute condition, or (ii) the expiration of ninety (90) days. During such period of continued care, Provider shall be deemed to continue to be a participating provider under the terms of the Agreement for purposes of reimbursement, utilization management, and quality of care; and Provider shall be reimbursed for Covered Services rendered to the Member in accordance with the terms, conditions, and rates of reimbursement in effect under the Agreement prior to its termination. Nothing in this section shall require a Payor to provide benefits that are not otherwise covered under the terms and provisions of the Member's benefit plan. Ark. Code § 23-99-408.

3. To the extent required by Ark. Code § 23-63-1801 et seq. and Rule 85 of Arkansas Insurance Regulations, the following provisions shall apply to the Agreement:

   a. Except in cases of fraud committed by Provider, Payor or CARECENTRIX may only exercise recoupment from Provider during the eighteen (18) month period after the date that Payor paid the claim submitted by Provider. Ark. Code § 23-63-1802(a).

   b. If Payor or CARECENTRIX exercises recoupment from Provider under this section, Payor or CARECENTRIX shall give Provider a written or electronic statement specifying the basis for the recoupment. Such statement shall contain, at a minimum, the information required by subsection (e) of this section. Ark. Code § 23-63-1802(b).

   c. If Payor or CARECENTRIX determines that payment was made for services not covered under a Member's benefit plan, Payor or CARECENTRIX shall give written notice to Provider of its intent to exercise recoupment and may:
      i. Request a refund from Provider; or
      ii. Make a recoupment of the payment from Provider in accordance with subsection (e) of this section. Ark. Code § 23-63-1803(a).

   d. Except in the case of fraud committed by Provider or as provided in the final clause of this subsection (d), the provisions of subsection (a) of this section shall not apply: (i) if Provider or other party acting on Provider's behalf verified from Payor, or Payor's agent for purposes of eligibility

verification, that an individual was a Member, and (ii) if Provider in good faith rendered services to the individual in reliance on such verification; provided that, Payor or CARECENTRIX shall have one hundred and twenty (120) days from the date of payment to notify Provider of a verification error and of the fact that services rendered will not be covered if the error was made in good faith at the time of the verification. Ark. Code § 23-63-1803(b).

e. If Payor or CARECENTRIX exercises recoupment pursuant to this section, Payor or CARECENTRIX shall provide written documentation to Provider that specifies:
   i. The amount of the recoupment;
   ii. The Member's name to whom the recoupment applies;
   iii. Patient identification number;
   iv. Date or dates of service;
   v. The health care service or services on which the recoupment is based;
   vi. The pending claims being recouped or that future claims will be recouped; and
   vii. Specific reason for the recoupment. Ark. Code § 23-63-1804.

f. For purposes of this section, the term "recoupment" shall have the meaning set forth in Ark. Code § 23-63-1801.

4. In accordance with the applicable provisions of Ark. Code § 23-63-113, CARECENTRIX is authorized to sell, lease, assign, convey, or otherwise grant access to Provider's services and contractual rates of reimbursement under the Agreement, to Payors and other entities. At least annually, and upon written request of Provider, CARECENTRIX shall disclose to Provider in writing or electronically all Payors and other entities to which access to Provider's services and rates of reimbursement under the Agreement has been granted.

5. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

   a. In the event that Payor or CARECENTRIX fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider or any agent, trustee, or assignee of Provider shall not: (i) maintain an action at law against a Member to collect sums owed by Payor or CARECENTRIX; (ii) collect or attempt to collect from the Member sums owed by Payor or CARECENTRIX; or (iii) make any statement, either written or oral, to any Member that makes demand for, or would lead a reasonable person to believe that a demand is being made for, payment of any amounts owed by Payor or CARECENTRIX. Ark. Code § 23-76-119(c).

   b. In the event of the insolvency of Payor or CARECENTRIX, Provider shall continue to render Covered Services to Members: (i) for the duration of the period for which premium payment has been made, and (ii) for a Member who is confined on the date of insolvency in an inpatient facility, until the Member's discharge from the inpatient facility or expiration of benefits. Ark. Code § 23-76-118(c). During such period, Provider shall be compensated for Covered Services rendered to Members in accordance with the rates of reimbursement under the Agreement.

6. In accordance with and to the extent required by Ark. Code § 23-99-1303, no clause or provision in the Agreement shall be construed to require Provider, as a condition of participation or continuation in CARECENTRIX's provider network, to:

   a. Serve in another provider network utilized by CARECENTRIX or a Payor affiliated with CARECENTRIX; or

   b. Provide Covered Services under another health benefit plan or product offered by CARECENTRIX or a Payor affiliated with CARECENTRIX.

7. In accordance with and to the extent required by Ark. Code § 23-99-1304, no clause, or provision in the Agreement shall be construed to:

    a. Prohibit or grant CARECENTRIX an option to prohibit Provider from contracting with another Payor to provide Covered Services at a lower price than the rate specified in the Agreement;

    b. Require or grant CARECENTRIX an option to require Provider to accept a lower payment in the event Provider agrees to provide Covered Services to another Payor at a lower rate;

    c. Require or grant CARECENTRIX an option to require termination or renegotiation of the Agreement if Provider agrees to provide Covered Services to another Payor at a lower rate; or

    d. Require Provider to disclose Provider's contractual reimbursement rates with other Payors.

8. In accordance with and to the extent required by Ark. Code § 23-99-1306, CARECENTRIX shall not prohibit Provider from entering into an Agreement with another Payor.

9. In accordance with and to the extent required by Ark. Code § 23-99-1305, CARECENTRIX shall provide "material amendments," as defined in Ark. Code § 23-99-1302, to Provider at least ninety (90) days before the effective date of the material amendment. The notice of material amendment shall be in writing, specify the precise Agreement to which the material amendment applies, and be conspicuously labeled: **"Notice of Material Amendment to Healthcare Contract",** and contain sufficient information about the amendment to allow a Provider to assess the financial impact, if any.

ADDENDUM FOR THE STATE OF CALIFORNIA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of California regarding provider contracts with providers rendering health care services in the State of California. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions of the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health care service plan, health maintenance organization, or disability or health insurer as those terms are defined in applicable California law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. In the event that Payor or CARECENTRIX fails to pay for Covered Services as set forth in a Member's plan, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from the Member any sums owed by Payor or CARECENTRIX. Neither Provider nor any agent, trustee, or assignee of Provider shall maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX.
   Cal. Health & Safety Code § 1379; 28 Cal. Code Regs. [CCR] § § 1300.67.8(e), 1300.67.4(a)(10).

2. Upon termination of the Agreement, Payor shall be liable, subject to the same contractual terms and conditions in effect prior to the termination, for Covered Services rendered by Provider to a Member who retains eligibility under Payor's plan or by operation of law under the care of Provider at the time of such termination until the Covered Services being rendered to the Member by Provider are completed, unless Payor or CARECENTRIX makes reasonable and medically appropriate provision for the assumption of such services by a participating provider. 28 CCR §§ 1300.67.8(e), 1300.67.4(a)(10); 10 CCR § 2240.2(d).

3. Provider shall not collect surcharges for Covered Services. If Payor or CARECENTRIX receives notice of any such surcharge, CARECENTRIX shall take appropriate action pursuant to the Agreement.
   28 CCR § 1300.67.8(d).

4. Except for applicable co-payments and deductibles, Provider shall not invoice or balance bill a Member for the difference between Provider's billed or customary charges and the reimbursement paid by Payor or CARECENTRIX for any Covered Service. 28 CCR § 1300.71(g)(4).

5. Provider shall report to CARECENTRIX in writing all surcharge and co-payment moneys paid by Members directly to Provider. Cal. Health & Safety Code § 1385.

6. In the event of the insolvency of Payor or CARECENTRIX, Provider shall continue to provide Covered Services to Members until the effective date of a Member's coverage in a successor plan pursuant to open enrollment or the allocation process conducted by the Director of the California Department of Managed Health Care, but in no event (i) for a period exceeding that required by the Agreement or forty-five (45) days in the event of allocation, whichever is greater, or (ii) for a period exceeding that required by the Agreement or thirty (30) days in the case of open enrollment, whichever is greater.
   Cal. Health & Safety Code §§ 1394.7(e), 1394.8(e).

7. Provider shall maintain and retain such records and provide such information to Payor and CARECENTRIX, or to the Director of the California Department of Managed Care, as may be necessary to demonstrate Payor's compliance with the provisions of the Knox-Keene Health Care Service Plan Act

of 1975 (Cal. Health & Safety Code §§ 1340 et seq.) and the rules thereunder. Provider shall retain such records for at least two (2) years; provided that, if the Agreement requires Provider to retain records for a longer period of time, the longer retention period will control. This section shall survive the termination of the Agreement, whether by rescission or otherwise. 28 CCR § 1300.67.8(b).

8. Provider shall grant Payor and CARECENTRIX access at reasonable times upon demand to the books, records, and papers of Provider relating to the services provided to Members; to the cost thereof; to payments received by Provider from Members (or from others on their behalf); and, unless Provider is compensated on a fee-for-service basis, to the financial condition of Provider. 28 CCR § 1300.67.8(c).

9. Notwithstanding any provision of the Agreement to the contrary, Payor, CARECENTRIX, and Provider are each responsible for their own acts or omissions, and are not liable for the acts or omissions of, or the costs of defending, each other. Nothing in this section shall preclude a finding of liability on the part of Payor, CARECENTRIX, or Provider, based on the doctrines of equitable indemnity, comparative negligence, contribution, or other statutory or common law bases for liability.
Cal. Health & Safety Code § 1371.25.

10. CARECENTRIX shall maintain a fast, fair, and cost-effective dispute resolution mechanism under which Provider may submit disputes according to the procedures for processing and resolving disputes as described in the Agreement and the Provider Manual, including the location and telephone number where information regarding disputes may be submitted. CARECENTRIX will inform Provider upon a change in the dispute resolution process. Disputes will be resolved in accordance with the timeframes required by applicable law. Cal. Health & Safety Code § 1367(h)(1); Cal. Ins. Code § 10123.137(a).

11. a. Provider shall cooperate and comply with, as applicable, Payor's language assistance program standards for Members pursuant to the requirements of California law and regulation. Such standards and mechanisms for providing language assistance services at no charge to Members will be communicated to Provider from time to time. Cal. Health & Safety Code § 1367.04(f); 28 CCR § 1300.67.04(c)(2)(E); 10 CCR § 2538.3(d).

    b. Informational notices explaining how Members may contact their plan, file a complaint with their plan, obtain assistance from the California Department of Managed Health Care, and seek an independent medical review are available in non-English languages through the Department's website. The notice and translations can be obtained online at www.hmohelp.ca.gov for downloading and printing. In addition, hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, California 95814. 28 CCR § 1300.67.04(c)(2)(D)(ii).

12. To the extent required by applicable law, if a material change is made to the Agreement or a manual, policy, or procedure document referenced in the Agreement, Provider will be given at least forty-five (45) business days' notice of the material change, unless the change is a result of a change in State or federal law or regulations or any accreditation requirements of a private sector accreditation organization which requires a shorter timeframe for compliance. Provider shall have the right to terminate the Agreement prior to the implementation of the change, in which case Provider shall give CARECENTRIX written notice of the termination prior to the expiration of such forty-five (45) business day period. The parties may mutually agree to waive the forty-five (45) business day notice requirement.
Cal. Health & Safety Code § 1375.7(b)(1)(A); Cal. Ins. Code § 10133.65(c).

13. To the extent required by applicable law, Provider will be given advance notice of a material change to the quality improvement or utilization management programs or procedures described in Agreement or the Provider Manual. Such change will be made pursuant to the requirements of Section 12 of this Addendum; provided that, a change to such quality improvement or utilization management programs or procedures may be made at any time if the change is necessary to comply with State or federal law or regulations or

any accreditation requirements of a private sector accreditation organization. Cal. Health & Safety Code § 1375.7(b)(3); Cal. Ins. Code § 10133.65(b)(2).

14. Provider is not obligated to accept additional Members as patients if, in the reasonable professional judgment of Provider, accepting additional patients would endanger patients' access to, or continuity of, care. Cal. Health & Safety Code § 1375.7(b)(2); Cal. Ins. Code § 10133.65(b)(1).

15. Upon termination of the Agreement for reasons other than a medical disciplinary cause, fraud, or other criminal activity, Provider will, upon request, continue to provide Covered Services to a Member who at the time of the Agreement's termination was receiving Covered Services from Provider for one of the following conditions, as further specified below: (a) an acute condition; (b) a serious chronic condition; (c) a pregnancy; (d) a terminal illness; (e) the care of a newborn child between birth and thirty-six (36) months; or (f) a procedure that is authorized by Payor or CARECENTRIX as part of a documented course of treatment to occur within one hundred eighty (180) days of the termination date of the Agreement. As defined in applicable law, a "medical disciplinary cause or reason" means that aspect of Provider's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. For purposes of this section:

    a. An "acute condition" is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Provider will continue to provide Covered Services to a Member with an acute condition for the duration of the Member's acute condition.
    b. A "serious chronic condition" is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration. Provider will continue to provide Covered Services to a Member with a serious chronic condition for the period of time necessary to complete a course of treatment and to arrange for the safe transfer to another provider, as determined by Payor and CARECENTRIX in consultation with the Member and Provider, and consistent with good professional practice; provided that, continued Covered Services for a serious chronic condition shall not exceed twelve (12) months from the termination date of the Agreement.
    c. A "pregnancy" refers to the three (3) trimesters of pregnancy and the immediate postpartum period. Provider will continue to provide Covered Services to a Member for the duration of the Member's pregnancy.
    d. A "terminal illness" is an incurable or irreversible condition that has a high probability of causing death within one (1) year or less. Provider will continue to provide Covered Services for the duration of a Member's terminal illness, which may exceed twelve (12) months from the termination date of the Agreement.
    e. Provider will continue to provide Covered Services for the care of a newborn child Member between birth and age thirty-six (36) months for a period not to exceed twelve (12) months from the termination date of the Agreement.
    f. Provider will perform a procedure that is a Covered Service authorized by Payor or CARECENTRIX as part of a documented course of treatment for a Member, and has been recommended and documented by Provider to occur within one hundred eighty (180) days of the termination date of the Agreement.
    g. With respect to a newly covered Member, the periods for continued care coverage after the termination date of the Agreement, if different from those above, are specified in applicable law.

    To the extent that Provider continues to render Covered Services to a Member after the termination date of the Agreement, Provider agrees to be subject to the same contractual terms and conditions that were in effect under the Agreement prior to such termination, including but not limited to credentialing, utilization management, quality assurance, and reimbursement rates and payment terms. Payor and CARECENTRIX shall not be required to continue the services of Provider after the termination date of the Agreement if Provider does not agree to comply with such contractual terms and conditions, and to accept the

reimbursement rates and payment terms required by this provision. Nothing in this section shall require Payor to cover services or provide benefits that are not otherwise covered under the terms and conditions of the Member's benefit plan. Cal. Health & Safety Code § 1373.96; Cal. Ins. Code § 10133.56.

16. To the extent that information relating to claims processing and claims payment is required by law to be disclosed to Provider, such information is set forth in the Agreement including but not limited to Schedule A (Health Care Services, Reimbursement Schedule) and the fee schedule thereto, the Provider Manual, and the online Provider Portal at www.carecentrixportal.com. To the extent required by applicable law:
    a. Disclosure of such required information, in paper or electronic format (which may include a website containing this information) or another mutually agreeable accessible format, will include: (i) information regarding claims processes including directions for the electronic transmission, physical delivery and mailing of claims, all claim submission requirements, instructions for confirming receipt of claims, and a phone number for claims inquiries and filing information; and (ii) information regarding provider dispute processes including the identity of the office responsible for receipt and resolution of disputes, directions for the electronic transmission or physical delivery and mailing of disputes, all claim dispute requirements, the timeframe for acknowledgment of receipt of a dispute, the phone number for dispute inquiries and filing information, and directions for filing substantially similar multiple claim disputes and other billing or contractual disputes.
    b. Disclosure of such required information in electronic format will include: (i) information as to the amount of payment for each service to be provided under the Agreement, including any fee schedules or other factors or units used in determining the fees for each service; and (ii) detailed payment policies and rules and nonstandard coding methodologies, if applicable, used to process claim payments.
    c. The information described above will be disclosed to Provider upon initial contracting and thereafter annually on or before the anniversary date of the Agreement, and upon Provider's written request.
    d. CARECENTRIX will provide at least forty-five (45) days' prior written notice to Provider before instituting any changes, amendments, or modifications to the disclosures required pursuant to this section.
    e. CARECENTRIX may disclose the fee schedules and other required information mandated by subsection (b) above through the use of a website, so long as CARECENTRIX provides written notice to Provider at least forty-five (45) days prior to implementing a website transmission format or posting any changes to the mandatory information on the website. 28 CCR § 1300.71(*l*)-(o); Cal. Ins. Code § 10133.66

17. The Agreement and its contracted reimbursement rates may be leased or accessed by Payors or other contracting agents, not including workers' compensation insurers or automobile insurers. Payors actively encourage Members to use CARECENTRIX's participating providers by, among other things, financial incentives, provider directories, toll-free telephone numbers, or internet web site addresses supplied directly to Members. To the extent required by applicable law, upon execution of the Agreement and thereafter within thirty (30) calendar days of CARECENTRIX's receipt of Provider's written request, a summary of Payors eligible to access the contracted reimbursement rates under the Agreement shall be provided or made available to Provider. In the event that a Payor implements a product or network that does not actively encourage Members to use participating providers, Provider shall have the right to decline to participate in such product or network upon execution of the Agreement and subsequent renewal or amendment thereof. Such election will not cause Provider to be excluded from Payors' products or networks that actively encourage Members to use participating providers.
    Cal. Health & Safety Code § 1395.6; Cal. Ins. Code § 10178.3; Cal. Bus. & Prof. Code § 511.1.

18. No provision in the Agreement shall waive or conflict with any applicable provision in the Insurance Code or the Knox-Keene Health Care Service Plan Act of 1975. Notwithstanding anything to the contrary set forth in the Agreement, to the extent that applicable law mandates a specific definition for terms that are

defined in the Agreement, the definition mandated by applicable law shall control. Cal. Ins. Code § 10133.65(b)(3); Cal. Health & Safety Code § 1375.7(b)(4).

19. Provider shall not make any additional charges to Members for rendering Covered Services except as provided for in the contract between Payor and the Member. 10 CCR § 2240.4(b)(2).

20. Provider's primary consideration shall be the quality of health care services rendered to Members. 10 CCR § 2240.4(b)(4).

21. Provider shall not discriminate against any Member in the provision of Covered Services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health services or supplies, or other unlawful basis, including without limitation, the filing by such Member of any complaint, grievance, or legal action against Provider. 10 CCR § 2240.4(b)(5).

22. The Agreement, including this Addendum and any schedules, exhibits, or documents referenced therein, contains all the terms and conditions agreed upon by the parties pertaining to the rendering of Covered Services by Provider to Members. 10 CCR § 2240.4(b)(3).

23. To the extent required by applicable law, Provider shall comply with the applicable requirements of Cal. Health & Safety Code § 1367.27 and Cal. Ins. Code § 10133.15, as set forth in this section. In the event of a conflict between the requirements of this section and those in the Agreement, including the Provider Manual, this section shall control with respect to Payor's plans subject to applicable California laws and regulations governing provider directories.

    a. Provider shall inform CARECENTRIX within five (5) business days when either of the following occurs:

        (1) Provider is not accepting new Members or new patients; or

        (2) If Provider previously did not accept new Members or new patients, Provider is currently accepting new Members and new patients.

    b. If Provider is not accepting new patients, and if Provider is contacted by a Member or a potential Member seeking to become a new patient, Provider shall direct the individual to CARECENTRIX for assistance in finding another provider and to the Department of Insurance or the Department of Managed Health Care to report any inaccuracy in the provider directory. CARECENTRIX will notify Payor if it is determined that Provider's information, as previously reported to Payor, needs correction or updating.

    c. Provider shall affirmatively respond within thirty (30) business days to a notification from CARECENTRIX asking Provider: (i) to confirm that Provider's information, as previously submitted to CARECENTRIX, is current and accurate, including whether provider is accepting new patients; or (ii) to update and correct the information that Provider previously submitted to CARECENTRIX. Verification of Provider's information will be required at least annually, and may be required more frequently, based on Payor's plan or CARECENTRIX's network provider policies. Provider shall respond to the notification in the manner specified by CARECENTRIX.

        (1) If Provider does not respond to CARECENTRIX's notification asking Provider to verify or to update and correct Provider's information, or if Provider responds with partial or inaccurate information that cannot be verified by CARECENTRIX, Provider will be notified that if CARECENTRIX does not receive a response within ten (10) business days, Provider will be removed from the list of providers that CARECENTRIX submits to Payor at the next update of CARECENTRIX's provider information.

(2) Provider will be removed from the list of providers that CARECENTRIX submits to Payor at the next required update after the ten (10)-day notice period referenced above. Notwithstanding the foregoing, Provider will not be removed from such list if Provider responds to CARECENTRIX with the required information before the end of the ten (10)-day notice period.

(3) Provider will be restored to the list of providers that CARECENTRIX submits to Payor, once a full and accurate response is received from Provider and is verified in accordance with CARECENTRIX's policies and requirements for updating and correcting the provider information submitted to Payor.

(4) To the extent permitted by applicable law, CARECENTRIX may terminate the Agreement, in accordance with the termination provisions thereof, because of a pattern or repeated failure by Provider to alert CARECENTRIX to a change in Provider's information that CARECENTRIX must submit to Payor pursuant to applicable California provider directory laws and regulations.

ADDENDUM FOR THE STATE OF COLORADO

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Colorado regarding provider contracts with providers rendering health care services in the State of Colorado. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean a carrier, including but not limited to a health maintenance organization, as those terms are defined in applicable Colorado law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Provider shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Payor or CARECENTRIX. Payor or CARECENTRIX shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of Provider. Colo. Rev. Stat. [C.R.S.] § 10-16-121(1)(a); 3 Code Colo. Regs. [CCR] § 702-4-2-15(5).

2. CARECENTRIX shall not terminate the Agreement because Provider expresses disagreement with a decision by Payor or CARECENTRIX, if applicable, to deny or limit benefits to a Member; or because Provider assists the Member to seek reconsideration of such decision; or because Provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the patient's plan or not, policy provisions of a plan, or Provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients. C.R.S. § 10-16-121(1)(b); 3 CCR 702-4-2-15(5).

3. To the extent required by law, CARECENTRIX shall comply with the applicable requirements of C.R.S. § 10-16-106.5(3), (4), and (5) in the performance of claims processing functions under the Agreement. C.R.S. § 10-16-121(1)(c).

4. Provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers for Covered Services, so long as Provider adheres to the utilization review policies and procedures of CARECENTRIX and Payor. C.R.S. § 10-16-121(1)(d).

5. To the extent required by law, CARECENTRIX shall offer at least one method of payment to Provider that does not require an associated fee and shall not restrict the method or form of payment to Provider to only credit card payments. C.R.S. § 10-16-121.3(2).

6. To the extent required by law, if CARECENTRIX initiates a payment to Provider using, or changes the payment method to, electronic funds transfer payments including virtual credit card payments, CARECENTRIX shall:
   (a) Notify Provider if any fee is associated with a particular payment method;
   (b) Advise Provider of available payment methods and provide clear instructions to Provider as to how to select an alternative payment method; and
   (c) With each payment, remit an explanation of payment to Provider. C.R.S. § 10-16-121.3(3).

7. To the extent required by law, if CARECENTRIX initiates a payment to Provider using, or changes the payment method to, a health care electronic funds transfer and remittance advice transaction, CARECENTRIX shall not charge a fee solely to transmit the payment to Provider unless Provider consents to the fee. C.R.S. § 10-16-121.3(4).

8. Under no circumstances shall a Member be liable to Provider for money owed to Provider by Payor or

CARECENTRIX. In no event shall Provider collect or attempt to collect from a Member any money owed to Provider by Payor or CARECENTRIX. Nothing in this section shall prohibit the collection of coinsurance, deductibles, or copayments as specifically provided in the Member's health benefit plan. C.R.S. § 10-16-705(3).

9. With respect to Members enrolled in a health maintenance organization (HMO) plan, in no event, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or persons (other than Payor) acting on behalf of the Member for Covered Services provided pursuant to the Agreement. This provision does not prohibit Provider from collecting applicable supplemental charges, copayments, or fees for services not covered by the Member's plan delivered on a 'fee-for-service' basis to the Member. This provision shall survive the termination of the Agreement for Covered Services rendered prior to the termination of the Agreement, regardless of the cause giving rise to termination, and shall be construed to be for the benefit of Members. This provision is not intended to apply to services provided after the Agreement has been terminated. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf insofar as such contrary agreement relates to liability for payment of Covered Services provided under the terms and conditions of the Agreement. Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after the Colorado Commissioner of Insurance has received written notification of the proposed changes. 3 CCR 702-4-7-1, § 12.

10. Provider shall share with other providers who are treating or have treated the same Member of an HMO plan, medical record information which facilitates the continuity of health care services, consistent with State and federal statutes and regulations. 6 CCR 1011-2(V)(E).

11. To the extent required by law and applicable to Provider, the following provisions shall apply:

    a. In addition to the right to terminate the Agreement based on a material change to the Agreement in accordance with C.R.S. § 25-37-104(2), if the term of the Agreement is for a duration of less than two (2) years, the Agreement may be terminated by Provider or CARECENTRIX without cause upon at least ninety (90) days' prior written notice to the other party. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement without cause, such longer notification period will apply. If the term of the Agreement is for a duration of two (2) years or more, the Agreement may be terminated without cause in accordance with the terms set forth in the Agreement, unless applicable network adequacy/continuity of care regulations under 3 CCR 702-4-2-56(5) require a longer notice period for termination without cause. C.R.S. § 25-37-111(2).

    b. CARECENTRIX or Provider may terminate the Agreement for cause for the reasons stated in the Agreement, including the Provider Manual. Such notice of termination for cause shall be provided by the terminating party to the other party in accordance with the required method, timeframe, and address for giving such notices as specified in the Agreement. C.R.S. § 25-37-103(1)(c).

12. Provider shall not assign or delegate the rights or responsibilities under the Agreement without the prior written consent of CARECENTRIX. C.R.S. § 10-16-705(8).

13. Provider shall not discriminate, with respect to the provision of medically necessary Covered Services, against Members that are participants in a publicly financed program. C.R.S. § 10-16-705(9).

14. The sole responsibility for obtaining any necessary preauthorization for services, treatments, or procedures rests with Provider, not with the Member. C.R.S. § 10-16-705(14).

15. To the extent required by law and applicable to Provider, CARECENTRIX shall provide Provider with at least ninety (90) days' written notice prior to the effective date of a material change to the Agreement. For purposes of this section, the term "material change" shall have the meaning set forth in C.R.S. § 25-37-102(9). Such notice shall be conspicuously entitled "**Notice of Material Change to Contract**." If Provider objects in writing to the material change within fifteen (15) days of such notice and there is no resolution of the objection, CARECENTRIX or Provider may terminate the Agreement upon written notice of termination to the other party, but no later than sixty (60) days prior to the effective date of the material change. If Provider does not object to the material change within fifteen (15) days as required by this section, the material change shall be effective as specified in the notice of material change to the Agreement. If the material change is the addition of a new category of coverage and Provider objects within fifteen (15) days as required by this section, the material change shall not be effective as to Provider, and such objection shall not be a basis upon which CARECENTRIX may terminate the Agreement. Notwithstanding anything in this section to the contrary, the Agreement may be modified by operation of law as required by any applicable State or federal law or regulation, and CARECENTRIX may disclose such change to Provider by any reasonable means. C.R.S. §§ 25-37-104, 25-37-105.

16. To the extent required by law and applicable to Provider, the following provisions shall be added to the Agreement:

    (i) CARECENTRIX shall provide in writing or make reasonably available to Provider, a summary disclosure form that summarizes provisions contained in the Agreement relating to the following: the terms governing compensation and payment; any category of coverage for which Provider is to provide service; the duration of the Agreement and how the Agreement may be terminated; the identity of the person or entity responsible for processing Provider's claims for compensation or payment for Covered Services; any internal mechanism required to resolve disputes that arise under the terms or conditions of the Agreement; and the subject and order of addenda, if any, to the Agreement. The summary disclosure form shall be for informational purposes only and shall not be a term or condition of the Agreement; such disclosure shall reasonably summarize the applicable provisions of the Agreement. C.R.S. § 25-37-103.

    (ii) The utilization management and quality management programs that are used to review, monitor, evaluate, or assess the Covered Services provided to Members pursuant to the Agreement are referenced in the Agreement and summarized in the Provider Manual. C.R.S. § 25-37-103(1)(d).

    (iii) The Agreement applies to network rental arrangements and is for the purpose of assigning, allowing access to, selling, renting, or giving CARECENTRIX's rights to Provider's services. The third party accessing Provider's services through the Agreement shall be obligated to comply with all applicable terms and conditions of the Agreement; except that a self-funded plan receiving administrative services from CARECENTRIX or its affiliates shall be solely responsible for payment to Provider. To the extent applicable, Members receiving services under the Agreement shall be provided with appropriate identification by Payors or their representatives, stating where claims should be sent and where inquiries should be directed. The Provider Manual contains information that specifies where Provider's claims for services should be sent and where inquiries pursuant to the Agreement should be directed. C.R.S. § 25-37-108.

    (iv) Upon sixty (60) days' notice to CARECENTRIX, Provider may decline to provide Covered Services pursuant to the Agreement to new patients who are Members. The notice shall state the reason(s) for such action. As used in this provision, the term "new patients" shall have the meaning set forth in C.R.S. § 25-37-110.

17. To the extent required by law, the definitions or other provisions in the Agreement shall not conflict with the applicable definitions or provisions contained in Payor's managed care plan or in the "Consumer Protections Standards Act for the Operation of Managed Care Plans" (C.R.S. § 10-16-701 et seq.). C.R.S. § 10-16-705(15). The term "managed care plan" shall have the meaning set forth in C.R.S. § 10-16-102.

18. To the extent required by C.R.S. 10-16-705 (4), the following provisions shall be added to the Agreement:

a. Members who are continuing care patients shall be allowed to continue receiving Covered Services from Provider for up to ninety (90) days after the date the Member is provided with notice of the termination of the Agreement. Such notice shall indicate that such Members have the right to elect continued transitional care from Provider if the termination of the Agreement affects the status of Provider. Such Members shall be provided Covered Services or continuing care according to their in-network benefit level cost-sharing amount during the period beginning on the date on which the notice of termination is provided and ending on the earlier of the end of the ninety (90) day period or the date on which the Member is no longer a continuing care patient with Provider. C.R.S. § 10-16-705(4)(b); C.R.S. § 10-16-705 (4)(d)(II)(A).

b. In the event that coverage under a health benefit plan is terminated for any reason other than nonpayment of premium, fraud, or abuse, Provider shall continue rendering Covered Services to a Member being treated at an in-patient facility (if applicable) until the Member is discharged. C.R.S. § 10-16-705(4)(c).

c. Payor or CARECENTRIX shall comply with the following requirements if Provider is treating a Member who is a continuing care patient and if the Agreement is terminated pursuant to C.R.S. § 10-16-705(4)(d)(I):

(i) Provide the notice specified in section 18 (a);
(ii) Provide the Member with an opportunity to notify the Payor or CARECENTRIX of the need for transitional care;
(iii) Permit the Member to elect to continue to receive Covered Services under the same terms and conditions under the Agreement, with respect to the course of treatment furnished by Provider relating to the Member's status as a continuing care patient during the period beginning on the date on which the notice specified in section 18(a) was provided and ending on the earlier of the ninety-first (91) day after that date or the date on which the Member is no longer a continuing care patient. C.R.S. § 10-16-705(4)(d)(II):

For purposes of this section, the terms below shall be defined as specified below:

"Continuing care patient" means a Member who is undergoing a course of treatment for a serious and complex medical condition, which course of treatment is provided by Provider; is undergoing a course of inpatient care provided by Provider (if applicable to the Agreement); is pregnant and undergoing a course of treatment for the pregnancy provided by Provider; is terminally ill as determined under section 1861 (dd)(3)(A) of the federal "Social Security Act", as amended, and is receiving treatment for the illness from Provider; or is scheduled to undergo nonelective surgery from Provider (if applicable to the Agreement), including the receipt of postoperative care from the Provider with respect to the surgery.

"Serious and complex medical condition" means, in the case of acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm or, in the case of a chronic illness or condition, a condition that is life-threatening, degenerative, potentially disabling, or congenital and requires specialized medical care over a prolonged period of time.

"Terminated" or "termination" means the expiration or nonrenewal of the Agreement; except that "terminated" or "termination" does not include a termination for failure to meet applicable quality standards or for fraud.

19. Subject to applicable network adequacy/continuity of care regulations under 3 CCR 702-4-2-56 in section 20, in the event that the Agreement is terminated with or without cause by CARECENTRIX, Members must be properly notified of the termination pursuant to C.R.S. § 10-16-705(7). During any continuation of care periods, Provider agrees to render Covered Services to Members in accordance with the rates of compensation, terms, and conditions under the Agreement. C.R.S. § 25-37-111(1).

20. To the extent required by 3 CCR 702-4-2-56 "Network Adequacy and Continuity of Care for Health Benefit Plans," the following provisions shall apply to the Agreement:

    a. Defined terms used in this section shall have the meaning(s) set forth in 3 CCR 702-4-2-56(4) and, if not defined therein, then as set forth in C.R.S. § 10-16-102. Such terms include, but are not limited to, "active course of treatment," "health condition," "life-threatening health condition," "serious acute health condition, chronic health condition, or life-limiting illness," and other applicable terms.

    b. CARECENTRIX and Provider shall provide at least sixty (60) days written notice to each other before Provider is removed or leaves the network without cause. When Provider gives or receives such notice, Provider shall supply CARECENTRIX with a list of Provider's patients who receive Covered Services under Payor's plan pursuant to the Agreement.

    c. If Provider leaves or is removed from the network, CARECENTRIX shall provide reasonable procedures to transition a Member who is in an active course of treatment to another participating provider in a manner that provides for continuity of care. A Member must have been undergoing treatment by Provider, or must have been seen at least once in the previous twelve (12) months by Provider, for that Member to be considered in an active course of treatment.

    d. The following transition procedures, among others required by law or regulation, shall apply:

        i. CARECENTRIX shall review requests for continuity of care made by the Member or the Member's authorized representative.

        ii. Requests for continuity of care shall be reviewed by CARECENTRIX's Medical Director after consultation with the treating provider. This requirement applies to (i) Members who meet the applicable criteria listed in 3 CCR 702-4-2-56(5), and (ii) who are under the care of Provider that has not been removed or leaving the network for cause.

        iii. The continuity of care period for Members who are in their second or third trimester of pregnancy shall extend through the postpartum period.

        iv. The continuity of care period for Members who are undergoing an active course of treatment shall extend to the earlier of:

            1. The termination of the course of treatment by the Member or the treating provider;

            2. Ninety (90) days after the effective date of Provider's departure or termination from the network, unless CARECENTRIX's Medical Director determines that a longer period is necessary;

            3. The date that care is successfully transitioned to a participating provider;

            4. Benefit limitations under the plan are met or exceeded; or

            5. The care is no longer medically necessary.

e. In addition to the requirements under 3 CCR 702-4-2-56(5)(G), a continuity of care request may only be granted when Provider that is departing or terminated from the network:

   i. Agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to CARECENTRIX for that Member as provided in the original Agreement, or by the new payment and terms agreed upon and executed between Provider and CARECENTRIX; and

   ii. Agrees in writing not to seek any payment from the Member for any amount for which the Member would not have been responsible if Provider were still a participating provider.

f. The obligation to hold the Member harmless for Covered Services rendered in Provider's capacity as a participating provider survives the termination of the Agreement. The hold harmless obligation does not apply to services rendered after the termination of the Agreement, except to the extent that thein-network relationship is extended to provide continuity of care. 3 CCR 702-4-2-56(5)(I).

ADDENDUM FOR THE STATE OF CONNECTICUT

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Connecticut regarding provider contracts with providers rendering health care services in the State of Connecticut. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions of the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, managed care organization, health maintenance organization, health care center, or carrier, as those terms are defined in applicable Connecticut law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that CARECENTRIX is a "preferred provider network" as defined in Connecticut General Statutes (C.G.S.) § 38a-479aa(a), the following provisions are added to the Agreement in accordance with the requirements of applicable law:

    a. The Agreement shall be transferred and assigned to Payor for the provision of future Covered Services by Provider to Members, at the discretion of Payor, in the event that CARECENTRIX (a) becomes insolvent; (b) otherwise ceases to conduct business, as determined by the Connecticut Insurance Commissioner; or (c) demonstrates a pattern of nonpayment of authorized claims, as determined by the Commissioner, for a period in excess of ninety (90) days. C.G.S. § 38a-479bb(d)(10).

    b. In the event of the failure, for any reason, of CARECENTRIX, Payor shall provide coverage for the Member to continue to receive Covered Services from the Provider that treated the Member under the Agreement, regardless of whether Provider participates in any plan operated by Payor. In the event of such failure, Payor shall continue coverage of Covered Services to the Member until the earlier of (a) the date that the Member's treatment is completed under a treatment plan that was authorized and in effect on the date of the failure, or (b) the date that the benefit contract between the Member and Payor terminates. Payor shall compensate Provider for such continued Covered Services at the reimbursement rate due to Provider under the Agreement. C.G.S. § 38a-479bb(j).

2. To the extent required by the applicable provisions of C.G.S. § 38a-478h:

    a. The Agreement shall conform to Section 2 of Public Act No. 16-205, C.G.S. § 38a-477g [*provider contracts*], and shall include notice provisions for the removal or departure of Provider in accordance with C.G.S. § 38a-472f (g) [*continuity of care*]; and

    b. Neither Payor nor CARECENTRIX shall take or threaten to take any action against Provider in retaliation for Provider's assistance to a Member under the provisions of C.G.S. § 38a-591g [*external reviews and expedited external reviews*].

3. Nothing in the Agreement shall be construed as prohibiting or limiting any cause of action or contract rights a Member otherwise has. C.G.S. § 38a-478i.

4. Nothing in the Agreement shall be construed as prohibiting Provider from discussing with a Member any treatment options and services available in or out of CARECENTRIX's provider network, including experimental treatments, or from disclosing to a Member who inquires, the method used to compensate Provider under the Agreement. C.G.S. § 38a-478k.

5. To the extent that Provider utilizes laboratories or testing facilities for Members, Provider shall utilize laboratories or testing facilities covered by the Member's benefit plan or shall notify the Member if Provider intends to utilize a laboratory or testing facility not covered by the Member's plan. C.G.S. § 38a-478q. Nothing in this section is intended to authorize Provider to utilize laboratories or testing facilities for Members except to the extent otherwise permitted under the Agreement.

6. The provisions of this section are added to the Agreement in accordance with the applicable requirements of C.G.S. § 38a-193(c) [HMOs]:
   A. Provider agrees, in the event of Payor's or CARECENTRIX's insolvency, to continue to provide Covered Services as promised in the Agreement to Members of Payor for the duration of the period for which premiums on behalf of the Member were paid to Payor, or until the Member's discharge from inpatient facilities, whichever time is greater.
   B. Notwithstanding any other provision in the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Member's benefit plan.
   C. Provider may not bill a Member for Covered Services, except for cost-sharing amounts, where Payor or CARECENTRIX denies payment because Provider has failed to comply with the terms or conditions of the Agreement.
   D. Provider further agrees (i) that the provisions of subsections (A), (B), and (C), of this section shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Payor's Members, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on Members' behalf.
   E. If Provider contracts with other providers or facilities who agree to provide Covered Services to Members with the expectation of receiving payment directly or indirectly from Payor or CARECENTRIX, such providers or facilities shall agree to abide by the provisions of subsections (A), (B), (C), and (D), of this section.

7. Provider shall not collect or attempt to collect from a Member sums owed by Payor or CARECENTRIX. Provider, or an agent, trustee, or assignee of Provider, shall not (i) maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX, or (ii) request payment from a Member for such sums. For purposes of this section "request payment" includes, but is not limited to, submitting a bill for services not actually owed or submitting for such services an invoice or other communication detailing the cost of the services that is not clearly marked with the phrase "THIS IS NOT A BILL." Pursuant to C.G.S. § 20-7f, it is an unfair trade practice in violation of Chapter 735a for Provider to request payment from a Member, other than a copayment or deductible, for Covered Services, or to report to a credit reporting agency a Member's failure to pay a bill for Covered Services when Payor has primary responsibility for payment of such services. C.G.S. § 38a-193(c) [HMOs].

8. In the event of the insolvency of Payor or CARECENTRIX, Provider shall continue providing Covered Services to Members for the duration of the period for which premium payments have been made and, with respect to a Member confined to an inpatient facility on the date of the insolvency, until the Member's discharge from the inpatient facility or expiration of benefits. C.G.S. § 38a-193(d) [HMOs].

9. CARECENTRIX may make material changes to Provider's fee schedule once annually upon at least ninety (90) days' advance written notice of such changes. Upon receipt of such notice, Provider may terminate the Agreement by giving at least sixty (60) days' advance written notice to CARECENTRIX. In addition to the foregoing, CARECENTRIX may make material changes to Provider's fee schedule at any time to comply with the requirements of applicable federal or state law, regulation, or policy, or as otherwise permitted by C.G.S. § 38a-479b(a), provided that Provider is given at least thirty (30) days' advance written notice of such changes. If such federal or state law, regulation, or policy takes effect in less than thirty (30) days, CARECENTRIX shall give Provider as much notice as possible. C.G.S. § 38a-479b(a).

10. Neither Payor nor CARECENTRIX shall cancel, deny, or demand the return of full or partial payment for an authorized Covered Service due to administrative or eligibility error, more than eighteen (18) months after the date of the receipt of a clean claim, except if:
    a. There is a documented basis to believe that such claim was submitted fraudulently by Provider;
    b. Provider did not bill appropriately for such claim based on the documentation or evidence of what medical service was actually provided;
    c. Provider has been paid for such claim more than once;
    d. Such claim should have been or was paid by a federal or state program; or
    e. Provider received payment for such claim from a different insurer, payor, or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy. Provider shall have one (1) year after the date of the cancellation, denial, or return of full or partial payment to resubmit an adjusted secondary payor claim with Payor or CARECENTRIX on a secondary payor basis, regardless of timely filing requirements under the Agreement.

    Payor or CARECENTRIX shall give Provider at least thirty (30) days' advance written notice of the cancellation, denial, or demand for the return of full or partial payment pursuant to this section. C.G.S. § 38a-479b(c)(1)-(2).

11. In accordance with the prohibition of a "most favored nations" provision under C.G.S. § 38a-479b(d), no clause, covenant, or provision in the Agreement shall:
    i. Require Provider to (a) disclose Provider's reimbursement rates from any other contracted payor; (a) provide Covered Services under the Agreement at a payment or reimbursement rate equal to or lower than the lowest of such rates that Provider has contracted, or may contract, with any other payor; or (c) certify that Provider has not contracted with any other payor to provide Covered Services at a payment or reimbursement rate lower than the rates under the Agreement;
    ii. Prohibit or limit Provider from contracting with any other payor to provide Covered Services at a payment or reimbursement rate lower than the rates under the Agreement; or
    iii. Allow CARECENTRIX to terminate or renegotiate the Agreement prior to renewal if Provider contracts with any other payor to provide Covered Services at a lower payment or reimbursement rate than the rates under the Agreement.

12. CARECENTRIX does not come within the definition of a "contracting entity" in C.G.S. § 42-490 because CARECENTRIX does not contract with physicians, physician groups, physician hospital organizations, or other "health care providers" as defined in C.G.S. § 42-490. Accordingly, CARECENTRIX is not subject to the requirements of C.G.S. § 42-491 regarding a contracting entity's sale, lease, rental, assignment, or granting access to a health care provider's services, discounted rates, or fees under the provider contract. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

13. In accordance with the applicable provisions of C.G.S. § 38a-472f (e)(2), nothing in the Agreement shall permit, or be construed to permit, CARECENTRIX or Payor to do any of the following:
    a. Offer or provide an inducement to Provider that would encourage or otherwise incentivize Provider to provide less than medically necessary health care services to a Member;
    b. Prohibit Provider from (i) discussing any specific or all treatment options with Members, irrespective of CARECENTRIX's or Payor's position on such treatment options, or (ii) advocating on behalf of Members within the utilization review or grievance and appeals processes established by Payor or CARECENTRIX, or in accordance with any rights or remedies available to Members under C.G.S. §§ 38a-591a to 38a-591g, inclusive, or under federal law relating to internal or external claims grievance and appeals processes; or
    c. Penalize Provider because Provider reports in good faith to state or federal authorities any act or practice by CARECENTRIX or Payor that jeopardizes patient health or welfare.

14. To the extent required by C.G.S. § 38a-472f (g) and C.G.S. § 38a-193(e), the following continuity of care provisions shall apply to the Agreement:
    a. For reference purposes, defined terms used in this section shall have the meaning(s) set forth in C.G.S. § 38a-472f (g)(2)(A) and, if not defined therein, then as set forth in C.G.S. § 38a-472f (a). Such terms include, but are not limited to, "active course of treatment," "life-threatening condition," "serious condition," "treating provider," and other applicable terms.

    b. CARECENTRIX and Provider shall provide at least ninety (90) days' written notice to each other before CARECENTRIX removes Provider from the network or Provider leaves the network. If Provider receives a notice of removal or issues a departure notice, Provider shall provide to CARECENTRIX a list of Provider's patients who receive Covered Services under Payor's network plan pursuant to the Agreement and shall make a good faith effort to provide written notice to all such Members being treated on a regular basis by Provider (receiving treatment at least once in the last 12 months) of such removal or departure not later than thirty days after CARECENTRIX receives or issues a written notice of removal or issues a departure notice.

    c. CARECENTRIX shall establish and maintain reasonable procedures to transition a Member who is in an active course of treatment with Provider to another participating provider in a manner that provides for continuity of care. For purposes of this section, "Active course of treatment" means (i) a medically necessary, ongoing course of treatment for a "life-threatening condition"; (ii) a medically necessary, ongoing course of treatment for a "serious condition"; (iii) medically necessary care provided during the second or third trimester of pregnancy; or (v) a medically necessary, ongoing course of treatment for a condition for which a treating health care provider attests that discontinuing care by such health care provider would worsen the covered person's condition or interfere with anticipated outcomes. *See defined terms at* C.G.S. § 38a-472f (g)(2)(A).
    d. The following transition procedures, among others required by law or regulation, shall apply:
        (1) Any request for a continuity of care period must be made by the Member or the Member's authorized representative.
        (2) A request for a continuity of care period made by a Member who is in an active course of treatment by Provider, or by such Member's authorized representative, shall be reviewed by CARECENTRIX's medical director after consultation with the treating provider, so long as Provider was not removed from or did not leave CARECENTRIX's network for cause.
        (3) For a Member who is in the second or third trimester of pregnancy, the continuity of care period shall extend through the postpartum period.
        (4) The continuity of care period for a Member who is undergoing an active course of treatment shall extend to the earliest of the following:
            i. Termination of the course of treatment by the Member or the treating provider;
            ii. Ninety (90) days after the effective date of Provider's departure or termination from the network, unless CARECENTRIX's medical director determines that a longer period is necessary;
            iii. The date that care is successfully transitioned to another participating provider;
            iv. The date on which benefit limitations under the health benefit plan are met or exceeded; or
            v. The date that CARECENTRIX determines care is no longer medically necessary.

    e. CARECENTRIX shall only grant a continuity of care period as provided under subsection (d)(4) of this section if Provider agrees in writing: (i) to accept the same payment and abide by the same terms and conditions as provided in the Agreement when Provider was a participating provider, and (ii) not to seek any payment from the Member for any amount for which such Member would not have been responsible if Provider was still a participating provider.

15. To the extent required by Section 2 of Public Act No. 16-205, C.G.S. § 38a-477g, C.G.S. §§ 38a-479aa(l), 38a-479bb(d)(5) and C.G.S. § 38a-193(c), the following provisions are added to the Agreement:

    a. Provider agrees that in no event, including but not limited to, nonpayment by Payor or CARECENTRIX, the insolvency of Payor or CARECENTRIX, or a breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person (other than Payor or CARECENTRIX) acting on behalf of the Member for Covered Services provided pursuant to the Agreement. Except as otherwise specified in the Agreement or the Provider Manual, the Agreement does not prohibit Provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for non-covered services delivered on a fee-for-service basis to Members, or costs for non-covered services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's benefit plan. Subject to the requirements and conditions set forth in the Agreement or the Provider Manual, the Agreement does not prohibit Provider (except for a health care provider who is employed full-time on the staff of a Payor and who has agreed to provide services exclusively to that Payor's Members and no others) and a Member from agreeing to continue services solely at the expense of the Member, as long as Provider has clearly informed the Member that Payor does not cover or continue to cover a specific service or services. Except as provided herein, and except to the extent limited or otherwise provided in the Agreement or the Provider Manual, the Agreement does not prohibit Provider from pursuing any available legal remedy.

    b. In the event of Payor's or CARECENTRIX's insolvency or other cessation of operations, Provider's obligation to deliver Covered Services to Members without requesting payment from a Member, other than a coinsurance, copayment, deductible, or other out-of-pocket expense for such services, will continue until the earlier of: (i) the termination of the Member's coverage under Payor's network plan, including any extension of coverage provided under the terms of the Agreement or under applicable state or federal law for Members who are in an active course of treatment, as set forth in C.G.S. § 38a-472f (g)(2), or who are totally disabled; or (ii) the date on which the Agreement would have terminated if Payor or CARECENTRIX had remained in operation, including any extension of coverage required under applicable state or federal law for Members who are in an active course of treatment or who are totally disabled.

    c. The terms set forth in subsections a. and b. of this section shall: (i) be construed in favor of the Member; (ii) survive the termination of the Agreement regardless of the reason for the termination, including the insolvency of Payor or CARECENTRIX; and (iii) supersede any oral or written agreement between Provider and a Member, or a Member's authorized representative, that is contrary to or inconsistent with the requirements set forth in subsections a. or b. of this section.

    d. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, Members. Provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a Member's right to view, obtain copies of, or amend such Member's medical and health records.

    e. To the extent that a provision in the Agreement conflicts with provisions that are contained in Payor's network plan, or that are required under this section, under C.G.S. § 38a-472f [*network adequacy*], or under Section 3 of Public Act No. 16-205, C.G.S. § 38a-477h [*provider directories*], the conflicting provision of the Agreement shall not apply.

    f. Provider or CARECENTRIX may not assign or delegate any right or responsibility required under the Agreement without the prior written consent of the other party.

g. At the time the Agreement is signed, CARECENTRIX shall disclose to Provider all provisions, provider manuals, policies, and other documents incorporated by reference into the Agreement, if any. CARECENTRIX shall give Provider at least ninety days' advance written notice of any change to such provisions, provider manuals, policies, or other documents that will result in a material change to the Agreement or the procedures that Provider must follow pursuant to the Agreement. Provider has the right to appeal any such proposed change to the provisions, provider manuals, policies, or other documents. The definition of what is considered timely notice and a material change to the Agreement shall conform to the applicable requirements of C.G.S. § 38a-479b [*material changes to fee schedules*] and other applicable state and federal laws, and, to the extent not set forth therein, shall be consistent with the amendment and contract modification provisions in the Agreement, including Schedules and the Provider Manual.

h. For reference purposes, as used in Section 2 of Public Act No. 16-205, C.G.S. § 38a-477g, the defined terms: (i) "covered person," "facility," and "health carrier" shall have the meaning(s) set forth in C.G.S. § 38a-591a; (ii) "health care provider" shall have the meaning set forth in C.G.S, § 38a-477aa (a); and (iii) "intermediary," "network," "network plan," and "participating provider" shall have the meaning(s) set forth C.G.S. § 38a-472f (a).

16. To the extent required by Section 2 of Public Act No. 16-205, C.G.S. § 38a-477g, the following provisions shall apply to the Agreement:

a. Payor shall have the right to approve or disapprove the participation status of Provider in CARECENTRIX's network for the purpose of providing Covered Services to Payor's Members.

b. In the event of CARECENTRIX's insolvency, Payor shall have the right to require the assignment to Payor of the provisions of the Agreement that address Provider's obligation to provide Covered Services to Payor's Members. If Payor requires such assignment, Payor shall remain obligated to pay Provider for providing Covered Services under the same terms and conditions as CARECENTRIX prior to the insolvency.

ADDENDUM FOR THE STATE OF DELAWARE

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Delaware regarding provider contracts with providers rendering health care services in the State of Delaware. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health insurance company, health service corporation, health maintenance organization, or managed care organization, as those terms are defined in applicable Delaware law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent required by law and applicable to Provider, the following provisions shall be added to the Agreement in accordance with 18 Del. Admin. Code §§ 1403-7.0 to -7.3:

    a. Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person (other than Payor or CARECENTRIX) acting on behalf of the Member for Covered Services provided pursuant to the Agreement. The Agreement does not prohibit Provider from collecting coinsurance, deductibles, or co-payments, as specifically provided in the Member's evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to the Member.

    b. In the event of Payor's or CARECENTRIX's insolvency or other cessation of operations, Covered Services to Members will continue through the period for which a premium has been paid to Payor on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater. Covered Services to Members confined in an inpatient facility on the date of such insolvency or other cessation of operations will continue until the Member's continued confinement in an inpatient facility is no longer medically necessary.

    c. The provisions of subsections (a) and (b) of this section shall be construed in favor of the Member, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Payor, and shall supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by subsections (a) and (b) of this section.

    d. No definitions or other provisions contained in the Agreement shall conflict with or be construed to conflict with the definitions or provisions contained in this regulation, 18 Del. Admin. Code § 1403.

2. To the extent required by law and applicable to Provider, the following provisions shall be added to the Agreement in accordance with 18 Del. C. §§ 332-333 and 18 Del. Admin. Code § 1313:

    a. In the event that Payor's final decision regarding reimbursement for an individual claim, procedure, or service does not authorize reimbursement of Provider's claim in its entirety, Payor shall give Provider written notice of Provider's right to arbitration. Provider shall attempt to resolve disputes informally with Payor before requesting arbitration pursuant to this provision. The arbitrator may dismiss an arbitration petition without prejudice, if the arbitrator finds that Provider has not attempted to resolve the matter informally.

b. Petition for Arbitration: Provider or an authorized representative may request review of Payor's final reimbursement decision through arbitration by delivering a Petition for Arbitration to the Delaware Department of Insurance (the "Department") so that it is received by the Department no later than sixty (60) days after the date of mailing of Payor's final reimbursement decision. The Department shall make available, by mail and on its web site, a standardized form for a Petition of Arbitration. Provider or an authorized representative must deliver to the Department an original and three (3) copies of the Petition for Arbitration. At the time of delivering the Petition for Arbitration to the Department, Provider or an authorized representative must also: send a copy of the Petition to Payor by certified mail, return receipt requested; deliver to the Department a Proof of Service confirming that a copy of the Petition has been sent to Payor by certified mail, return receipt requested; and deliver to the Department a non-refundable filing fee. The fee shall be $50 for claims of $1,000 or less; in all other cases the fee shall be $100. The Department may refuse to accept any Petition that is not timely filed or does not otherwise meet the criteria for arbitration, including the disputes described in 18 Del. C. § 333(j)(1)-(3).

c. Response to Petition for Arbitration: Within twenty (20) days of receipt of the Petition, Payor must deliver to the Department an original and three (3) copies of a Response with supporting documents or other evidence attached. At the time of delivering the Response to the Department, Payor must also: send a copy of the Response and supporting documentation to Provider or an authorized representative by first class U.S. mail, postage prepaid; and deliver to the Department a Proof of Service confirming that a copy of the Response was mailed to Provider or an authorized representative. The Department may return any non-conforming Response to Payor. If Payor fails to deliver a Response to the Department in a timely fashion, the Department, after verifying proper service, and with written notice to the parties, may assign the matter to the next scheduled Arbitrator for summary disposition. The Arbitrator may determine the matter in the nature of a default judgment after establishing that the Petition is properly supported and was properly served on Payor. The Arbitrator may allow the re-opening of the matter to prevent a manifest injustice. A request for re-opening must be made no later than seven (7) days after notice of the default judgment.

d. Summary Dismissal of Petition by the Department: If the Department determines that the subject of the Petition is not appropriate for arbitration or is meritless on its face, the Department may summarily dismiss the Petition and provide notice of such dismissal to the parties.

e. Appointment of Arbitrator: Upon receipt of a proper Response, the Department shall assign an Arbitrator who shall schedule the matter for a hearing so that the Arbitrator can render a written decision within forty-five (45) days of the delivery to the Department of the Petition for Arbitration. The Arbitrator shall be of suitable background and experience to decide the matter in dispute and shall not be affiliated with any of the parties or with the patient whose care is at issue in the dispute.

f. Arbitration Hearing: The Arbitrator shall give notice of the arbitration hearing date to the parties at least ten (10) days prior to the hearing. The parties are not required to appear and may rely on the papers delivered to the Department. The arbitration hearing is to be limited, to the maximum extent possible, to each party being given the opportunity to explain their view of the previously submitted evidence and to answer questions by the Arbitrator. If the Arbitrator allows any brief testimony, the Arbitrator shall allow brief cross-examination or other response by the opposing party. The Delaware Uniform Rules of Evidence will be used for general guidance but will not be strictly applied. Because the testimony may involve evidence relating to personal health information that is confidential and protected by State or federal laws from public disclosure, the arbitration hearing shall be closed. The Arbitrator may contact, with the parties' consent, individuals or entities identified in the papers by telephone in or outside of the parties' presence for information to resolve the matter. The Arbitrator is to consider the matter based on the submissions of the parties and information otherwise obtained by the Arbitrator in accordance with this regulation, 18 Del. Admin. Code § 1313. The Arbitrator shall not consider any matter not contained in the original or supplemental submissions of the parties that has not been provided to the opposing party with at least five (5) days' notice, except claims of a continuing nature that are set out in the filed papers.

g. Arbitrator's Written Decision: The Arbitrator shall render a decision and mail a copy of the decision to the parties within forty-five (45) days of the filing of the Petition. The Arbitrator's decision is binding upon the parties, except as provided in 18 Del. C. § 333(f).

ADDENDUM FOR THE DISTRICT OF COLUMBIA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the District of Columbia regarding provider contracts with providers rendering health care services in the District of Columbia. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a carrier, health insurer, or health maintenance organization, as those terms are defined in applicable District of Columbia law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to prohibit, impede, or interfere in the discussions between Provider and a Member concerning medical treatment options, including discussions regarding financial coverage of those treatment options. Provider is permitted and required to discuss medical treatment options with a Member. CARECENTRIX may not terminate the Agreement solely because Provider discussed medical treatment options with a Member. D.C. Code § 31-3406(h).

2. To the extent that the Agreement applies to Covered Services rendered Members enrolled in a health maintenance organization ("HMO") plan, the following provisions shall be added to the Agreement to the extent applicable to Provider:

    a. In the event that Provider has not been paid for a Covered Service rendered to a Member as set forth in the Agreement, Provider shall not collect or attempt to collect from the Member any money owed to Provider by Payor or CARECENTRIX, except for applicable copayments and deductibles owed by the Member in accordance with the Member's benefit plan, or charges for health care services that are not Covered Services under the Member's evidence of coverage. Neither Provider nor any agent, trustee, or assignee of Provider shall maintain any action at law against the Member to collect any sums owed by Payor or CARECENTRIX. D.C. Code §§ 31-3412(d), 31-3401(23).

    b. In the event of the insolvency of Payor or CARECENTRIX, Provider shall continue to render Covered Services to Members: (i) for the duration of the period for which premium payment has been made, and (ii) for a Member who is confined on the date of insolvency in an inpatient facility, until the Member's discharge from the inpatient facility or expiration of benefits. D.C. Code § 31-3412(e). During such period, Provider shall be compensated for Covered Services rendered to Members in accordance with the rates of reimbursement under the Agreement.

    c. If Provider elects to terminate the Agreement, Provider shall give CARECENTRIX at least sixty (60) days' advance written notice of such termination. D.C. Code § 31-3412(f). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement, such longer notification period will apply.

3. To the extent required by law, Provider shall be allowed a minimum of one hundred and eighty (180) days from the date a Covered Service is rendered to a Member or, if applicable, the date of a Member's inpatient discharge to submit a claim for reimbursement of such Covered Services. D.C. Code § 31-3132(g).

4. a. To the extent required by law, Payor or CARECENTRIX may only retroactively deny reimbursement to Provider:
   i For services subject to coordination of benefits with another health insurer, during the eighteen (18)-month period after the date that Payor paid Provider; or
   ii Except as provided above, during the six (6)-month period after the date that Payor paid Provider.

   b. If Payor or CARECENTRIX retroactively denies reimbursement to Provider under subsection (a) of this section, Provider shall be provided with a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

   c. The requirements of subsection (a) of this section shall not apply if Payor or CARECENTRIX retroactively denies reimbursement to Provider because:
      i. The information submitted to Payor or CARECENTRIX was fraudulent;
      ii. The information submitted to Payor or CARECENTRIX was improperly coded, and Payor or CARECENTRIX provided sufficient information to Provider regarding the coding guidelines used by Payor or CARECENTRIX at least thirty (30) days prior to the date that the services subject to the retroactive denial were rendered; or
      iii. The claim submitted to Payor or CARECENTRIX was a duplicate claim.

   d. Information submitted by Provider to Payor or CARECENTRIX may be considered to be improperly coded for purposes of subsection (c) of this section if such information:
      i. Uses codes that do not conform with the coding guidelines used by Payor or CARECENTRIX applicable as of the date that services were rendered; or
      ii. Does not otherwise conform with Provider's contractual obligations to CARECENTRIX or Payor under the Agreement applicable as of the date that services were rendered.

   e. If Payor or CARECENTRIX retroactively denies reimbursement for services as a result of coordination of benefits, Provider shall have one hundred and eighty (180) days after the date of such denial, unless Payor or CARECENTRIX permits a longer time period, to submit a claim for reimbursement for the service to the health insurer responsible for payment.

   f. Payor or CARECENTRIX shall provide Provider with a written statement specifying the basis for a retroactive denial of reimbursement under this section.

   g. This section shall not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk-sharing arrangement. D.C. Code § 31-3133.

5. If Provider elects to terminate the Agreement, Provider shall notify CARECENTRIX in writing at least ninety (90) days before the termination. For at least ninety (90) days after the date of Provider's notice of termination, Provider shall continue to render Covered Services to Members for whom Provider was responsible for the delivery of Covered Services prior to the notice of termination.
   D.C. Code § 31-3134(b). During such period, Provider shall render Covered Services to such Members in accordance with the terms, conditions, and rates of reimbursement under the Agreement. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement, such longer notification period will apply.

ADDENDUM FOR THE STATE OF FLORIDA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Florida regarding provider contracts with providers rendering health care services in the State of Florida. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that the Payor is an HMO, the Member is not liable to Provider for any services for which such Payor or CARECENTRIX is liable. Fla. Stat. § 641.315(1).

2. Provider must give at least 60 days' advance written notice to CARECENTRIX and the Office of Insurance Regulation before terminating the Agreement for any reason. Nonpayment for goods or services rendered by Provider is not a valid reason for avoiding this 60 day advance notice requirement. Fla. Stat. § 641.315(2)(a). To the extent that the Agreement provides for a longer termination notice period, such notice period shall apply.

3. CARECENTRIX must give at least 60 days' advance written notice to Provider and the Office of Insurance Regulation before terminating, without cause, the Agreement. This advance notice requirement shall not apply in a case in which a patient's health is subject to imminent danger. Fla. Stat. § 641.315(2)(b).

4. In accordance with Fla. Stat. § 641.234(3), the Agreement may be terminated by an order of the Florida Insurance Department**.**

5. Provider should refer to the Provider Manual for information regarding utilization management processes, the mailing address or electronic address where claims should be sent for processing, the telephone number a provider may call for questions and concerns regarding claims, and the address of any separate claims processing centers for specific types of services (if applicable). Fla. Stat. § 641.315(4), (8).

6. A complete schedule of reimbursements for all services for which Provider and CARECENTRIX are contracted is available upon request. Fla. Stat. § 641.315(4)(d).

7. Nothing in the Agreement shall be construed to restrict Provider's ability to communicate information to a Member regarding medical care or treatment options for the Member when Provider deems knowledge of such information by the Member to be in the best interest of the health of the Member. Fla. Stat. § 641.315(5).

8. Nothing in the Agreement shall be construed to prohibit Provider from entering into a commercial contract with another HMO or network or to prohibit CARECENTRIX or the Payor from entering into a commercial contract with any other provider. Fla. Stat. § 641.315(6).

9. Provider shall post a consumer assistance notice, prominently displayed and clearly noticeable, in Provider's reception area (if applicable). Such notice must state the address and toll-free telephone number of the Agency for Health Care Administration, the Statewide Provider and Subscriber Assistance Program, and the Department of Insurance. The notice shall also state that the toll-free number for the applicable Payor appears on the Member's identification card. Fla. Stat. § 641.511(11).

10. After the exhaustion of the Agreement's internal process to resolve disputes relating to the payment of provider claims, but before the initiation of arbitration to resolve such disputes, either party may initiate the Agency for Health Care Administration dispute resolution process to the extent that such process applies by providing written notice to the other party. Fla. Stat. § 408.7057.

11. If the Agreement is terminated for any reason other than for cause, CARECENTRIX and Provider shall allow Members for whom treatment was active to continue care when medically necessary through completion of treatment of a condition for which the Member was receiving care at the time of termination so long as Member retains eligibility under a plan until the Member selects another treating provider, or during the next open enrollment period offered by the Payor, whichever is longer, but not longer than 6 months after termination of this Agreement. Members who have initiated a course of prenatal care, regardless of the trimester in which care was initiated, may continue care until completion of postpartum care. This does not prevent Provider from refusing to continue to provide care to a Member who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this provision, CARECENTRIX and Provider shall continue to be bound by the terms of the Agreement. Changes made within 30 days before termination of a contract are effective only if agreed to by both parties. Fla. Stat. § 641.51(8).

12. CARECENTRIX does not come within the definition of a "contracting entity" in Fla. Stat. § 627.64731 because CARECENTRIX does not contract with physicians, physician group practices, or other "participating providers" as defined in Fla. Stat. § 627.64731. Accordingly, CARECENTRIX is not subject to the requirements of Fla. Stat. § 627.64731 regarding a contracting entity's sale, lease, renting, or otherwise granting access to the health care services of a participating provider under a health care contract. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

FLORIDA ADDENDUM – BCBSFL PROVISIONS

The following language is hereby incorporated into the Provider Agreement and shall be binding upon Provider for all Services rendered to or on behalf of any members or covered lives of Blue Cross Blue Shield of Florida or its affiliates (collectively "BCBSFL"). The parties agree that in the event that any of the following provisions conflict with the Provider Agreement (the "Agreement") executed by the parties then the provisions below shall control:

1. Provider shall comply with all inspections, evaluations and audits conducted by CareCentrix, its customers and their designees, the Agency for Health Care Administration ("AHCA"), the U.S. Department of Health and Human Services ("DHHS"), the Florida Comptroller General, and all accrediting agencies to which CareCentrix or its customers or their designees are subject or their designees. Such compliance shall include without limitation providing access to any and all books, contracts, financial records, medical records, patient care documentation and other records of Providers for at least ten (10) years during the term of the Agreement and following termination for any reason.

2. Provider shall cooperate in any investigation and/or examination by CareCentrix, its customers or government entity or their designees relating to the provision of Services pursuant to this Agreement.

3. For the purpose of conducting the activities specified herein, Provider shall make reasonably available its premises, physical facilities, equipment and records relating Services, and any additional relevant information that may be reasonably required by CareCentrix, BCBSFL, AHCA, DHHS, the Florida Comptroller General, all accrediting agencies to which BCBSFL is subject, or their designees may require.

4. Provider has established and will maintain a formal compliance and anti-fraud program to detect and prevent the incidence of fraud and abuse relating to the provision of Services. Such program, which shall be maintained throughout the term of this Agreement, shall, at minimum, comply with all state and federal program integrity requirements including any requirements detailed under the Patient Protection and Recovery Act of 2010 ("PPACA") and CMS requirements and guidelines, as applicable. Provider shall immediately report to CareCentrix any incident of fraud, waste or abuse associated with the Services.

5. Following the occurrence of any of the following events, Provider shall immediately notify CareCentrix in writing within the time periods set forth below:

    a. Within twenty four (24) hours if: (i) Provider or any of its officers or directors, is indicted or convicted of a felony; (ii) Provider becomes the subject of a material investigation by a state or federal agency or department or regulatory body in which Provider has the potential to be subject to criminal charges or subject to an action for violation of Laws; or (iii) Provider's license to provide services in any state or accreditation or credentialed status is limited, restricted, revoked or otherwise terminated or any other action is taken by the state or any other regulatory body that would materially impair the ability of Network Provider to provide or arrange for Services to Members;

    b. Within one (1) business day if: (i) Provider's license accreditation or credentialing status is limited, restricted, revoked or otherwise terminated, or any other action is taken by the State of Florida or any other regulatory body that would materially impair the ability of Provider to provide or arrange for Services to Members;(ii) Provider is materially sanctioned by a government entity; or (iii) Provider's eligibility to participate in the Medicare or Medicaid programs, as applicable, is suspended, limited, restricted, or otherwise terminated;

    c Within five (5) business days if: (i) Provider is required to pay damages in any malpractice action by way of judgment or settlement notification related to Services; (ii) Provider receives notice of intent to file or actual filing of any professional liability action against Provider (or an entity in which Provider has an ownership interest, other than a publicly traded company) that involves the Services provided

pursuant to this Agreement; provided, however, that compliance with the foregoing shall not constitute notice or compliance with the notice provisions of Chapter 766, Florida Statutes; (iii) there is a material negative change in the ability of Provider to render Services; or (iv) any other act, event, occurrence, or the like that materially affects Provider's ability to carry out its duties and obligations or otherwise perform Services under this Agreement.

6. Upon termination of this Agreement for any reason or cause, Provider shall cooperate with CareCentrix by taking reasonable and medically appropriate measures to assure the timely transition of Services to Members. Provider shall furnish any information and take any action including, without limitation providing a list of Members receiving Services and continuation of care as CareCentrix may reasonably request in order to effectuate an orderly and systematic transition of such Member. Provider agrees that the provisions of this Addendum shall survive the termination and expiration of this Agreement.

7 Provider shall comply with the following for the term of this Agreement and for up to ten (10) years following the termination of the Provider's provision of Services under this Agreement:

   a. Maintain and provide complete and accurate fiscal records, medical records, claims records, and financial records as needed by CareCentrix and its customers to satisfy their respective reporting obligation under applicable laws rules and regulations and for management of Services, including but not limited to accrediting agencies, HEDIS (as applicable), and financial and administrative information.

   b. Provide CareCentrix with claims and encounter claims in a format that is acceptable to CareCentrix and its customers that follows industry standards for claims and including use of appropriate software codes in a manner and within the time frames required for CareCentrix and its customers to comply with applicable laws, rules, and regulations.

   c. Submit to CareCentrix all clinical information for Services provided to Members as set forth in this Agreement.

8. Provider comply with the following, as applicable: (i) BCBSFL's medical coverage guidelines, medical management, quality assessment and performance improvement policies and programs, quality indicator and utilization management programs and peer review; (ii) advance directives, as applicable; (iii) CMS, AHCA, accrediting agencies,' CareCentrix's, and BCBSFL's policies and procedures and programs, as applicable; (iv) BCBSFL's and CareCentrix's member grievance and appeal/expedited appeal processes and any such other processes required by Laws, including gathering and forwarding information to BCBSFL and CareCentrix on a timely basis, as required in BCBSFL's and CareCentrix's policies and procedures, that shall permit BCBSFL and CareCentrix to meet required timeframes for disposition of grievances and appeals and to comply with final determinations rendered. Provider shall notify CareCentrix within two (2) business days if a BCBSFL Member files an informal or formal complaint as set forth in BCBSFL's grievance procedure and to refer Members who have complaints about Services to CareCentrix; (v) with BCBSFL's vendors to coordinate care to BCBSFL members; (vi) BCBSFL's requirements for verifying eligibility and benefits of members; and (vii) CMS standards in relation to quality, utilization, and management of services.

MEDICARE ADVANTAGE DUAL ELIGIBLE SPECIAL NEEDS PLAN ADDENDUM FOR THE STATE OF FLORIDA

This Medicare Advantage Dual Eligible Special Needs Plan ("DSNP") Addendum for the State of Florida (this "Addendum") supplements and is made part of the Provider Agreement (the "Agreement") between CARECENTRIX and the provider listed on the signature page of the Agreement to which this Addendum relates ("Provider"). The provisions in this Addendum are added to the Agreement to comply with state and federal laws and regulations applicable to provider contracts with providers rendering health care services to individuals who are eligible for services pursuant to a DSNP plan ("DSNP Plan") in Florida (the "DSNP Members"). In the event of a conflict between the terms of this Addendum and the terms of the Agreement, including any other addendum, attachment, or exhibit thereto, the terms of this Addendum shall control with respect to the subject matter hereof, unless otherwise required by law.

The following provisions are added to the Agreement:

1. Provider agrees to provide all health care services within the scope of Provider's license and this Agreement for which DSNP Members are eligible to receive coverage ("Covered Services") in accordance with the Agreement as amended by this Addendum. Provider further agrees to participate in any training regarding available benefits, services and requirements applicable to services rendered to DSNP Members. Details on such Covered Services are found at the applicable DSNP Plan website. For Florida Blue, go to https://www.floridablue.com/sbc/search/byplan and https://medicare.websales.floridablue.com/files/medicare_flblue/pdfs/33885%200817R1%20CY2018%20DSNP%20EOC%20H1026%20063.pdf.

2. Provider will accept CARECENTRIX's payment as payment in full for Covered Services provided to DSNP Members and will not file claims for Medicaid reimbursement to the Medicaid Fiscal Agent for such services.

3. Provider shall not file additional claims for Medicaid deductibles or copayments and will not balance bill DSNP Members.

4. Notwithstanding any provision to the contrary, Provider shall not under any circumstances including but not limited to non-payment by the DSNP Plan or CARECENTRIX, insolvency of the DSNP Plan or CARECENTRIX or breach of this Agreement, bill, charge, collect a deposit from, seek compensation or remuneration from or have any recourse against any DSNP Member for fees that are the responsibility of the DSNP Plan or CARECENTRIX. Provider shall not seek payment from the Member for any Covered Services provided to the Member within the terms of this Agreement and shall look solely to CARECENTRIX or the DSNP Plan for compensation for Covered Services rendered.

5. Provider shall notify CARECENTRIX immediately in the event Provider has concerns regarding the services rendered to DSNP Members, including but not limited to, violations of applicable law and if a DSNP Member is at risk for or has suffered serious harm, impairment or death.

6. Provider shall comply with all applicable laws, CMS and State Medicaid agency requirements, and DSNP Plan requirements applicable to Provider and services rendered to DSNP Members.

7. All of the provisions in the Medicare Addendum to the Agreement shall also apply to services rendered to DSNP Members.

ADDENDUM FOR THE STATE OF GEORGIA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Georgia regarding provider contracts with providers rendering health care services in the State of Georgia. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an accident and health insurer, health maintenance organization, managed care entity, or health care insurer offering a preferred provider arrangement, as those terms are defined in applicable Georgia law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. A Member shall be held harmless for provider utilization review decisions over which the Member has no control. Ga. Comp. R. & Regs. r. 120-2-44-.04(3).

2. Prospective authorizations and any other authorizations that Provider is required to obtain for Covered Services under the Agreement shall be conducted in accordance with the applicable provisions set forth in the Agreement and the Provider Manual. Ga. Comp. R. & Regs. r. 120-2-80-.06(4).

3. The Agreement shall not contain a financial incentive or disincentive program that directly or indirectly compensates Provider for ordering or providing less than medically necessary and appropriate care to Members or for denying, reducing, limiting, or delaying such care. Nothing in this section shall be deemed to prohibit the use of a capitated payment arrangement consistent with the intent of this section. O.C.G.A. § 33-20A-6(a).

4. Provider shall not be penalized for (i) considering, studying, or discussing medically necessary or appropriate care with or on behalf of a Member; or (ii) providing testimony, evidence, records, or any other assistance to a Member who is disputing a denial, in whole or in part, of a health care treatment or service or claim therefor. O.C.G.A. § 33-20A-7.

5. a. Provider shall not be prohibited from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the Agreement.
   b. Provider shall not be required to accept a lower payment or reimbursement rate if Provider agrees to provide health care services to another party at a lower rate than the payment or reimbursement rate specified in the Agreement.
   c. Provider shall not be required to terminate or renegotiate the Agreement in the event that Provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the Agreement.
   d. Provider shall not be required to disclose, to Payor or CARECENTRIX, Provider's contractual payment or reimbursement rates with other parties.
   e. Payor and CARECENTRIX shall not have the option to require Provider to act contrary to the provisions of this section. Ga. Comp. R. & Regs. r. 120-2-20-.03.

6. CARECENTRIX may lease, rent, or otherwise grant access to the Agreement to a Payor, third-party administrator, or another entity that administers or processes claims on behalf of the Payor (individually and collectively, "third party," as defined in O.C.G.A. § 33-20D-1), subject to the requirements set forth in this section of this Addendum.

a. To the extent required by O.C.G.A. § 33-20D-3(a), the following provisions shall be added to the Agreement:

(1) The Agreement permits CARECENTRIX to enter into an agreement with a Payor or other third party, allowing such Payor or third party to obtain CARECENTRIX's rights and responsibilities under the Agreement as if such Payor or third party were CARECENTRIX;

(2) The Agreement, as well as all agreements between CARECENTRIX and a Payor or other third party, prohibits such Payor or third party from increasing the contractual discounts or otherwise reducing the compensation to Provider to an amount below that which Provider was entitled from CARECENTRIX for health care services at the time such Payor or third party was granted access to the Agreement, unless such Payor or third party becomes a "contracting entity" (as defined in O.C.G.A. § 33-20D-1); and

(3) A Payor or other third party accessing the Agreement is contractually obligated to comply with all applicable terms, limitations, and conditions of the Agreement.

b. CARECENTRIX shall maintain an Internet website, mobile communication device application, or other readily available mechanism, such as a toll-free telephone number, through which Provider may obtain a listing, updated at least every 30 days, of the Payors and other third parties with which CARECENTRIX has executed contracts to grant access to Provider's health care services and contractual discounts pursuant to the Agreement. Provider may obtain such listing at the CARECENTRIX provider portal website, or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual. O.C.G.A. § 33-20D-3(b).

c. All information made available to Provider in accordance with the requirements of O.C.G.A. Title 33, Chapter 20D (Rental Provider Network), shall be confidential and shall not be disclosed to any person or entity not employed by Provider or involved in Provider's practice or the administration thereof without the prior written consent of CARECENTRIX; provided, however, that this shall not preclude Provider from disclosing such information to an outside consultant or attorney for the purpose of assisting Provider with any disputes with CARECENTRIX. O.C.G.A. § 33-20D-3(c).

d. Nothing contained in O.C.G.A. Title 33, Chapter 20D (Rental Provider Network), shall be construed to prohibit CARECENTRIX from requiring Provider to execute a reasonable confidentiality agreement to ensure that confidential or proprietary information disclosed by CARECENTRIX is not used for any purpose other than Provider's direct practice management or billing activities. O.C.G.A. § 33-20D-3(d).

7. In the event that Payor's provider directory accessed through the Payor's website includes Provider at the time a prospective Member selects his or her health benefit plan during the designated open enrollment time frame, and subsequent to open enrollment in the succeeding plan year, Provider is no longer in-network for the Member's benefit plan, CARECENTRIX shall reimburse Provider for covered services at its most recent contracted in-network rates for 180 days after the date of termination of the Agreement or through the last day of the Member's coverage, whichever occurs sooner. Provider shall accept CARECENTRIX's payment in full. O.C.G.A. § 33-20C-2(g)(1).

   This section shall not apply if Payor's provider directory accessed through the Payor's website accurately displayed any future date on which Provider would become out of network, 15 days prior to the beginning of, and all during, the designated open enrollment time frame. O.C.G.A. § 33-20C-2(g)(3)(D).

ADDENDUM FOR THE STATE OF HAWAII

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Hawaii regarding provider contracts with providers rendering health care services in the State of Hawaii. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health carrier, health maintenance organization, or entity that offers or administers a managed care plan, as those terms are defined in applicable Hawaii law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Provider is a "health care professional" as defined in Haw. Rev. Stat. § 432E-1, Provider shall: (i) discuss all treatment options with a Member, including the option of no treatment at all; (ii) ensure that persons with disabilities have an effective means of communication with Provider and the managed care plan; (iii) discuss all risks, benefits, and consequences to treatment and nontreatment, as provided in applicable law; and (iv) discuss with the Member and the Member's immediate family advanced health-care directives and durable powers of attorney in relation to medical treatment, as provided in applicable law. Haw. Rev. Stat. § 432E-4(b), (c).

2. Neither CARECENTRIX nor Payor shall impose any type of prohibition, disincentive, penalty, or other negative treatment upon Provider for discussing or providing any information regarding treatment options and medically necessary or appropriate care, including no treatment, even if the information relates to services or benefits not covered by the managed care plan. Haw. Rev. Stat. § 432E-4(d). CARECENTRIX or Payor shall not prohibit Provider from advocating on behalf of the Member within the utilization review or grievance or appeals processes established by the Payor or CARECENTRIX or in accordance with any rights or remedies available under applicable state or federal law. Haw. Rev. Stat. § 431: 26-104(j).

3. Provider shall comply with CARECENTRIX's and Payor's requests for any information necessary for the managed care plan to comply with the requirements of Haw. Rev. Stat. § 432E-1 et seq. (Patients' Bill of Rights and Responsibilities Act) regarding standards for measuring quality, outcomes, access, satisfaction, and utilization of services. Haw. Rev. Stat. § 432E-10(a).

4. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by Haw. Rev. Stat. § 432D-8(d), (e), and (f):

    a. In the event that Payor fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from the Member sums owed by Payor or CARECENTRIX. Neither Provider nor or any agent, trustee, or assignee of Provider, shall maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX.

    b. In the event of Payor's insolvency, Provider shall continue to provide Covered Services to Members for the duration of the contract period after Payor's insolvency for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of insolvency, until the Member's discharge from the inpatient facility or expiration of benefits.

    c. In the event that Provider elects to terminate the Agreement, Provider shall give CARECENTRIX at least sixty (60) days' advance written notice of the termination. Notwithstanding the foregoing, if the

Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, the longer notification period will apply.

5. To the extent required by Haw. Rev. Stat. § 431:26-104 (l), the following provisions shall be added to the Agreement:

   a. Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person other than the Payor or CARECENTRIX, acting on behalf the Member for services provided pursuant to this Agreement.

   b. This Agreement does not prohibit Provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to a Member; provided that Provider shall not bill or collect from a Member or a person acting on behalf of a Member any charges for non-covered services or services that do not meet the criteria in section 432E-1.4, Hawaii Revised Statutes, unless an agreement of financial responsibility specific to the service is signed by the Member or a person acting on behalf of the Member and is obtained prior to the time services are rendered.

   c. This Agreement does not prohibit Provider, except for a health care professional who is employed full-time on the staff of Payor or CARECENTRIX and has agreed to provide services exclusively to Payor or CARECENTRIX's Members and no others, and a Member from agreeing to continue services solely at the expense of the Member; provided that Provider has clearly informed the Member that Payor may not cover or continue to cover a specific service or services.

   d. Except as provided herein, this Agreement does not prohibit Provider from pursuing any available legal remedy. Haw. Rev. Stat. § 431: 26-104(b).

6. In the event of Payor or CARECENTRIX's insolvency or other cessation of operations, Provider's obligation to deliver Covered Services to the Member without balance billing shall continue until the earlier of:

   a. The termination of the Member's coverage, including any extension of coverage provided under the contract or applicable state or federal law for Members who are in an active course of treatment or totally disabled; or

   b. The date this Agreement, including any required extension for a Member in an active course of treatment, would have terminated if Payor or CARECENTRIX had remained in operation. Haw. Rev. Stat. § 431: 26-104(c)

7. The provisions in sections (5) and (6) of this Addendum: (i) shall be construed in favor of the Member, (ii) shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of the Payor or CARECENTRIX, and (iii) shall supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with the hold harmless and continuation-of-covered services required by Sections (5) and (6) of this Addendum. Haw. Rev. Stat. § 431: 26-104(d).

8. In no event shall Provider collect or attempt to collect from a Member any money owed to Provider by the Payor or CARECENTRIX. Haw. Rev. Stat. § 431: 26-104(e)

9. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members and comply with the applicable state and federal laws related to the confidentiality of medical and health records and the Member's right to see, obtain copies of, or amend the Member's medical and health records. Haw. Rev. Stat. § 431: 26-104(k)

10. To the extent required by HRS § 431:26-104 (l), the following provisions shall apply to the departure of Provider from the CARECENTRIX provider network:

a. CARECENTRIX and Provider shall provide at least sixty (60) days written notice to each other before Provider is removed or leaves the CARECENTRIX provider network without cause;

b. CARECENTRIX shall make a good faith effort to provide written notice of Provider's removal or leaving the network within thirty (30) days or receipt or issuance of a notice provided in accordance with subsection (a) to Members who are patients seen on a regular basis by Provider who is leaving the CARECENTRIX provider network, irrespective of whether the removal or leaving the CARECENTRIX provider network is for cause or without cause;

c. When Provider leaves or is removed from the CARECENTRIX provider network, CARECENTRIX shall establish reasonable procedures to transition all Members who are in an active course of treatment to another network provider in a manner that provides for continuity of care;

d. CARECENTRIX shall provide the notice required by subsection (b) and shall make available to Members a list of available network providers in the same geographic area who are of the same provider type and information about how Members may request continuity of care as provided in subsection (e);

e. The continuity of care procedures are subject to the following provisions:
   1. Any request for continuity of care shall be made to CARECENTRIX by the Member or the Member's authorized representative;
   2. Requests for continuity of care shall be reviewed by CARECENTRIX's medical director after consultation with Provider for Members who are under the care of Provider who has not been removed or left the network for cause and who are undergoing an active course of treatment, have a life-threatening health condition; or have a serious acute condition as defined in HRS § 431:26-101
   3. Any decisions made with respect to a Member's request for continuity of care shall be subject to the CARECENTRIX internal and external grievance and appeal processes in accordance with applicable state or federal law or regulations;
   4. The continuity of care period for Members who are in their second or third trimester of pregnancy shall extend through the postpartum period; and
   5. The continuity of care period for Members who are undergoing an active course of treatment shall extend through the earliest of: (i) The termination of the course of treatment by the Member or Provider; (ii) ninety (90) days, unless the CareCentrix Medical Director determines that a longer period is necessary; (iii) the date that care is successfully transitioned to a network provider; (iv) the date that benefit limitations under the plan are met or exceeded; or (v) the date that care is not medically necessary; and

f. A continuity of care request shall only be granted when:
   1. Provider agrees in writing to accept the same payment from and abide by the same terms and conditions with respect to CARECENTRIX for that Member as provided in the Agreement; and
   2. Provider agrees in writing not to seek any payment from the Member for any amount for which the Member would not have been responsible if Provider were still in CARECENTRIX provider network.

11. To the extent required by Haw. Rev. Stat. § 431: 26-104(m), the rights and responsibilities under this Agreement shall not be assigned or delegated by either party without the prior written consent of the other party. Haw. Rev. Stat. § 431: 26-104(m)

12. To the extent required by Haw. Rev. Stat. § 431: 26-104(s)(2) and (3) Provider shall be given timely notification if:

    a. A material change is made to this Agreement;

b. A change is made to provisions or documents that would result in a material change to this Agreement; or

c. A change in Provider's network participation status

For purposes of this section, the term "material change" shall mean any major change to the Agreement including but not limited to substantial changes in the rights and obligations of Provider or substantial changes to Provider's fee schedule. The term "timely notification" shall mean sixty (60) days' notice. Haw. Rev. Stat. § 431: 26-104(s)(4).

ADDENDUM FOR THE STATE OF IDAHO

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Idaho regarding provider contracts with providers rendering health care services in the State of Idaho. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health insurer, managed care organization, insurer offering a managed care plan, or organization entering into a preferred provider arrangement, as those terms are defined in applicable Idaho law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. CARECENTRIX or Payor shall not offer, and the Agreement shall not contain, any incentive plan that includes a specific payment made, in any type or form, to Provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate Covered Services provided with respect to a specific Member or group of Members with similar medical conditions. Nothing in this section shall be construed to prohibit incentive plans that involve general payments such as capitation payments or shared risk agreements that are not tied to specific medical decisions involving specific Members or groups of Members with similar medical conditions. Idaho Code §§ 41-3928; 41-1846(1)(f).

2. CARECENTRIX or Payor shall not refuse to contract with or compensate Provider for Covered Services solely because Provider has in good faith communicated with one or more current, former, or prospective patients regarding the provisions, terms, or requirements of Payor's plans as they relate to the needs of Provider's patients. Idaho Code § 41-3927(5).

3. Provider shall be permitted, when practicing in conformity with community standards, to advocate for Provider's patient without being subject to termination or penalty for the sole reason of such advocacy. Idaho Code § 41-3927(8).

4. In no event, including but not limited to nonpayment by Payor or CARECENTRIX, shall Provider require a Member to guarantee payment or make additional payments for Covered Services rendered under the Agreement, other than specified deductibles, copayments, or coinsurance. Balance billing by Provider, as defined in regulations of the Idaho Department of Insurance, is prohibited by the Agreement. Idaho Code §§ 41-3915(4), (5); 41-1846(2); Idaho Admin. Code r. 18.01.26.015.02; 015.03; 004.02.

5. In the event that CARECENTRIX proposes to terminate or not renew the Agreement because of a breach of the Agreement, CARECENTRIX shall provide written notice of the breach to Provider, and Provider shall have a reasonable period of time to cure the breach prior to termination or nonrenewal of the Agreement. If the breach has not been cured within such period of time, the Agreement may be terminated or not renewed by CARECENTRIX; provided, however, that if the breach of the Agreement for which CARECENTRIX is terminating or not renewing the Agreement is a willful breach, fraud, or a breach which poses an immediate danger to the public health or safety, the Agreement may be terminated or not renewed by CARECENTRIX immediately. Idaho Code § 41-3927(2).

6. Reasonable due process provisions for the resolution of Provider grievances and the protection of the rights of the parties are set forth in the dispute resolution provisions of the Agreement and the Provider Manual. Idaho Code § 41-3927(3).

7. On request and within a reasonable time, CARECENTRIX shall make available to Provider any documents referred to or adopted by reference in the Agreement except for information which is proprietary or a trade secret or confidential personnel records. Idaho Code § 41-3927(7).

8. To the extent required by Idaho Code § 41-3927(6) and applicable to Provider, in the event that the Agreement contains an indemnification and hold harmless provision for CARECENTRIX but does not contain such a provision for Provider under comparable circumstances, the following provision shall be added to the indemnification section of the Agreement:

   CARECENTRIX shall defend, indemnify, and hold harmless Provider, including Provider's officers, directors, employees, agents, and stockholders, ("Provider Indemnified Parties") from and against any and all claims, liabilities, losses, damages, costs, or expenses of any kind (including reasonable attorneys' fees) ("Indemnified Amounts") incurred by the Provider Indemnified Parties as a result of CARECENTRIX's acts or omissions, but only to the extent that such Indemnified Amounts are caused by the negligence or other wrongful act or omission of CARECENTRIX.

9. In accordance with the applicable requirements of Idaho Code § 41-3927(4), nothing in the Agreement shall be construed to require Provider to agree to any of the following:

   a. To deny a Member access to services not covered by Payor's plan if the Member is informed that he or she will be responsible to pay for the noncovered services and the Member nonetheless desires to obtain such services;

   b. To refrain from treating a Member even at that Member's request and expense if Provider had been, but is no longer, a participating provider in the CARECENTRIX provider network under the Member's plan, and Provider has notified the Member that Provider is no longer a participating provider in such network under the Member's plan;

   c. To the unnegotiated adjustment of Provider's contractual reimbursement rate under the Agreement to equal the lowest reimbursement rate that Provider has agreed to charge any other payor;

   d. To a requirement that Provider adjust, or enter into negotiations to adjust, Provider's charges under the Agreement if Provider agrees to charge another payor lower rates; or

   e. To a requirement that Provider disclose Provider's contractual reimbursement rates from other payors.

10. CARECENTRIX does not come within the definition of an "insurer" in Idaho Code § 41-5601, and is not subject to the requirements of Idaho Code § 41-1847 regarding an insurer's assignment of the benefits of a health insurance contract with a practitioner or facility. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms, limitations, and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

ADDENDUM FOR THE STATE OF ILLINOIS

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Illinois regarding provider contracts with providers rendering health care services in the State of Illinois. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an accident and health insurer, managed care entity, health maintenance organization, or organization offering a health care plan or preferred provider arrangement plan, as those terms are defined in applicable Illinois law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

I. To the extent that CARECENTRIX is a "health care preferred provider program administrator" as defined in 50 Ill. Admin. Code § 2051.220, the following provisions shall be added to the Agreement in accordance with applicable law and regulation:

1. The specific Covered Services for which Provider shall be responsible under the Agreement, including any discount services, discount amount, or discounted fee schedule reflecting discounted rates, are identified in "Schedule A" to the Agreement and the applicable health care services reimbursement schedule. Information regarding any applicable copayments, benefit maximums, limitations, and exclusions under a Member's plan can be obtained by contacting the applicable Payor or Payor designee at the toll-free telephone number identified by CARECENTRIX or listed in the Provider Manual. 50 Ill. Admin. Code § 2051.290(a).

2. Provider shall comply with applicable administrative policies and procedures of CARECENTRIX, including but not limited to credentialing or recredentialing requirements, utilization review requirements, and referral procedures, as set forth in the Agreement, including the addendums, exhibits, and attachments to the Agreement, the Provider Manual, the CARECENTRIX provider portal website, and written communications from CARECENTRIX to Provider from time to time. 50 Ill. Admin. Code § 2051.290(b).

3. In accordance with 50 Ill. Admin. Code § 2051.290(c), when payments are due to Provider for services rendered to a Member, Provider shall maintain and make medical records available:

   a. To CARECENTRIX and/or Payor for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to Members;

   b. To appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating Member grievances or complaints; and

   c. To show compliance with the applicable State and federal laws related to privacy and confidentiality of medical records.

4. Provider shall be licensed as required by the State of Illinois to provide the Covered Services for which Provider is responsible under the Agreement, and shall notify CARECENTRIX immediately whenever there is a change in licensure or certification status. 50 Ill. Admin. Code § 2051.290(d).

5. Notification procedures for termination of the Agreement are set forth in the termination provisions of the Agreement. In accordance with 50 Ill. Admin. Code § 2051.290(f), such procedures shall require, but are not limited to, the following:

a. Either Provider or CARECENTRIX may terminate the Agreement without cause by giving not less than thirty (30) days' prior written notice to the other party. Notwithstanding the foregoing, if the Agreement provides for a longer notice period with respect to a party's termination of the Agreement without cause, such longer notice period shall apply; and

b. CARECENTRIX may immediately terminate the Agreement for cause.

6. In the event of termination of the Agreement, Provider shall be responsible for continuation of Covered Services to Members as set forth in the Agreement and the Provider Manual, to the extent that such continuation of Covered Services to Members: (i) is required by law or regulation, or (ii) is voluntarily included in the Agreement by CARECENTRIX. 50 Ill. Admin. Code § 2051.290(g).

7. The rights and responsibilities under the Agreement may not be sold, leased, assigned, assumed, or otherwise delegated by either party without the prior written consent of the other party. Provider's written consent must be obtained for any assignment or assumption of the Agreement if CARECENTRIX is bought by another preferred provider program administrator or an insurer. A clause within the Agreement allowing assignment will be deemed consent so long as the assignment is in accordance with the terms of the Agreement. The assignee must comply with all the terms and conditions of the Agreement, including all checklists, policies, and fee schedules. By executing the Agreement, Provider understands and agrees that Provider is consenting to the assignment by CARECENTRIX of its rights and responsibilities under the Agreement in accordance with the terms of the Agreement, and to the assignment or assumption of the Agreement if CARECENTRIX is bought by another preferred provider program administrator or an insurer. Any such assignee must comply with all the terms and conditions of the Agreement, including all appendices, policies, and fee schedules. 50 Ill. Admin. Code § 2051.290(h).

8. Provider shall have and maintain adequate professional liability and malpractice insurance coverage in amounts satisfactory to CARECENTRIX, as further specified in the Agreement. Provider shall notify CARECENTRIX in writing within no less than ten (10) days after Provider's receipt of notice of any reduction or cancellation of the required coverage. 50 Ill. Admin. Code § 2051.290(i). Notwithstanding the foregoing, if the Agreement requires Provider to notify CARECENTRIX of a reduction or cancellation of such required coverage within a shorter period of time, such shorter notification period shall apply.

9. Provider shall provide Covered Services without discrimination against any Member on the basis of participation in the preferred provider program, source of payment, age, sex, ethnicity, religion, sexual preference, health status, or disability. 50 Ill. Admin. Code § 2051.290(j).

10. Except to the extent otherwise specified in the Agreement or the Provider Manual, Provider shall not be responsible for collecting applicable copayments, coinsurance, and/or deductibles from Members as provided by the Member's plan. To the extent specified in the Agreement or the Provider Manual, CARECENTRIX shall be responsible for collecting applicable Member copayments, coinsurance, and deductibles as provided by the Member's plan. This provision shall include any amount of applicable discounts or, alternatively, a fee schedule that reflects any discounted rates. With respect to services for which payment is denied because the services are not medically necessary or are not otherwise covered under the Member's plan, Provider shall not charge the Member for such services unless, in advance of the provision of such services, the Member agrees in writing to accept the financial responsibility for such services. 50 Ill. Admin. Code § 2051.290(k).

11. To the extent required by the Agreement or the Provider Manual, Provider shall maintain twenty-four (24) hour on-call coverage, seven (7) days per week, and respond to patient and/or CARECENTRIX contacts within thirty (30) minutes of the call, including weekends, evenings, and holidays, unless otherwise specified by the Agreement. 50 Ill. Admin. Code § 2051.290(*l*).

12. The obligations of CARECENTRIX and Payor, respectively, regarding payment to Provider for Covered Services rendered to Members in accordance with the Agreement, shall be as set forth in the compensation and payment provisions of the Agreement, including but not limited to "Schedule A" to the Agreement and the applicable health care services reimbursement schedule, and the Provider Manual. 50 Ill. Admin. Code § 2051.290(m).

13. Any administrative services to be performed by CARECENTRIX under the Agreement, as well as the types of information that will be submitted to or accessible by Provider, shall be as set forth in the Agreement, the Provider Manual, or the CARECENTRIX provider portal website. 50 Ill. Admin. Code § 2051.290(n).

14. CARECENTRIX will provide a method for Provider to access each Payor to obtain benefit information and adequate notice of change in benefits and copayments, to the extent applicable. Such information can be obtained by contacting the applicable Payor or Payor designee identified by CARECENTRIX, at the Payor's or Payor designee's toll-free telephone number indicated by CARECENTRIX or listed in the Provider Manual. CARECENTRIX will provide or make available all of its operational policies that apply to Provider under the Agreement, which policies may be set forth in the Agreement, the Provider Manual, the CARECENTRIX provider portal website, and/or written communications to Provider from time to time. 50 Ill. Admin. Code § 2051.290(o).

15. The applicable internal appeal or arbitration procedures for settling contractual disputes or disagreements between CARECENTRIX and Provider arising out of the Agreement, shall be as set forth in the Agreement and the Provider Manual. 50 Ill. Admin. Code § 2051.290(p).

16. The Agreement may be sold, leased, assigned, assumed, or otherwise delegated by CARECENTRIX to a Payor or another preferred provider program administrator as set forth in this section. To the extent that the terms of such transaction affect the provision of Covered Services by Provider, including any additional discount, repricing, or other consideration, such terms shall be clearly described in the Agreement. The Payor or the other preferred provider program administrator accessing the Agreement shall be contractually obligated to comply with all applicable terms, limitations, and conditions of the Agreement, including all appendices, policies, and fee schedules. CARECENTRIX shall provide to Provider upon request a written or electronic list of all current Payors to which the Agreement has been sold, leased, assigned, assumed, or otherwise delegated. By executing the Agreement, Provider understands and agrees that Provider is consenting to the assignment of the Agreement by CARECENTRIX in accordance with the terms of the Agreement. Any such assignee must comply with all the terms and conditions of the Agreement, including all checklists, policies, and fee schedules. 50 Ill. Admin. Code § 2051.300(b), (d).

II. To the extent that Covered Services are provided to Members enrolled in a health maintenance organization ("HMO") plan as defined in 215 Ill. Comp. Stat. [ILCS] § 125/1-2, the following provisions shall be added to the Agreement to the extent required by applicable law or regulation:

1. Provider shall participate in the quality assurance programs of CARECENTRIX and Payor as mandated by the Illinois Health Maintenance Organization Act, unless the Illinois Department of Public Health determines otherwise. 215 ILCS 125/2-8(b); 50 Ill. Admin. Code § 4521.50(a)(4).

2. If Provider proposes to terminate the Agreement, Provider shall give CARECENTRIX: (i) at least sixty (60) days' advance written notice before terminating the Agreement with cause, as defined in the Agreement, and (ii) at least ninety (90) days' advance written notice before terminating the Agreement without cause. 50 Ill. Admin. Code § 4521.50(a)(5). Notwithstanding the foregoing, if the Agreement provides for a longer notice period with respect to Provider's termination of the Agreement with or without cause, respectively, such longer applicable notice period shall apply.

3. Provider shall maintain, and shall provide CARECENTRIX with evidence of, adequate professional liability insurance, effective as of the effective date of the Agreement. Provider shall give CARECENTRIX at least fifteen (15) days' advance written notice of cancellation of such insurance coverage. 50 Ill. Admin. Code § 4521.50(a)(7). Notwithstanding the foregoing, if the Agreement provides for a longer notice period in the event of cancellation of such insurance coverage, such longer notice period shall apply.

4. To the extent required by 50 Ill. Admin. Code § 4521.50(e) and applicable to Provider, the following hold-harmless clause shall be added to the Agreement:

   "Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX of amounts due Provider under this Agreement, insolvency of Payor or CARECENTRIX, or any breach of this Agreement by Payor or CARECENTRIX, shall Provider or its assignees or subcontractors have a right to or seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against the Member, persons acting on the Member's behalf (other than Payor), or the employer or group contract holder, for Covered Services provided pursuant to this Agreement, except for the payment of applicable copayments or deductibles for services covered by the Member's plan or fees for services not covered by the Member's plan. The requirements of this clause shall survive any termination of this Agreement for Covered Services rendered prior to such termination, regardless of the cause of such termination. Members, persons acting on the Member's behalf (other than Payor), and the employer or group contract holder shall be third party beneficiaries of this clause. This clause shall supersede any oral or written agreement now existing or hereafter entered into between Provider and the Member, persons acting on the Member's behalf (other than Payor), and the employer or group contract holder."

III. The following provisions shall be added to the Agreement in accordance with the applicable requirements of 215 ILCS 134, the Illinois Managed Care Reform and Patient Rights Act, and 215 ILCS 124/15, the Illinois Network Adequacy and Transparency Act:

1. To the extent required by 215 ILCS 134/15(c), Provider shall provide the following, if applicable, to a Member upon request:

   a. Information related to Provider's educational background, experience, training, specialty, and board certification, if applicable.

   b. The names of licensed facilities, if any, in the CARECENTRIX provider network where Provider presently has privileges for the treatment, illness, or procedure that is the subject of the request.

   c. Information regarding Provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

2. To the extent required by 215 ILCS 134/20 and 215 ILCS 124/15, CARECENTRIX shall give Provider at least sixty (60) days' advance written notice of termination or nonrenewal of the Agreement. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination or nonrenewal of the Agreement by CARECENTRIX, such longer notification period shall apply. The notice shall include a name and address to which Provider may direct comments and concerns regarding the nonrenewal or termination, and the telephone number maintained by the Illinois Department of Insurance for consumer complaints. CARECENTRIX may provide immediate written notice to Provider, without giving sixty (60) days' advance written notice, when Provider's license has been disciplined by a State licensing board, or when CARECENTRIX reasonably believes direct imminent physical harm to Member(s) under the providers care may occur. In addition, pursuant to the applicable requirements of 50 Ill. Admin. Code § 2051.290(f), CARECENTRIX may terminate the Agreement immediately for cause.

3. Neither Payor nor CARECENTRIX shall retaliate against Provider for advocating for medically appropriate health care services for Members. For purposes of this section, "to advocate for medically appropriate health care services" means: (a) to appeal a decision to deny payment for a health care service pursuant to the reasonable grievance or appeal procedure established by Payor or, if applicable, CARECENTRIX, or (b) to protest a decision, policy, or practice that Provider, consistent with that degree of learning and skill ordinarily possessed by other health care providers practicing in the same or a similar locality and under similar circumstances, reasonably believes impairs Provider's ability to provide appropriate health care services to Provider's patients. This section shall not be construed to prohibit Payor or, if applicable, CARECENTRIX from: (i) making a determination not to pay for a particular health care service, or (ii) enforcing reasonable peer review or utilization review protocols or determining whether Provider has complied with those protocols. 215 ILCS 134/35.

4. In the event of termination of the Agreement, the following provisions regarding continuation of Covered Services to Members apply pursuant to 215 ILCS 124/5:

   a. If Provider leaves the CARECENTRIX provider network for reasons other than termination of the Agreement in situations involving imminent harm to Member(s) or a final disciplinary action by a State licensing board and Provider remains within the service area, CARECENTRIX shall permit Members to continue an ongoing course of treatment with the Provider during a transitional period for the following duration: (a) Ninety (90) days from the date of the notice to the Member of Provider's disaffiliation from CARECENTRIX if the Member has an ongoing course of treatment; or (b) If the Member has entered the third trimester of pregnancy at the time of Provider's disaffiliation, a period that includes the provision of post-partum care directly related to the delivery. 215 ILCS 124/20(a)

   b. Notwithstanding the provisions of paragraph (a) of this section , such care shall be authorized by CARECENTRIX during the transitional period in accordance with the following: (a) Provider receives continued reimbursement from CARECENTRIX at the rates and terms and conditions applicable under the terminated Agreement prior to the start of the transitional period; (b) Provider adheres to CARECENTRIX and/or Payor's quality assurance requirements, including provision of necessary medical information related to such care to CARECENTRIX and/or Payor; and (c) Provider otherwise adheres to CARECENTRIX and/or Payor's policies and procedures, including, but not limited to, procedures regarding referrals and obtaining preauthorizations for treatment. 215 ILCS 124/20(b)

   c. The provisions of this section governing health care provided during the transition period do not apply if the Member has successfully transitioned to another participating provider in the CARECENTRIX provider network, if the Member has already met or exceeded the benefit limitations of the plan, or if the care provided is not medically necessary. 215 ILCS 124/20(c)

ADDENDUM FOR THE STATE OF INDIANA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Indiana regarding provider contracts with providers rendering health care services in the State of Indiana. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer or a health maintenance organization as defined in applicable Indiana law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to prohibit Provider from disclosing (a) financial or other incentives to limit medical services by Provider, or (b) all treatment options available to a Member, including those not covered by the Member's plan. Payor or CARECENTRIX shall not penalize Provider financially, or in any other manner, for making a disclosure permitted under this section. Ind. Code § 27-8-11-4.5(a)-(b); § 27-13-15-1(a)(1)-(3).

2. In the event that Payor or CARECENTRIX fails to pay for Covered Services for any reason, a Member who is enrolled in a health maintenance organization (HMO) plan shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Ind. Code § 27-13-15-1(a)(4). Provider, or any trustee, agent, representative, or assignee of Provider, shall not bring or maintain a legal action against a Member enrolled in an HMO plan to collect sums owed to Provider by Payor or CARECENTRIX. Ind. Code § 27-13-15-3. The provisions of this section are in addition to the protections for all Members set forth in the Agreement.

3. To the extent that Provider renders Covered Services to Members of a health maintenance organization (HMO) plan, Provider shall give CARECENTRIX at least sixty (60) days' advance written notice before terminating the Agreement, unless Provider renders thirty percent (30%) or more of the services required by Members in the HMO plan, in which case Provider must give CARECENTRIX at least one hundred twenty (120) days' advance written notice of termination of the Agreement. Ind. Code § 27-13-17-1. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will control.

4. In the event that the Agreement is terminated by Provider, or is terminated by CARECENTRIX other than due to a quality of care issue, Provider shall, upon request, continue to provide Covered Services to a Member who is enrolled in a health maintenance organization (HMO) plan for up to sixty (60) days following termination of the Agreement or, in the case of a pregnant HMO Member in the third trimester of pregnancy, throughout the term of the Member's pregnancy. During such continuation period, Provider (i) shall continue to accept the terms and conditions of the Agreement, together with applicable deductibles and copayments, as payment in full; and (ii) is prohibited from billing the HMO Member for any amounts in excess of the Member's applicable deductible or copayment. Ind. Code § 27-13-36-6.

5. The Agreement shall not contain a "most favored nation" provision that: (a) prohibits, or grants Payor or CARECENTRIX an option to prohibit, Provider from contracting with another payor to accept lower payment for health care services than the payment specified in the Agreement; (b) requires, or grants Payor or CARECENTRIX an option to require, Provider to accept a lower payment from Payor or CARECENTRIX if Provider agrees with another payor to accept lower payment for health care services;

(a) requires, or grants Payor or CARECENTRIX an option of, termination or renegotiation of the Agreement if Provider agrees with another payor to accept lower payment for health care services; or (b) requires Provider to disclose Provider's reimbursement rates under contracts with other payors. Any such provision shall be void and deleted in its entirety. Ind. Code § 27-13-15-4; § 27-8-11-9.

6. a. Payor or CARECENTRIX shall not, more than two (2) years after the date on which an overpayment on a claim was made to Provider by Payor: (a) request that Provider repay the overpayment, or (b) adjust a subsequent claim filed by Provider as a method of obtaining reimbursement of the overpayment from Provider.

   b. Payor or CARECENTRIX shall not be required to correct a payment error to Provider more than two (2) years after the date on which a payment on a claim was made to Provider by Payor.

   c. This section shall not apply in cases of fraud by Provider, the Member, or Payor with respect to the claim on which the overpayment or underpayment was made. Ind. Code §§ 27-13-36.2-8; 27-8-5.7-10.

7. CARECENTRIX may lease, rent, or otherwise grant access to Provider's health care services under the Agreement to Payors and other third parties specified in Ind. Code § 27-1-37.3-7(2). Any such Payor or third party that is granted access to Provider's health care services under the Agreement shall be obligated to comply with all the applicable terms of the Agreement. CARECENTRIX shall maintain an Internet web page or a toll-free telephone number through which Provider may obtain a listing, updated at least semiannually, of the third parties to which access to Provider's health care services under the Agreement has been granted. Ind. Code § 27-1-37.3-8(a).

8. Nothing in the Agreement shall be construed to prohibit Provider from disclosing health care service claims data to the Member's employer providing the Member's coverage. However, any disclosure of claims data by Provider must comply with health privacy laws, including the federal Health Insurance Portability and Accountability Act (HIPAA) (P.L. 104-191). Ind. Code §27-1-37-7.

ADDENDUM FOR THE STATE OF IOWA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Iowa regarding provider contracts with providers rendering health care services in the State of Iowa. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a carrier, health maintenance organization, or health care insurer, as those terms are defined in applicable Iowa law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed as prohibiting Provider from, or penalizing Provider for: (i) discussing treatment options with a Member, irrespective of Payor's or CARECENTRIX's position on such treatment options; (ii) advocating on behalf of a Member within the utilization review or grievance processes established by Payor or CARECENTRIX; or (iii) reporting, in good faith, to State or federal authorities any act or practice by Payor or CARECENTRIX that, in the opinion of Provider, jeopardizes patient health or welfare. Iowa Code § 514C.15; Iowa Admin. Code r. 191-35.32, 191-40.22, 191-27.8.

2. Upon termination of the Agreement by CARECENTRIX, unless the termination is for cause, Provider shall continue to provide Covered Services to a Member in the second or third trimester of pregnancy throughout the term of the Member's pregnancy including postpartum care related to the childbirth and delivery. During such continuation period, payment for Covered Services rendered to such Member shall be in accordance with the terms, conditions, and rates of reimbursement under the Agreement. Iowa Code § 514C.14.

3. To the extent applicable to Provider, upon termination of the Agreement by CARECENTRIX, unless the termination is for cause, Provider shall continue to provide Covered Services to a Member who is undergoing a specified course of treatment for a terminal illness or a related condition, for a period of up to ninety (90) days from the date of termination. During such continuation period, payment for Covered Services rendered to such Member shall be in accordance with the terms, conditions, and rates of reimbursement under the Agreement. Iowa Code § 514C.17.

4. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization plan, the following provision shall be added to the Agreement in accordance with the requirements of Iowa Admin. Code r. 191-40.18:

   "Provider, or its assignee or subcontractor, hereby agrees that in no event, including, but not limited to nonpayment by the health maintenance organization ('HMO') or CARECENTRIX, insolvency of the HMO or CARECENTRIX, or breach of this Agreement, shall Provider, or its assignee or subcontractor, bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or persons other than the HMO acting on the Member's behalf for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or copayments on the HMO's behalf made in accordance with terms of the applicable coverage agreement between the HMO and the Member.

   "Provider, or its assignee or subcontractor, further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the HMO Member, and that (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf."

ADDENDUM FOR THE STATE OF KANSAS

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Kansas regarding provider contracts with providers rendering health care services in the State of Kansas. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health insurer or a health maintenance organization, as those terms are defined in applicable Kansas law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

    a. If there is valid Medicaid coverage providing benefits for the same loss or condition covered by Payor under the Agreement, the Medicaid coverage shall be the source of last resort of any payment to Provider. Kan. Stat. Ann. [K.S.A.] § 40-3208(b).

    b. Nothing in the Agreement shall require, or be construed to require, Members to guarantee payment to Provider, other than copayments and deductibles, in the event of nonpayment by Payor or CARECENTRIX for Covered Services performed under the Agreement. If Payor or CARECENTRIX fails to pay for Covered Services rendered to a Member as set forth in the Agreement, the Member or covered dependents shall not be liable to Provider for any amounts owed by Payor or CARECENTRIX. Any action by Provider to collect or attempt to collect from a Member any sum owed to Provider by Payor or CARECENTRIX, shall be deemed to be an unconscionable act within the meaning of K.S.A. § 50-627, and amendments thereto. K.S.A. § 40-3209(b).

    c. In the event of the insolvency of Payor, Provider shall continue to provide Covered Services to Members for the duration of the contract period after Payor's insolvency for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of insolvency, until the Member's discharge from the inpatient facility or expiration of benefits. K.S.A. § 40-3227(k).

    d. If Provider's participation under the Agreement is terminated, Provider shall continue to provide Covered Services to Members for a period up to ninety (90) days from the date of termination, in those cases where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence, and where the Member has special circumstances such as a disability, a life-threatening illness, or is in the third trimester of pregnancy. The Member shall not be liable to Provider for any amounts owed for Covered Services, other than for any deductibles or copayment amounts specified in the certificate of coverage or other contract between the Member and Payor. During this continuation period, Payor shall pay Provider for Covered Services rendered to the Member at the previously contracted rate of reimbursement specified in the Agreement. K.S.A. § 40-3230.

2. Nothing in the Agreement shall be construed to prohibit or restrict Provider from discussing with or disclosing to any Member or other individual any medically appropriate health care information that Provider deems appropriate regarding the nature of treatment options, the risks or alternatives thereto, the process used or the decision made to approve or deny health care services, the availability of alternate

therapies, consultations, or tests, or from advocating on behalf of the Member within the utilization review or grievance processes established by Payor or CARECENTRIX. K.S.A. § 40-4604.

3. The Agreement shall not include a compensation arrangement that directly or indirectly serves as an inducement to Provider to reduce or limit the delivery of medically necessary services with respect to a Member in any health benefit plan. Compensation arrangements which involve capitation payments or other risk sharing provisions shall not be considered inducements. K.S.A. § 40-4605.

4. To the extent required by law, in the event that Payor or CARECENTRIX, as applicable, erroneously pays a claim providing payment to which Provider is not entitled, Payor or CARECENTRIX shall not initiate a request for reimbursement or refund of the erroneous payment, or in any other way seek to recoup the erroneous payment, unless such action is initiated within eighteen (18) months after the end of the month in which the erroneous payment was made. In cases of fraud by the Member or Provider, such action may be initiated within the applicable statute of limitations pursuant to K.S.A. 60-513, and amendments thereto. In the case of an audit of the records of a pharmacy by Payor or CARECENTRIX or their representatives, the period covered by the audit shall not exceed two (2) years from the date the claim was submitted or adjudicated or as otherwise provided by State or federal law. K.S.A. § 40-2442(f).

ADDENDUM FOR THE STATE OF KENTUCKY

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Kentucky regarding provider contracts with providers rendering health care services in the State of Kentucky. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean an insurer that issues a managed care plan or a health benefit plan, as those terms are defined in applicable Kentucky law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. In accordance with Kentucky Revised Statutes [KRS] 304.17A-527(1)(a), Provider shall not under any circumstance, including (i) nonpayment of moneys due Provider by Payor or CARECENTRIX, (ii) insolvency of Payor or CARECENTRIX, or (iii) breach of the Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or any persons acting on behalf of a Member, for Covered Services provided in accordance with the Agreement or any amounts that are the legal obligation of Payor or CARECENTRIX under the Agreement. This provision shall not prohibit collection of any applicable deductible amounts, copayment amounts, coinsurance amounts, and amounts for noncovered services. This provision shall survive the termination of the Agreement regardless of the cause giving rise to such termination, is intended to be for the benefit of Members, and supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and a Member, or persons acting on behalf of a Member. Modifications to this section will become effective no earlier than the date permitted by applicable law.

2. a. In accordance with KRS 304.17A-527(1)(b), if the Agreement is terminated for any reason, other than a quality of care issue or fraud, Provider shall continue to provide Covered Services to any Member receiving such services at the time of the termination, and Payor shall continue to reimburse Provider for Covered Services in accordance with the rates and compensation terms under the Agreement, until the Member is discharged from an inpatient facility (if applicable), or the active course of treatment is completed, whichever is greater, and in the case of a pregnant woman, Covered Services shall continue to be provided through the end of the post-partum period if the pregnant woman Member is in her fourth or later month of pregnancy at the time the Agreement is terminated. This provision shall survive the termination of the Agreement.

   b. Pursuant to KRS 304.17A-643, if the Agreement is terminated or not renewed for a reason other than quality, Provider may request, with the concurrence of the Member or authorized person, to continue treatment for the Member in special circumstances. As used in this section, "special circumstances" includes a circumstance in which a Member has a disability, a congenital condition, a life-threatening illness, or is past the 24th week of pregnancy where the disruption of the Member's continuity of care could cause medical harm. With respect to those Members who retain eligibility under a health benefit plan and who are in an active course of treatment for special circumstances, Provider shall continue to provide Covered Services in accordance with the terms of the Agreement: (i) for a period up to nine (9) months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness; (ii) if a Member is beyond the 24th week of pregnancy, for a period that extends through the delivery of the child, immediate post-partum care, and examination within the first six (6) weeks following delivery; or (iii) for a period up to ninety (90) days after the effective date of termination for all other Members in an active course of treatment for special circumstances. Provider shall be compensated for such Covered Services in accordance with the same guidelines, rates, and

payment schedules as under the Agreement, and shall report to CARECENTRIX on the care being provided.

3. In accordance with KRS 304.17A-527(d), CARECENTRIX shall, upon request of Provider, provide or make available to Provider when contracting or renewing the Agreement, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under the Agreement for Covered Services rendered by Provider, prior to the final execution or renewal of the Agreement. Pursuant to KRS 304.17A-577, any change to payment or fee schedules applicable to Provider under the Agreement shall be made available to Provider at least ninety (90) days prior to the effective date of the amendment. The foregoing clause shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

4. In accordance with KRS 304.17A-527(e), if Provider enters into any subcontract agreement with another provider to provide licensed health care services to a Member, and if such subcontracted provider will bill Payor, CARECENTRIX, or the Member directly for such subcontracted services, the subcontract agreement must meet all requirements of KRS 304.17A and shall be filed with the Commissioner of the Department of Insurance as required by KRS 304.17A-527(e). Notwithstanding the foregoing, nothing in this section shall be construed to create a right under the Agreement for Provider to enter into any such subcontract agreement. If and to the extent that subcontracting by Provider is otherwise permitted under the terms of the Agreement, any such subcontracting arrangement shall require the prior written consent of CARECENTRIX.

5. In accordance with KRS 304.17A-728 and 806 Ky. Admin. Regs. [KAR] 17:300, § 3, the health care services to which any contractual discounts apply are listed in Schedule A to the Agreement, Health Care Services Reimbursement Schedule. Such services may include home health care, home infusion therapy, hospice, durable medical equipment, respiratory services, and/or other services as specified and agreed to by Provider and CARECENTRIX in Schedule A to the Agreement. Such services are further described in the Provider Manual.

6. The Agreement shall not contain a most-favored-nation provision as that term is used in KRS 304.17A-560. Nothing in this section shall be construed to prohibit CARECENTRIX and Provider from negotiating payment rates and performance-based contract terms that would result in Payor or CARECENTRIX receiving a rate that is as favorable, or more favorable, than the rates negotiated between Provider and other health insurance issuers.

7. In accordance with KRS 304.17A-530, nothing in the Agreement shall be construed to limit Provider's disclosure to a Member, or to another person acting on behalf of a Member, of any information relating to the Member's medical condition or treatment options. Nothing in the Agreement shall be construed to penalize Provider or allow for termination of the Agreement because Provider discusses medically necessary or appropriate care with a Member or with another person acting on behalf of a Member. Provider shall not be prohibited from discussing all treatment options with a Member. Other information determined by Provider to be in the best interests of a Member may be disclosed by Provider to the Member or to another person acting on behalf of the Member. Nothing in the Agreement shall be construed to penalize Provider for discussing with a Member any applicable financial incentives and financial arrangements between Provider and CARECENTRIX.

8. In accordance with KRS 304.17A-150 and 806 KAR 17:300, § 3, nothing in the Agreement shall be construed to require Provider, as a condition of participation in a health benefit plan of Payor, to participate in any of Payor's other health benefit plans.

9. In accordance with KRS 304.17A-532, nothing in the Agreement shall be construed to require the mandatory use of a hospitalist, if applicable. This section is added to this Addendum for regulatory

purposes only, and shall not be interpreted to mean that Provider is a physician or that hospital services are covered under the Agreement.

10. Pursuant to KRS 304.17A-708, Payor shall not be required to correct a claim payment error to Provider, if Provider's request for a claim payment correction is filed more than twenty-four (24) months after the date that Provider received payment for the claim from Payor. Except in cases of fraud, Payor may only retroactively deny reimbursement to Provider during the twenty-four (24) month period after the date that Payor paid the claim submitted by Provider.

11. In addition to the termination provisions and policies set forth in the Agreement and the Provider Manual, the following provisions are added to the Agreement pursuant to KRS 304.17A-525:

    a. Provider acknowledges that CARECENTRIX has informed Provider of CARECENTRIX's termination, removal, and withdrawal policies from the provider network. CARECENTRIX shall inform Provider of any changes to such policies in accordance with the terms of the Agreement.

    b. If Provider's participation will be terminated or withdrawn prior to the date of the termination of the Agreement as a result of a professional review action, CARECENTRIX and Provider shall comply with the standards in 42 U.S.C. § 11112, if applicable. Notwithstanding the foregoing, nothing in this subsection shall be construed to mean that Provider is a physician or that CARECENTRIX's provider network includes participating physicians.

    c. If CARECENTRIX finds that Provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, CARECENTRIX's medical director shall promptly notify the appropriate professional state licensing board.

12. a. [*Effective until January 1, 2017*] Provider acknowledges that the requirements of KRS 304.17A-578 do not apply to the Agreement because such provisions are applicable only to agreements with a participating provider who is a physician licensed under KRS Chapter 311, an advanced practice registered nurse licensed under KRS Chapter 314, a psychologist licensed under KRS Chapter 319, or an optometrist licensed under KRS Chapter 320. None of the foregoing types of providers has entered into an agreement with CARECENTRIX to provide health care services under the Agreement.

    b. [*Effective January 1, 2017*] To the extent required by KRS 304.17A-235, CARECENTRIX shall give Provider at least ninety (90) days' notice of a material change to the Agreement. As used in this section, the defined term "material change" shall have the same meaning as set forth in KRS 304.17A-235(1). A notice of a material change to the Agreement shall conform to the applicable requirements of KRS 304.17A-235. CARECENTRIX and Provider, respectively, shall comply with the applicable provisions of KRS 304.17A-235 regarding a proposed material change to the Agreement.

        i. In accordance with the applicable requirements of KRS 304.17A-235(6), if CARECENTRIX makes a change to the Agreement that changes an existing prior authorization, precertification, notification, or referral program, or changes an edit program or specific edits, CARECENTRIX shall provide notice of such change to Provider at least fifteen (15) days prior to the change.

ADDENDUM FOR THE STATE OF LOUISIANA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Louisiana regarding provider contracts with providers rendering health care services in the State of Louisiana. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health insurer, health maintenance organization, managed care organization, or preferred provider organization, as those terms are defined in applicable Louisiana law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to interfere with the ability of Provider to communicate with a Member regarding his or her health care, including but not limited to communications regarding treatment options and medical alternatives, or other coverage arrangements. This section does not permit Provider to solicit for alternative coverage arrangements for the primary purpose of securing financial gain. La. Rev. Stat. § 22:1007(B).

2. CARECENTRIX or Payor shall not: (i) refuse to contract, renew, cancel, restrict, or otherwise terminate the Agreement solely on the basis of a medical communication; or (ii) refuse to refer Members to Provider or allow others to refer Members to Provider, refuse to compensate Provider for Covered Services, or take other retaliatory action against Provider solely on the basis of a medical communication. As used in this section, "medical communication" means information regarding the mental or physical health care needs or the treatment of a patient. La. Rev. Stat. § 22:1007(C).

3. No communication by Provider regarding treatment options shall be represented or construed to expand or revise the scope of benefits or Covered Services under a Member's managed care plan or insurance contract. La. Rev. Stat. § 22:1007(D).

4. Nothing in the Agreement or any applicable written policy or procedure shall be construed to prohibit or restrict Provider from filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of Payor or CARECENTRIX which may negatively impact upon the quality of, or access to, patient care. La. Rev. Stat. § 22:1007(E).

5. Nothing in the Agreement or any applicable written policy or procedure shall be construed to prohibit or restrict Provider from advocating to Payor or CARECENTRIX on behalf of the Member for approval or coverage of a particular course of treatment or for the provision of Covered Services. La. Rev. Stat. § 22:1007(F).

6. To the extent required by law, the Agreement shall not contain a clause purporting to transfer to Provider by indemnification or otherwise any liability relating to activities, actions, or omissions of Payor or CARECENTRIX. La. Rev. Stat. § 22:1007(G).

7. Nothing in the Agreement shall be construed to include an incentive or specific payment made directly, in any form, to Provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to a specific Member or groups of Members with similar medical conditions. This section shall not prohibit incentive plans that involve general payments, such as capitation payments, or shared-risk arrangements that are not tied to specific medical decisions involving a

specific Member or groups of Members with similar medical conditions. La. Rev. Stat. §§ 22:1008, 40:2207, 22:263(E)-(F).

8. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, in the event that Payor fails to pay for Covered Services as set forth in the evidence of coverage, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from the Member any sums owed by Payor or CARECENTRIX. Provider or any agent, trustee, or assignee of Provider, shall not maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX. La. Rev. Stat. § 22:263(A)-(C).

9. Pursuant to the requirements of La. Rev. Stat. § 22:1005, upon termination of the Agreement by Provider or CARECENTRIX, the following continuity of care provisions shall apply, to the extent that Provider is a health care practitioner licensed, certified, or registered to perform specified health care services consistent with State law subject to direct supervision by a physician licensed to practice medicine by the Louisiana State Board of Medical Examiners:

    a. In the event that a Member has been diagnosed as being in a high-risk pregnancy or is past the twenty-fourth (24th) week of pregnancy, the Member shall be allowed to continue receiving Covered Services, subject to the consent of the treating Provider, through delivery and postpartum care related to the pregnancy and delivery.

    b. In the event that a Member has been diagnosed with a life-threatening illness, the Member shall be allowed to continue receiving Covered Services, subject to the consent of the treating Provider, until the course of treatment is completed, not to exceed three (3) months from the effective date of such termination.

    c. Provider shall be compensated for rendering Covered Services pursuant to this section according to the reimbursement rates and terms in effect prior to termination of the Agreement. In addition, the contractual requirements for Provider to comply with CARECENTRIX's and Payor's utilization management and quality management policies and procedures shall remain in effect for the applicable period specified in subsections (a) or (b) of this section.

    d. The provisions of this section shall not apply when:

        i. The reason for termination of the Agreement is due to suspension, revocation, or applicable restriction of Provider's license to practice in Louisiana by the Louisiana State Board of Medical Examiners, or for another documented reason related to quality of care;

        ii. The Member chooses to change Provider;

        iii. The Member moves out of the geographic service area of Provider or Payor; or

        iv. The Member requires only routine monitoring for a chronic condition but is not in an acute phase of the condition.

10. Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms, limitations, and conditions of the Agreement. To the extent required by La. Rev. Stat. § 40:2203.1 and applicable to Provider, when Provider's "alternative rates of payment" under the Agreement are accessed by a "group purchaser" through a "preferred provider organization" (PPO) (as those terms are defined in La. Rev. Stat. § 40:2202), the group purchaser shall comply with one of the following: (i) the PPO will be identified on the Member benefit card issued by the group purchaser or other entity accessing the Agreement; or (ii) when more than one PPO's name or logo is shown on the Member benefit card, the applicable contractual agreement that shall be binding on Provider shall be determined as specified in such law; or (iii) when no PPO is listed on the Member benefit card, the plan sponsor or insurer identified by the card shall be deemed to be the group purchaser for purposes of

such law; or (iv) if the group purchaser or other entity does not issue or utilize a Member benefit card, Provider will be notified in writing at least thirty (30) days prior to an entity's accessing services through the PPO under the Agreement. To the extent required by such law, CARECENTRIX will post on the CARECENTRIX provider portal website, a list of entities accessing services under the Agreement, and will update such list at least thirty (30) days before an entity accesses services under the Agreement. Provider may also obtain a copy of such list, updated as required by law, by contacting CARECENTRIX at the toll-free telephone numbers specified in the Provider Manual.

11. To the extent required by law: (i) CARECENTRIX and Provider will participate in a resource monitoring component to ensure quality control both for Members' patient care and for cost effectiveness; and (ii) procedures to encourage prompt payment of claims for Covered Services rendered by Provider shall be included in the Agreement and the Provider Manual. La. Rev. Stat. § 40:2202(5)(e).

ADDENDUM FOR THE STATE OF MAINE

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Maine regarding provider contracts with providers rendering health care services in the State of Maine. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that the Agreement provides for amendments upon notification by CARECENTRIX, CARECENTRIX will give Provider 60 days advance notice of the amendment. If an amendment that substantially impacts the rights and obligations of Provider is made to a manual, policy or procedure document referenced in the Agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, CARECENTRIX shall give 60 days' notice to Provider. After the 60 day notice period has expired, the amendment shall be binding on both CARECENTRIX and Provider subject to any Provider rights to object and/or terminate as specified in the Agreement. Provider and CARECENTRIX may mutually agree to waive the 60 day notice requirement. 24-A M.R.S. § 4303(9).

2. Notwithstanding anything to the contrary set forth in the Agreement, each party must provide the other with at least 60 days' advance written notice of termination of the Agreement. To the extent that the Agreement provides for a longer termination notice period, such notice period shall apply. Any such termination shall be conducted in accordance with the processes mandated by applicable law. If Provider wishes to appeal such termination, the appeal will be conducted in accordance with the process set forth in the Provider Manual, subject to applicable law. 24-A M.R.S. § 4204(8).

3. If CARECENTRIX should choose to terminate or not renew the Agreement, CARECENTRIX will notify Provider of this decision in writing. The notice will include the reason(s) for the termination or nonrenewal including reference to the evidence or documentation leading to the decision and a notice of Provider's right to request a hearing or review. If Provider wishes to request a hearing with regard to the termination of the Agreement, Provider must notify CARECENTRIX in writing within 30 days of Provider's receipt of the notice of termination. A hearing will be held no earlier than 30 days after receipt of the request for hearing by CARECENTRIX. To the extent required by law, the hearing shall be conducted by a panel of at least 3 people appointed by CARECENTRIX, at least one-third of which shall be clinical peers of Provider. The panel shall render a decision in a timely manner and shall notify Provider of the decision in writing which will include one of the following resolutions: (a) unconditional reinstatement; (b) provisional reinstatement subject to certain conditions as set forth by CARECENTRIX; or (c) termination. Termination will be effective no earlier than 60 days after Provider's receipt of the hearing panel's decision or the termination date in the Agreement, whichever is earlier. If Provider is unsatisfied with the panel's decision, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement. The requirements set forth in this provision do not apply in cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, or a final disciplinary action by a state licensing board or other governmental agency that impairs Provider's ability to practice. 24-A M.R.S. § 4303(3-A).

4. Upon termination of the Agreement, except in cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, or a final disciplinary action by a state licensing board

or other governmental agency that impairs Provider's ability to practice, Provider shall continue to provide Covered Services, for those Members who retain eligibility and are in active treatment under Provider's care at the time of such termination, for a transitional period of 60 days from the date of notice to the Member of Provider's termination, or if the Member is in the second or third trimester of pregnancy at the time of the termination of the Agreement, and Provider is treating the Member during the pregnancy, the transitional period shall extend through the provision of postpartum care directly related to the pregnancy. During the transitional period under this provision, Provider shall: (a) continue to accept reimbursement for Covered Services at the rates applicable prior to the start of the transitional period as payment in full and shall not impose cost-sharing with respect to the Member in an amount that would exceed the cost-sharing that would have been imposed had the Agreement not been terminated; (b) adhere to CARECENTRIX's quality assurance requirements and provide the necessary medical information related to such care; and (c) otherwise adhere to CARECENTRIX's policies and procedures, including but not limited to procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by CARECENTRIX. Provider has no obligation under the Agreement to provide services to individuals who cease to be Members. 24-A M.R.S. § 4303(7).

5. A Member's responsibility for the cost of Covered Services is limited to the cost-sharing provisions expressly disclosed in the Member's health benefit plan, such as deductibles, copayments and coinsurance, and, if the Member has paid the Member's share of the charge as specified in the Member's plan, the Member shall be held harmless from any additional amount owed to Provider for Covered Services. If the Payor or CARECENTRIX fails to pay Provider for Covered Services as set forth in the Agreement, the Member is not liable to Provider for any sums owed by the Payor or CARECENTRIX for such Covered Services. Provider may not collect any amount from Member for Covered Services beyond the amount permitted by the terms of the Member's plan, notwithstanding the Payor's or CARECENTRIX's insolvency, the Payor's or CARECENTRIX's failure to pay the amount owed, or any other breach by the Payor or CARECENTRIX of this Agreement. Any modification, addition, or deletion to this provision shall become effective upon the review and approval of the Maine Bureau of Insurance when such approval is required by law. 24-A M.R.S. § 4204(6).

6. If included in the Agreement, any "Most Favored Nation" provision prohibited by 24-A M.R.S. § 4303(17) is hereby deleted in its entirety.

7. Provider may not be terminated or otherwise disciplined because Provider advocates for medically appropriate health care. Provider is not prohibited from disclosing to any Member any information Provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, availability of other therapy, consultations or tests or the decision to authorize or deny health care services or benefits. Nothing in this Agreement shall be construed to incent Provider to limit or deny medically necessary care to Members. 24-A M.R.S. § 4303(3), (3-B).

ADDENDUM FOR THE STATE OF MARYLAND

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Maryland regarding provider contracts with providers rendering health care services in the State of Maryland. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health insurer, nonprofit health service plan, health maintenance organization, or carrier, as those terms are defined in applicable Maryland law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent required by applicable law, (a) Provider shall be permitted to submit a claim for reimbursement of a Covered Service pursuant to the terms of the Agreement within one hundred and eighty (180) days of the date on which such service is rendered; and (b) Provider shall be permitted ninety (90) working days after the date of denial of a claim, to appeal such denial pursuant to the terms of the Agreement. Md. Code Ins. § 15-1005(d).

2. To the extent required by applicable law, within thirty (30) days after Payor's receipt of a claim from Provider for reimbursement under the Agreement, Payor shall (a) mail or otherwise transmit payment for the claim in accordance with Md. Code Ins. § 15-1005, or (b) send a notice of receipt and status of the claim that states: (i) that Payor refuses to reimburse all or part of the claim and the reason for the refusal; (ii) that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or (iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. "Clean claim" means a claim for reimbursement as defined in regulations adopted by the Maryland Commissioner of Insurance under Md. Code Ins. § 15-1003. Md. Code Ins. § 15-1005(c); Code Md. Regs. [COMAR] 31.10.11.02.

3. CARECENTRIX shall provide a Provider Manual to Provider that sets forth the claims filing procedures under the Agreement, including: (a) the address where claims should be sent for processing; (b) the telephone number at which Provider's questions and concerns regarding claims may be addressed; (c) the name, address, and telephone number of CARECENTRIX; and (d) the address and telephone number of any separate claims processing center for specific types of services, if applicable. CARECENTRIX will update the information contained in the Provider Manual from time to time as appropriate and inform Provider of such updates. Md. Code Ins. § 15-1004(d).

4. To the extent required by applicable law, Payor or CARECENTRIX shall not retroactively deny reimbursement to Provider on a claim beyond the six (6) month period after the date that Payor paid Provider for such claim, except as follows: Payor or CARECENTRIX may retroactively deny reimbursement for services that are subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare program, during the eighteen (18) month period after the date that Payor paid such claim. Md. Code Ins. § 15-1008(c)(1). Notwithstanding the foregoing, the requirements of this section shall not apply if Payor or CARECENTRIX retroactively denies reimbursement to Provider because: (a) the information submitted to Payor or CARECENTRIX was fraudulent; (b) the information submitted to Payor or CARECENTRIX was improperly coded, and Payor or CARECENTRIX provided sufficient information to Provider regarding the coding guidelines used by Payor or CARECENTRIX at least thirty (30) days prior to the date that the services subject to the

retroactive denial were rendered; or (c) the claim submitted to Payor or CARECENTRIX was a duplicate claim. Md. Code Ins. § 15-1008(e).

5. To the extent required by applicable law, if Payor or CARECENTRIX has preauthorized or approved a health care service for a Member, Payor or CARECENTRIX shall not deny reimbursement to Provider for such preauthorized or approved service unless: (a) the information submitted to Payor or CARECENTRIX regarding the service to be delivered to the Member was fraudulent or intentionally misrepresentative; (b) critical information requested by Payor or CARECENTRIX regarding the service to be delivered to the Member was omitted, such that Payor's or CARECENTRIX's determination would have been different had it known the critical information; (c) the planned course of treatment for the Member, which was approved by Payor or CARECENTRIX, was not substantially followed by Provider; or (d) on the date that the preauthorized or approved service was delivered, (i) the patient was not a Member covered by Payor's plan, (ii) Payor maintained an automated eligibility verification system that was available to Provider by telephone or via the Internet, and (iii) according to the verification system, the patient was not a Member covered by Payor's plan. Md. Code Ins. § 15-1009(b).

6. To the extent applicable to Provider under Maryland law, (a) CARECENTRIX shall give Provider at least ninety (90) days' prior written notice of termination of the Agreement, unless the termination is for reasons related to fraud, patient abuse, incompetency, or loss of licensure status; and (b) Provider shall give CARECENTRIX at least ninety (90) days' prior written notice of termination of the Agreement; and (c) if Provider elects to terminate the Agreement, Provider shall continue to render Covered Services to a Member for whom Provider was responsible for delivering such services before the notice of termination, for at least ninety (90) days after the date of notice of termination. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement, such longer notification period will apply. Nothing in this section shall be construed to limit or reduce the protections for Members under the continuation of care provisions set forth in the Agreement. Md. Code Ins. § 15-112(b)(1)(ii)(5); § 15-112.2(e).

7. Provider shall not be prohibited from discussing with or communicating to a Member, public official, or other person, information that is necessary for the delivery of health care services, including:
   a. communications that relate to treatment alternatives;
   b. communications that are necessary or appropriate to maintain the provider-patient relationship while the Member is under Provider's care;
   c. communications that relate to a Member's right to appeal a coverage determination with which Provider or the Member does not agree; and
   d. opinions and the basis of an opinion about public policy issues. Md. Code Ins. § 15-116.

8. CARECENTRIX shall not terminate the Agreement with Provider on basis of: (i) gender, race, age, religion, national origin, or a protected category under the federal Americans with Disabilities Act; (ii) the type or number of appeals that Provider files under Md. Code Ins. § 15-10B-01 et seq.; (iii) the number of grievances or complaints that Provider files on behalf of a patient under Md. Code Ins. § 15-10A-01 et seq.; or (iv) the type or number of complaints or grievances that Provider files or requests for review under the internal review system established pursuant to Md. Code Ins. § 15-112(h). Md. Code Ins. § 15-112(e).

9. CARECENTRIX shall not terminate the Agreement or otherwise penalize Provider for: (i) advocating the interests of a patient through the internal review system established pursuant to Md. Code Ins. § 15-112(h); (ii) filing an appeal under Md. Code Ins. § 15-10B-01 et seq.; or (iii) filing a grievance or complaint on behalf of a patient under Md. Code Ins. § 15-10A-01 et seq. Md. Code Ins. § 15-112(g).

10. Nothing in the Agreement shall be construed to require Provider to participate in a health maintenance organization (HMO) provider panel as a condition of participating in a non-HMO provider panel. Md. Code Ins. § 15-112.2(b).

11. To the extent required by law, CARECENTRIX shall make a list of applicable Payors available to Provider via the Provider Manual or other appropriate method. Md. Code Ins. § 15-112(m).

12. To the extent required by law, no term or condition in the Agreement shall: (a) prohibit Provider from offering to provide services to the enrollees of carriers that are not contracted with CARECENTRIX at a lower rate of reimbursement than under the Agreement; (b) require Provider to give CARECENTRIX the same reimbursement arrangement that Provider has with a carrier not contacted with CARECENTRIX, if such arrangement is for a lower rate of reimbursement than under the Agreement; or (c) require Provider to certify that the reimbursement rates under the Agreement are not higher than the reimbursement rates being received by Provider from carriers not contracted with CARECENTRIX. Md. Code Ins. § 15-112(*l*).

13. Nothing in the Agreement shall be construed to require Provider to indemnify or hold Payor harmless from a coverage decision or negligent act of Payor. Md. Code Health-General § 19-710(t); Md. Code Ins. § 15-117.

14. CARECENTRIX shall not assign, transfer, or subcontract the Agreement, in whole or in part, to an insurer that offers personal injury protection coverage under Md. Code Health-General § 19-505 without first informing Provider and obtaining Provider's written consent. CARECENTRIX shall not terminate, limit, or otherwise impair Provider's rights under the Agreement on the basis that Provider refused to agree to an assignment, transfer, or subcontract of all or part of the Agreement to an insurer that offers personal injury protection coverage under Md. Code Health-General § 19-505. Md. Code Ins. § 15-125(b).

15. Provider has the right to elect not to serve on a provider panel for workers' compensation services. CARECENTRIX shall not terminate, limit, or otherwise impair the Agreement based on Provider's election not to serve on a provider panel for workers' compensation services. Md. Code Ins. § 15-125(c).

16. For purposes of the Agreement, "Experimental Medical Care" shall have the meaning set forth in the applicable Payor's plan documents. Md. Code. Ins. § 15-123(d).

17. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan pursuant to Maryland law, the following provisions shall be added to the Agreement:

    a. Provider shall not, under any circumstances, including nonpayment of moneys due to Provider by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from, or have any recourse against the Member or any persons other than Payor acting on behalf of the Member, for Covered Services provided in accordance with the Agreement. This provision shall not prevent collection from Members of copayments or supplemental charges in accordance with the terms of the Member's benefit plan, or charges for services not covered by the Member's benefit plan. This provision shall survive the termination of the Agreement, regardless of the cause of termination. Md. Code Health-General § 19-710(i).

    b. The administration of coordination of benefits under the Agreement shall comply with applicable Maryland law. COMAR 31.12.02.13(C)(4)(b).

    c. The provision of Covered Services under the Agreement shall be governed by applicable Maryland law. COMAR 31.12.02.13(C)(4)(k).

ADDENDUM FOR THE STATE OF MASSACHUSETTS

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Massachusetts regarding provider contracts with providers rendering health care services in the State of Massachusetts. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a carrier, accident or health insurer, nonprofit hospital service corporation, nonprofit medical service corporation, health maintenance organization, or organization entering into a preferred provider arrangement, as those terms are defined in applicable Massachusetts law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Payor and CARECENTRIX shall not refuse to contract with or compensate Provider for Covered Services solely because Provider has in good faith: (a) communicated with or advocated on behalf of one of more of its prospective, current, or former patients regarding the provisions, terms, or requirements of Payor's health benefit plans as they relate to the needs of Provider's patients; or (b) communicated with one or more of its prospective, current, or former patients with respect to the method by which Provider is compensated by Payor or CARECENTRIX for services provided to the patient.
   211 Code Mass. Regs. [CMR] 52.11(1). Nothing in this section shall be construed to permit Provider to disclose specific compensation terms under the Agreement, which terms are hereby required to be held confidential. 211 CMR 52.11(12).

2. Provider is not required to indemnify Payor or CARECENTRIX for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs, and any associated charges, incurred in connection with any claim or action brought against Payor or CARECENTRIX based on Payor's or CARECENTRIX's management decisions, utilization review provisions, or other policies, guidelines, or actions. 211 CMR 52.11(2).

3. The Agreement shall not contain any incentive plan that includes a specific payment made to Provider as an inducement to reduce, delay, or limit specific, medically necessary Covered Services. Provider shall not profit from provision of Covered Services that are not medically necessary or medically appropriate. Payor and CARECENTRIX shall not profit from denial or withholding of Covered Services that are medically necessary or medically appropriate. 211 CMR 52.11(3)(a), (b). Nothing in 211 CMR 52.11(3) shall be construed to prohibit an incentive plan that involves general payments such as capitation payments or shared risk agreements that are made with respect to Provider or which are made with respect to groups of Members if the Agreement, to the extent that it imposes risk on Provider for the costs of care, services, and equipment provided or authorized by another health care provider, complies with 211 CMR 52.11(4). 211 CMR 52.11(3)(c).

4. If the Agreement contains a risk arrangement as described in 211 CMR 52.11(3)(c), CARECENTRIX may not enter into a new contract, revise the risk arrangement in the Agreement, or revise the fee schedule in the Agreement which imposes financial risk on Provider for the costs of care, services, or equipment provided or authorized by another provider, unless the Agreement includes specific provisions with respect to the following: (a) stop loss protection; (b) minimum patient population size for Provider; and (c) identification of the health care services for which Provider is at risk. 211 CMR 52.11(4).

5. Neither Provider nor CARECENTRIX shall have the right to terminate the Agreement without cause. 211 CMR 52.11(6).

6. CARECENTRIX shall provide a written statement to Provider of the reason or reasons for Provider's involuntary disenrollment. 211 CMR 52.11(7).

7. CARECENTRIX shall notify Provider in writing of modifications in payments, modifications in Covered Services, or modifications in procedures, documents, or requirements, including those associated with utilization review, quality management and improvement, credentialing, and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided sixty (60) days before the effective date of such modification unless such other date for notice is mutually agreed upon between Provider and CARECENTRIX. 211 CMR 52.11(8).

8. Provider shall not bill Members for charges for Covered Services other than for deductibles, copayments, or coinsurance. 211 CMR 52.11(9).

9. Provider shall not bill Members for nonpayment by Payor or CARECENTRIX of amounts owed under the Agreement due to the insolvency of Payor or CARECENTRIX. This requirement shall survive the termination of the Agreement for services rendered prior to the termination of the Agreement, regardless of the cause of the termination. 211 CMR 52.11(10).

10. Provider shall comply with Payor's and CARECENTRIX's requirements for utilization review, quality management and improvement, credentialing, and the delivery of preventive health services. 211 CMR 52.11(11).

11. Nothing in 211 CMR 52.11 shall be construed to preclude CARECENTRIX from requiring Provider to hold confidential specific compensation terms under the Agreement, as set forth in the confidentiality provisions of the Agreement. 211 CMR 52.11(12).

12. To the extent applicable to the Agreement, nothing in 211 CMR 52.11 shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers. 211 CMR 52.11(13).

13. If and to the extent that CARECENTRIX contracts with health care professionals to render Covered Services as participating providers under the Agreement, nurse practitioners who satisfy applicable credentialing requirements shall be recognized as participating providers, and the services of such nurse practitioners shall be treated in a nondiscriminatory manner for Covered Services provided for the purposes of health maintenance, diagnosis, and treatment. Subject to the foregoing, to the extent that the following services are otherwise included in the Agreement, such nondiscriminatory treatment shall include, but not be limited to, coverage of applicable plan benefits for primary care, intermediate care, and inpatient care, including care provided in a hospital, clinic, professional office, home care setting, long-term care setting, mental health or substance abuse program, or any other setting when rendered by a licensed nurse practitioner, who is a participating provider and is practicing within the scope of his or her professional license, to the extent that the Agreement currently provides reimbursement for identical Covered Services when rendered by a professional provider of health care licensed by the Commonwealth of Massachusetts. 211 CMR 52.11(15).

14. To the extent that Provider renders Covered Services to Members of a Payor that is a health maintenance organization ("HMO Payor"), the following shall apply: Provider agrees that in no event, including but not limited to nonpayment by HMO Payor or CARECENTRIX of the amounts due Provider under the Agreement, insolvency of HMO Payor or CARECENTRIX, or any breach of the Agreement, shall

Provider or its assignees or subcontractors have a right to seek any type of payment from, bill, charge, collect a deposit from, or have any recourse against, the Member, any persons acting on behalf of the Member, other than HMO Payor, the employer or the group HMO contract holder for Covered Services provided pursuant to the Agreement except for the payment of applicable co-payment, co-insurance, or deductibles for services covered by HMO Payor. The requirements of this provision shall survive any termination of the Agreement for services rendered prior to the termination, regardless of the cause of such termination. Members, any persons acting on their behalf, other than HMO Payor, and the employer or group HMO contract-holder shall be third-party beneficiaries of this provision. This provision supersedes any oral or written agreement hereafter entered into between Provider and the Member, persons acting on the Member's behalf, other than HMO Payor, and the employer or group HMO contract holder. Mass. Gen. Laws [M.G.L.] c. 176G, § 21.

15. To the extent required by applicable law, within forty-five (45) days after receipt by Payor or Payor's designee of a complete claim from Provider, Payor shall (i) make payments for the provision of such Covered Services, (ii) notify Provider in writing of the reason or reasons for nonpayment, or (iii) notify Provider in writing of what additional information or documentation is necessary to complete said claim for reimbursement. If Payor fails to comply with the preceding requirements, Payor shall pay, in addition to any reimbursement for Covered Services provided, interest on such benefits, which shall accrue beginning forty-five (45) days after such receipt of such claim at the rate of one and one-half percent (1.5%) per month, not to exceed eighteen percent (18%) per year. The provisions of this section relating to interest payments shall not apply to a claim that Payor or Payor's designee is investigating because of suspected fraud. M.G.L. c. 176I, § 2; M.G.L. 176G, § 6.

16. If Provider is involuntarily disenrolled, other than disenrollment for quality-related reasons or for fraud, Payor and CARECENTRIX shall allow:
    a. Any female Member who is in her second or third trimester of pregnancy to continue treatment with Provider, consistent with the terms of the Member's health benefit plan, for the period up to and including the Member's first postpartum visit; and
    b. Any Member who is terminally ill to continue treatment with Provider, consistent with the terms of the Member's health benefit plan, until the Member's death.

    During the period of continued treatment by Provider under subsections (a) and (b) of this section, Provider shall: (i) accept reimbursement for Covered Services at the rates applicable under the Agreement prior to the notice of disenrollment as payment in full, and not impose cost sharing with respect to the Member in an amount that would exceed the cost sharing that could have been imposed if Provider had not been disenrolled; (ii) adhere to CARECENTRIX's and Payor's quality assurance standards, and provide CARECENTRIX and Payor with necessary medical information related to the care provided; and (iii) adhere to CARECENTRIX's and Payor's policies and procedures, including procedures regarding referrals, obtaining prior authorization, and providing services pursuant to a treatment plan, if any, approved by CARECENTRIX or Payor. Nothing in this section shall be construed to require the coverage of plan benefits that would not have been covered if Provider had remained a participating provider under the Agreement. M.G.L. c. 176O, § 15(b), (c), (e).

17. To the extent used in the Agreement and required by law, the terms below are defined as follows:

    "Adverse determination" means a determination, based upon a review of information provided, by Payor or its designated utilization review organization, to deny, reduce, modify, or terminate an admission, continued inpatient stay, or the availability of any other health care services, for failure to meet the requirements for coverage based on medical necessity, appropriateness of health care setting and level of care, or effectiveness.

    "Emergency medical condition" means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious

impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in section 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. section 1395dd(e)(1)(B).

"Medical necessity" or "medically necessary" means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:

a. the service is the most appropriate available supply or level of service for the insured in question, considering potential benefits and harms to the individual;
b. is known to be effective, based on scientific evidence, professional standards, and expert opinion, in improving health outcomes; or
c. for services and interventions not in widespread use, is based on scientific evidence.

"Participating provider" means a provider who, under a contract with the carrier or with its contractor or subcontractor, has agreed to provide health care services to insureds with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the carrier.

"Utilization review" or "utilization management" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Such techniques may include, but are not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review. M.G.L. c. 176O, § 1 and 211 CMR 52.03.

18. Provider shall not charge a fee to Members as a condition to be part of Provider's panel of patients. Massachusetts Division of Insurance, Managed Care Check List: Requirements for Provider Contracts.

19. To the extent that Payor contracts with CARECENTRIX to perform some or all of the functions governed by the requirements of M.G.L. c. 176O, Payor shall be responsible for ensuring compliance by CARECENTRIX with the applicable provisions of M.G.L. c. 176O (Health Insurance Consumer Protections). Any failure by CARECENTRIX to meet such requirements shall be the responsibility of Payor to remedy, and shall subject Payor to any and all enforcement actions, including financial penalties authorized under M.G.L. c. 176O. M.G.L. c. 176O, § 2(d).

20. In accordance with the requirements of M.G.L. c. 176O, § 9A and 211 CMR 152.05, to the extent applicable to the Agreement:

    a. Provider shall have the right to opt out of any new select network or tiered network health benefit plan introduced by Payor at least sixty (60) days before the plan is submitted to the Massachusetts Commissioner of Insurance for approval.

    b. Nothing in the Agreement shall be construed to: (i) guarantee Provider a right to participate in any select network plan or tiered network plan; (ii) require or permit Provider, Payor, or CARECENTRIX to alter or terminate the Agreement, in whole or in part, to affect parity with an agreement with other carriers or health care providers based on Payor's decision to introduce or modify a select network plan or tiered network plan; (iii) require Payor to place all members of a provider group, whether local practice groups or facilities, in the same tier of a tiered network plan; or (iv) require Payor to include all members of a provider group, whether local practice groups or facilities, in a select network plan on an all-or-nothing basis. Any supplemental payment required or permitted under the Agreement shall not be enforceable unless each payment has been publicly disclosed to the Commissioner of Insurance as a condition of State accreditation, including the amount and purpose of each payment and whether or not each payment is included within Provider's reported relative prices and health status adjusted total medical expenses under M.G.L. c. 118G, § 6. To the extent that the Agreement contains any provision prohibited by this section, the duties and obligations under such provision shall apply only to health benefit plans not subject to M.G.L. c. 176O, § 9A and 211 CMR 152.05.

    c. Payor shall notify Provider in writing at least sixty (60) days before the effective date of any modification to the process used to classify participating providers by benefit tier, the timelines used

to make and implement reclassification decisions by benefit tier, the information collected from participating providers, and the criteria used to make classifications.

d. Provider shall have the right: to receive notification of Payor's classification of Provider to a benefit tier; to be provided with an explanation of the information, past experience, and other criteria used by Payor to make classification decisions; and to appeal classification decisions to Payor and receive a decision on such appeal prior to the new classification being made available on Payor's website and in material provided to employers and individuals.

e. Payor shall notify Provider about health benefit plans that use networks subject to 211 CMR 152.05, as set forth in Payor's applicable guidelines for such notification.

21. To the extent required by law, Provider shall inform CARECENTRIX promptly when Provider availability to see new patients changes (including whether they have a waitlist). 211 CMR 52.15 (17).

MEDICAID ADDENDUM FOR THE STATE OF MASSACHUSETTS

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Massachusetts regarding provider contracts with providers rendering health care services in the State of Massachusetts to Managed Medicaid Members. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a carrier, accident or health insurer, nonprofit hospital service corporation, nonprofit medical service corporation, health maintenance organization, or organization entering into a preferred provider arrangement, as those terms are defined in applicable Massachusetts law.
References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. HHS, the Comptroller General, the Executive Office of Health and Human Services ("EOHHS") or their designees have the right to audit, evaluate, and inspect books, contracts, computer or electronic systems including medical records and documentation of Provider and any other pertinent information for a period of 10 years from the final date of the Payor's contract period or the date of completion of any audit, whichever is later.

2. Provider shall not hold any Member liable for payment of any fees that are the obligation of the Payor or CareCentrix.

3. Provider shall provide services under the Agreement in accordance with the Payor's contractual obligations to CMS and the EOHHS.

4. All delegated activities and reporting requirements are specified in the Agreement. If CMS, EOHHS, the Payor, or CareCentrix determine that such delegated and/or reporting activities are not performed satisfactorily, such delegation and or reporting responsibility may be revoked by CareCentrix upon notice to Provider.

5. Provider's and CareCentrix's performance shall be monitored by the Payor on an ongoing basis.

6. Provider and CareCentrix shall safeguard Member privacy and the confidentiality of Member health records.

7. Provider and CareCentrix shall comply with all applicable federal and state laws, regulations and CMS instructions, including laws relating to the confidentiality and disclosure of medical records, or other health and enrollment information.

8. Provider and CareCentrix shall each maintain liability protection sufficient to protect itself against any losses arising from any claims against itself, including, at a minimum, workers' compensation insurance, comprehensive liability insurance, and property damage insurance.

9. In the event of a conflict between Massachusetts general law or Massachusetts regulation and the state law or state regulation where Provider is based, Massachusetts state law or regulation will prevail.

10. CareCentrix's credentialing process will be reviewed and approved by the Payors, and the Payors will audit that credentialing process on an ongoing basis. Payors reserve the right to approve, suspend or terminate Provider's participation in the CareCentrix provider network with respect to the Payor's Members.

11. Neither CareCentrix nor Provider has the right to terminate this Agreement without cause. In the event CareCentrix initiates a termination of the Agreement, CareCentrix shall provide a written statement to

Provider of the reason or reasons for termination with cause. In the event this Agreement is terminated, Provider shall assist with transitioning Members to new providers, including sharing Member medical records and other relevant Member information as directed by CareCentrix, the Payor or Member.

12. Clean Claims for Covered Services provided under the Agreement will be paid within 60 days of receipt by CareCentrix.

13. Provider shall render services under the Agreement in a culturally competent manner to all Members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds.

14. Provider shall ensure that medical information is released in accordance with applicable Federal or State law, or pursuant to court orders or subpoenas.

15. Provider shall maintain Member records and information in an accurate and timely manner in accordance with applicable law, community standards, and the requirements specified in the Provider Manual.

16. Provider shall ensure timely access by Members to the records and information that pertain to them.

17. Members will not be held liable for Medicare Part A and B cost sharing. Specifically, Medicare Parts A and B services must be provided at zero cost-sharing to Members.

18. Provider shall not bill Members for charges for Covered Services other than pharmacy co-payments, if applicable.

19. Provider does not render emergency services so the obligations of EMTALA do not apply to Provider, but Provider will not create any conflicts with hospital actions required to comply with EMTALA.

20. Provider is prohibited from closing or otherwise limiting Provider's acceptance of Members as patients unless the same limitations apply to all commercially insured patients.

21. CareCentrix and Payors are prohibited from refusing to pay Provider for the provision of Covered Services solely because Provider has in good faith:

    a. Communicated with or advocated on behalf of one or more prospective, current or former patients regarding the provisions, terms or requirements of the Payor's health benefit plans as they relate to the needs of Provider's patients; or
    b. Communicated with one or more prospective, current or former patients with respect to the method by which Provider is compensated by CareCentrix for services provided to the Member.

22. Provider is not required to indemnify CareCentrix or Payors for any expenses and liabilities, including, without limitation, judgments, settlements, attorneys' fees, court costs and any associated charges, incurred in connection with any claim or action brought against CareCentrix or Payors based on CareCentrix's or Payor's management decisions, utilization review provisions or other policies, guidelines or actions.

23. Provider must comply with CareCentrix's and Payor's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services, asapplicable.

24. CareCentrix shall notify Provider in writing of modifications in payments, modifications in Covered Services or modifications in CareCentrix's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider and the effective date of the modifications. The notice shall be provided 30 days before the effective date ofsuch

modification unless such other date for notice is mutually agreed upon between CareCentrix and Provider or unless such change is mandated by CMS or EOHHS without 30 days prior notice.

25. CareCentrix shall not make payment to Provider for a Provider Preventable Condition.

26. As a condition of payment, Provider shall comply with the reporting requirements as set forth in 42 C.F.R. § 447.26(d) and as may be specified by CareCentrix or the Payor.

27. Provider and CareCentrix shall comply with all applicable requirements governing physician incentive plans including but not limited to such requirements appearing at 42 C.F.R. Parts 417, 422, 434, 438, and 1003, and shall not agree to incentive plans that include a specific payment made directly or indirectly to Provider as an inducement to deny, reduce, delay, or limit specific, Medical Necessary Services furnished to an individual Member.

28. Provider shall comply with all Member payment restrictions, including balance billing restrictions, and CareCentrix shall implement a plan to identify and revoke or provide other specified remedies in the event that Provider does not comply with such provisions.

29. Provider shall not seek or accept payment from any Member for any Covered Service rendered, nor shall Provider have any claim against or seek payment from the Commonwealth for any Covered Service rendered to a Member. Provider shall look solely to CareCentrix and the applicable Payor for payment with respect to Covered Services rendered to Members. Furthermore, Provider shall not maintain any action at law or in equity against any Member or the Commonwealth to collect any sums that are owed by CareCentrix or the Payor for any reason, even in the event that CareCentrix or the Payor fails to pay for or becomes insolvent or otherwise breaches the terms and conditions of the Agreement. This requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

30. The applicable Payor shall remain fully responsible for meeting all of the terms and requirements (including all applicable state and federal regulations) of the Payor's contract with CMS and EOHHS regardless of whether the Payor subcontracts for performance under such contract. No such subcontract will operate to relieve the Payor of its legal responsibilities under such contract. Payor will monitor and ensure that all utilization management activities comply with all provisions of such contract.

31. Provider is prohibited from billing Members for missed appointments or refusing to provide services to Members who have missed appointments. Provider shall work with Members and CareCentrix to assist Members in keeping their appointments.

32. Provider shall not refuse to provide services to a Member because the Member has an outstanding debt with the Provider from a time prior to the patient becoming a Member.

33. Provider shall not have any interest that will conflict, as determined by EOHHS, with the performance of services under the Payor's contract with CMS and EOHHS. Without limiting the generality of the foregoing, EOHHS requires that no such related entity have any financial, legal, contractual or other business interest in any entity performing ICO enrollment functions for EOHHS.

34. Nothing in the Agreement shall be construed to restrict or limit the rights of health benefit plans to include as providers religious non-medical providers or to utilize medically based eligibility standards or criteria in deciding provider status for religious non-medical providers.

35. Provider shall not profit from the provision of Covered Services to Members that are not Medically Necessary or medically appropriate.

36. Provider shall submit to CareCentrix all marketing material pertaining to the services provided to Members hereunder 120 days prior to distribution so that CareCentrix can submit such materials to the Payor for approval prior to distribution.

37. Provider shall maintain current knowledge, ability and expertise in Provider's practice area as required by applicable law and at a minimum will conform with recognized managed care industry standards such as those provided by NCQA and relevant state regulations, when obtaining Continuing Medical Education (CME) credits or continuing Education Units (CEUs) and participate in training opportunities as appropriate.

38. Provider shall not assign or transfer any right or interest in this Agreement including any entity that results from a merger of Provider with another entity without the prior written consent of CareCentrix.

ADDENDUM FOR THE STATE OF MICHIGAN

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Michigan regarding provider contracts with providers rendering health care services in the State of Michigan. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a carrier, insurer, health maintenance organization, health plan, or health care corporation, as those terms are defined in applicable Michigan law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

    a. Provider shall not seek payment from the Member for Covered Services provided pursuant to the Agreement, except for the collection of applicable copayments, coinsurances, and deductibles as specified in the Member's benefit plan. Mich. Comp. Laws [MCL] § 500.3529(3).

    b. Provider shall meet applicable licensure or certification requirements to render services pursuant to the Agreement. CARECENTRIX and Payor shall be given appropriate access to records or reports concerning Provider's services to Members. Provider shall cooperate with the quality assurance activities of CARECENTRIX and Payor. MCL 500.3529(4).

    c. In the event of the insolvency of Payor, Provider shall continue to provide Covered Services to Members for the duration of the contract period for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of the insolvency, until the Member's discharge from the inpatient facility. Such continuation of services, pursuant to a process approved by the Michigan Director of the Department of Insurance and Financial Services, shall not be solely the responsibility of Provider. MCL 500.3561(c).

2. If CARECENTRIX terminates the Agreement, CARECENTRIX shall provide a written explanation of the reason for the termination of the Agreement upon request of the Provider. MCL 500.3531(8).

3. In accordance with the applicable requirements of MCL 500.3405a and Bulletin 2013-4-04-INS of the Michigan Department of Insurance, the Agreement shall not contain, use, or enforce a "most favored nation clause," defined as a clause that does any of the following:

    a. Prohibits, or grants Payor or CARECENTRIX an option to prohibit, Provider from contracting with another party to provide health care services at a lower rate than the payment or reimbursement rate specified in the Agreement.

    b. Requires, or grants Payor or CARECENTRIX an option to require, Provider to accept a lower payment or reimbursement rate if Provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the Agreement.

    c. Requires, or grants Payor or CARECENTRIX an option to require, termination or renegotiation of the Agreement if Provider agrees to provide health care services to any other party at a lower rate than the payment or reimbursement rate specified in the Agreement.

    d. Requires Provider to disclose, to Payor or CARECENTRIX or their designees, Provider's contractual payment or reimbursement rates with other parties.

4. CARECENTRIX is not an "organization" that contracts with health care providers as defined in MCL § 550.52. Accordingly, CARECENTRIX is not subject to the Michigan prudent purchaser agreement requirements of MCL § 550.51, et seq. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

5. Provider agrees that any and all legal disputes with Members shall be governed by Michigan law.

ADDENDUM FOR THE STATE OF MINNESOTA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Minnesota regarding provider contracts with providers rendering health care services in the State of Minnesota. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health carrier, health insurer, health plan company, managed care organization, or health maintenance organization, as those terms are defined in applicable Minnesota law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Provider acknowledges that Provider has received or been given access to a copy of the complete Agreement, including all attachments and exhibits thereto, the Provider Manual, a general description of applicable coding guidelines, other applicable guidelines and treatment parameters, and the fee schedule applicable to the Agreement. Minn. Stat. § 62Q.735(1).

2. To the extent required by Minn. Stat. § 62Q.735(2), the following provisions shall apply to notifications to Provider of proposed amendments or changes to the Agreement:

    a. Provider shall be notified of any amendment or change in the terms of the Agreement at least forty-five (45) days prior to the effective date of the proposed change, with the exception of amendments required by law or governmental regulatory authority, in which case notice shall be given to Provider when the requirement is made known to CARECENTRIX.

    b. Provider shall be notified of any amendment or change in the Agreement that alters the fee schedule or materially alters the written contractual policies and procedures governing the Agreement at least forty-five (45) days prior to the effective date of the proposed change. Provider shall have the opportunity to terminate the Agreement, in accordance with the termination provisions of the Agreement, before the amendment or change is deemed to be in effect.

    c. The parties may waive the disclosure requirements in subsections a. and b. of this section by mutual written consent in accordance with Minn. Stat. § 62Q.735(2)(c).

3. To the extent required by Minn. Stat. § 62Q.739(a) and applicable to Provider, in the event that the Agreement contains a unilateral indemnification provision for CARECENTRIX, the following provision shall be added to the indemnification section of the Agreement:

    CARECENTRIX shall defend, indemnify, and hold harmless Provider, including Provider's officers, directors, employees, agents, and stockholders, ("Provider Indemnified Parties") from and against any and all claims, liabilities, losses, damages, costs, or expenses of any kind (including reasonable attorneys' fees) ("Indemnified Amounts") incurred by the Provider Indemnified Parties as a result of CARECENTRIX's acts or omissions, but only to the extent that such Indemnified Amounts are caused by the negligence or other wrongful act or omission of CARECENTRIX.

4. Notwithstanding any prohibitions in Minn. Stat. § 62Q.739, the Agreement may be unilaterally terminated by either party in accordance with the terms of the Agreement.

5. The Agreement shall not be terminated, or fail to be renewed, without cause by CARECENTRIX unless Provider has been given a written notice of the termination or nonrenewal at least one hundred and

twenty (120) days before the effective date. Minn. Stat. § 62Q.739(b). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination or nonrenewal of the Agreement without cause by CARECENTRIX, the longer notification period will apply.

6. To the extent required by Minn. Stat. § 62Q.56(1a) and applicable to Provider, if the Agreement is terminated by CARECENTRIX for reasons other than for cause, Provider shall be permitted upon request to continue to provide Covered Services to a Member who is being treated by Provider at the time of the termination, in accordance with the following provisions:

   a. For up to one hundred twenty (120) days after the effective date of the termination, to a Member who is engaged in a current course of treatment with Provider for one or more of the following conditions: (i) an acute condition; (ii) a life-threatening mental or physical illness; (iii) pregnancy ; (iv) a physical or mental disability defined as an inability to engage in one or more major life activities, provided that the disability has lasted or can be expected to last for at least one (1) year, or can be expected to result in death; or (v) a disabling or chronic condition that is in an acute phase; or

   b. For the rest of a Member's life if a physician certifies that the Member has an expected lifetime of one hundred and eighty (180) days or less.

   The continuity of care provisions in this section shall apply only if Provider agrees to: (i) accept as payment in full the lesser of the reimbursement rate for Covered Services under the Agreement prior to its termination or Provider's regular fee for such Covered Services; (ii) adhere to CARECENTRIX's and Payor's preauthorization requirements; and (iii) provide CARECENTRIX and Payor with all necessary medical information related to the care provided to the Member. Nothing in this section shall require a Payor to provide coverage for a health care service or treatment that is not covered under the Member's health plan. Minn. Stat. § 62Q.56(2a).

7. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

   a. PROVIDER AGREES NOT TO BILL, CHARGE, COLLECT A DEPOSIT FROM, SEEK REMUNERATION FROM, OR HAVE ANY RECOURSE AGAINST AN ENROLLEE OR PERSONS ACTING ON THEIR BEHALF FOR SERVICES PROVIDED UNDER THIS AGREEMENT. THIS PROVISION APPLIES TO BUT IS NOT LIMITED TO THE FOLLOWING EVENTS: (i) NONPAYMENT BY THE HEALTH MAINTENANCE ORGANIZATION OR (ii) BREACH OF THIS AGREEMENT. THIS PROVISION DOES NOT PROHIBIT THE PROVIDER FROM COLLECTING CO-PAYMENTS OR FEES FOR UNCOVERED SERVICES.

      THIS PROVISION SURVIVES THE TERMINATION OF THIS AGREEMENT FOR AUTHORIZED SERVICES PROVIDED BEFORE THIS AGREEMENT TERMINATES, REGARDLESS OF THE REASON FOR TERMINATION. THIS PROVISION IS FOR THE BENEFIT OF THE HEALTH MAINTENANCE ORGANIZATION ENROLLEES. THIS PROVISION DOES NOT APPLY TO SERVICES PROVIDED AFTER THIS AGREEMENT TERMINATES.

      THIS PROVISION SUPERSEDES ANY CONTRARY ORAL OR WRITTEN AGREEMENT EXISTING NOW OR ENTERED INTO IN THE FUTURE BETWEEN THE PROVIDER AND THE ENROLLEE OR PERSONS ACTING ON THEIR BEHALF REGARDING LIABILITY FOR PAYMENT FOR SERVICES PROVIDED UNDER THIS AGREEMENT. Minn. Stat. § 62D.123(1).

   b. Provider shall cooperate with and participate in the quality assurance programs, dispute resolution procedures, and utilization review programs of CARECENTRIX and Payor. Minn. Stat. § 62D.123(2).

c. Provider shall give CARECENTRIX at least one hundred and twenty (120) days' advance written notice in the event that Provider elects to terminate the Agreement without cause. Minn. Stat. § 62D.123(3). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement without cause by Provider, the longer notification period will apply.

d. Provider shall not have recourse against Members or persons acting on their behalf for amounts above those specified in the evidence of coverage as co-payments for Covered Services. This section applies but is not limited to the following events: (i) nonpayment by Payor; (ii) insolvency of Payor; and (iii) breach of the Agreement. This section does not limit Provider's ability to seek payment from any person other than the Member, the Member's guardian or conservator, the Member's immediate family members, or the Member's legal representative, in the event of nonpayment by Payor. Minn. Stat. § 62D.12(5).

e. Neither Payor nor CARECENTRIX shall take retaliatory action against Provider solely on the grounds that Provider disseminated accurate information regarding coverage of benefits or accurate benefit limitations of a Member's contract or accurate interpreted provisions of the Agreement that limit the prescribing, providing, or ordering of care. Minn. Stat. § 62D.12(15).

8. The following provisions shall be added to the Agreement to the extent required by Minn. Stat. § 62J.71 and applicable to Provider:

   a. Nothing in the Agreement or any directive pursuant to the Agreement shall be construed to prohibit Provider from:
      i. Communicating with a Member with respect to the Member's health status, health care, or treatment options, if Provider is acting in good faith and within the Provider's scope of practice as defined by law;
      ii. Making a recommendation regarding the suitability or desirability of a health plan company, health insurer, or health coverage plan for a Member, unless Provider has a financial conflict of interest in the Member's choice of health plan company, health insurer, or health coverage plan;
      iii. Providing testimony, supporting or opposing legislation, or making any other contact with State or federal legislators or legislative staff or with State and federal executive branch officers or staff;
      iv. Disclosing accurate information about whether services or treatment will be paid for by a patient's health plan company or health insurer or health coverage plan; or
      v. Informing a Member about the nature of the reimbursement methodology used by the Member's plan to pay Provider, subject to subsection d. of this section.

   b. Neither CARECENTRIX nor Payor shall take retaliatory action against Provider solely on the grounds that Provider:
      i. Refused to enter into an agreement or provide services or information in a manner that is prohibited under this subsection b., or took any of the actions listed in subsection a. of this section;
      ii. Disclosed accurate information about whether a health care service or treatment is covered by a Member's plan;
      iii. Discussed diagnostic, treatment, or referral options that are not covered or are limited by the Member's plan;
      iv. Criticized coverage of the Member's plan; or
      v. Expressed personal disagreement with a decision made by Payor, CARECENTRIX, or a person, organization, or health care provider, regarding treatment or coverage provided to a patient of Provider, or assisted or advocated for the patient in seeking reconsideration of such a decision, provided that Provider makes it clear that Provider is acting in a personal capacity and not as a representative of or on behalf of Payor, CARECENTRIX, or the entity that made the decision.

c. Nothing in this section prohibits CARECENTRIX or Payor from taking action against Provider if CARECENTRIX or Payor has evidence that Provider's actions are illegal, constitute medical malpractice, or are contrary to accepted medical practices.

d. Nothing in this section prohibits a provision in the Agreement, or a directive pursuant to the Agreement, that requires Provider to keep confidential or to not use or disclose the specific amounts paid to Provider, Provider fee schedules, Provider salaries, and other proprietary information of CARECENTRIX or Payor.

9. Provider shall not retaliate or take adverse action against a Member or patient who, in good faith, makes a complaint against Provider. Minn. Stat. § 62J.80.

10. Nothing in the Agreement shall be construed to give any financial incentive to Provider based solely on the number of services denied or referrals not authorized by Provider. This section does not prohibit capitation or other compensation methods that serve to hold health care providers financially accountable for the cost of caring for a patient population. Minn. Stat. § 72A.20(33).

11. The Agreement shall not: (i) prohibit, or grant CARECENTRIX or Payor an option to prohibit, Provider from contracting with other insurers or payors to provide services at a lower price than the payment specified in the Agreement; (ii) require, or grant CARECENTRIX or Payor an option to require, Provider to accept a lower payment in the event Provider agrees to provide services to any other insurer or payor at a lower price; or (iii) require, or grant CARECENTRIX or Payor an option of, termination or renegotiation of the Agreement in the event Provider agrees to provide services to any other insurer or payor at a lower price. Minn. Stat. §§ 62A.64, 62Q.736.

12. CARECENTRIX or Payor may only adjust or exercise recoupment on paid clean claims [as defined in Minn. Stat.§62Q.75(1)(b)] within the twelve (12) month period following payment, except when related to coordination of benefits, subrogation, duplicate claims, retroactive terminations, fraud, and abuse. Minn. Stat. § 62Q.75(4).

ADDENDUM FOR THE STATE OF MISSISSIPPI

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Mississippi regarding provider contracts with providers rendering health care services in the State of Mississippi. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health carrier, health insurer, health maintenance organization, or managed care entity that offers a managed care plan, as those terms are defined in applicable Mississippi law or regulation. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. The specific services for which Provider shall be responsible, including any limitations or conditions on such services, are set forth in Schedule "A" to the Agreement and the corresponding fee schedule, as amended. 19 Miss. Admin. Code 3:14.06(A).

2. Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person (other than Payor or CARECENTRIX) acting on behalf of the Member for Covered Services provided pursuant to the Agreement. The Agreement does not prohibit Provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the Member's evidence of coverage, or fees for non-Covered Services delivered on a fee-for-service basis to Members. Nor does the Agreement prohibit Provider (except for a health care professional who is employed full-time on the staff of Payor and has agreed to provide services exclusively to Payor's Members and no others) and a Member from agreeing to continue services solely at the expense of the Member, as long as Provider has clearly informed the Member that Payor may not cover or continue to cover a specific service or services. Except as provided herein, the Agreement does not prohibit Provider from pursuing any available legal remedy. 19 Miss. Admin. Code 3:14.06(B); Miss. Code Ann. § 83-41-325(13).

3. In the event of Payor's or CARECENTRIX's insolvency or other cessation of operations, Provider shall continue to provide Covered Services to Members through the period for which a premium has been paid to Payor on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater. Covered Services to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary. 19 Miss. Admin. Code 3:14.06(C); Miss. Code Ann. § 83-41-325(16).

4. The provisions of Sections 2 and 3 of this Addendum: (i) shall be construed in favor of the Member; (ii) shall *survive the termination of the Agreement* regardless of the reason for termination, including the insolvency of Payor or CARECENTRIX; and (iii) shall supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by Sections 2 and 3 of this Addendum. 19 Miss. Admin. Code 3:14.06(D).

5. In no event shall Provider collect or attempt to collect from a Member any money owed to Provider by Payor or CARECENTRIX. 19 Miss. Admin. Code 3:14.06(E). Neither Provider nor any agent, trustee, or

assignee of Provider, shall maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX. Miss. Code Ann. § 83-41-325(14), (15).

6. CARECENTRIX shall make its selection standards for participating providers available for review by the Commissioner of Insurance. 19 Miss. Admin. Code 3:14.06(G).

7. Provider's rights and responsibilities with respect to CARECENTRIX's applicable administrative policies and programs, including but not limited to terms, including payment, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs, are set forth in the Agreement, the Provider Manual, and the applicable Addenda to the Agreement. 19 Miss. Admin. Code 3:14.06(H).

8. Nothing in the Agreement shall be construed to offer an inducement to Provider to provide less than medically necessary services to a Member. 19 Miss. Admin. Code 3:14.06(I).

9. Nothing in the Agreement shall be construed to prohibit Provider from discussing treatment options with Members irrespective of CARECENTRIX's or Payor's position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by CARECENTRIX or Payor. 19 Miss. Admin. Code 3:14.06(J).

10. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members, and shall comply with the applicable state and federal laws related to the confidentiality of medical or health records. 19 Miss. Admin. Code 3:14.06(K).

11. Provider and CARECENTRIX shall each give the other party at least sixty (60) days' advance written notice before terminating the Agreement without cause. 19 Miss. Admin. Code 3:14.06(L); Miss. Code Ann. § 83-41-325(17). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement without cause, such longer notification period will apply.

12. Provider shall not assign or delegate Provider's rights or responsibilities under the Agreement without the prior written consent of CARECENTRIX. 19 Miss. Admin. Code 3:14.06(M).

13. Provider shall furnish Covered Services to all Members without regard to the Member's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions. 19 Miss. Admin. Code 3:14.06(N).

14. Unless otherwise directed by CARECENTRIX, Provider shall not collect applicable coinsurance, copayments, or deductibles from Members. Provider shall notify Members of their personal financial obligations for non-Covered Services in accordance with the applicable provisions of the Agreement or as directed by CARECENTRIX. 19 Miss. Admin. Code 3:14.06(O).

15. Nothing in the Agreement shall be construed to penalize Provider because Provider, in good faith, reports to federal or state authorities any act or practice by Payor or CARECENTRIX that jeopardizes patient health or welfare. 19 Miss. Admin. Code 3:14.06(P).

16. Provider agrees to utilize the mechanism established by Payor to timely verify a person's eligibility under Payor's plan, as required in the Provider Manual. 19 Miss. Admin. Code 3:14.06(Q).

17. The applicable procedures for the resolution of administrative, payment, or other disputes arising under the Agreement are set forth in the Agreement and the Provider Manual. 19 Miss. Admin. Code 3:14.06(R).

18. The payment and reimbursement methodologies applicable to the Agreement are set forth in the Compensation sections and Schedule "A" to the Agreement. 19 Miss. Admin. Code 3:14.06(S).

19. To the extent required by law or regulation, the definitions or other provisions in the Agreement shall not conflict with the applicable definitions or provisions contained in Payor's managed care plan or the Managed Care Plan Network Adequacy Regulation. 19 Miss. Admin. Code 3:14.06(T).

20. CARECENTRIX and Provider shall comply with all the applicable requirements of Section 14.06 of the Managed Care Plan Network Adequacy Regulation, as set forth in the preceding sections of this Addendum. 19 Miss. Admin. Code 3:14.07(A).

21. Payor shall have the right to approve or disapprove Provider's participation in CARECENTRIX's network of participating providers for the purpose of delivering Covered Services to Payor's Members. 19 Miss. Admin. Code 3:14.07(C).

22. CARECENTRIX shall allow the Commissioner of Insurance access to its books, records, financial information, and any documentation of Covered Services provided to Members under the Agreement, as necessary to determine compliance with the Managed Care Plan Network Adequacy Regulation. 19 Miss. Admin. Code 3:14.07(G).

23. Payor shall have the right, in the event of CARECENTRIX's insolvency, to require the assignment to Payor of the provisions of the Agreement addressing Provider's obligation to furnish Covered Services to Members. 19 Miss. Admin. Code 3:14.07(H).

24. To the extent required by Miss. Ins. Dept. Bulletin 2008-1, CARECENTRIX will give Provider at least sixty (60) days' prior written notice of proposed changes to the reimbursement rates or other material financial terms of the Agreement. This requirement does not apply to changes or amendments to the Agreement required by legislative, regulatory, or other legal authority, as provided in the Agreement.

ADDENDUM FOR THE STATE OF MISSOURI

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Missouri regarding provider contracts with providers rendering health care services in the State of Missouri. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health maintenance organization, health carrier, or insurer as those terms are defined in applicable Missouri law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

I. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement in accordance with the requirements of applicable law and regulation:

1. Provider shall not be prohibited or restricted from disclosing to any Member any information that Provider deems appropriate regarding the nature of treatment; risks or alternatives thereto; the availability of other therapy, consultation, or test; the decision of Payor or CARECENTRIX to authorize or deny services; or the process that Payor or CARECENTRIX uses or proposes to use to authorize or deny health care services or benefits. Mo. Rev. Stat. § 354.441.

2. Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person, other than Payor or CARECENTRIX, acting on behalf of the Member, for Covered Services provided pursuant to the Agreement. The Agreement shall not prohibit Provider from collecting coinsurance, deductibles, or co-payments, as specifically provided in the Member's evidence of coverage, or fees for services not covered under the Member's plan and delivered on a fee-for-service basis to the Member. The Agreement shall not prohibit Provider (except for a health care professional who is employed full time on the staff of Payor and who has agreed to provide services exclusively to Payor's Members and no others) and a Member from agreeing to continue services solely at the expense of the Member, as long as Provider has clearly informed the Member that Payor may not cover or continue to cover a specific service or services, and the Member agrees in writing to assume financial responsibility for such services. Except as provided herein, the Agreement does not prohibit Provider from pursuing any available legal remedy, including but not limited to collecting from any insurance carrier providing coverage to a Member. Mo. Rev. Stat. § 354.606.2.

3. In the event of Payor's or CARECENTRIX's insolvency or other cessation of operations, Covered Services to Members shall continue through the period for which a premium has been paid to Payor on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater. Mo. Rev. Stat. § 354.606.3.

4. The provisions of Sections 2 and 3 of this Addendum shall: (a) be construed in favor of the Member; (b) survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Payor or CARECENTRIX; and (c) supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is

inconsistent with the hold harmless and continuation of Covered Services provisions required by Sections 2 and 3 of this Addendum. Mo. Rev. Stat. § 354.606.4.

5. Payor, CARECENTRIX, and Provider are independent contractors. Under no circumstances, including but not limited to those sets of circumstances described in Sections 2 and 3 of this Addendum, shall Provider bill, charge, or in any way seek to hold a Member legally liable for the payment of any fees which are the legal obligation of Payor or CARECENTRIX. Mo. Code Regs. [CSR] tit. 20, § 400-7.080(2).

6. The rights and responsibilities of Provider under the Agreement shall not be assigned or delegated by Provider without the prior written consent of CARECENTRIX. Mo. Rev. Stat. § 354.606.13.

7. Provider shall furnish Covered Services to all Members without regard to the Member's enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed program of health care services. Mo. Rev. Stat. § 354.606.14.

8. Provider and CARECENTRIX shall provide at least sixty (60) days' written notice to each other before terminating the Agreement without cause. The written notice shall include an explanation of why the Agreement is being terminated. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with regard to termination of the Agreement without cause, such longer notification period will apply. Within fifteen (15) working days of the date that Provider either gives or receives notice of termination, Provider shall supply CARECENTRIX with a list of Provider's patients who are covered by Payor's plan. Upon termination of the Agreement, Payor or CARECENTRIX, as applicable, shall provide written notice of such termination within thirty (30) working days to all Members who are patients seen on a regular basis by Provider, irrespective of whether the termination is for cause or without cause. Mo. Rev. Stat. § 354.609.1.

9. Upon termination of the Agreement, Provider shall continue to provide Covered Services to a Member for a period of up to ninety (90) days where the continuation of care is medically necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy, or life-threatening illness. During such period of continued care, the Member shall not be liable to Provider for any amounts owed for Covered Services other than deductibles or co-payment amounts specified in the Member's certificate of coverage. In the event that Provider is authorized to continue treating a Member pursuant to this section after termination of the Agreement, Provider shall be compensated for Covered Services provided to such Member in accordance with the previously contracted rates and terms under the Agreement. Mo. Rev. Stat. § 354.612.

10. Payor or CARECENTRIX, as applicable, shall monitor, on an on-going basis, the ability, clinical capacity, and legal authority of Provider to furnish Covered Services to Members. Upon request, Provider shall furnish records that Payor or CARECENTRIX may require to document or demonstrate Provider's capability of meeting the terms of the Agreement. Mo. Rev. Stat. § 354.603.1(3).

11. Payor shall make its entire provider network available to all Members unless a contract holder of a benefit plan has agreed in writing to a different or reduced network in accordance with Mo. Rev. Stat. § 354.603.2 and 20 CSR 400-7.095. Notwithstanding legitimate and medically based referral patterns, neither Payor nor CARECENTRIX nor Provider shall act in a manner that unreasonably restricts a Member's access to the entire provider network, subject to the scope of Provider's licensure and the specific types of Covered Services provided under the Agreement. Mo. Rev. Stat. § 354.603.1(4).

12. The specific Covered Services for which Provider shall be responsible are identified in "Schedule A" of the Agreement and any other applicable addendums, exhibits, or attachments to the Agreement. Any limitations or conditions on Provider's rendering of such Covered Services are set forth in the

Agreement, including but not limited to any applicable addendums, exhibits, or attachments thereto, and the Provider Manual. Changes to the Agreement are made pursuant to the amendment provisions in the Agreement; revisions to the Provider Manual are communicated to Provider from time to time. Such changes and revisions will be made in accordance with the requirements of applicable law. Mo. Rev. Stat. § 354.606.1.

13. Provider shall cooperate and comply with CARECENTRIX's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or State programs. Such policies, programs, and procedures are set forth in the Agreement, including but not limited to any addendums, exhibits, and attachments thereto, and the Provider Manual. Mo. Rev. Stat. § 354.606.8.

14. Provider shall make health records available to appropriate State and federal authorities involved in assessing the quality of care but shall not disclose individual identities, or investigating the grievances or complaints of Members, and shall comply with the applicable State and federal laws related to the confidentiality of medical or health records. Mo. Rev. Stat. § 354.606.12.

15. To the extent that Provider has an obligation to collect applicable coinsurance, co-payments, or deductibles from Members pursuant to the Members' evidence of coverage, such obligation, if any, is specified in the Agreement. Mo. Rev. Stat. § 354.606.15.

16. Provider will contact Payor to verify an individual's eligibility and benefit availability prior to providing any service, equipment, or supply item. Payors' toll-free telephone numbers are listed in the Provider Manual. Mo. Rev. Stat. § 354.606.15.

17. The procedures for resolution of administrative, payment, or other disputes arising under the Agreement between Provider and CARECENTRIX are set forth in the Agreement and the Provider Manual. Mo. Rev. Stat. § 354.606.19. Nothing in any arbitration process described therein shall supersede the applicable requirements of Mo. Rev. Stat. §§ 354.600 to 354.636.

18. CARECENTRIX will give Provider at least thirty (30) days to review the proposed Agreement. Mo. Rev. Stat. § 354.609.6.

19. Nothing in the Agreement shall be construed to conflict with a Member's rights pursuant to the applicable provisions of Mo. Rev. Stat. § 538.205 et seq. Missouri Department of Insurance, HMO Provider Agreements Checklist.

20. The Agreement does not offer, and shall not be construed to offer, any inducement for Provider to provide less than medically necessary services to a Member. Mo. Rev. Stat. § 354.606.10.

21. Provider shall not be prohibited from advocating in good faith on behalf of Members within the utilization review or grievance processes established by Payor or CARECENTRIX. Mo. Rev. Stat. § 354.606.11.

22. Payor or CARECENTRIX shall not penalize Provider because Provider, in good faith, reports to State or federal authorities any act or practice by Payor or CARECENTRIX that may jeopardize patient health or welfare. Mo. Rev. Stat. § 354.606.16.

23. In accordance with Mo. Rev. Stat. § 354.609.5, CARECENTRIX shall not terminate the Agreement solely or in part because Provider in good faith:

    a. Advocates on behalf of a Member;

b. Files a complaint against Payor or CARECENTRIX;

c. Appeals a decision of Payor or CARECENTRIX;

d. Provides information or files a report with the Missouri Department of Insurance, Financial Institutions, and Professional Registration; or

e. Requests a hearing or review pursuant to this section.

24. To the extent required by Mo. Rev. Stat. § 354.621.1, CARECENTRIX and Provider shall comply with all applicable requirements of Mo. Rev. Stat. §§ 354.600 to 354.636.

25. To the extent applicable to the Agreement, CARECENTRIX shall transmit to Payor, utilization documentation and claims paid documentation relating to Payor's Members. Payor shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Members pursuant to the Agreement. Mo. Rev. Stat. § 354.621.3.

26. CARECENTRIX shall maintain the books, records, financial information, and documentation of services provided to Members pursuant to the Agreement at its principal place of business in the State of Missouri, if applicable, and shall preserve such records for five (5) years in a manner that facilitates regulatory review. Mo. Rev. Stat. § 354.621.4.

27. In accordance with Mo. Rev. Stat. § 354.621.5, CARECENTRIX shall allow Payor or the Director of the Missouri Department of Insurance, Financial Institutions, and Professional Registration to access CARECENTRIX's books, records, financial information, and any documentation of services provided to Members under the Agreement, as necessary to determine compliance with the requirements of Mo. Rev. Stat. §§ 354.600 to 354.636.

28. Payor shall have the right, in the event of CARECENTRIX's insolvency, to require the assignment to Payor of the provisions of the Agreement addressing Provider's obligation to furnish Covered Services to Members. Mo. Rev. Stat. § 354.621.6.

II. The following provisions shall be added to the Agreement in accordance with the requirements of applicable health insurance law and regulation:

1. To the extent required by law, Provider may file a claim for reimbursement for a Covered Service provided in the State of Missouri for a period of up to six (6) months from the date of service, unless the Agreement specifies a different standard for filing such a claim, in which case the standard specified in the Agreement shall apply. Mo. Rev. Stat. § 376.384.1(2).

2. To the extent required by law, Payor or CARECENTRIX shall not request a refund or offset against a claim more than twelve (12) months after Payor has paid a claim except in cases of fraud or misrepresentation by Provider. Mo. Rev. Stat. § 376.384.1(3).

3. To the extent required by law, reimbursement of claims for Covered Services under the Agreement shall comply with the applicable requirements of Mo. Rev. Stat. §§ 376.383 and 376.384.

4. To the extent required by law, coordination of benefits under Agreement shall comply with the applicable requirements of 20 CSR 400-2.030.

5. The Agreement shall be governed by the requirements of applicable State of Missouri Statutes and Regulations and any applicable federal law.

ADDENDUM FOR THE STATE OF MONTANA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Montana regarding provider contracts with providers rendering health care services in the State of Montana. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health carrier, health care insurer, or health maintenance organization, as those terms are defined in applicable Montana law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. The following provisions shall be added to the Agreement to the extent applicable to Provider and required by Mont. Code Ann. [MCA] § 33-36-202:

    a. Provider agrees that Provider shall not for any reason, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement, or have any recourse from or against a Member or a person other than Payor or CARECENTRIX acting on behalf of the Member for Covered Services provided pursuant to the Agreement. The Agreement does not prohibit Provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the Member's evidence of coverage, or fees for noncovered services delivered on a fee-for-service basis to a Member. The Agreement does not prohibit Provider (except a health care professional who is employed full-time on the staff of Payor and who has agreed to provide services exclusively to that Payor's Members and no others) and a Member from agreeing to continue services solely at the expense of the Member if Provider has clearly informed the Member that Payor may not cover or continue to cover a specific service or services. Except as provided in the Agreement, the Agreement does not prohibit Provider from pursuing any legal remedy available for obtaining payment for services from Payor.

    b. In the event of Payor's or CARECENTRIX's insolvency or other cessation of operations, Covered Services to Members will continue through the end of the period for which a premium has been paid to Payor on behalf of the Member or until the Member's discharge from an acute care inpatient facility, whichever occurs last. Covered Services to a Member confined in an acute care inpatient facility on the date of insolvency or other cessation of operations must be continued by Provider until the Member's confinement in an acute care inpatient facility is no longer medically necessary.

    c. The provisions of subsections (a) and (b) of this section shall be construed in favor of the Member; shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Payor or CARECENTRIX; and shall supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by subsections (a) and (b) of this section.

    d. Provider shall not collect or attempt to collect from a Member any money owed to Provider by Payor or CARECENTRIX.

2. CARECENTRIX shall notify Provider, in writing, of Provider's responsibilities concerning CARECENTRIX's or Payor's applicable administrative policies and programs, including but not limited to payment terms, utilization reviews, the quality assurance program, credentialing, grievance procedures, data

reporting requirements, confidentiality requirements, and any applicable federal or State requirements. § 33-36-204(1), MCA.

3. Nothing in the Agreement shall be construed to offer an inducement to Provider to provide less than medically necessary services to a Member. § 33-36-204(2), MCA.

4. Nothing in the Agreement shall be construed to prohibit Provider from discussing a treatment option with a Member or from advocating on behalf of a Member within the utilization review or grievance processes established by CARECENTRIX or Payor. § 33-36-204(3), MCA.

5. Provider shall make health records available to appropriate State and federal authorities, in accordance with applicable State and federal laws related to the confidentiality of medical or health records, when the authorities are involved in assessing the quality of care or investigating a grievance or complaint of a Member. § 33-36-204(4), MCA.

6. Provider and CARECENTRIX shall each give the other party at least sixty (60) days' prior written notice before terminating the Agreement without cause. § 33-36-204(5), MCA. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement without cause, such longer notification period will apply.

7. Provider shall furnish Covered Services to all Members without regard to the Member's enrollment in the plan as a private purchaser or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services because of Provider's lack of training, experience, or skill or because of a restriction on Provider's license. § 33-36-204(6), MCA.

8. Provider's obligations, if any, to collect applicable coinsurance, copayments, or deductibles from Members pursuant to the evidence of coverage, or to notify Members of Members' personal financial obligations for noncovered services, are set forth in the Agreement and the Provider Manual. § 33-36-204(7), MCA.

9. Nothing in the Agreement shall be construed to penalize Provider because Provider, in good faith, reports to State or federal authorities an act or practice by Payor or CARECENTRIX that may adversely affect patient health or welfare. § 33-36-204(8), MCA.

10. The procedures for resolution of administrative, payment, or other disputes arising under the Agreement are set forth in the Agreement and the Provider Manual. § 33-36-204(10), MCA.

11. To the extent required by law, the definitions or other provisions in the Agreement shall not conflict with the applicable definitions or provisions contained in Payor's managed care plan or in the Montana Managed Care Plan Network Adequacy and Quality Assurance Act. § 33-36-204(11), MCA. As used in this Addendum, the term "managed care plan" shall have the meaning set forth in § 33-36-103, MCA.

12. Payor shall have the right, in the event of CARECENTRIX's insolvency, to require the assignment to Payor of the provisions of the Agreement addressing Provider's obligation to furnish Covered Services to Members. § 33-36-209(7), MCA.

13. To the extent required by law, the Agreement shall not include an indemnification or hold harmless clause for the acts or conduct of Payor or CARECENTRIX. § 33-37-104(2), MCA.

14. CARECENTRIX may not terminate the Agreement prior to the expiration of its term except for just cause. For purposes of this section, "just cause" means reasonable grounds for termination based on a failure to satisfactorily perform contract obligations or other legitimate business reason. § 33-37-104(3), MCA.

15. Payor or CARECENTRIX shall not by oral or written contract, by an oral or written direction or requirement, or by a financial inducement or penalty prohibit Provider from making or interfere with Provider's making a medical communication to a Member; provided that, the foregoing provision: (a) shall not apply to a contract, direction, requirement, financial inducement, or penalty that prohibits Provider from disclosing a trade secret as defined in § 30-14-402, MCA, or that prohibits Provider from referring a Member to another plan or managed care organization in which Provider has a direct financial interest, and (b) shall not apply to the terms of the Agreement that require Provider to participate in and cooperate with all programs, policies, and procedures implemented by Payor or CARECENTRIX to ensure, review, or improve the quality of health care. § 33-1-802, MCA. Payor or CARECENTRIX shall not take any of the actions specified in § 33-1-803, MCA, with regard to Provider because Provider has made a medical communication to a Member or to the guardian or legal representative of the Member. For purposes of this section, the term "medical communication" shall have the meaning set forth in § 33-1-801, MCA.

ADDENDUM FOR THE STATE OF NEBRASKA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Nebraska regarding provider contracts with providers rendering health care services in the State of Nebraska. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health carrier, or health maintenance organization, as those terms are defined in applicable Nebraska law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. The following provisions shall be added to the Agreement to the extent applicable to Provider and required by the Nebraska Managed Care Plan Network Adequacy Act:

    a. Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person, other than Payor or CARECENTRIX, acting on behalf of the Member for Covered Services provided pursuant to the Agreement. The Agreement does not prohibit Provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the Member's evidence of coverage, or fees for noncovered health care services delivered on a fee-for-service basis to Members. Nor does the Agreement prohibit Provider (except for a health care professional who is employed full time on the staff of Payor and has agreed to provide Covered Services exclusively to Payor's Members and no others) and a Member from agreeing to continue health care services solely at the expense of the Member as long as Provider has clearly informed the Member that Payor may not cover or continue to cover a specific health care service or health care services. Except as provided herein, the Agreement does not prohibit Provider from pursuing any available legal remedy. Neb. Rev. Stat. § 44-7106(2)(b).

    b. In the event of Payor's or CARECENTRIX's insolvency or other cessation of operations, Covered Services to Members will continue through the period for which a premium has been paid to Payor on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater. Covered Services to Members confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary. Neb. Rev. Stat. § 44-7106(2)(c).

    c. The provisions of subsections (a) and (b) of this section shall be construed in favor of the Member; shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Payor or CARECENTRIX; and shall supersede any oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by subsections (a) and (b) of this section. Neb. Rev. Stat. § 44-7106(2)(d).

2. In no event shall Provider collect or attempt to collect from a Member any money owed to Provider by Payor or CARECENTRIX. Neb. Rev. Stat. § 44-7106(2)(e).

3. At the time the Agreement is executed, CARECENTRIX shall notify Provider of Provider's responsibilities with respect to CARECENTRIX's or Payor's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs,

credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or State programs. Neb. Rev. Stat. § 44-7106(2)(g).

4. Nothing in the Agreement shall be construed to offer an inducement to Provider to provide less than medically necessary health care services to a Member. Neb. Rev. Stat. § 44-7106(2)(h).

5. Nothing in the Agreement shall be construed to prohibit Provider from discussing treatment options with Members irrespective of CARECENTRIX's or Payor's position on the treatment options, or from advocating on behalf of Members within the utilization review or grievance processes established by CARECENTRIX or Payor. Neb. Rev. Stat. § 44-7106(2)(i).

6. Provider shall make health records available to appropriate State and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members, and shall comply with the applicable State and federal laws related to the confidentiality of medical or health records. Neb. Rev. Stat. § 44-7106(2)(j).

7. Provider and CARECENTRIX shall each give the other party at least sixty (60) days' prior written notice before terminating the Agreement without cause. Neb. Rev. Stat. § 44-7106(2)(k). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement without cause, such longer notification period will apply.

8. Provider shall not assign or delegate Provider's rights or responsibilities under the Agreement without the prior written consent of CARECENTRIX. Neb. Rev. Stat. § 44-7106(2)(*l*).

9. Provider shall furnish Covered Services to all Members without regard to the Member's enrollment in a managed care plan as a private purchaser of the managed care plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render health care services due to limitations arising from lack of training, experience, skill, or licensing restrictions. Neb. Rev. Stat. § 44-7106(2)(m). As used in this Addendum, the term "managed care plan" shall have the meaning set forth in Neb. Rev. Stat. § 44-7103.

10. Provider's obligations, if any, to collect applicable coinsurance, copayments, or deductibles from Members pursuant to the evidence of coverage, and Provider's obligations, if any, to notify Members of their personal financial obligations for noncovered health care services, are set forth in the Agreement and the Provider Manual. Neb. Rev. Stat. § 44-7106(2)(n).

11. Nothing in the Agreement shall be construed to penalize Provider because Provider, in good faith, reports to State or federal authorities any act or practice by Payor or CARECENTRIX that jeopardizes patient health or welfare. Neb. Rev. Stat. § 44-7106(2)(o).

12. The procedures for resolution of administrative, payment, or other disputes arising under the Agreement are set forth in the Agreement and the Provider Manual. Neb. Rev. Stat. § 44-7106(2)(q).

13. To the extent required by law, the definitions or other provisions in the Agreement shall not conflict with the applicable definitions or provisions contained in Payor's managed care plan or in the Nebraska Managed Care Plan Network Adequacy Act. Neb. Rev. Stat. § 44-7106(2)(r).

14. Payor shall have the right, in the event of CARECENTRIX's insolvency, to require the assignment to Payor of the provisions of the Agreement addressing Provider's obligation to furnish Covered Services to Members. Neb. Rev. Stat. § 44-7107(h).

15. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent applicable to Provider and required by the Nebraska Health Maintenance Organization Act:

    a. If Payor fails to pay for Covered Services as set forth in the Agreement, the Member will not be liable to Provider for any sum owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from the Member sums owed by Payor or CARECENTRIX. Provider, or an agent, trustee, or assignee of Provider, shall not maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX. Neb. Rev. Stat. § 44-32,141.

    b. If Provider terminates the Agreement, Provider shall give CARECENTRIX at least sixty (60) days' prior written notice of termination. Neb. Rev. Stat. § 44-32,142. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

    c. In the event of the insolvency of Payor, Provider shall continue to provide Covered Services to Members for the duration of the contract period after Payor's insolvency for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of the insolvency, until the Member's discharge from the inpatient facility or expiration of benefits. Neb. Rev. Stat. § 44-32,143.

ADDENDUM FOR THE STATE OF NEVADA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Nevada regarding provider contracts with providers rendering health care services in the State of Nevada. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health carrier, managed care organization, or health maintenance organization, as those terms are defined in applicable Nevada law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. If Provider or CARECENTRIX elects to terminate the Agreement, the terminating party must give the other party at least ninety (90) days' advance written notice before the effective date of termination. Nev. Admin. Code [NAC] § 689B.160. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination, such longer notification period will apply.

2. Except if the Agreement is terminated by CARECENTRIX for reasons of medical incompetence or professional misconduct by Provider, Provider shall continue to provide Covered Services for the medical condition(s) for which a Member is actively undergoing a medically necessary course of treatment from Provider at the time of such termination, if the Member and Provider agree that continuity of care is desirable, until the later of:

   a. the 120th day after date the Agreement is terminated; or
   b. if the medical condition is pregnancy, the 45th day after:
      i. the date of delivery; or
      ii. if the pregnancy does not end in delivery, the date of the end of the pregnancy.

   During the continuation period under this section, Provider agrees to provide Covered Services to the Member in accordance with the terms, conditions, and rates of reimbursement in effect under the Agreement prior to its termination. Provider further agrees not to seek payment from the Member for any Covered Services provided by Provider during such continuation period, except for applicable copayments, coinsurance, or deductibles as specified in the Member's benefit plan. Nev. Rev. Stat. [NRS] §§ 689B.0303, 695C.1691, 695G.164.

3. The Agreement may be modified at any time pursuant to a written amendment executed by both parties. In addition, CARECENTRIX may amend the Agreement by giving Provider forty-five (45) days' written notice of the modification of the schedule of payments under the Agreement, including any changes to the fee schedule applicable to Provider's practice. If Provider fails to object in writing to the modification within such forty-five (45) day period, the modification shall become effective at the end of such period. If Provider timely objects in writing to the modification within such forty-five (45) day period, the modification will not become effective unless agreed to by both parties in writing. NRS 689B.015(3), 695C.125(2), 695G.430(2). To the extent permitted by law, nothing in this section shall preclude or limit amendments required by legislative, regulatory, or other legal authority from becoming effective in accordance with CARECENTRIX's notice to Provider as set forth in the Agreement.

4. Upon request at execution of the Agreement, and thereafter within seven (7) days after receipt of Provider's request, CARECENTRIX shall provide the schedule of payments applicable to Provider under the Agreement, including any changes to the fee schedule applicable to Provider's practice. NRS 689B.015(4), 695C.125(3), 695G.430(3).

5. Neither Payor nor CARECENTRIX shall restrict or interfere with any communication between Provider and a Member regarding any information that Provider determines is relevant to the health care of the Member. NRS 695G.400.

6. Neither Payor nor CARECENTRIX shall terminate the Agreement, demote, refuse to contract with, or refuse to compensate Provider solely because Provider, in good faith: (a) advocates in private or in public on behalf of a Member; (b) assists a Member in seeking reconsideration of a decision to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority. NRS 695G.410.

7. Neither Payor nor CARECENTRIX shall offer or pay any type of material inducement, bonus, or other financial incentive to Provider to deny, reduce, withhold, limit, or delay specific medically necessary health care services to a Member. Nothing in this section prohibits an arrangement for payment that uses capitation or other financial incentives, if the arrangement is designed to provide an incentive to Provider to use health care services effectively and consistently in the best interest of the health care of the Member. NRS 695G.420.

8. CARECENTRIX will make available to Provider in the Provider Manual information regarding the functioning and operation of the quality management program that applies to the Agreement. NRS 695G.180; NAC 695C.400.

9. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

    a. Provider shall release the Member from liability for the cost of Covered Services rendered to the Member pursuant to the Agreement, except for any copayment or nominal payment made by the Member as specified in the Member's benefit plan or for a service not covered under the Member's evidence of coverage. NAC 695C.190(2).

    b. The Agreement shall be effective for not less than one (1) year, subject to any right of termination stated in the Agreement. NAC 695C.190(3).

    c. Provider shall participate in CARECENTRIX's quality management program as referenced in the Agreement and described in the Provider Manual. NAC 695C.190(4).

    d. Provider shall render all medically necessary Covered Services required by the Agreement to each Member for the period for which a premium has been paid to Payor. NAC 695C.190(5).

    e. Provider shall submit proof of insurance against loss resulting from injuries to third persons as a result of Provider's professional practice, or a reasonable substitute for such proof as determined by CARECENTRIX. To the extent permitted by law, Provider shall indemnify Payor and CARECENTRIX from any liability resulting from the health care services rendered by Provider under the Agreement. NAC 695C.190(6).

    f. Payor, Provider, and CARECENTRIX agree to the schedule for the payment of claims under the Agreement as required by Section 695C.185 of Nevada Revised Statutes. NRS 695C.187.

10. CARECENTRIX does not come within the definition of a “third party” in N.R.S. § 687B.664 because CARECENTRIX does not contract with “health carriers” or with other “third party” as defined by N.R.S. § 687B.625 to gain access to a provider network contract as defined in N.R.S. § 687B.658. Accordingly, CARECENTRIX is not subject to the requirements of N.R.S. § 687B.694 et seq. regarding a third party’s sale, lease, rental, assignment, or granting access to a health care provider’s services, discounted rates, or fees under the provider contract. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider’s services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX’s customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

ADDENDUM FOR THE STATE OF NEW HAMPSHIRE

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of New Hampshire regarding provider contracts with providers rendering health care services in the State of New Hampshire. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX, Payor's or CARECENTRIX's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons acting on behalf of Members for Covered Services. This does not prohibit Provider from collecting coinsurance, deductibles, or copayments or fees for uncovered services delivered on a fee-for-service basis to Members nor does this prohibit Provider and a Member from agreeing to continue services solely at the expense of the Member as long as the Provider has clearly informed the Member that the Payor may not cover or continue to cover a specific service or services. This provision shall survive the termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of the Member. This provision supersedes any oral or written contrary agreement now existing or hereafter entered into ween Provider and Member or persons acting on their behalf. Any modifications, additions, or deletions to the provisions of this section shall become effective on a date no earlier than 15 business days after the Commissioner has received written notice of such proposed changes. N.H. Rev. Stat. § 420-J:8(I).

2. CARECENTRIX shall not terminate or refuse to renew the Agreement, discriminate against, or penalize Provider for participating in a Member's internal grievance procedure or external review. Nothing in this Agreement shall be construed to limit the information Provider may disclose to patients or to prospective patients regarding the provisions, terms, or requirements of the Payor's products as they relate to the needs of Provider's patients except for trade secrets of significant competitive value. Nothing in this Agreement shall create an inducement for Provider to withhold medically necessary care to a patient. N.H. Rev. Stat. § 420-J:8(V), (VIII.a), (X).

3. Provider is allowed a 60 day period from the postmarked date to review any proposed Agreement and any amendment to an existing Agreement, excluding those modifications that are expressly permitted under the existing Agreement. Failure to object in writing within the 60 day period shall be deemed to constitute acceptance of the proposed Agreement or amendment to the Agreement. However, if the terms, benefits, and conditions of the Agreement must be changed to comply with applicable state or federal law or regulation, Provider shall continue to perform services under the Agreement as so modified. N.H. Rev. Stat. § 420-J:8(VII), (VIII.d).

4. Upon termination of the Agreement, Provider, at the option of Member, shall continue to provide Covered Services for specific conditions for which a Member was under Provider's care at the time of such termination so long as Member retains eligibility until the earlier of completion of such services or the expiration of 60 days. Provider shall be compensated for Covered Services provided to any such Member in accordance with the compensation arrangements under the Agreement until 60 days following termination. Provider has no obligation under the Agreement to provide services to individuals who cease

to be Members. This provision shall not apply if Provider was terminated due to unprofessional behavior. N.H. Rev. Stat. § 420-J:8(XI).

5. Nothing in the Agreement shall be construed to require or obligate a provider who is employed by a hospital or any affiliate to refer patients to providers also employed or under contract with the hospital or any affiliate. N.H. Rev. Stat. § 420-J:8(XIV).

ADDENDUM FOR THE STATE OF NEW JERSEY

The provisions set forth in this Addendum are being added to the Agreement to comply with the legislative and regulatory requirements of the State of New Jersey regarding provider contracts with providers rendering health care services in the State of New Jersey. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. References to CARECENTRIX in this Addendum shall mean CareCentrix, Inc., for services in the State of New Jersey where the Payor reimburses on a fee-for-service basis, and CareCentrix of New Jersey, Inc., for services in the State of New Jersey where the Payor reimburses on a capitated or risk basis. CareCentrix of New Jersey, Inc., a wholly owned subsidiary of CareCentrix, Inc., is added to the Agreement for purposes of such capitated or risk business in the State of New Jersey only.

1. With respect to health care services rendered in the State of New Jersey, Section 3.03 (a) and (b) of the Agreement entitled **Payment Terms** shall not apply and the following Section 3.03(a) and (b) shall apply instead:

   3.03 Payment Terms

   (a) Except as provided in (b) below or otherwise herein, PROVIDER will be paid the undisputed amount payable under this Agreement for authorized Covered Services within 45 days after CARECENTRIX's receipt of a properly completed, accurate, non-duplicated invoice containing all required data elements as specified in the Provider Manual ("Clean Claim") from PROVIDER or the period of time required by applicable law. Clean claims for Covered Services subject to the New Jersey prompt pay law are required to be paid within 30 days of receipt if submitted electronically and within 40 days of receipt for paper claim submissions, and, if paid late, are subject to simple interest at the rate of 10% per annum. N.J.S.A. 17:48H-33.1(d).

   (b) For those Payors designated by CARECENTRIX, CARECENTRIX shall be the representative of PROVIDER solely for purposes of accepting Provider's claims submissions and billing and receiving payment from such Payors for the Covered Services rendered by PROVIDER. When CARECENTRIX receives a Clean Claim for Covered Services from PROVIDER as to such Payors, CARECENTRIX will bill the applicable Payor on behalf of PROVIDER in accordance with the rate and other terms agreed upon by CARECENTRIX with such Payor. Clean Claims for Covered Services subject to the New Jersey prompt pay law are required to be paid within 30 days of receipt if submitted electronically and within 40 days of receipt for paper claim submissions, and, if paid late, are subject to simple interest at the rate of 10% per annum. N.J.S.A. 17:48H-33.1(d). All other Clean Claims for Covered Services will be paid within 10 days of the date CARECENTRIX receives both payment in full and a complete explanation of payment from the Payor for such Clean Claim for Covered Services. PROVIDER will be reimbursed for such claims in accordance with the rate specified in this Agreement. PROVIDER understands and agrees that, as to Payors subject to this subsection (b), CARECENTRIX is not the delegate of the Payor for purposes of claims processing.

2. Any sections of the Agreement that conflict with applicable state or federal law are effectively amended to conform to the requirements of the state or federal law. N.J.A.C. 11:24B-5.2(a)1.

3. The compensation methodology is specified in the Compensation section of the Agreement, the Reimbursement Schedule attached to the Agreement, the Provider Manual, and/or the CareCentrix Provider Portal. To the extent that a different compensation methodology and terms apply to different products, such methodology, terms, and complete fee schedule shall be specified in the Agreement, the

Provider Manual, and/or the CareCentrix Provider Portal. In the event that fees for Covered Services under the Agreement are not individually negotiated, CARECENTRIX shall make available to Provider and prospective network providers complete fee schedule(s) that are or are to be included in the Agreement. Fee schedules shall be supplied in writing unless CARECENTRIX makes the fees for included CPT or HCPCS codes available on the CARECENTRIX Provider Portal or otherwise makes them available electronically to providers. To the extent that Provider is reimbursed for covered services on a basis other than fee-for-service (for example, capitation, per diem, or percent of charges), the Agreement shall specify the dollar amount or methodology used by CARECENTRIX to determine reimbursement, and shall identify the services included in and excluded from the alternate reimbursement methodology. The compensation methodology shall not provide financial incentives to Provider for the withholding of covered health care services that are medically necessary. This does not prohibit or limit the use of capitated payment arrangements between CARECENTRIX and Provider except that capitation shall not be the sole method of reimbursement if Provider primarily provides supplies rather than services. To the extent that some portion of the compensation is tied to the occurrence of a pre-determined event or the non-occurrence of a pre-determined event, the event must be clearly specified, and Provider has a right to receive a periodic accounting of the funds held which shall be no less frequently than annually. Provider may appeal a decision denying compensation to which Provider believes it is entitled under the terms of the Agreement in accordance with the appeal process described in the Provider Manual as modified by this Addendum. N.J.A.C. 11:24B-5.2(a)2; 11:24C-4.3(c)1.i. and ii.; N.J.A.C. 11:24C-4.4; N.J.A.C. 11:24C-4.3(b)1; N.J.A.C. 11:24C-4.3(b).

4. Provider's activities and records relevant to the provision of health care services may be monitored from time to time either by CARECENTRIX, the Payor, or another contractor acting on behalf of CARECENTRIX or the Payor in order for CARECENTRIX or the Payor to perform quality assurance and continuous quality improvement functions. N.J.A.C. 11:24B-5.2(a)3.

5. Provider shall comply with CARECENTRIX's quality assurance program. CARECENTRIX is responsible for the day-to-day administration of such program. Provider may lodge complaints regarding such program and otherwise provide feedback regarding CARECENTRIX's operations by contacting CARECENTRIX and provide feedback regarding Payor operations by contacting the applicable Payor identified on the patient identification card. N.J.A.C. 11:24B-5.2(a)4; N.J.A.C. 11:24-15.2(b).

6. Provider must comply with the applicable Payor's utilization management program as adopted by CARECENTRIX for such Payor. Depending on the arrangement with the applicable Payor, CARECENTRIX may be responsible for making authorization approval decisions with the applicable Payor making any denial determinations or CARECENTRIX may be responsible for making both authorization approval and denial decisions. The utilization management program requirements are specified in the Provider Manual, including the method for obtaining a utilization management decision and appealing a utilization management decision. Provider has the right to obtain the name and phone number of the physician denying or limiting a service or procedure. The Provider Manual and/or patient identification card include information and/or a telephone number through which Provider may receive information regarding utilization management protocols, any parameters that may be placed on the use of one or more protocols, and how Provider can review and provide comment on the applicable protocols for Provider's practice area. To the extent required by New Jersey law, Provider has the right to rely upon the written or oral authorization of a service if made by the applicable Payor or the entity identified as being responsible for the day-to-day operations of the utilization management program and such services will not be retroactively denied as not medically necessary except in cases where there was material misrepresentation of the facts to the Payor or the entity responsible for the day-to-day operations of the utilization management program, or fraud. N.J.A.C. 11:24B-5.2(a)5; N.J.A.C. 11:24C-4.3(c)1.v.

7. Information regarding the rights and obligations of Provider when appealing a utilization management decision on behalf of a covered person may be obtained in the Provider Manual, the applicable denial letter and/or by calling the phone number on the patient identification card, including whether Provider

must obtain the consent of the covered person in order for the appeal to be reviewed in accordance with the Stage 1 and Stage 2 process as set forth at N.J.A.C. 11:24-8 and 11:24A-3.5 or whether failure to obtain consent of the covered person results in review of the appeal using a separate complaint or provider grievance process. In the event that an appeal instituted by Provider on behalf of a covered person will be entertained as a member utilization management appeal without the covered person's consent, such appeals will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the covered person's specific consent to the appeal is obtained. Provider is not limited to submitting an appeal on behalf of the covered person in situations in which the covered person may be financially liable for the costs of the health care services. N.J.A.C. 11:24B-5.2(a)6; N.J.A.C. 11:24-15.2(b).

8. This Agreement is governed by New Jersey law. N.J.A.C. 11:24B-5.2(a)7.

9. The term of this Agreement and renewal and termination rights and obligations are specified in the provision of this Agreement entitled Term and Termination. The Agreement may automatically renew, provided, however, that no adverse change may be made to the terms of the Agreement upon its automatic renewal. Any such adverse change may be made to the Agreement as set forth in section 22 below, either before or after renewal of the Agreement. To the extent required by law, CARECENTRIX will give Provider 90 days advance notice of a termination of this Agreement and Provider has a right to request a hearing regarding such termination except when the termination is based on nonrenewal of the contract, a determination of fraud, breach of contract by Provider or in the opinion of the CARECENTRIX medical director Provider represents an imminent danger to a patient or the public health, safety and welfare. Such termination notice will include the reason for termination and process for requesting a hearing. Any such hearing will not be deemed an abrogation of Provider's legal rights. In the event of a termination, Provider will continue to provide services at the contract rate in accordance with N.J.A.C. 11:24-3.5. N.J.A.C. 11:24B-5.2(a)8 and 9; 11:24C-4.3(c)1.iii.; N.J.A.C. 11:24C-4.3(e); N.J.A.C. 11:24-15.2(b).

10. In no event, including but not limited to nonpayment by Payor or CARECENTRIX, shall Provider bill or otherwise pursue payment from a covered person for the costs of services or supplies rendered in-network that are covered or for which benefits are payable under the covered person's plan regardless of whether the provider agrees with the amount paid or to be paid for the services or supplies rendered. Further, in the event of insolvency of CARECENTRIX, Provider agrees to continue to provide covered services to covered persons through the date payments were made by Payor for such services. N.J.A.C. 11:24B-5.2(a)10; N.J.A.C. 11:24-15.2(b).

11. Provider must be licensed as required by law, credentialed and otherwise eligible to participate in various programs as appropriate. The time periods for credentialing and recredentialing are specified in the Provider Manual. Provider must comply with CARECENTRIX's credentialing process. Provider shall maintain malpractice insurance in the amount of not less than $1,000,000 per occurrence and $3,000,000 annual aggregate. N.J.A.C. 11:24B-5.2(a)11 and 12; N.J.A.C. 11:24-15.2(b).

12. The services to be provided by Provider are specified in the Agreement, as amended, including but not limited to Schedule A. N.J.A.C. 11:24B-5.2(a)13; N.J.A.C. 11:24-15.2(b).

13. Provider has the right and obligation to communicate openly with all covered persons regarding diagnostic tests and treatment options. N.J.A.C. 11:24B-5.2(a)14; N.J.A.C. 11:24-15.2(b).

14. Provider shall not be terminated or otherwise penalized because of complaints or appeals that Provider files on its own behalf, or on behalf of a covered person, or for otherwise acting as an advocate for covered persons in seeking appropriate, medically necessary health care services covered under the covered person's health benefits plan. N.J.A.C. 11:24B-5.2(a)15; 11:24-15.2.(b) 2 and 3.

15. Provider shall not discriminate in its treatment of a Payor's covered persons. N.J.A.C. 11:24B-5.2(a)16; N.J.A.C. 11:24-15.2(b).

16. The procedures for submitting and handling claims, including any penalties that may result in the event that claims are not submitted timely, the standards for determining whether submission of a claim has been timely, how any interest on late claims will be paid to Provider, and the process for Provider to dispute the handling or payment of claims is specified in the Agreement and Provider Manual. Claims should be submitted to the address referenced in the Provider Manual or by contacting the CARECENTRIX Provider Resolution Team at the toll free number specified in the Provider Manual. N.J.A.C. 11:24B-5.2(a)17. Monthly invoices are not required, but claims must be submitted to CARECENTRIX within 60 days of the date of service or within the timeframe required by applicable law if later. To the extent applicable, N.J.S.A. 45:1-10.1 allows licensed health care professionals to submit claims in which the patient has assigned benefits within 180 days of the last date of service for a course of treatment.

17. Provider may submit and seek resolution of complaints and grievances, separate and apart from submitting complaints and grievances on behalf of a covered person, and complaints addressing compensation and claim issues may be submitted in accordance with the procedures specified in the Provider Manual and Agreement, as modified by the applicable terms in this Addendum. Such procedures shall comply with N.J.S.A. 17B:27-44.2e and 26:2J-8.1e to the extent applicable (for example, to the extent CARECENTRIX is delegated by the Payor to handle such complaints and grievances and to the extent required by New Jersey law, the time frame for submitting any such complaints and grievances shall not be less than 90 days following Provider's receipt of the claims determination, only one level of appeal will apply, and the timeframe for resolving such complaints and grievances shall not exceed 30 days following receipt of the complaint or grievance. To the extent provided under New Jersey law, Provider may submit complaints and grievances to the Department if not satisfied with the resolution of the complaint or grievance through the internal provider complaint mechanism, and any such matters submitted for arbitration must be submitted within 90 days of receipt of the appeal determination, and the amount in dispute must be $1,000 or more (Provider may aggregate disputed claim amounts to meet the $1,000 threshold). N.J.A.C. 11:24B-5.2(a)18; N.J.A.C. 11:24C-4.3(c)1.vii.

18. To the extent required by New Jersey law, recoveries of overpayments to Provider shall conform to N.J.S.A. 17B:27-44.2d (10), (11), and -44.2e, and 26:2J-8.1d (10), (11), and -8.1e (for example, except in situations involving fraud, 45 days' notice of the overpayment, stay of recovery efforts pending internal payment appeal and state sponsored arbitration if applicable, 18 month limitation on recoveries from the date of payment, recoupment permitted means of recovery if provided sufficient detail so provider can reconcile each covered person's bill).

19. The standards for confidentiality regarding health care information and exchange of information between the parties are specified in the Miscellaneous Terms of the Agreement. N.J.A.C. 11:24B-5.2(a)19; N.J.A.C. 11:24-15.2(b).

20. The Payor is a third party beneficiary of the Agreement, with privity of contract, and a right to enforce the provisions of the Agreement in the event that CARECENTRIX fails to do so. N.J.A.C. 11:24B-5.7(a); N.J.A.C. 11:24-15.2(b).

21. The provision in the Agreement entitled Independent Contractor shall be deleted and replaced with the following: Provider and CARECENTRIX are independent contractors as permitted by statute, regulation, and/or common law. Provider and CARECENTRIX have no employment, partnership, or joint venture relationship. N.J.A.C. 11:24B-5.2(b)1.

22. The methods by which the Agreement may be amended, renewed, and terminated are specified in the Amendment and Waiver section, and the Term and Termination section, of the Agreement. Any provision in the Agreement that establishes a unilateral right of a party to amend the Agreement and requires a party

to abide by the amended terms of the Agreement during a notice of termination period in the event that one party elects to terminate the Agreement rather than accept the amendment shall not apply unless such amendment is required by state or federal law. To the extent that the terms of the Agreement have been the subject of negotiation between the parties, no changes shall be made unilaterally to the administration of the Agreement materially impacting those terms. For example, if rates have been negotiated, carriers may not unilaterally introduce Multiple Procedure Logic or changes to billing requirements that would result in a material reduction in reimbursement for services affected by the change. Any adverse change or amendment to the Agreement may be made in accordance with the terms of the Agreement only upon ninety (90) days' notice prior to the effective date of the change or amendment. If Provider declines to accept the amendment, Provider may terminate the Agreement as set forth in N.J.A.C. 11:24C-4.3(c)3. N.J.A.C. 11:24B-5.2(c)2; N.J.A.C. 11:24C-4.3(c)1.iv.; N.J.A.C. 11:24C-4.3(c)3; N.J.A.C. 11:24C-4.3(c)4; N.J.A.C. 11:24C-4.3(d).

23. To the extent required by New Jersey law, (a) the term "Medical necessity" or "medically necessary" shall mean or describe a health care service that a health care provider, exercising his prudent clinical judgment, would provide to a covered person for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the covered person's illness, injury or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury or disease; and (b) with respect to services or supplies that are medically necessary under the terms of the applicable plan but that were not pre-certified or pre-authorized and for which payment is denied solely on that basis, upon substantiation of such medical necessity, payment will be made at 50% of what would otherwise have been paid had pre-certification or pre-authorization been obtained for the medically necessary service. N.J.S.A. 17B:30-50; N.J.A.C. 11:24B-5.2(c)6.

24. Provider's obligation to maintain liability insurance is specified in the Insurance section of the Agreement. N.J.A.C. 11:24C-4.3(c)1.vi.

25. The Agreement shall not contain a most favored nation clause, or clauses having a similar effect. N.J.A.C. 11:24C-4.3(c)2.

26. Pursuant to the applicable requirements of N.J.A.C. 11:24C-4.3(c)5, the Agreement specifically provides that CARECENTRIX may enter into agreements with third parties allowing the third parties to obtain CARECENTRIX's rights and responsibilities under the Agreement as if the third party were CARECENTRIX. Such third parties may include, but are not limited to, preferred provider organizations (PPOs), organized delivery systems (ODSs), and such other entities to which CARECENTRIX may lease its provider network, in accordance with the terms set forth below:

    a. Every third party accessing the Agreement is contractually obligated to comply with all of its terms;

    b. CARECENTRIX shall identify all such third parties in existence as of the date the Agreement is entered into;

    c. CARECENTRIX shall include on its website a listing, updated no less frequently than every ninety (90) days, identifying all such third parties;

    d. The source of the discount shall be identified on all remittance advices and/or explanations of payment under which a discount is taken;

    e. CARECENTRIX shall notify the third party of the termination of the Agreement upon issuance of the notice of termination by CARECENTRIX or upon receipt of the notice of termination from Provider;

f. The third party ceases its right to Provider's discounted rate upon termination of the Agreement. For purposes of this subsection f., "third party" does not include any employer or other group for which CARECENTRIX provides administrative services, including at least the payment of claims; and

g. CARECENTRIX shall deliver to Provider a copy of any agreement relied on in the adjudication of a claim within thirty (30) days after the date of a request from Provider subject to the terms of such agreement.

27. CARECENTRIX shall deliver to Provider a copy of the fully executed initial Agreement and any amendments thereto within thirty (30) days after the effective date of the initial or amended Agreement, and within thirty (30) days after the date of a request from Provider for a copy of the Agreement and/or amendments thereto. N.J.A.C. 11:24C-4.3(f).

28. CARECENTRIX shall make available online the name of any commercially available software used by CARECENTRIX for editing claims, together with a description of CARECENTRIX-specific edits in a manner detailed enough to provide an understanding of such specific edits. N.J.A.C. 11:24C-4.3(b)2.

29. To the extent required by N.J. Stat. § 17B:30-34.1, the following shall apply:

    a. The Agreement shall not mandate only one form of payment from CARECENTRIX to Provider including, but not limited to, payment by credit card, electronic funds transfer, or check.

    b. If any available payment method has a fee associated with it, CARECENTRIX shall, prior to initiating its first payment to Provider, or upon changing the payment methods available to Provider:

        i. Notify Provider that there may be fees associated with a particular payment method, and that CARECENTRIX shall disclose any fees beyond what Provider would normally pay to process a payment using that particular payment method; and
        ii. Furnish Provider with clear instructions on the CARECENTRIX's website, or through means other than the Agreement, as to how to select each payment method.

    c. If Provider requests a change in the available payment method, CARECENTRIX shall implement the change to the payment method selected by Provider within 30 business days, subject to federal and State verification measures to prevent fraud and abuse.

30. Defined terms, including but not limited to, "Adverse change," "adverse amendment," "Health care provider" or "provider, "most favored nation clause," and "Multiple Procedure Logic" set forth in those provisions above required by N.J.A.C. 11:24C-4 are set forth at N.J.A.C. 11:24C-4.2

ADDENDUM FOR THE STATE OF NEW MEXICO

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of New Mexico regarding provider contracts with providers rendering health care services in the State of New Mexico. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health care insurer, managed health care plan, or health maintenance organization, as those terms are defined in applicable New Mexico law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. The specific health care services for which Provider shall be responsible, including any limitations or conditions on such services, are set forth in the Agreement, including but not limited to Schedule "A" and other attachments, addendums, and exhibits to the Agreement, and in the Provider Manual. N.M. Admin. Code [NMAC] § 13.10.22.12(B).

2. Provider agrees that in no event, including but not limited to nonpayment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Member or person acting on behalf of the Member, for Covered Services provided pursuant to the Agreement. This does not prohibit Provider from collecting co-insurance, deductibles, or copayments as specifically provided in the evidence of coverage, or fees for non-covered health care services delivered on a fee-for-service basis to Members, nor from any recourse against Payor or its successor. The hold harmless provision required by this section shall survive the termination of the Agreement regardless of the reason for the termination, including the insolvency of Payor or CARECENTRIX. NMAC 13.10.22.12(C), (L).

3. The rights and responsibilities of Provider and CARECENTRIX with respect to CARECENTRIX's administrative policies and programs, including but not limited to payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or State programs, are set forth in the Agreement, including applicable addendums, attachments, and exhibits thereto, and in the Provider Manual. NMAC 13.10.22.12(D).

4. Provider shall make health records available to CARECENTRIX and Payor to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity and appropriateness of health care services provided to Members. The confidentiality of such health records shall be maintained pursuant to applicable State and federal laws. Provider shall also make such health records available to appropriate State and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of Members. Provider shall comply with applicable State and federal laws related to the confidentiality of medical or health records. NMAC 13.10.22.12(E).

5. The rights and responsibilities of Provider under the Agreement shall not be assigned or delegated by Provider without the prior written consent of CARECENTRIX. NMAC 13.10.22.12(F).

6. Provider shall maintain adequate professional liability and malpractice insurance coverage in amounts satisfactory to CARECENTRIX. Provider shall notify CARECENTRIX not more than ten (10) days after Provider's receipt of notice of any reduction or cancellation of such coverage. NMAC 13.10.22.12(G).

Notwithstanding the foregoing, if the Agreement requires Provider to notify CARECENTRIX of a reduction or cancellation of coverage in less than ten (10) days, the shorter notice period shall apply.

7. Provider shall observe, protect, and promote the rights of Members as patients. NMAC 13.10.22.12(H).

8. Provider shall provide Covered Services without discrimination on the basis of a Member's participation in the health care plan, age, gender, ethnicity, religion, sexual orientation, health status, or disability, and without regard to the source of payments made for Covered Services rendered to a Member. This requirement shall not apply to circumstances when Provider appropriately does not render services due to limitations arising from Provider's lack of training, experience, or skill, or due to licensing restrictions. Payor shall provide interpreters for limited English proficient (LEP) Members and interpretative services for Members who qualify under the Americans with Disabilities Act (ADA). Such interpretive services will be made available to Provider's office at no cost to Provider. NMAC 13.10.22.12(I).

9. In accordance with performance standards set forth in the Provider Manual, Provider shall maintain twenty-four (24) hour on-call coverage seven (7) days per week, unless otherwise specified by the Agreement. NMAC 13.10.22.12(J).

10. The procedures for the resolution of disputes between the parties arising out of the Agreement are set forth in the Agreement and in the Provider Manual. NMAC 13.10.22.12(K); N.M. Stat. § 59A-57-6(C).

11. To the extent required by law, those terms used in the Agreement that are defined by New Mexico statutes and Division of Insurance regulations will be used in the Agreement in a manner consistent with any definitions contained in said laws or regulations. NMAC 13.10.22.12(M).

12. Nothing in the Agreement shall be construed to:
    a. offer an inducement, financial or otherwise, to provide less than medically necessary services to a Member;
    b. penalize Provider for assisting a Member to seek a reconsideration of Payor's decision to deny or limit benefits to the Member;
    c. prohibit Provider from discussing treatment options with Members irrespective of Payor's or CARECENTRIX's position on the treatment options, or from advocating on behalf of a Member or Members within the utilization review or grievance processes established by Payor or CARECENTRIX;
    d. prohibit Provider from using disparaging language or making disparaging comments when referring to Payor or CARECENTRIX; or
    e. require Provider to violate any recognized fiduciary duty of Provider's profession or to place Provider's license in jeopardy. NMAC 13.10.22.12(N); N.M. Stat. § 59A-57-6(A).

13. To the extent required by law and applicable to Provider, in the event that Payor fails to pay Provider who is a health care professional, or fails to pay a Member for out-of-pocket covered expenses, within forty-five days (45) after a clean claim for Covered Services has been received by Payor, Payor shall be liable for the amount due and unpaid, with interest on that amount at the rate of one and one half (1½) times the rate established by a bulletin entered by the New Mexico Superintendent of Insurance in January of each calendar year. For the purposes of this section, "clean claim" means a manually or electronically submitted claim that contains all the required data elements necessary for accurate adjudication without the need for additional information from outside of Payor's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by Payor, or particular circumstances requiring special treatment that prevents timely payment from being made by Payor. NMAC 13.10.22.12(O). As defined in NMAC 13.10.22.7, the term "health care professional" means a physician or other health care practitioner, including a pharmacist, who is licensed, certified, or otherwise authorized by the State to provide health care services consistent with State law.

14. To the extent required by law, no clause in the Agreement shall have the effect of relieving either party of liability for its actions or inactions. N.M. Stat. § 59A-16-21.1(D).

15. The following continuation of care and transition of treatment provisions shall apply to the Agreement to the extent required by NMAC 13.10.23.14(A) to (E):

    a. In the event that either party terminates the Agreement without cause, a Member who is in an ongoing course of treatment with Provider on the effective date of termination shall be permitted to continue to receive Covered Services from Provider: (i) for a transitional period that is sufficient to permit coordinated transition planning consistent with the Member's condition and needs relating to continuity of care, and, in any event, not less than thirty (30) days; and (ii) with respect to a Member who has entered the third trimester of pregnancy at the time of termination, for a transitional period that shall include the provision of post-partum care directly related to the delivery.

    b. Neither Payor nor CARECENTRIX shall be required to permit the Member to continue treatment with Provider for a transitional period if the Agreement was terminated for reasons related to medical competence or professional behavior.

    c. For transitional periods exceeding thirty (30) days, CARECENTRIX shall authorize continued care as provided in this section, only if Provider agrees: (i) to accept reimbursement for Covered Services at the rates applicable under the Agreement prior to the start of the transitional period as payment in full; (ii) to adhere to CARECENTRIX's quality assurance requirements and to provide CARECENTRIX and Payor with necessary medical information related to such care; and (iii) to otherwise adhere to CARECENTRIX's policies and procedures, including but not limited to procedures regarding referrals, pre-authorization, and treatment planning approved by CARECENTRIX.

16. The following provisions shall apply to termination of the Agreement by CARECENTRIX to the extent required by NMAC 13.10.16.9:

    a. In the event that CARECENTRIX proposes to terminate the Agreement, CARECENTRIX shall provide a written explanation to Provider for the proposed termination, and shall deliver reasonable advance written notice to Provider prior to the proposed effective date of the termination. Such notice shall be delivered if the termination is for cause, if the termination is at the convenience CARECENTRIX, if the termination is by virtue of a fixed termination date in the Agreement, or if CARECENTRIX does not intend to offer renewal of the Agreement. For purposes of this section, "reasonable advance written notice" is a minimum of thirty (30) days, except when the quality of care provided to Members is the basis of CARECENTRIX's proposed termination. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by CARECENTRIX, the longer notification period will apply.

    b. When the quality of care provided to Members is the basis for termination, and CARECENTRIX has a good faith and reasonable belief that further care by Provider would result in imminent and significant harm to Members, CARECENTRIX is not required to provide advance written notice of termination of the Agreement, but shall follow the expedited fair hearing process in NMAC 13.10.16.9(A) if Provider disputes the termination.

    c. In the event that CARECENTRIX terminates the Agreement for cause, Provider may dispute whether CARECENTRIX has adequate cause to terminate Provider's participation under the Agreement for cause, in accordance with the fair hearing process provided in NMAC 13.10.16.9(A).

    d. Nothing in this section shall be construed to prohibit CARECENTRIX from terminating the Agreement without cause.

17. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement as required by N.M. Stat. § 59A-46-13(E), (F), and (G):

a. In the event that Payor or CARECENTRIX, as applicable, fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from the Member sums owed by Payor or CARECENTRIX. Neither Provider nor any agent, trustee, or assignee of Provider, shall maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX.

b. In the event of the insolvency of Payor, Provider shall continue to provide Covered Services to Members for the duration of the contract period after Payor's insolvency for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of the insolvency, until the Member's discharge from the inpatient facility or expiration of benefits. Payor may be required by the New Mexico Superintendent of Insurance to maintain insurance, insolvency reserves, letters of credit, or other arrangements to assure that benefits to Members are continued as specified in this subsection.

c. Provider shall give CARECENTRIX at least sixty (60) days' advance written notice of termination of the Agreement. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

ADDENDUM FOR THE STATE OF NEW YORK

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of New York regarding provider contracts with providers rendering health care services in the State of New York. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurance company licensed to offer accident and health insurance subject to Article 32 of New York Insurance Law, a corporation licensed pursuant to Article 43 of New York Insurance Law, or an entity possessing a certificate of authority under Article 44 of the New York Public Health Law, except to the extent that any of the foregoing is excluded under applicable law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to prohibit or restrict Provider from:

    a. Disclosing to a Member or a Member's designated representative, any information that Provider deems appropriate regarding: (i) a condition or course of treatment, including the availability of other therapies, consultations, or tests; or (ii) the provisions, terms, or requirements of Payor's or CARECENTRIX's products to the extent that they relate to the Member. N.Y. Ins. Law § 3217-b(a).

    b. Filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of Payor or CARECENTRIX, which Provider believes may have a negative impact upon the quality of, or access to, patient care. N.Y. Ins. Law § 3217-b(b).

    c. Advocating to Payor or CARECENTRIX on behalf of a Member for approval of coverage of a particular course of treatment or for the provision of Covered Services. N.Y. Ins. Law § 3217-b(c).

2. Nothing in the Agreement shall be construed to transfer to Provider, by indemnification or otherwise, liability for the activities, actions, or omissions of Payor or CARECENTRIX, as opposed to the activities, actions, or omissions of Provider. N.Y. Ins. Law § 3217-b(d).

3. To the extent required by New York law and not otherwise preempted by federal law, the method by which payments to Provider shall be calculated, and the other payment terms and conditions specified in N.Y. Ins. Law § 3217-b(e), are set forth in the Agreement, including applicable schedules thereto and the Provider Manual. To the extent permitted by N.Y. Ins. Law § 3217-b(e)(5), either party may seek resolution of a dispute arising pursuant to the payment terms of the Agreement through a proceeding under article seventy-five of the civil practice law and rules (N.Y. Civ. Prac. Law, Art. 75, Arbitration).

4. To the extent required by New York law and not otherwise preempted by federal law, Provider shall have in place business processes to ensure the timely provision of provider directory information to CARECENTRIX. Provider shall submit such provider directory information to CARECENTRIX, at a minimum, when Provider begins or terminates the Agreement, when there are material changes to the content of the provider directory information of the Provider, and at any other time, including upon CARECENTRIX's request, as Provider determines to be appropriate. For the purposes of this section, "provider directory information" shall include the name, address, specialty, telephone number, and digital

contact information of Provider, and whether Provider is accepting new patients. N.Y. Ins. Law § 3217-b (m); NY CLS Pub Health § 4406-c (11) [HMOs].

5. To the extent required by New York law and not otherwise preempted by federal law, Provider shall reimburse a Member for the full amount paid by the Member in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the New York Department of Financial Services in accordance with 42 U.S.C. § 300gg-139(b), for Covered Services involved when the Member is provided with inaccurate network status information by a Payor in a provider directory or in response to a request that stated that Provider was a participating provider when Provider was not a participating provider. In the event a Payor or CARECENTRIX provides inaccurate network status information to the Member indicating the Provider was a participating provider when such provider was not a participating provider, Payor or CARECENTRIX shall reimburse Provider for the out-of-network services regardless of whether the Payor's coverage includes out-of-network services. This provision shall not be construed to prohibit Provider from requiring in the terms of the Agreement that Payor or CARECENTRIX remove Provider from the Payor's provider directory at the time of termination of the Agreement, or that Payor or CARECENTRIX bear financial responsibility for providing inaccurate network status information to Member. N.Y. Ins. Law § 3217-b (n); NY CLS Pub Health § 4406-c (12) [HMOs].

6. a. The Agreement shall not contain a most favored nation provision. N.Y. Ins. Law § 3217-b (o)(1)(A); NY CLS Pub Health § 4406-c (13)(a)(i) [HMOs].

   b. The Agreement shall not restrict Provider or CARECENTRIX from disclosing: (i) actual claims costs, or (ii) price or quality information required to be disclosed under federal law, including the allowed amount, negotiated rates or discounts, or any other claim-related financial obligations, including, but not limited to, Member cost-sharing covered by the Agreement, to any Member, group or other entity receiving health care services pursuant to the Agreement, or to any public compilation of reimbursement data such as the New York all payer database required by law or regulation. No disclosure shall include protected health information or other information covered by statutory or other privilege. N.Y. Ins. Law §3217-b (o)(1)(B); NY CLS Pub Health § 4406-c (13)(a)(ii) [HMOs].

7. To the extent required by New York law and not otherwise preempted by federal law, Provider shall initially submit a claim within one hundred and twenty (120) days after the date of service unless a longer time period is permitted under the Agreement or applicable law. Provider shall be permitted to request reconsideration of a claim that is denied exclusively because it was submitted untimely; and Payor shall pay such claim in accordance with applicable law if Provider can demonstrate that non-compliance was a result of an unusual occurrence and that Provider has a pattern or practice of submitting claims in compliance with timely submission requirements. Payor may reduce the reimbursement due for an untimely claim by an amount not to exceed twenty-five percent (25%) of the amount that would have been paid had the claim been submitted in a timely manner; provided, however, that nothing herein shall preclude the parties from agreeing to a lesser reduction. Payor may deny the claim in full for a claim submitted three hundred and sixty-five (365) days or more after the date of service. N.Y. Ins. Law § 3224-a(g) and (h).

8. The following provisions shall be added to the Agreement if and to the extent that CARECENTRIX and Payor enter into a financial risk transfer agreement that is subject to N.Y. Comp. Code R. & Regs., Tit. 11, Chap. IV, Subchap. B, Part 101 (Regulation 164):

   a. Provider shall not, in the event of default by CARECENTRIX, demand payment from Payor for any Covered Services rendered to Members for which the in-network capitation payment was made by Payor to CARECENTRIX pursuant to a financial risk transfer agreement that includes a prepaid

capitation arrangement and is subject to Regulation 164 of the New York State Department of Financial Services. 11 NYCRR § 101.4(a)(1).

b. Provider shall not collect or attempt to collect from a Member any amounts owed to Provider for Covered Services, other than any amounts that the Member is obligated to pay pursuant to the Member's applicable health benefit plan. Provider acknowledges that this subsection (b) is in addition to the protections afforded to Members under New York Insurance Law Section 4307(d). 11 NYCRR § 101.4(a)(2).

c. In the event that the financial risk transfer agreement between Payor and CARECENTRIX is terminated by the Superintendent of the New York State Department of Financial Services (the "Superintendent") pursuant to 11 N.Y.C.R.R. § 101.9(a)(7), the Agreement with Provider may be assigned on a prospective basis (without any obligation to pay any amounts owed to Provider by CARECENTRIX) to each payor that entered into a financial risk transfer agreement with CARECENTRIX, for a period of time that is determined by either: (i) the Commissioner of the New York State Department of Health with respect to payors [HMOs] certified pursuant to Article 44 of the New York Public Health Law, or (ii) the Superintendent with respect to all other payors. This assignment is necessary in order to provide the services that Payor is legally obligated to deliver to its Members. However, no such assignment shall exceed twelve (12) months from the date that the financial risk transfer agreement between Payor and CARECENTRIX is terminated by the Superintendent. 11 NYCRR § 101.4(a)(3).

ADDENDUM FOR THE STATE OF NORTH CAROLINA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of North Carolina regarding provider contracts with providers rendering health care services in the State of North Carolina. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. The Agreement, including any attached or incorporated amendments, exhibits, addenda (including but not limited to this Addendum for the State of North Carolina), or appendices, constitutes the entire agreement. 11 N.C. Admin. Code [NCAC] 20.0202(1).

2. The Agreement is effective as of the date specified on the first page of the Agreement in the section identifying the parties, unless otherwise provided therein, and the term of the Agreement shall run from such effective date and as specified in the Term provision of the Agreement. 11 NCAC 20.0202(3).

3. The Agreement may be terminated upon written notice as provided in the Termination provision of the Agreement. Following termination of the Agreement or in the event of Payor or CARECENTRIX insolvency, Provider shall cooperate to ensure a smooth transitioning of Member care and administrative duties and records. In the event of Payor or CARECENTRIX insolvency, Provider will continue to provide Covered Services to Members under Provider's care through the date that premium was paid. 11 NCAC 20.0202(4), (5).

4. Provider shall maintain licensure, accreditation, and credentials sufficient to meet CARECENTRIX's credential verification program requirements and notify CARECENTRIX of subsequent changes in the status of any information relating to Provider's professional credentials. Information regarding credentialing requirements is found in the Provider Manual and credentialing application package. 11 NCAC 20.0202(6).

5. Provider shall maintain professional liability coverage in an amount acceptable to CARECENTRIX and notify CARECENTRIX of subsequent changes in the status of professional liability insurance coverage on a timely basis. 11 NCAC 20.0202(7).

6. Provider shall not bill any Member for Covered Services, and such prohibition against billing Members shall survive the termination of this Agreement for any reason, including CARECENTRIX or Payor insolvency. This provision shall not prohibit Provider and Member from agreeing to continue non-covered services at the member's own expense, as long as Provider has notified Member in advance that Payor may not cover or continue to cover specific services and the Member chooses to receive the service. CARECENTRIX shall be responsible for collecting Member copayments, coinsurance, and deductibles unless otherwise provided in the Agreement or directed by CARECENTRIX. 11 NCAC 20.0202(8).

7. Provider shall arrange for call coverage or other back-up to provide Covered Services to Members in accordance with the accessibility standards required by law and applicable accrediting bodies with respect to home care services. 11 NCAC 20.0202(9).

8. Providers can verify eligibility, based on current information held by the Payor, before rendering health care services by contacting the phone number and/or website listed on the patient identification card. Mutually agreeable provision may be made for cases where incorrect or retroactive information was submitted by an employer group. 11 NCAC 20.0202(10).

9. Provider shall maintain confidentiality of member medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law; maintain adequate medical and other health records according to industry, CARECENTRIX, and Payor standards; and make copies of such records available to CARECENTRIX, Payors, and the Department of Insurance in conjunction with its regulation of the Payor. 11 NCAC 20.0202(11).

10. Provider shall cooperate with Members and Member grievance procedures. 11 NCAC 20.0202(12).

11. Provider shall not discriminate against Members on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage. 11 NCAC 20.0202(13).

12. Provider will be reimbursed for Covered Services rendered to Members in accordance with the fee schedule specified in the Agreement. 11 NCAC 20.0202(14).

13. The following data and information will be provided to Provider: (a) performance feedback reports or information if compensation is related to efficiency criteria; and (b) information on benefit exclusions, administrative and Utilization Management requirements, credential verification programs, Quality Management programs, and provider sanction policies. Such information is available in the Provider Manual, at the CARECENTRIX website, in other written materials provided to Provider, and/or at the phone number or website listed on the patient identification card. To the extent required by law, notification of changes to these requirements shall be provided in the same manner and will allow Provider time to comply with changes. 11 NCAC 20.0202(15).

14. Provider shall comply with the CARECENTRIX Utilization Management program, credential verification programs, Quality Management programs, and provider sanctions program, provided, however, that none of these shall override the professional and ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to Members. 11 NCAC 20.0202(16).

15. Provider authorizes and CARECENTRIX and/or Payors will include the name of Provider in a directory distributed or made available to Members. 11 NCAC 20.0202(17).

16. Contractual differences between Provider and CARECENTRIX will be resolved in accordance with the dispute resolution process set forth in the Provider Manual and Agreement. 11 NCAC 20.0202(18).

17. Provider's duties and obligations under the Agreement shall not be assigned, delegated, or transferred without the prior written consent of CARECENTRIX. CARECENTRIX shall notify Provider in writing of any duties or obligations that are to be delegated or transferred before the delegation or transfer to the extent required by law and not already specified in the Agreement. 11 NCAC 20.0202(19).

18. To the extent required by law, the term Medically Necessary shall mean services or supplies that are provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease, and except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes; necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms; within generally accepted standards of medical care in the community; and not solely for the convenience of the Member, the Member's family, or Provider. For Medically Necessary services, nothing in this provision precludes a Payor from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered. N.C. Gen. Stat. § 58-3-200(b); 11 NCAC 20.0202(2).

19. To the extent required by law:

    a. Clean claims for Covered Services must be submitted within 180 days after the date of provision of care, provided, however, that failure to submit a claim within such timeframe does not invalidate or reduce a claim if it was not reasonably possible for Provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Member, later than one year from the time submittal of the claim is otherwise required. N.C. Gen. Stat. § 58-3-225(f).

    b. Clean claims for Covered Services will be payable within the timeframes set forth in North Carolina General Statutes Section 58-3-225 and, if not paid within such timeframe, interest will be payable as specified in N.C. Gen. Stat. § 58-3-225(e).

    c. Overpayments may be recovered through a demand for a refund and offset of future payments subject to the timelines and process set forth in North Carolina General Statutes Section 58-3-225. N.C. Gen. Stat. § 58-3-225(h).

20. To the extent required by N.C. Gen. Stat. § 58-50-295, the Agreement shall not do any of the following:

    a. Prohibit, or grant CARECENTRIX or Payor an option to prohibit, Provider from contracting with another health insurance carrier to provide health care services at a rate that is equal to or lower than the payment specified in the Agreement.

    b. Require Provider to accept a lower payment rate in the event that Provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the Agreement.

    c. Require, or grant CARECENTRIX or Payor an option to require, termination or renegotiation of the Agreement in the event that Provider agrees to provide health care services to any other health insurance carrier at a rate that is equal to or lower than the payment specified in the Agreement.

    d. Require, or grant CARECENTRIX or Payor an option to require, Provider to disclose, directly or indirectly, Provider's contractual rates with another health insurance carrier.

    e. Require, or grant CARECENTRIX or Payor an option to require, the non-negotiated adjustment by CARECENTRIX of Provider's contractual rate under the Agreement to equal the lowest rate Provider has agreed to charge any other health insurance carrier.

    f. Require, or grant CARECENTRIX or Payor an option to require, Provider to charge another health insurance carrier a rate that is equal to or more than the reimbursement rate specified in the Agreement.

21. With respect to any deemer amendments to this Agreement wherein the Agreement is amended upon notice and Provider's failure to timely object, Provider shall be given at least 60 days from receipt of such proposed amendment to object, and, if Provider fails to object in writing to such amendment within the 60-day period, such amendment shall be effective.

22. This Agreement shall be governed by and construed in accordance with North Carolina law.

ADDENDUM FOR THE STATE OF NORTH DAKOTA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of North Dakota regarding provider contracts with providers rendering health care services in the State of North Dakota. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, carrier, health care insurer, or health maintenance organization, as those terms are defined in applicable North Dakota law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. a. Payor or CARECENTRIX shall not restrict or interfere with any medical communication by Provider or take any of the following actions against Provider solely on the basis of a medical communication: (i) refusal to contract with Provider; (ii) termination of or refusal to renew the Agreement with Provider; (iii) refusal to refer patients to or allow others to refer patients to Provider; or (iv) refusal to compensate Provider for Covered Services that are medically necessary. This provision does not prohibit any mutually agreed-upon terms and conditions in the Agreement, including terms and conditions requiring Provider to participate in and cooperate with all programs, policies, and procedures developed or operated by Payor or CARECENTRIX to assure, review, or improve the quality and effective utilization of health care services, as further specified in N.D. Cent. Code § 26.1-04-03(15).

   b. As used in this section, the term "medical communication" means any communication, other than a knowing and willful misrepresentation, made by a health care provider to a patient regarding the health care needs or treatment options of the patient and the applicability of the health plan to the patient's needs or treatment, including: (i) tests, consultations, and treatment options; (ii) risks or benefits associated with tests, consultations, and options; (iii) variation in experience, quality, or outcome among any health care providers or health care facilities providing any medical service; (iv) the process, basis, or standard used by an entity to determine whether to authorize or deny health care services or benefits; and (v) financial incentives or disincentives based on service utilization provided by an entity to a health care provider. N.D.C.C. § 26.1-04-03(14).

   c. Payor or CARECENTRIX shall not take any of the actions prohibited under subsection a. above against Provider solely because Provider, in good faith, reports to State or federal authorities an act or practice by Payor or CARECENTRIX that jeopardizes patient health or welfare, or advocates on behalf of a patient in a utilization review program or grievance procedure. N.D.C.C. § 26.1-04-03(18).

2. The Agreement shall not contain an incentive plan that includes a specific payment made to, or withheld from, Provider as an inducement to deny, reduce, limit, or delay medically necessary care covered by the Payor's health plan and provided with respect to a patient. This section does not prohibit incentive plans, including capitation payments or shared-risk arrangements, that are not tied to specific medical decisions with respect to a patient. N.D.C.C. § 26.1-04-03(17).

3. Notwithstanding anything in the Agreement to the contrary, the Agreement shall not require Provider to indemnify Payor or CARECENTRIX for Payor's or CARECENTRIX's negligence, willful misconduct, or breach of the Agreement, and shall not require Provider as a condition of participation to waive any right to seek legal redress against Payor or CARECENTRIX. N.D.C.C. § 26.1-04-03(16).

4. The Agreement shall not contain a provision that requires Provider to receive, as payment for Covered Services rendered under the Agreement, the lowest payment that Provider charges or receives from any other entity. N.D.C.C. § 26.1-04-03(19).

5. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

   a. In the event that Payor fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from the Member sums owed by Payor or CARECENTRIX. Neither Provider nor any agent, trustee, or assignee of Provider, shall maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX. N.D.C.C. § 26.1-18.1-12(4).

   b. In the event of Payor's insolvency, Provider shall continue to provide Covered Services to Members for the duration of the contract period after Payor's insolvency for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of insolvency, until the Member's discharge from the inpatient facility or expiration of benefits. N.D.C.C. § 26.1-18.1-12(5).

   c. In the event that Provider elects to terminate the Agreement, Provider shall give CARECENTRIX at least sixty (60) days' advance written notice of the termination. N.D.C.C. § 26.1-18.1-12(6). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, the longer notification period will apply.

6. To the extent that Covered Services are rendered to Members through a preferred provider arrangement (PPO), the following provisions shall be added to the Agreement to the extent required by N.D.C.C. § 26.1-47-02 and applicable to Provider:

   a. The Agreement, including but not limited to the attachments, addendums, and exhibits thereto, and the Provider Manual shall: (i) establish the amount and manner of payment to Provider, which may include capitation payments; (ii) include mechanisms, subject to the minimum standards imposed by N.D.C.C. § 26.1-26.4, which are designed to review and control the utilization of health care services and establish a procedure for determining whether health care services rendered are medically necessary; and (iii) include mechanisms which are designed to preserve the quality of health care.

   b. In the event that Provider is placed at risk for the cost or utilization of health care services, the Agreement shall specifically include a description of Provider's responsibilities with respect to Payor's and CARECENTRIX's applicable administrative policies and programs, including utilization review, quality assessment and improvement programs, credentialing, grievance procedures, and data reporting requirements.

   c. In the event that Payor fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX.

   d. In the event of Payor's insolvency, Covered Services for a Member shall continue for the period for which premium payment has been made and until the Member's discharge from inpatient facilities.

   e. If either party elects to terminate the Agreement without cause, the terminating party shall provide the other party at least sixty (60) days' advance written notice of the termination. Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement without cause, the longer notification period will apply.

   f. The Agreement shall not restrict Provider from entering into preferred provider arrangements or other arrangements with other health care insurers.

g. Nothing in the Agreement shall be construed to offer an inducement to Provider to provide less than medically necessary services to a Member. This provision does not prohibit capitation payments or shared-risk arrangements which are not tied to specific medical decisions with respect to a patient.

h. Provider shall not be penalized because Provider, in good faith, reports to State or federal authorities any act or practice by Payor or CARECENTRIX that jeopardizes patient health or welfare.

ADDENDUM FOR THE STATE OF OHIO

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Ohio regarding provider contracts with providers rendering health care services in the State of Ohio. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual that is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. The services to be provided by Provider under the Agreement are identified in Schedule A to the Agreement and the corresponding fee schedule, as amended. Ohio Rev. Code § 1751.13(C)(1).

2. To the extent required by law and applicable to Provider, Provider agrees that in no event, including but not limited to nonpayment by a Payor, insolvency of a Payor, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member for Covered Services provided pursuant to the Agreement. This does not prohibit collection of coinsurance, deductibles, or copayments as specifically provided in the Member's plan or fees for non-Covered Services delivered on a fee-for-service basis to Members, nor from any recourse against the Payor or its successor. This provision shall survive the termination of the Agreement for Covered Services provided under the Agreement during the term of the Agreement, regardless of the reason for the termination, including the insolvency of a Payor. Ohio Rev. Code § 1751.13(C)(2), (12).

3. To the extent required by law and applicable to Provider, Provider shall continue to provide Covered Services to Members in the event of Payor's insolvency or discontinuance of operations as needed to complete any medically necessary procedures commenced but unfinished at the time of the Payor's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all Covered Services that constitute medically necessary follow-up care for that procedure. Provider shall not be required to continue to provide any Covered Services after the occurrence of any of the following: (a) the end of the 30-day period following the entry of a liquidation order; (b) the end of the Member's period of coverage for a contractual prepayment or premium; (c) the Member obtains equivalent coverage with another health insuring corporation or insurer or the Member's employer obtains such coverage for the Member; (d) the Member or the Member's employer terminates coverage under the contract; or (e) a liquidator effects a transfer of the Payor's obligations under the contract under the Insurance Chapter of the Ohio Revised Code. Ohio Rev. Code § 1751.13(C)(3).

4. The rights and responsibilities of Payors and Provider with respect to administrative policies and programs, including, but not limited to, payment systems, utilization review, quality assurance, assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs are set forth in the Agreement, the Provider Manual, and the applicable Addenda to the Agreement. Ohio Rev. Code § 1751.13(C)(4).

5. Provider shall maintain health records pertaining to Members as confidential consistent with applicable state and federals laws relating to the confidentiality of medical or health records. Provider shall make such records available to CARECENTRIX as required in order to monitor and evaluate the quality of care provided under the Agreement, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to Members. Such

records shall be made available to appropriate state and federal authorities involved in assessing quality or care or in investigating the grievances or complaints of Members. Ohio Rev. Code § 1751.13(C)(5).

6. The contractual rights and responsibilities of Provider may not be assigned or delegated without CARECENTRIX's prior written consent. Ohio Rev. Code § 1751.13(C)(6).

7. Provider shall maintain adequate professional liability and malpractice insurance and shall notify CARECENTRIX not more than 10 days after Provider's receipt of notice of any reduction or cancellation of such coverage. Ohio Rev. Code § 1751.13(C)(7).

8. Provider shall observe, protect, and promote the rights of Members for whom Provider renders services under the Agreement. Ohio Rev. Code § 1751.13(C)(8).

9. Provider shall provide services without discrimination on the basis of a Member's participation in a health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, or source of payments made for health care services rendered to a Member. This does not apply to circumstances when Provider does not render services due to limitations arising from the Provider's lack of training, experience, or skill or due to licensing restrictions. Ohio Rev. Code § 1751.13(C)(9).

10. The applicable procedures for the resolution of disputes arising out of the Agreement are set forth in the Agreement and Provider Manual and shall be subject to Ohio Rev. Code § 3963.02(F) to the extent applicable. Ohio Rev. Code § 1751.13(C)(11); Ohio Rev. Code § 3963.02(F).

11. Those terms used in the Agreement that are defined under Ohio Revised Code Chapter 1751 shall be used in the Agreement in a manner consistent with such law to the extent applicable. Ohio Rev. Code § 1751.13(C)(13).

12. To the extent required under applicable law, the Ohio health insuring corporation and Payors have the statutory responsibility to monitor and oversee the offering of Covered Services to Members. Ohio Rev. Code § 1751.13(G).

13. The parties acknowledge that Payors are third-party beneficiaries to the Agreement. Ohio Rev. Code § 1751.13(F)(2).

14. Payors have the right to approve or disapprove the providers that participate in the network rendering services to their Members. Ohio Rev. Code § 1751.13(F)(3).

15. The Agreement applies to network rental arrangements, and one purpose of the Agreement is selling, renting, or giving CARECENTRIX's rights to the services of Provider, and the third party accessing Provider's services is any of the following: a Payor or a third-party administrator or other entity responsible for administering claims on behalf of the Payor; or a preferred provider organization or preferred provider network, or an entity that is engaged in the business of providing electronic claims transport between CARECENTRIX and the Payor or third-party administrator, as further described in Ohio Rev. Code § 3963.02(A)(1)(c). CARECENTRIX shall require that the third party accessing Provider's services through the Agreement is obligated to comply with all applicable terms and conditions of the Agreement, including but not limited to the products for whiorch Provider has agreed to provide services; except that a Payor receiving administrative services from CARECENTRIX or its affiliate shall be solely responsible for payment to Provider. CARECENTRIX shall maintain a web page that contains a listing of the third parties described herein with whom CARECENTRIX contracts for the purpose of selling, renting, or giving CARECENTRIX's rights to the services of Provider. Refer to the CARECENTRIX website at www.carecentrix.com and the CARECENTRIX provider portal at www.carecentrixportal.com. Such listing of third parties shall be updated at least every six (6) months and be accessible to all participating providers. Alternatively, CARECENTRIX shall maintain a toll-free

telephone number accessible to all participating providers by means of which participating providers may access the same listing of such third parties. Ohio Rev. Code § 3963.02(A)(2).

16. To the extent consistent with the terms of the Agreement, Provider may provide Covered Services to Members covered under an HMO, PPO, Medicare and/or Medicaid Plan. Ohio Rev. Code § 3963.03(A)(2).

17. Nothing in the Agreement shall be construed to: (a) directly or indirectly offer an inducement to Provider to reduce or limit medically necessary health care services to Members; (b) penalize Provider for assisting a Member to seek reconsideration of a decision to deny or limit benefits to the Member; (c) limit or otherwise restrict Provider's ethical and legal responsibility to fully advise Members about their medical condition and medically appropriate treatment options; (d) penalize Provider for principally advocating for medically necessary health care services; (e) penalize Provider for providing information or testimony to a legislative or regulatory body or agency (this does not apply to libel or slander or the disclosure of trade secrets); or (f) violate Chapter 3963 of the Ohio Revised Code. Ohio Rev. Code § 1751.13(D).

18. To the extent required by law and to the extent the Agreement gives CARECENTRIX the right to amend the Agreement upon notification to Provider, CARECENTRIX will give Provider 90 days advance notice of a material change to the Agreement. A "material change" or "material amendment" is as defined under Ohio Rev. Code § 3963.01. If Provider objects in writing to the material change within 15 days and there is no resolution of the objection, either party may terminate the Agreement upon written notice of termination to the other party not later than 60 days before the effective date of the material change. If Provider does not object to the material change within the required timeframe, the change will be effective as specified in the notice of material change to the Agreement. A material amendment may be effective earlier if delay could result in imminent harm to a Member; it is required by state or federal law, rule or regulation; or the Provider affirmatively accepts the material amendment in writing and agrees to an earlier effective date. Ohio Rev. Code § 3963.04.

19. The Addenda to the Agreement include the Rate Exhibit, Medicare Advantage, Medicaid and Managed Medicaid Addendum, State of Ohio Medicaid Addendum, and this regulatory Addendum for the State of Ohio, as applicable. Ohio Rev. Code § 3963.03(A)(6).

ADDENDUM FOR THE STATE OF OKLAHOMA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Oklahoma regarding provider contracts with providers rendering health care services in the State of Oklahoma. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a carrier, insurer, health maintenance organization, managed care entity, or health care plan, as those terms are defined in applicable Oklahoma law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to permit CARECENTRIX to terminate or fail to renew Provider's participation under the Agreement for advocating on behalf of a Member for appropriate and medically necessary health care for the Member. 36 Okla. Stat. § 6593(D).

2. To the extent required by law, CARECENTRIX or Payor shall not seek indemnification from Provider, whether contractual or equitable, for liability imposed by the Oklahoma Managed Health Care Reform and Accountability Act. 36 Okla. Stat. § 6593(E).

3. The following provisions shall be added to the Agreement to the extent required by 63 Okla. Stat. § 2550.3 or Okla. Admin. Code § 365:40-5-71(4):

    a. In the event that CARECENTRIX terminates the Agreement for reasons other than for cause, Provider shall continue to provide Covered Services under the terms of the Agreement for up to ninety (90) days from the date of notice to the Member, for a Member who is under Provider's care at the time of such termination and who: (i) has a degenerative and disabling condition or disease; (ii) is terminally ill; or (iii) has entered the third trimester of pregnancy, in which case additional provision of Covered Services by Provider shall continue through at least six (6) weeks of postpartum evaluation. During any such continued care period, Provider shall accept the terms and conditions set forth in subsection (d) of this section.

    b. If Provider voluntarily chooses to terminate the Agreement, Provider shall give CARECENTRIX at least ninety (90) days' prior written notice of such termination.

    c. In the event that Provider voluntarily terminates the Agreement, Provider shall continue to provide Covered Services under the terms of the Agreement for a Member who is in an ongoing course of treatment with Provider at the time of such termination, for a transitional period: (i) of up to ninety (90) days from the date of Provider's notice of termination to CARECENTRIX; or (ii) in the case of a Member who has entered the third trimester of pregnancy at the time of Provider's termination, for a period that includes delivery and postpartum care. During any such transitional period, Provider shall accept the terms and conditions set forth in subsection (d) of this section.

    d. In the event that Provider renders Covered Services to a Member pursuant to subsection (a) or (c) of this section, Provider shall: (i) accept reimbursement for Covered Services at the rates applicable to such services under the Agreement as payment in full; (ii) adhere to CARECENTRIX's and Payor's quality assurance requirements, and provide to CARECENTRIX and Payor necessary medical information related to such continued care; and (iii) otherwise adhere to CARECENTRIX's and Payor's policies and procedures, including, but not limited to, policies and procedures regarding referrals, and obtaining preauthorization and treatment plan approval from CARECENTRIX.

4. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

   a. Provider shall give CARECENTRIX at least ninety (90) days' advance written notice of termination of the Agreement. 36 Okla. Stat. § 6913(F).

   b. CARECENTRIX shall give Provider at least ninety (90) days' advance written notice of termination of the Agreement for reasons other than cause. In the event that CARECENTRIX terminates the Agreement for cause, the applicable notice and termination provisions set forth in the Agreement shall control. Okla. Admin. Code § 365:40-5-71(1).

   c. In the event that Payor fails to pay for health care services as set forth in the Agreement, a Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from a Member any sums owed by Payor or CARECENTRIX. Provider or Provider's agent, trustee, or assignee shall not maintain an action at law against a Member to collect sums owed by Payor or CARECENTRIX. 36 Okla. Stat. § 6913(D).

   d. In the event of the insolvency of Payor, Provider shall continue to provide Covered Services to Members for the duration of the contract period after Payor's insolvency for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of the insolvency, until the Member's discharge from the inpatient facility or expiration of benefits. 36 Okla. Stat. § 6913(F); Okla. Admin. Code § 365:40-5-72.

5. Provider acknowledges and agrees that one purpose of the Agreement is to permit Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms, limitations, and conditions of the Agreement. Provider may obtain an updated list of CARECENTRIX's customers by contacting CARECENTRIX at the toll-free telephone numbers specified in the Provider Manual or by accessing such list at the CARECENTRIX provider portal website. To the extent required by 36 Okla. Stat. § 1219.3(B), Provider expressly authorizes CARECENTRIX to sell, lease, and otherwise transfer information regarding the payment and reimbursement terms of the Agreement, and acknowledges that Provider has received prior adequate notification of same from CARECENTRIX.

6. To the extent required by law, CARECENTRIX shall not restrict the acceptable method of payment from CARECENTRIX to Provider to only credit card payments. 36 Okl. St. § 1219.6(B).

7. To the extent required by law, if initiating or changing payments to Provider using electronic funds transfer payments, including virtual credit card payments, CARECENTRIX shall:

   a. Notify Provider if any fees are associated with a particular payment method; and

   b. Advise Provider of the available methods of payment and provide clear instructions as to how to select an alternative payment method. 36 Okl. St. § 1219.6(C).

8. To the extent required by law, if CARECENTRIX initiates or changes payments to Provider through an Automated Clearing House Network, as codified in 45 CFR Sections 162.1601 and 162.1602, CARECENTRIX shall not charge a fee solely to transmit the payment to Provider unless Provider has consented to the fee. 36 Okl. St. § 1219.6(D).

9. To the extent required by law, CARECENTRIX shall not unilaterally remove Provider from the network solely because Provider informs the Member of the full range of physicians and providers available to the Member, including out-of-network providers. This provision should not be construed to prohibit CARECENTRIX from allowing the Agreement to expire by its own terms or negotiating a new Agreement with Provider at the end of the Agreement term. This Agreement shall not prohibit, penalize, terminate, or otherwise restrict Provider from referring to an out-of-network provider

provided the Member signs an acknowledgment of referral that the Member may be responsible for higher coinsurance and deductibles and charges which exceed the allowable charges of an in-network provider.

ADDENDUM FOR THE STATE OF OREGON

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Oregon regarding provider contracts with providers rendering health care services in the State of Oregon. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health maintenance organization, or carrier, as those terms are defined in applicable Oregon law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. In the event that Payor fails to pay for health care services covered by a Member's health benefit plan, Provider shall not bill or otherwise attempt to collect from the Member amounts owed by Payor, and Members shall not be liable to Provider for any sums owed by Payor. Or. Rev. Stat. [ORS] § 743B.204.

2. To the extent required by law, Payor will give Provider, upon Provider's request, an annual accounting accurately summarizing the financial transactions under the Agreement for that year. ORS 743B.405(2)(c).

3. Provider may withdraw from the care of a Member when, in the professional judgment of Provider, it is in the best interest of the Member to do so. ORS 743B.405(2)(d).

4. To the extent required by law, a doctor of medicine or osteopathy licensed under ORS chapter 677 shall be retained and responsible for all final medical and mental health decisions relating to coverage or payment for services rendered pursuant to the Agreement. ORS 743B.405(2)(e).

5. Payor and Provider shall provide continuity of care to Members to the extent required by ORS 743.854. ORS 743B.405(2)(h).

6. CARECENTRIX shall not terminate or otherwise financially penalize Provider for:

    a. Providing information to or communicating with a Member in a manner that is not slanderous, defamatory, or intentionally inaccurate concerning:
        i. Any aspect of the Member's medical condition;
        ii. Any proposed treatment or treatment alternatives, whether covered by Payor's health benefit plan or not; or
        iii. Provider's general financial arrangement with CARECENTRIX. ORS 743B.403(1).

    b. Referring a Member to another provider, whether or not that provider is under contract with CARECENTRIX. If Provider refers a Member to another provider, Provider shall:
        i. Comply with CARECENTRIX's written policies and procedures with respect to any such referrals; and
        ii. Inform the Member that the referral services may not be covered by Payor. ORS 743B.403(2).

    c. Allocation of costs for referral services under subsection (b) of this section shall be a matter of contract between Provider and CARECENTRIX or, as applicable, Provider and Payor. Allocation of costs to Provider by contract shall not be considered a penalty under this section. ORS 743B.403(2).

7. Except in the case of misrepresentation, precertification determinations under the Agreement shall be subject to the following to the extent required by law:

   a. Precertification determinations relating to benefit coverage and medical necessity shall be binding on Payor if obtained no more than thirty (30) days prior to the date the service is provided.

   b. Precertification determinations relating to Member eligibility shall be binding on Payor if obtained no more than five (5) business days prior to the date the service is provided. ORS 743B.420.

8. To the extent required by law, the criteria used in the utilization review process pursuant to the Agreement and the method of development of the criteria shall be made available for review to Provider upon request. ORS 743B.423(2)(a).

9. Provider will be paid for Covered Services rendered to Members pursuant to the Agreement in accordance with the applicable requirements of ORS 743B.450 and ORS 743B.452.

10. To the extent required by law, except in the case of fraud or abuse of billing, and except as provided in ORS743 B.451(3) or ORS 743. B.451(5), Payor or CARECENTRIX may not request a refund from Provider of a payment previously made to satisfy a claim unless Payor or CARECENTRIX does so in writing, specifying the reasons for the request, on or before the last day of the period specified by the Agreement or eighteen (18) months after the date the payment was made, whichever is earlier. If Payor or CARECENTRIX requests a refund for reasons related to coordination of benefits with another payor or entity responsible for payment of a claim, the request for refund must: (i) be made in writing within thirty (30) months after the date the payment was made, (ii) specify why Provider owes the refund, and (iii) include the name and mailing address of the other payor or entity that has primary responsibility for payment of the claim. If Provider fails to contest the request for refund in writing to Payor or CARECENTRIX within thirty (30) days after receipt of the request, the request for refund shall be deemed accepted, and the refund must be paid. ORS 743 B.451
11. To the extent required by law, except in the case of fraud, and except as provided in ORS 743B.453(3), Provider may not request additional payment from Payor to satisfy a claim unless Provider does so in writing, specifying the reasons for the request, on or before the last day of the period specified by the Agreement or eighteen (18) months after the date the claim was denied or the payment intended to satisfy the claim was made, whichever is earlier. If Provider requests additional payment from Payor to satisfy a claim for reasons related to coordination of benefits with another payor or entity responsible for payment of a claim, the request for additional payment must: (i) be made in writing within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made, (ii) specify why Payor owes the additional payment, and (iii) include the name and mailing address of the other payor or entity that has disclaimed responsibility for payment of the claim. ORS 743 B.453.

12. The Agreement specifically authorizes CARECENTRIX to enter into contracts with third parties to provide access to Provider's health care services and discounted rates under the Agreement. Any third party that contracts for the right to exercise CARECENTRIX's rights under the Agreement shall be contractually obligated to comply with all applicable terms, limitations, and conditions of the Agreement. ORS 743B.502(1). For purposes of this section, the term "third party" shall have the meaning set forth in ORS 743.082, and includes a payer, third-party administrator, preferred provider organization or network, and other entities specified in such statute. Upon entering into the Agreement, CARECENTRIX shall give Provider in writing or electronically a list of all third parties known by CARECENTRIX at the time, to which CARECENTRIX has or will provide access to Provider's health care services and discounted rates under the Agreement. CARECENTRIX shall maintain an Internet website, toll-free telephone number, or other readily available mechanism through which Provider may obtain a list, updated at least every ninety (90) days, of all third parties that have access to Provider's health care services and discounted rates under the Agreement. ORS 743B.502 (2). Provider may obtain such list at the CARECENTRIX provider portal website, or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

ADDENDUM FOR THE STATE OF PENNSYLVANIA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Pennsylvania regarding provider contracts with providers rendering health care services in the State of Pennsylvania. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a managed care plan, health maintenance organization, or insurer as those terms are defined in applicable Pennsylvania law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Provider hereby agrees that in no event, including but not limited to, non-payment by Payor or CARECENTRIX, insolvency of Payor or CARECENTRIX, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation or reimbursement from, or have any recourse against a Member or persons other than Payor acting on the behalf of a Member, for Covered Services under the Agreement. This provision does not prohibit collection of any applicable co-payments, coinsurance, or deductibles in accordance with the terms of the benefit plan contract between Payor and the Member, or amounts for noncovered services. Provider further agrees that the hold harmless provisions herein shall survive the termination of the Agreement regardless of the cause giving rise to such termination, shall be construed for the benefit of Members, and shall supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and a Member or persons acting on a Member's behalf. If Payor is health maintenance organization ("HMO"), any modification, addition, or deletion to the provisions of this section shall become effective on a date no earlier than fifteen (15) days after the Pennsylvania Secretary of Health has received written notice of such proposed changes. 28 Pa. Admin. Code [Pa. Code] § 9.722(e)(1); 31 Pa. Code §§ 301.122, 152.104(a)(3)(i).

2. Nothing in the Agreement shall be construed to permit Payor or CARECENTRIX to sanction, terminate, or fail to renew Provider's participation under the Agreement for any of the following reasons:
    a. Advocating for medically necessary and appropriate health care services for a Member consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care.
    b. Filing a complaint, grievance or external review on behalf of and with the written consent of a Member pursuant to the procedures set forth in applicable Pennsylvania insurance law, or helping a Member to file a complaint, grievance or external review.
    c. Protesting a decision, policy, or practice that Provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with its ability to provide medically necessary and appropriate health care.
    d. Provider has a practice that includes a substantial number of patients with expensive medical conditions.
    e. Provider objects to the provision of, or refuses to provide, a health care service on moral or religious grounds.
    f. Taking another action specifically permitted by Sections 2113, 2121, and 2171 of the Act (40 Pa. Stat. [P.S.] §§ 991.2113, 991.2121, and 991.2171). 28 Pa. Code § 9.722(c).

3. Nothing in the Agreement shall be construed to permit Payor or CARECENTRIX to penalize or restrict Provider from discussing:

a. The process that Payor or CARECENTRIX, if applicable, uses or proposes to use to deny payment for a health care service;
b. Medically necessary and appropriate care with or on behalf of a Member, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation, or tests;
c. Payor's decision to deny payment for a health care service; or
d. Other information that Provider reasonably believes is necessary to provide full information concerning the health care of a Member. 28 Pa. Code § 9.722(d); 40 P.S. § 991.2113(a).

4. Nothing in the Agreement shall be construed to prohibit or restrict disclosure of medically necessary and appropriate health care information, and any such provision is contrary to public policy and shall be void and unenforceable. 40 P.S. § 991.2113(b).

5. Nothing in Sections 2, 3, or 4 of this Addendum shall:

   a. Prohibit Payor or CARECENTRIX, as applicable, from making a determination not to pay for a particular medical treatment, supply, or service; enforcing reasonable peer review or utilization review protocols; or making a determination that Provider has or has not complied with appropriate protocols.

   b. Be construed as requiring Payor to provide, reimburse for, or cover counseling, referral, or other health care services if Payor: (i) objects to the provision of that service on moral or religious grounds; and (ii) makes available information on its policies regarding such health care services to Members and prospective Members. 40 P.S. § 991.2113(d).

6. Records containing identifiable information regarding a Member's health, diagnosis, and treatment shall be kept confidential by Provider, Payor, and CARECENTRIX in accordance with Section 2131 of the Act (40 P.S. § 991.2131) and all applicable State and federal laws and regulations. Access to such records will be permitted to those employees and agents of the Pennsylvania Department of Health, the Insurance Department, and, when necessary, the Department of Human Services with direct responsibility for quality assurance, investigation of complaints or grievances, enforcement, or other activities related to compliance with applicable laws and regulations of Pennsylvania. Nothing in the foregoing is intended to prevent or limit access and disclosures otherwise authorized by 40 P.S. § 991.2131. 28 Pa. Code § 9.722(e)(2); 31 Pa. Code § 152.104(a)(3)(v).

7. Provider shall participate in, and abide by the decisions of, the quality assurance, utilization review, and Member complaint and grievance systems of Payor and CARECENTRIX, as applicable. 28 Pa. Code § 9.722(e)(3); 31 Pa. Code § 152.104(a)(3)(ii),(iii).

8. Disputes arising out of the Agreement shall be resolved in accordance with the dispute resolution provisions and procedures set forth in the Agreement and the Provider Manual. 28 Pa. Code § 9.722(e)(4).

9. Provider shall adhere to all applicable State and federal laws and regulations. 28 Pa. Code § 9.722(e)(5).

10. To the extent applicable and not otherwise preempted by federal law, the provisions of 40 P.S. § 991.2166 and 31 Pa. Code § 154.18 concerning prompt payment of claims shall apply to Payor's payment of claims for Covered Services submitted by Provider under the Agreement. 28 Pa. Code § 9.722(e)(6).

11. Neither Provider nor CARECENTRIX shall be permitted to terminate the Agreement without cause upon less than sixty (60) days' prior written notice to the other party. 28 Pa. Code § 9.722(e)(7). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement without cause, such longer notification period will apply.

12. If Payor is an HMO, Provider shall give CARECENTRIX at least sixty (60) days' advance written notice of termination of the Agreement. 31 Pa. Code § 301.124. Notwithstanding the foregoing, if the Agreement

provides for a longer notification period with respect to Provider's termination of the Agreement, such longer notification period will apply.

13. CARECENTRIX shall give Provider at least thirty (30) days' prior written notice of any amendment to the Agreement, or any changes to policies or procedures materially affecting Provider or the provision or payment of Covered Services to Members, unless such amendment or change is required by State or federal law or regulation. 28 Pa. Code § 9.722(e)(8).

14. The reimbursement method used to reimburse Provider for Covered Services under the Agreement is set forth in the Agreement and applicable schedules and attachments thereto. 28 Pa. Code § 9.722(f)(1).

15. The Agreement shall not include a financial incentive that compensates Provider for providing less than medically necessary and appropriate care to a Member. Nothing in this section shall be deemed to prohibit Payor from using a capitated payment arrangement or other risk-sharing arrangement. 40 P.S. § 991.2112; 28 Pa. Code § 9.722(f)(3).

16. The Agreement shall not include an incentive reimbursement system for licensed professional health care providers which shall weigh utilization performance as a single component more highly than quality of care, Member services, and other factors collectively. 28 Pa. Code § 9.722(f)(2). This section is added to this Addendum for regulatory purposes and is not intended to classify Provider as a licensed professional health care provider.

17. Provider acknowledges and agrees that nothing contained in the Agreement limits the following:
    a. The authority of Payor to ensure Provider's participation in and compliance with Payor's quality assurance, utilization management, Member complaint and grievance systems, and procedures or limits.
    b. The Pennsylvania Department of Health's authority to monitor the effectiveness of Payor's system and procedures or the extent to which Payor adequately monitors any function delegated to CARECENTRIX, or to require Payor to take prompt corrective action regarding quality of care or consumer grievances and complaints.
    c. Payor's authority to sanction or terminate Provider if Provider is found to be providing inadequate or poor quality care or failing to comply with Payor's systems, standards, or procedures as agreed to by CARECENTRIX. 28 Pa. Code § 9.725(1).

18. Provider acknowledges and agrees that any delegation by Payor to CARECENTRIX for performance of quality assurance, utilization management, credentialing, provider relations, and other medical management systems under the Agreement shall be subject to Payor's oversight and monitoring of CARECENTRIX's performance. 28 Pa. Code § 9.725(2).

19. Provider acknowledges and agrees that Payor, upon failure of CARECENTRIX to properly implement and administer the medical management systems, or to take prompt corrective action after identifying quality, Member satisfaction, or other problems, may terminate Payor's contract with CARECENTRIX, and that as a result of such termination, Provider's participation in Payor's benefit plan contracts with Members may also be terminated. 28 Pa. Code § 9.725(3).

20. The Member financial hold-harmless provisions in Section 1 of this Addendum shall prevent Provider and CARECENTRIX (in its capacity as an integrated delivery system, if applicable) from billing Members for Covered Services, other than authorized co-payments, coinsurance, or deductibles, under any circumstances including insolvency of Payor or CARECENTRIX. 28 Pa. Code § 9.725(4).

21. Provider shall abide by Payor's and CARECENTRIX's rules and regulations for preferred providers, including, to the extent applicable, those regarding hospital privileges, credentialing, in-office reviews, and similar rules. 31 Pa. Code § 152.104(a)(3)(iv).

22. Provider's participation and preferred status in CARECENTRIX's provider network shall be terminated immediately if Provider is found to be harming patients. 31 Pa. Code § 152.104(a)(3)(vi).

23. Except if CARECENTRIX terminates the Agreement for cause, including breach of the Agreement, fraud, criminal activity, or posing a danger to a Member or to the health, safety, or welfare of the public as determined by CARECENTRIX, if CARECENTRIX initiates termination of the Agreement with Provider, a Member may continue an ongoing course of treatment with Provider at the Member's option for a transitional period of up to sixty (60) days from the date the Member was notified by CARECENTRIX of the termination or pending termination. CARECENTRIX, in consultation with the Member and Provider, may extend the transitional period if determined to be clinically appropriate. In the case of a Member in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this section shall be covered by Payor under the same terms and conditions applicable prior to the termination. Nothing in this section shall require Payor to cover health care services that are not otherwise covered under the terms and conditions of the Member's benefit plan. 40 P.S. § 991.2117.

24. In the event of the insolvency of a Payor that is an HMO, Provider shall continue to provide Covered Services to Members (i) for the duration of the period after the insolvency for which premium payment has been made and (ii) with respect to Members who are confined on the date of insolvency in an inpatient facility, until either the Member's discharge from the inpatient facility or the expiration of the Member's benefits—limited to Covered Services directly related to the condition which occasioned the admission—whichever comes later. 31 Pa. Code § 301.123.

ADDENDUM FOR THE STATE OF RHODE ISLAND

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Rhode Island regarding provider contracts with providers rendering health care services in the State of Rhode Island. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

I. If Payor is a "health care entity" that operates a "health plan" as those terms are defined in R.I. Gen. Laws § 27-18.8-2, the following requirements of R.I. Gen. Laws, Chapter 27-18.8, and its implementing regulations shall be incorporated into the Agreement to the extent applicable and not preempted by federal law. A health care entity means a licensed insurance company, health maintenance organization, or other entity specified in the applicable definition.

   1. No Member shall be liable to Provider for charges for Covered Services, except for amounts due for co-payments, when such services were provided or made available to Members by a licensed health maintenance organization (HMO) during a period in which premiums were paid by or on behalf of the Member.

   2. The Agreement shall not include a "most favored rate clause," defined in R.I. Gen. Laws § 27-18.8-2 as a provision whereby the rates or fees to be paid to Provider by Payor are fixed, established, or adjusted to be equal to or lower than the rates or fees paid to Provider by any other health care entity.

   3. The Agreement shall not be terminated by CARECENTRIX "without cause"; provided, however, that "cause" shall include, but is not limited to, the lack of need due to economic considerations.

   4. The mechanism to provide for the continuity of care to Members upon termination of the Agreement is set forth in the Agreement. In addition, the following provisions shall apply to such continuity of care, to the extent required by Code of Rhode Island Rules, Title 216 RICR 40-10-21 § 21.8:

      a. Upon termination of the Agreement, CARECENTRIX shall have a process in place to allow Members' care to be transferred to an alternate participating provider in the same or similar specialty as Provider.

      b. Upon termination of the Agreement for reasons other than Provider's medical competence, quality of care, or professional conduct, CARECENTRIX shall provide for the transition of Members' care in accordance with Code of Rhode Island Rules, Title 216 RICR 40-10-21 § 21.7 (N)(2) as follows:

         i. Termination of the Agreement shall not affect the method of payment or reduce the amount of reimbursement to Provider for Covered Services rendered to any Member in active treatment for an acute medical condition at the time Provider terminates the Agreement until the active treatment is concluded or, if earlier, one (1) year after the termination.

         ii. During such active treatment period, Provider shall be subject to all the terms, conditions, and rates of the terminated Agreement for the provision of Covered Services including, but not limited to, all reimbursement provisions that limit the Member's liability for Covered Services.

5. With respect to the provisions of Code of Rhode Island Rules, Title 216 RICR 40-10-21 §§ 21.7 (J), (K), and (L), CARECENTRIX does not credential any "professional provider," i.e., non-institutional provider, as that term is defined in §§ 21.3 (25) of such regulations.

6. With respect to the provisions of Code of Rhode Island Rules, Title 216 RICR 40-10-21 §§ 21.7 (M) and (N), CARECENTRIX does not contract with any "physician" for the "provider network," as those terms are defined in §§ 21.3 (22) and (29) of such regulations.

II. If Payor is a "health maintenance organization" as defined in R.I. Gen. Laws § 27-41-2, the following requirements of R.I. Gen. Laws, Chapter 27-41, and its implementing regulations shall be incorporated into the Agreement to the extent applicable and not preempted by federal law:

1. As required by R.I. Gen. Laws § 27-41-13(h), in the event of the insolvency of a health maintenance organization (HMO), Members enrolled in the HMO will not be liable for charges for Covered Services received before the time of insolvency, and the following provisions shall apply:

   a. Benefits, including professional services, for all Members enrolled in the HMO who are confined at the time of insolvency in hospitals, skilled nursing facilities, intermediate care facilities, or home health agencies and are receiving Covered Services shall continue to be paid without interruption until the earlier of discharge or ninety (90) days or, in the alternative, for federally qualified HMOs which are licensed pursuant to R.I. Gen. Laws, Chapter 27-41, confinement coverage shall be provided which meets federal standards for federally qualified HMO plans.

   b. All Members enrolled in the HMO will be covered without interruption by the lesser of their current coverage or a fully qualified program as defined in R.I. Gen. Laws § 42-62-10, or its equivalent as approved by the Director of the Department of Business Regulation, for a period of thirty (30) days following the insolvency, unless such HMO Members are afforded an opportunity to enroll in another insurance plan as defined in subsection (c) of this section without waiting periods or exclusions or limitations based on health status.

   c. Members enrolled in the HMO, as well as enrolled groups, will be afforded the opportunity within thirty (30) days to purchase other health insurance equivalent to the lesser of their current coverage or a fully qualified program as defined in R.I. Gen. Laws § 42-62-10 on a group basis if they are enrolled in the HMO on a group basis and on a direct pay basis otherwise, with full credit for all prepaid premiums without waiting periods or exclusions or limitations based on health status. In the event that a contract providing for coverage commensurate with the lesser of current coverage or a fully qualified program as defined in R.I. Gen. Laws § 42-62-10 is not reasonably available, the provisions of R.I. Gen. Laws § 27-41-13(h)(3) shall govern.

III. CARECENTRIX does not come within the definition of a "contracting entity" in R.I. Gen. Laws § 27-20.10-1 because CARECENTRIX does not contract with physicians, physician organizations, or physician hospital organizations, which comprise the definition of "provider" in R.I. Gen. Laws § 27-20.10-1. Accordingly, CARECENTRIX is not subject to the requirements of R.I. Gen. Laws §§ 27-20.10-3, 10-4, or 10-6 regarding a contracting entity's granting access to a provider's health care services and contractual discounts pursuant to a provider network contract. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

ADDENDUM FOR THE STATE OF SOUTH CAROLINA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of South Carolina regarding provider contracts with providers rendering health care services in the State of South Carolina. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health maintenance organization, or managed care organization as those terms are defined in applicable South Carolina law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent required by law, Payor or CARECENTRIX may not initiate overpayment recovery efforts more than eighteen (18) months after the initial payment was received by Provider; however, this time limit does not apply to the initiation of overpayment recovery efforts: (a) based upon a reasonable belief of fraud or other intentional misconduct; (b) required by a self-insured plan; or (c) required by a State or federal government program. S.C. Code § 38-59-250.

2. With respect to Members enrolled in a health maintenance organization ("HMO") plan, the following "hold harmless agreement" shall be added to the Agreement, as required by S.C. Code § 38-33-130(B), consistent with South Carolina Department of Insurance Form SCID 505, as a condition of Provider's participation as a health care provider in the HMO plan:

   > "Provider hereby agrees not to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have recourse against, enrollees of the HMO or persons acting on their behalf, for health care services which are rendered to such enrollees by Provider, and which are covered benefits under enrollees' evidence of coverage. This agreement extends to all covered health care services furnished to the enrollee during the time he or she is enrolled in, or otherwise entitled to benefits promised by, the HMO. This agreement further applies in all circumstances including, but not limited to, non-payment by the HMO or CARECENTRIX and insolvency of the HMO or CARECENTRIX.
   >
   > "This agreement shall not prohibit collection of copayments from enrollees by Provider in accordance with the terms of the evidence of coverage issued by the HMO. The Provider further agrees that this agreement shall be construed to be for the benefit of enrollees of the HMO and that this agreement supersedes any oral or written contrary agreement now existing or hereafter entered into between the Provider and such enrollees, or persons acting on their behalf."

3. Nothing in the Agreement shall be construed to limit: (a) Provider's ability to discuss with a Member, the treatment options available to the Member, risks associated with treatments, utilization management decisions, and recommended course of treatment; or (b) Provider's legal obligations to a Member as specified under Provider's professional license. S.C. Code § 38-71-1740(A)(2).

4. To the extent required by law, each party to the Agreement is responsible for the legal consequences and costs of its own acts or omissions. Provider is not responsible for the acts or omissions, or both, of Payor or CARECENTRIX; and Payor or CARECENTRIX is not responsible for the acts or omissions, or both, of Provider. S.C. Code § 38-71-1740(A)(1).

5. Nothing in Sections 3 or 4 of this Addendum shall: (a) permit Provider to disclose trade secrets in violation of the confidentiality provisions of the Agreement; (b) subject Payor or CARECENTRIX to

liability for clinical decisions made solely by Provider; or (c) limit the ability of CARECENTRIX to otherwise prudently administer the Agreement. S.C. Code § 38-71-1740(B).

6. In the event that Provider terminates the Agreement, Provider shall, if requested, continue to provide Covered Services to a Member who is receiving treatment for an illness covered under a closed panel health plan on the date of termination, subject to the terms and rates of the Agreement, for a period of ninety (90) days or the anniversary date of the plan, whichever occurs first. For purposes of this section, the term "closed panel health plan" shall have the meaning set forth in S.C. Code § 38-71-1720. S.C. Stat. § 38-71-1730(A)(4).

ADDENDUM FOR THE STATE OF SOUTH DAKOTA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of South Dakota regarding provider contracts with providers rendering health care services in the State of South Dakota. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health carrier, health maintenance organization, or licensed insurance company that offers a managed care plan, as those terms are defined in applicable South Dakota law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. In no event shall Provider collect or attempt to collect from a Member any money owed to Provider by Payor or CARECENTRIX, nor shall Provider have any recourse against a Member for any Covered Services in excess of the copayment, coinsurance, or deductible amounts specified in the evidence of coverage. S.D. Codified Laws [SDCL] § 58-17F-11(2).

2. Provider's responsibilities with respect to CARECENTRIX's applicable administrative policies and programs, including payment terms, utilization review, quality assessment and improvement programs, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or state programs, are set forth in the Agreement and the Provider Manual. SDCL 58-17F-11(4).

3. Nothing in the Agreement shall be construed to prohibit or penalize Provider: (a) from discussing treatment options with Members, irrespective of Payor's or CARECENTRIX's position on the treatment options; (b) from advocating on behalf of Members within the utilization review or grievance processes established by Payor or CARECENTRIX; or (c) from, in good faith, reporting to state or federal authorities any act or practice by Payor or CARECENTRIX that jeopardizes patient health or welfare. SDCL 58-17F-11(5).

4. In accordance with the terms of the Agreement, any attachments or addendums thereto, and the Provider Manual, Provider shall make available to CARECENTRIX and Payor, upon request, health records necessary to process claims, perform necessary quality assurance or quality improvement programs, or to comply with any lawful request for information from appropriate state authorities. The confidentiality of such health records shall be maintained in accordance with applicable state and federal law. SDCL 58-17F-11(6).

5. Provider and CARECENTRIX shall each give the other party at least sixty (60) days' prior written notice before terminating the Agreement without cause. SDCL 58-17F-11(7). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement without cause, such longer notification period will apply.

6. To the extent required by law, if CARECENTRIX terminates the Agreement without cause, or if Provider voluntarily chooses to terminate the Agreement, CARECENTRIX shall, upon request by Provider or the Member: (a) permit a Member who is receiving Covered Services pursuant to an ongoing course of treatment from Provider at the time of termination, to continue such ongoing course of treatment for up to ninety (90) days following the effective date of the termination; and (b) permit a Member who has entered the second trimester of pregnancy at the time of termination, to continue receiving Covered Services from Provider through the provision of postpartum care directly related to the delivery; provided that, Provider

must agree to accept all the terms and conditions of the Agreement, including but not limited to reimbursement terms, for the duration of any such continued care period. SDCL 58-17F-11(7).

7. Provider's obligations, if any, to collect applicable coinsurance, copayments, or deductibles from Members pursuant to the evidence of coverage, or to notify Members of Members' personal financial obligations for noncovered services, are set forth in the Agreement and the Provider Manual. SDCL 58-17F-11(8).

8. Payor shall have the right, in the event of CARECENTRIX's insolvency, to require the assignment to Payor of the provisions of the Agreement addressing Provider's obligation to furnish Covered Services to Members. SDCL 58-17F-12(7).

ADDENDUM FOR THE STATE OF TENNESSEE

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Tennessee regarding provider contracts with providers rendering health care services in the State of Tennessee. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. As required by Tenn. Code Ann. § 56-32-105(c), any enrollee of a licensed health maintenance organization shall be held harmless and relieved from any liability for services rendered by Provider except for reasonable copayment and uncovered expenses. Any modification, addition, or deletion to this "hold harmless" provision shall become effective on a date no earlier than thirty (30) days after the applicable State regulatory agency has received written notice of the proposed change.

2. The following provision concerning continued services, rights, and obligations upon termination of the Agreement is required by Tenn. Code Ann. § 56-7-2358; provided that, to the extent that a provision of the Agreement concerning continued services, rights, and obligations upon termination of the Agreement exceeds the requirements of Tennessee law, the requirements of such provision of the Agreement shall apply:

    a. If Provider terminates the Agreement, or if CARECENTRIX terminates the Agreement without cause, then Provider and CARECENTRIX shall allow a subscriber or enrollee who is:

        i. Under active treatment for a particular injury or sickness, to continue to receive Covered Services from Provider for the injury or sickness for a period of one hundred twenty (120) days from the date of notice of termination; and

        ii. In the second trimester of pregnancy, to continue care with Provider until completion of postpartum care.

        iii. Being treated at an inpatient facility to remain at the facility until the patient is discharged.

    b. Subsection 2.a. above shall apply only if Provider agrees to continue to be bound by the terms, conditions, and reimbursement rates of the Agreement.

3. To the extent required by law:

    a. Clean claims for Covered Services will be payable within the timeframes set forth in Tenn. Code Ann. § 56-7-109 and, if not paid within such timeframes, interest will be payable as specified in Tenn. Code Ann. § 56-7-109.

    b. Correction of payment errors and the recoupment of reimbursements will be subject to the timeframes and conditions specified in Tenn. Code Ann. § 56-7-110.

4. To the extent required by Tenn. Stat. Ann. § 56-7-1013(c), any change to payment or fee schedules applicable to Provider shall be made available to Provider at least ninety (90) days prior to the effective date of the amendment that incorporates such change; provided that, this requirement shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar

organization. CARECENTRIX will provide the fee schedule to Provider within ten (10) days of Provider's written request to CARECENTRIX to the extent required by Tenn. Stat. Ann. § 56-7-1013 (f) .

5. CARECENTRIX does not come within the definition of a "contracting entity" in Tenn. Code Ann. § 56-60-102 because CARECENTRIX does not contract with physicians, physician organizations, or physician hospital organizations, which comprise the definition of "provider" in Tenn. Code Ann. § 56-60-102. Accordingly, CARECENTRIX is not subject to the requirements of Tenn. Code Ann. § 56-60-105 regarding a contracting entity's granting access to a provider's health care services and contractual discounts pursuant to a provider network contract. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

ADDENDUM FOR THE STATE OF TEXAS

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Texas regarding provider contracts with providers rendering health care services in the State of Texas. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent applicable, Payors will comply with all applicable Texas statutes and rules pertaining to prompt payment of Clean Claims with respect to payment to Provider for Covered Services under the Agreement, including but not limited to, 28 Tex. Admin. Code § 21.2801 et seq. 28 Tex. Admin. Code §§ 3.3703(a)(11), 11.901(a)(8).

2. Claims submission processes are set forth in the CARECENTRIX Provider Manual, as amended from time to time. To the extent required by Texas law, Provider may submit a claim to CARECENTRIX not later than the 95th day after the date Provider provides the medical care or health care services for which the claim is made. Tex. Ins. Code §§ 843.341, 1301.106.

3. Upon request by Provider during the initial provider contract negotiation, CARECENTRIX will include a provision in the base provider contract indicating that it will not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted with or in a batch submission with a Clean Claim that is deficient. A "batch submission" is a group of electronic claims submitted for processing at the same time within HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number. 28 Tex. Admin. Code §§ 3.3703(a)(22), 11.901(c).

4. Upon request and to the extent required by Texas law, Provider will be provided with the information necessary to determine that Provider is being compensated in accordance with the Agreement. 28 Tex. Admin. Code §§ 3.3703(a)(20), 11.901(a)(11).

5. If Provider is compensated on a discounted fee basis, the Member's financial obligation for deductibles or coinsurance shall be determined based upon the discounted fee arrangement with the applicable Payor and not upon the Provider's full billed charge. Tex. Ins. Code § 1301.060; 28 Tex. Admin. Code § 3.3703(a)(10).

6. Provider acknowledges and agrees that the Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit medically necessary services. This provision shall not prohibit the savings from cost effective utilization of health services by contracting providers from being shared with providers in the aggregate. Tex. Ins. Code §§ 843.314, 1301.068; 28 Tex. Admin. Code § 3.3703(a)(7).

7. To the extent Provider maintains an office location where Members access services, Provider shall post a notice to Members at the Provider's location on the process for resolving complaints with CARECENTRIX. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints. Tex. Ins. Code § 843.283; 28 Tex. Admin. Code § 11.901(a)(6).

8. CARECENTRIX shall not engage in any retaliatory action, including termination of or refusal to renew the Agreement, because Provider, on behalf of a Member, reasonably filed a complaint against CARECENTRIX or has appealed a decision of CARECENTRIX. Tex. Ins. Code §§ 843.281, 1301.066; 28 Tex. Admin. Code §§ 3.3705(b)(11), 11.901(a)(2).

9. A. CARECENTRIX will not as a condition of the Agreement or in any other manner prohibit, attempt to prohibit or discourage Provider from discussing with or communicating in good faith to a Member who is a current, prospective or former patient or a party designated by such Member, with respect to: (a) information or opinions regarding the Member's health care including the Member's medical condition or treatment options; (b) information or opinions regarding the provisions, terms, requirements, or services of the Member's health benefit plan as they relate to the medical needs of the Member; (c) the fact that Provider's contract with CARECENTRIX has terminated or that Provider will otherwise no longer be providing care for Members; or (d) the fact that, if medically necessary Covered Services are not available through participating providers, Payors must, upon the request of Provider, and within time appropriate to the circumstances relating to the delivery of the services and the condition of the Member, but in no event to exceed 5 business days after receipt of reasonably requested documentation, allow referral to a non-participating provider. Tex. Ins. Code §§ 843.363(a), 1301.067(a); 28 Tex. Admin. Code §§ 3.3703(a)(13), 11.903(a).

   B. CARECENTRIX will not in any way penalize or terminate Provider or refuse to compensate Provider for Covered Services for communicating with a Member who is a current, prospective or former patient, or a party designated by Member, in any manner protected by this provision. Tex. Ins. Code §§ 843.363(b), 1301.067(b); Tex. Admin. Code §§ 3.3703(a)(13), 11.903(b).

10. A. If CARECENTRIX terminates the Agreement, CARECENTRIX shall give Provider not less than 90 days' prior written notice of the termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by CARECENTRIX, such longer notification period will apply. Tex. Ins. Code §§ 843.306, 1301.057; 28 Tex. Admin. Code §§ 3.3706(d), 11.901(a)(5).

   B. Notice and Hearing. If CARECENTRIX should choose to terminate the Agreement, CARECENTRIX will notify Provider of this decision in writing. The notice will include the reason(s) for the termination and a notice of Provider's right to request a hearing or review. On request and before the effective date of the termination, but within a period not to exceed 60 days, Provider shall be entitled to a review of the proposed termination by an advisory review panel. Tex. Ins. Code §§ 843.306, 1301.057.

   When CARECENTRIX chooses to terminate Provider's participation with respect to commercial HMO plans, the advisory review panel shall be composed of physicians and providers appointed by CARECENTRIX, including at least one representative in Provider's specialty or a similar specialty, if available, who serve on a standing Quality Management committee or Utilization Management committee. Tex. Ins. Code § 843.306.

   The decision of the advisory review panel must be considered but is not binding on CARECENTRIX. On request, a copy of the recommendation of the advisory review panel and CARECENTRIX's determination shall be given to Provider. If Provider is unsatisfied with the determination, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement and Provider Manual. Tex. Ins. Code §§ 843.306, 1301.057.

C. The requirements regarding notice and hearing set forth in subsection B. above do not apply in the case of imminent harm to patient health, action against license to practice, or fraud. Tex. Ins. Code §§ 843.306, 1301.057.

D. (1) In the event the Agreement is terminated by Provider, CARECENTRIX will provide assistance to Provider, and Provider shall give reasonable advance notice of such termination to those Members whom Provider is currently treating and who are affected by the termination. Tex. Ins. Code §§ 843.309, 1301.160(b); 28 Tex. Admin. Code §§ 3.3703(a)(18), 3.3706(j)(2), 11.901(a)(11)(H).

(2) In the event the Agreement is terminated by CARECENTRIX, Members whom Provider is currently treating and who are affected by the termination shall be provided with notice of the termination at least 30 days prior to the effective date of such termination; provided, however, that such Members may be notified immediately if the Agreement is terminated for reasons related to imminent harm. Tex. Ins. Code §§ 843.308(b), 843.309, 1301.160(c); 28 Tex. Admin. Code §§ 3.3706(j)(3), 11.901(a)(4).

E. (1) If Provider is terminated for reasons other than medical competence or professional conduct, Provider shall continue to provide Covered Services for those Members who retain eligibility and whom (i) Provider has identified to CARECENTRIX as having special circumstances (i.e. persons with a disability, acute condition, life-threatening illness, past the 24th week of pregnancy, or a condition such that Provider reasonably believes that discontinuing care could cause harm to the Member); and (ii) Provider has requested to continue treatment. Provider shall be compensated for Covered Services provided pursuant to this provision in accordance with the compensation arrangements under the Agreement for a period of 9 months for those Members diagnosed with a terminal illness at the time of termination of the Agreement, through delivery, immediate post-partum care and the follow-up checkup within the first 6 weeks of delivery for Members past the 24th week of pregnancy at the time of termination, and for a period of 90 days following termination for all others. Tex. Ins. Code §§ 843.362, 1301.152 to 1301.154; 28 Tex. Admin. Code §§ 3.3703(a)(12), 11.901(a)(3).

(2) Provider shall not seek payment from the Member with respect to services rendered pursuant to this provision of amounts for which the Member would not be responsible if Provider were still a participating provider. Tex. Ins. Code §§ 843.362(c), 1301.153(c).

11. Nothing in the Agreement shall be construed to require Provider to indemnify CARECENTRIX for any tort liability resulting from acts or omissions of CARECENTRIX. Tex. Ins. Code §§ 843.310, 1301.065; 28 Tex. Admin. Code §§ 3.3703(a)(9), 11.901(a)(7).

12. To the extent that CARECENTRIX conducts uses or relies upon economic profiling to terminate the Agreement, CARECENTRIX shall make available to Provider on request the economic profile of Provider, including the written criteria by which Provider's performance was measured. An economic profile will be adjusted to recognize the characteristics of Provider's practice that may account for variations from expected costs. Tex. Ins. Code §§ 843.313, 1301.058; 28 Tex. Admin. Code § 3.3703(a)(14).

13. Any quality assessment (as that term is defined under Texas law) shall be conducted through a panel of not less than 3 physicians selected by CARECENTRIX from among a list of participating physicians, which list is to be provided by participating physicians in the applicable service area. Tex. Ins. Code § 1301.059; 28 Tex. Admin. Code § 3.3703(a)(15).

14. To the extent provided under Texas law, Provider may obtain a waiver of any requirement for the use of information technology as established or required under Texas law. Tex. Ins. Code § 1213.003; 28 Tex. Admin. Code §§ 11.901(a)(13), 21.3701.

15. Provider shall look only to the applicable Payor and agrees to hold Members harmless for compensation for all Covered Services provided to Members during the term of this Agreement. Under no circumstances, including but not limited to, nonpayment by Payor, Payor insolvency, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, or seek compensation, remuneration, or reimbursement from, or have any recourse against, Medicare, Medicaid, Members or persons (other than Payor) acting on the Member's behalf for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of copayments, coinsurance, or deductibles in accordance with the terms of the applicable plan, nor does this provision affect the right of Provider to collect fees for services provided to Members which do not constitute Covered Services. Provider further agrees that this section shall: (i) survive the termination of this Agreement regardless of the reason for termination; (ii) supersede any oral or written agreement now existing or hereafter entered into between Provider and a Member or a person acting on the Member's behalf; and (iii) be construed to be for the benefit of the Member. Any modifications, additions, or deletions to this provision shall be effective no earlier than fifteen (15) days after the Texas Commissioner of Insurance has received written notice of such changes. Tex. Ins. Code § 843.361; 28 Tex. Admin. Code § 11.901(a)(1).

16. Unless the Agreement terminates for reasons of medical competence or professional behavior, termination shall not release Payor of its obligation to compensate Provider for the continued care and treatment of any Member who is under Special Circumstances (as defined below). As used in this section, "Special Circumstances" shall mean a Member who has a disability, an acute condition, a life-threatening illness, who is past the twenty-fourth (24th) week of pregnancy, or who has a condition that Provider reasonably believes could cause harm to the Member if such care or treatment is discontinued. To be reimbursed for providing continued care and treatment under this section, Provider must identify the Member's Special Circumstances to CARECENTRIX, request that the Member be permitted to continue treatment under Provider's care, and agree not to seek payment from the Member of any amounts for which the Member would not be responsible if this Agreement were not terminated. Compensation to Provider shall be in accordance with the fee schedule in effect as of the termination date. Treatment of Special Circumstances as described herein shall be governed by the dictates of medical prudence and medical necessity. The requirements of this section shall not extend beyond ninety (90) days from the effective date of termination, or beyond nine (9) months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness, or for a pregnant Member who at the time of termination is past the twenty-fourth (24th) week of pregnancy, beyond delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks after delivery. In addition to the foregoing, termination shall not release Provider or Payor from liability to the other with respect to services rendered to Members, monies paid, or other actions through the date of termination, nor shall it relieve Provider of the obligation not to bill Members for Covered Services. This section shall survive termination of the Agreement for any reason. Tex. Ins. Code §§ 843.362, 1301.152 to 1301.154; 28 Tex. Admin. Code §§ 3.3703(a)(12), 11.901(a)(3).

17. Provider shall retain in Provider's records updated information concerning a Member's other health benefit plan coverage. Tex. Ins. Code §§ 843.349, 1301.134; 28 Tex. Admin. Code §§ 3.3703(a)(21), 11.901(b).

18. CARECENTRIX does not come within the definition of a "contracting entity" in Tex. Ins. Code § 1458.001 because CARECENTRIX does not enter into a direct contract with a physician, optometrist, physician hospital organization, hospital, or other individual or entity defined as a "provider" in Tex. Ins. Code § 1458.001. Accordingly, CARECENTRIX is not subject to the requirements of Tex. Ins. Code §§ 1458.051, 1458.101, or 1458.102 concerning a contracting entity's providing a person access to health care services or contractual discounts under a provider network contract, or selling, leasing, or otherwise transferring information regarding the payment or reimbursement terms of a provider network contract. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and

contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

19. CARECENTRIX does not come within the definition of a "general contracting entity" in Tex. Ins. Code § 1458.001 because CARECENTRIX does not enter into a direct contract with a physician, optometrist, physician hospital organization, hospital, or other individual or entity defined as a "provider" in Tex. Ins. Code § 1458.001. Accordingly, CARECENTRIX is not subject to the requirements of Tex. Ins. Code § 1458.101 concerning a general contracting entity's entering, amending or renewing a provider network contract that includes an anti-steering, anti-tiering, gag, or most favored nation clause.

20. If Payor is a health maintenance organization, as defined by Tex. Ins. Code § 843.002, the following provisions shall be added to the Agreement to the extent required by applicable law:

    A. CARECENTRIX or Payor will not terminate the Agreement solely because Provider informs a Member of the full range of physicians and providers available to the Member, including out-of-network providers. Tex. Ins. Code § 843.306(f).

    B. CARECENTRIX or Payor will not, as a condition of the Agreement or in any other manner, prohibit, attempt to prohibit, or discourage Provider from discussing with or communicating in good faith to a Member who is a current, prospective, or former patient or a person designated by such Member, with respect to information regarding the availability of facilities, both in-network and out-of-network, for the treatment of the Member's medical condition. Tex. Ins. Code § 843.363(a)(4).

21. If Payor is an insurer, as defined by Tex. Ins. Code § 1301.001, the following provisions shall be added to the Agreement to the extent required by applicable law:

    A. CARECENTRIX or Payor will not in any manner prohibit, attempt to prohibit, penalize, terminate, or otherwise restrict Provider from communicating with a Member about the availability of out-of-network providers for the provision of the Member's medical or health care services. Tex. Ins. Code § 1301.0058(a).

    B. CARECENTRIX or Payor will not terminate the Agreement or otherwise penalize Provider solely because Provider's patients who are Members use out-of-network providers for medical or health care services. Tex. Ins. Code § 1301.0058(b).

    C. Except in a case of a medical emergency as determined by Provider, before Provider may make an out-of-network referral for a Member, if applicable, Provider must inform the Member: (i) that the Member may choose a preferred provider or an out-of-network provider; (ii) if the Member chooses an out-of-network provider, the Member may incur higher out-of-pocket expenses; and (iii) whether Provider has a financial interest in the out-of-network provider. Tex. Ins. Code § 1301.0058(c).

ADDENDUM FOR THE STATE OF UTAH

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Utah regarding provider contracts with providers rendering health care services in the State of Utah. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health maintenance organization, or managed care organization, as those terms are defined in applicable Utah law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed as limiting Provider's ability to advise Provider's patients or clients fully about treatment. Utah Code § 31A-4-106(5).

2. During the first two (2) years of the Agreement, CARECENTRIX may terminate the Agreement, with or without cause, upon giving Provider the requisite amount of notice provided in the Agreement, but in no case shall such notice be less than sixty (60) days. Notwithstanding the foregoing, if CARECENTRIX has a reasonable basis to believe that Provider has engaged in fraudulent conduct or poses a significant risk to patient care or safety, CARECENTRIX may immediately suspend Provider from further performance under the Agreement, provided that the remaining provisions required by law are followed in a timely manner before termination may become final. CARECENTRIX's internal appeal process with respect to termination of the Agreement is set forth in the Provider Manual. Utah Code § 31A-22-617.1(2).

3. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement in accordance with the requirements of Utah Code § 31A-8-407:

    a. If Payor fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX.

    b. In the event that Payor becomes insolvent, the rehabilitator or liquidator may require Provider to continue to provide Covered Services to Members until the earlier of ninety (90) days after the date of the filing of a petition for rehabilitation or liquidation, or the date that the term of the Agreement ends. The rehabilitator or liquidator may reduce the fees that Provider is otherwise entitled to receive under the Agreement during such continuation period, but may not reduce a fee to less than seventy-five percent (75%) of the regular fee set forth in the Agreement. Provider shall accept the reduced payment as payment in full and shall relinquish the right to collect additional amounts from the Member. The Member shall continue to pay the copayments, deductibles, and other payments for services received from Provider that the Member was required to pay before the filing of a petition for rehabilitation or liquidation.

    c. Neither Provider, nor any agent or trustee of Provider, nor any of their assignees, shall maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX, or to collect the amount of the regular fee reduction authorized in accordance with subsection (b) of this section.

4. In the event of the insolvency of a Payor that is a "managed care organization," as defined in Utah Code § 31A-27a-403(1), the provisions of subsections 3(b) and 3(c) of this Addendum shall apply to the Agreement to the extent that Covered Services are rendered to Members of the managed care organization's plan. Utah Code § 31A-22-617(1)(c).

5. CARECENTRIX does not come within the definition of an “insurer” or “third party administrator” in Utah Code § 31A-1-301, or “managed care organization” in Utah Code § 31A-45-102, or a “health maintenance organization” or “limited health plan” in Utah Code § 31A-8-101. Accordingly, CARECENTRIX is not subject to the requirements of Utah Code §§ 31A-45-301(6) or 31A-8-407(4) regarding an insurer’s, managed care organization’s or health maintenance organization’s permitting an entity not under common ownership or control, to use or otherwise lease the insurer’s, managed care organization’s or health maintenance organization’s network of participating providers. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider’s services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement, including the fee schedule and applicable general payment policies set forth in the Agreement. Provider may obtain a list of CARECENTRIX’s customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

ADDENDUM FOR THE STATE OF VERMONT

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Vermont regarding provider contracts with providers rendering health care services in the State of Vermont. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. CARECENTRIX shall not prohibit Provider from, or penalize Provider for discussing treatment options with Members regardless of CARECENTRIX's or Payor's position on the treatment options, or advocating on behalf of Members within the utilization review or grievance process, nor shall it penalize Provider because Provider in good faith reports to state or federal authorities any act or practice by CARECENTRIX or a Payor that jeopardizes Member health or welfare. Code Vt. R. 21 040 010 § 5.3(F).

2. Provider may give feedback to CARECENTRIX, on an ongoing basis, for CARECENTRIX's or Payor's use in assessing and enhancing CARECENTRIX's or Payor's Quality Management program, Utilization Management program, Member appeal procedures, and dispute resolution process. In addition, Provider may be invited to give input annually in the form of a written survey. Code Vt. R. 21 040 010 § 5.3(G).

3. Pursuant to Vermont laws, Payors shall be bound by and comply with all applicable Quality Assurance Standards and Consumer Protections for Managed Care Plans requirements, as may be amended from time to time. 18 V.S.A. § 9414.

4. In the event of Payor's insolvency or other cessation of operations, Covered Services to Member shall continue through the contract period for which premiums have been paid on behalf of the Member. This provision shall be construed in favor of the Member, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Payor, and shall supersede any oral or written contrary agreement between Provider and Member or Member's representative. 8 V.S.A. § 5102b; Code Vt. R. 21 040 010 § 5.3(M), (N).

5. Upon termination of the Agreement without cause, Provider shall continue to provide Covered Services for specific conditions for which a Member was under Provider's care at the time of such termination as follows: (a) Members with life-threatening, disabling or degenerative conditions shall be allowed to continue undergoing a course of treatment for 60 days from the date of termination or until the assumption of such treatment by another provider, whichever is shorter; and (b) Members who are in the second or third trimester of a pregnancy shall be permitted to continue to receive medically necessary Covered Services from Provider until the completion of postpartum care. The terms and conditions of the Agreement shall continue to apply. Provider shall be compensated for such continued care in accordance with the compensation arrangements that were in effect under the Agreement prior to termination. Members shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than copayments, deductibles, or coinsurance. Provider has no obligation under the Agreement to provide services to individuals who cease to be Members.
   Code Vt. R. 21 040 010 § 5.1(G).

6. To the extent applicable, amendments to this Agreement may only be made in accordance with 18 V.S.A. § 9418d.

7. CARECENTRIX shall provide such information sufficient for Provider to determine compensation or payment terms for Covered Services. Such information shall include: the manner of payment and, on request, the fee-for-service dollar amount allowable for each CPT code for those CPT codes that Provider typically uses or actually bills. Payor shall provide a readily available mechanism that includes information on the commercially available claims editing software used, standards used for claims edits, payment percentages for modifiers, and any significant edits to the claims software. The applicable Payor is responsible for adjudicating the Provider's claims against the Member's benefit plan. 18 V.S.A. § 9418c(a).

8. To the extent consistent with the terms of the Agreement, Provider may provide Covered Services to Members covered under an HMO, PPO, indemnity, Medicare Advantage, Medicaid, and/or any other commercial health coverage plan. The reimbursement terms are the same for each such product unless otherwise specified. 18 V.S.A. § 9418c(a).

9. CARECENTRIX's internal appeal process is summarized in the Provider Manual posted at the CARECENTRIX provider portal. 18 V.S.A. § 9418c(a).

10. In accordance with 18 V.S.A. § 9418c(a), the following is a listing of Addenda to the Agreement:
    Exhibit A – Rate Exhibit
    Regulatory Addendum for the State of Vermont
    Medicare Advantage, Medicaid, and Managed Medicaid Addendum

11. CARECENTRIX does not come within the definition of a "contracting entity," nor does the Agreement satisfy the definition of a "provider network contract," for purposes of 18 V.S.A. § 9418f, because CARECENTRIX does not contract with physicians, physician organizations, or physician hospital organizations, which comprise the definition of "provider" in 18 V.S.A. § 9418f. Accordingly, CARECENTRIX is not subject to the requirements of 18 V.S.A. § 9418f regarding a contracting entity's granting access to a provider's health care services and contractual discounts pursuant to a provider network contract. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

ADDENDUM FOR THE STATE OF VIRGINIA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Virginia regarding provider contracts with providers rendering health care services in the State of Virginia. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

I. To the extent applicable, and required by Va. Code § 3 8.2-3407.15, and not preempted by federal law, the following minimum fair business standards in the processing and payment of claims for Covered Services shall apply. For purposes of this section, the term "Clean Claim" shall have the meaning set forth in Va. Code § 38.2-3407.15(A) .

1. A claim shall be paid within forty (40) days of receipt of the claim except where the obligation to pay the claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

    1. The claim is determined not to be a Clean Claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another payor for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which Covered Services were accessed or provided; or

    2. The claim was submitted fraudulently.

    CARECENTRIX shall maintain a written or electronic record of the date of receipt of a claim. Provider shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. Within thirty (30) days after receipt of a claim, Provider will be notified of any defect or impropriety that prevents the claim from being deemed a Clean Claim and the information required to process and pay the claim will be requested. Upon receipt of the additional information necessary to make the original claim a Clean Claim, the claim will be paid in compliance with subsection 1 of this section. Payment of a claim for health care services which are Covered Services rendered pursuant to the Agreement cannot be refused if there is no timely notice or attempt to notify Provider of the matters identified above unless such failure was caused in material part by Provider; however, nothing herein shall preclude a retroactive denial of payment of such a claim unless such retroactive denial of payment of the claim would violate subsection 6 of this section. Beginning no later than January 1, 2026, all notifications and information required under this subsection shall be delivered electronically.

3. Any interest owing or accruing on a claim under Va. Code §§ 38.2-3407.1 or 38.2-4306.1, under the Agreement, or under any other applicable law, shall, if not sooner paid or required to be paid, be paid without the necessity of demand at the time the claim is paid or within sixty (60) days thereafter.

4. a. Reasonable policies shall be established and implemented to permit Provider: (i) to confirm in advance during normal business hours by free telephone or electronic means, if available, whether

the health care services to be provided are medically necessary and Covered Services; and (ii) to determine the requirements applicable to Provider (or to the type of health care services which Provider has contracted to deliver under the Agreement) for: (a) pre-certification or authorization of coverage decisions; (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim; (c) provider- specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims; and (d) other provider-specific applicable claims processing and payment matters necessary to meet the terms and conditions of the Agreement, including determining whether a claim is a Clean Claim. Provider should refer to the CareCentrix Provider Manual and Provider Portal for details on these policies.

Claims submitted by Provider may be bundled or downcoded. The specific bundling and downcoding policies that are reasonably expected to be applied to Provider's services on a routine basis as a matter of policy are (i) disclosed on CARECENTRIX's or Payor's website; or (ii) can be obtained by calling the CareCentrix Network Services team at the telephone number published in the Provider Manual posted on the CareCentrix Provider Portal. If such request is made by or on behalf of Provider, Provider shall be provided with such policies within ten (10) business days following the date the request is received.

b. Within ten (10) business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to Provider and to the health care services identified by Provider which Provider has contracted to deliver under the Agreement shall be made available to Provider. In the event the provision of the entire policy would violate any applicable copyright law, a clear explanation of the policy as it applies to Provider and to those health care services identified by Provider which Provider has contracted to deliver under the Agreement may instead be timely delivered to Provider.

5. A claim for a previously authorized health care service or a health care service for which Provider or Member was advised in advance of the provision of the health care services that the health care services are medically necessary and a Covered Service shall be paid, unless:

    1. The documentation for the claim provided by Provider clearly fails to support the claim as originally authorized;

    2. The refusal is because: (i) another payor is responsible for the payment; (ii) Provider has already been paid for the health care services identified on the claim; (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to CARECENTRIX by Provider, the Member, or other person not related to CARECENTRIX; or (iv) the individual receiving the health care services was not eligible to receive them on the date of service and CARECENTRIX did not know, and with the exercise of reasonable care could not have known, of the individual's eligibility status; or.

    3. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. CARECENTRIX shall not impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless CARECENTRIX specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, CARECENTRIX has provided a written explanation of why the claim is being retroactively adjusted, and: (i) the original claim was submitted fraudulently; (ii) the original claim payment was incorrect because Provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by Provider; or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed 12 months. Notwithstanding the provisions of clause (iii), Provider and CARECENTRIX may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. CARECENTRIX shall notify Provider at least thirty (30) days in advance of any retroactive denial or recovery or refund of a

previously paid claim. Beginning no later than January 1, 2026, all written communications, explanations, notifications, and related Provider responses applicable to this subsection shall be delivered electronically. The electronic method and location for delivery shall be agreed upon by CARECENTRIX and Provider and included in the Agreement.

7. Except as otherwise provided in this Section I, effective July 1, 2025, CARECENTRIX shall deliver provider contracts, related amendments, and notices exclusively to Provider in electronic format other than facsimile. Effective January 1, 2026, electronic Provider notifications to CARECENTRIX shall be directed to the following electronic mail address: Contract.Department@CareCentrix.com or such other subsequent electronic mail address identified in writing by CARECENTRIX to Provider as the electronic mail address for such notifications.

8. The Agreement shall include or attach at the time it is presented to Provider for execution: (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid which is applicable to Provider or to the range of health care services reasonably expected to be delivered by Provider on a routine basis under the Agreement; and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subsection 4 of this section) applicable Provider or to the range of health care services reasonably expected to be delivered Provider under the Agreement.

9. No amendment to the Agreement or to any addenda, schedule, exhibit, or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to Provider (or to the range of health care services reasonably expected to be delivered by Provider under the Agreement) shall be effective as to Provider, unless Provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least sixty (60) calendar days before the effective date, and Provider has failed to notify CARECENTRIX within thirty (30) calendar days of receipt of the documentation of Provider's intention to terminate the Agreement at the earliest date thereafter permitted under the Agreement.

10. In the event that the provision of a policy required to be provided under subsections 8 or 9 of this section would violate any applicable copyright law, Payor may instead comply with this section by providing a clear written explanation of the policy as it applies to Provider.

11. CARECENTRIX's claims payment dispute mechanism is described in the Agreement and Provider Manual. If a claim denial is overturned following completion of a dispute review, CARECENTRIX shall, on the day the decision to overturn is made, consider the claims impacted by such decision as Clean Claims. All applicable laws related to the payment of a Clean Claim shall apply to the payments due.

12. Beginning July 1, 2025, Payor shall make available through electronic means a way for Provider to determine whether a patient is covered by a health plan that is subject to the State Corporation Commission's jurisdiction.

13. Payor or CARECENTRIX shall not be in violation of the provisions of this section if its failure to comply is caused in material part by Provider, or if Payor's or CARECENTRIX's compliance is rendered impossible due to matters beyond Payor's or CARECENTRIX's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by Payor or CARECENTRIX.

14. CARECENTRIX shall not terminate or fail to renew the Agreement, or otherwise penalize Provider, for invoking any of Provider's rights under this section or under the Agreement.

15. Provider shall not discriminate against any Member solely due to the Member's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. This provision shall not be construed to require Provider to treat a Member who has threatened to make or

has made a professional liability claim against Provider or Provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against Provider or Provider's employer, agents, or employees.

II. If Payor is a "carrier" that uses a "provider panel" as those terms are defined in Va. Code § 38.2-3407.10(A), the following requirements of Va. Code § 38.2-3407.10 shall be incorporated into the Agreement to the extent applicable and not preempted by federal law:

1. Provider shall be notified at least ninety (90) days prior to the date of termination of the Agreement, except if the termination is for cause. If the Agreement provides for a longer notice of termination period, such longer notice period will apply, except if the termination is for cause.

2. a. Provider shall be permitted to render Covered Services to any Member for a period of at least ninety (90) days from the date of termination of the Agreement, except if the termination is for cause. Provider shall continue to render Covered Services to any Member who has an existing provider-patient relationship with Provider for a period of at least 90 days from the date of termination of the Agreement, except when Provider is terminated for cause.

b. Notwithstanding the provisions of subsection 2.a. of this section, Provider shall be permitted to continue rendering and shall continue rendering Covered Services to any Member who has an existing provider-patient relationship with Provider and who has been medically confirmed to be pregnant at the time of termination of the Agreement, except if the termination is for cause. Such treatment shall, at the Member's option, continue through the provision of Covered Services for postpartum care directly related to the delivery.

c. Notwithstanding the provisions of subsection 2.a. of this section, Provider shall be permitted to continue rendering and shall continue rendering Covered Services to any Member who has an existing provider-patient relationship with Provider and who is determined to be terminally ill, as defined under § 1861(dd)(3)(A) of the Social Security Act, at the time of termination of the Agreement, except if the termination is for cause. Such treatment shall, at the Member's option, continue for the remainder of the Member's life for Covered Services directly related to the treatment of the terminal illness.

d. Notwithstanding the provisions of subsection 2.a. of this section, Provider shall be permitted to continue rendering and shall continue rendering Covered Services to any Member who has an existing provider-patient relationship with Provider and who has been determined by a medical professional to have a life-threatening condition at the time of termination of the Agreement. Such treatment shall, at the Member's option, continue for up to one hundred and eighty (180) days for care directly related to the life-threatening condition.

e. Notwithstanding the provisions of subsection 2.a. of this section, Provider shall be permitted to continue rendering and shall continue rendering Covered Services to any Member who has an existing provider-patient relationship with Provider and who is admitted to and receiving treatment in any inpatient facility (if applicable to the Agreement) at the time of termination of the Agreement. Such admission and treatment shall continue until the Member is discharged from the inpatient facility.

For purposes of this subsection, "existing provider-patient relationship" means that Provider has rendered Covered Services to Member or admitted or discharged Member in the previous 12 months.

3. Provider shall be reimbursed under subsection 2 of this section in accordance with the terms of the Agreement in effect immediately before the effective date of the termination, for any Covered

Services received by the Member after the date of termination of the Agreement. Provider shall accept such reimbursement and any cost-sharing payment as payment in full. Provider shall continue to adhere to all policies and procedures and quality standards that were required immediately before the termination of the Agreement.

4. The Agreement does not require Provider to indemnify Payor or CARECENTRIX for Payor's or CARECENTRIX'S negligence, willful misconduct, or breach of the Agreement, if any. The Agreement does not require Payor or CARECENTRIX to indemnify Provider for Provider's negligence, willful misconduct, or breach of the Agreement, if any.

5. The Agreement does not require Provider, as a condition of participation in CARECENTRIX's provider network, to waive any right to seek legal redress against Payor or CARECENTRIX; provided that, nothing in the foregoing shall alter or limit the dispute resolution provisions or arbitration process set forth in the Agreement and the Provider Manual.

6. The Agreement does not prohibit, impede, or interfere with Provider in the discussion of medical treatment options with a Member.

7. The Agreement permits and requires Provider to discuss medical treatment options with a Member.

8. The Agreement does not include provisions that require Provider to deny Covered Services that Provider knows to be medically necessary and appropriate, and that are provided with respect to a specific Member or a group of Members with similar medical conditions.

9. Provider shall be permitted to refuse to participate in a provider panel owned or operated by Payor, an unaffiliated carrier, or other entity, subject to the terms and conditions specified in Va. Code § 38.2-3407.10(O).

10. Provider is not prohibited from discontinuing services to Members at any time due to misconduct, a refusal to follow Provider's policies and procedures, or on any other reasonable basis; however, Provider shall not discontinue services to Members solely on the basis that the Agreement was terminated. Va. Code § 38.2-3407.10(P).

III. If Payor is a "health maintenance organization" as defined in Va. Code §§ 38.2-5800 and 38.2-4300, the following requirements of Va. Code § 38.2-5805 shall be incorporated into the Agreement to the extent applicable and not preempted by federal law:

1. If Provider terminates the Agreement, Provider shall give at least sixty (60) days' advance notice of termination. If the Agreement provides for a longer notice of termination period, such longer notice period will apply.

2. Provider may not maintain, nor may any agent, trustee, or assignee of Provider maintain, any action at law against a Member to collect sums owed by Payor or CARECENTRIX.

3. In the event that Payor or CARECENTRIX fails to pay for Covered Services as set forth in the Agreement, or as specified in the contract between Payor and CARECENTRIX, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX.

4. The following "hold harmless" clause, as required by Va. Code § 38.2-5805(C)(9), shall be added to the Agreement for purposes of this section. As used herein, the term "managed care health insurance plan" (MCHIP or the Plan) shall have the meaning specified in Va. Code § 38.2-5800:

Hold Harmless Clause

Provider hereby agrees that in no event, including, but not limited to nonpayment by Payor, the managed care health insurance plan (the "Plan"), or CARECENTRIX; the insolvency of Payor, the Plan, or CARECENTRIX; or breach of this Agreement, shall Provider bill, charge, collect a deposit from; seek compensation, remuneration, or reimbursement from; or have any recourse against a Member or persons other than Payor for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable copayments or deductibles billed in accordance with the terms of the Member agreement for the Plan.

Provider further agrees that (i) this provision shall survive the termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of the Plan's Members and (ii) this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Member or persons acting on the Member's behalf.

IV. CARECENTRIX does not come within the definition of a "carrier" that contracts with a "provider panel" to provide health care services to the carrier's enrollees under the carrier's health benefit plan, as defined in Va. Code § 38.2-3407.10(A). Accordingly, CARECENTRIX is not subject to the requirements of Va. Code § 38.2-3407.10(O) regarding a carrier that rents or leases its provider panel to unaffiliated carriers. Notwithstanding the foregoing, Provider acknowledges and agrees that the Agreement permits Payors, managed care entities, and their representatives to access Provider's services and contractual rates of reimbursement under the Agreement, in accordance with and subject to all applicable terms and conditions of the Agreement. Provider may obtain a list of CARECENTRIX's customers at the CARECENTRIX provider portal website or by contacting CARECENTRIX at the toll-free telephone number specified in the Provider Manual.

V. If Provider is a participating pharmacy provider in the CARECENTRIX network, is located in Virginia, and holds an active permit from the Virginia Board of Pharmacy to conduct the practice of pharmacy in Virginia, the provisions of this section are incorporated into the Agreement to the extent required by Va. Code § 38.2-3407.15:1(B) and (C), and not preempted by federal law.

A. To the extent that Payor or its intermediary CARECENTRIX has the right or obligation to conduct audits of Provider pursuant to the Agreement, Payor or its intermediary CARECENTRIX is prohibited, in the absence of fraud: (i) from recouping amounts calculated from or arising out of any of the following, or (ii) from terminating or failing to renew the Agreement with Provider for invoking Provider's rights under any of the following:

1. Probability sampling, extrapolation, or other mathematical or statistical methods that allegedly project an error;
2. Clerical errors by Provider;
3. An act or omission of Provider that was not specifically prohibited or required by the Agreement when the claim was adjudicated unless the act or omission was a violation of applicable law or regulation;
4. The refusal of Payor or its intermediary CARECENTRIX to consider during an audit or audit appeal a pharmacy record in electronic form to validate a claim;
5. Dispensing fees or interest on the claim, except in the event of an overpayment, if the prescription was dispensed in accordance with applicable law or regulation;
6. Any claim authorized and dispensed more than 24 months prior to the date of the audit unless the claim is adjusted at the direction of the [State Corporation] Commission, except that this time period shall be tolled while the denial of the claim is being appealed;

7. An alleged breach of auditing requirements if they are not the same as the requirements that Payor or its intermediary CARECENTRIX applies to other participating pharmacy providers in the same setting;
8. The refusal of Payor or its intermediary CARECENTRIX to consider during an audit or audit appeal a pharmacy record, a prescriber or patient verification, or a prescriber record to validate a claim; or
9. The alleged failure of Provider to supply during an audit or audit appeal a pharmacy record not specifically identified in the Agreement.

B. As used in this section, the terms below have the meanings set forth in Va. Code § 38.2-3407.15:1(A) as follows:

"Audit" includes any audit conducted or authorized by Payor or its intermediary CARECENTRIX to determine whether Provider has complied with the terms and conditions for reimbursement under the Agreement.

"Clerical error" means any clerical or recordkeeping error or omission, such as typographical errors, scrivener's errors, or computer errors, in the keeping, recording, handling, or transcribing of pharmacy records. "Clerical error" does not include any clerical or recordkeeping error or omission that results in an overpayment by Payor or its intermediary CARECENTRIX, or the dispensing of a prescription in breach of applicable law or regulation.

"Fraud" means a knowingly or willfully false act of misrepresentation or an act in deliberate ignorance of the truth or falsity of the information as evidenced by a review of claims data, evaluation of Provider statements, physical review of pharmacy records, or use of similar investigative methods by Payor or its intermediary CARECENTRIX.

"Overpayment" means a payment by Payor or its intermediary CARECENTRIX to Provider that is greater than the rate or amount Provider is entitled to under the Agreement or applicable fee schedule.

"Pharmacy record" means a patient record, signature, or delivery log, or prescription, including written, phoned-in, faxed, or electronic prescriptions, whether original or substitute, that complies with applicable law and regulation.

MEDICAID ADDENDUM FOR THE STATE OF VIRGINIA

This Medicaid Addendum for the State of Virginia (this "Addendum") supplements and is made part of the Provider Agreement (the "Agreement") between CARECENTRIX and the provider listed on the signature page of the Agreement to which this Addendum relates ("Provider"). The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Virginia regarding provider contracts with providers rendering health care services in the State of Virginia to individuals covered under a Managed Medicaid plan. In the event of a conflict between the terms of this Addendum and the terms of the Agreement, including any other addenda, attachments, or exhibits thereto, the terms of this Addendum shall control with respect to the subject matter hereof, unless otherwise required by law.

DEFINITIONS. In addition to terms defined elsewhere the Agreement, the following terms when used in this Addendum shall have the meanings set forth below. If an identical term is defined in the Agreement, the definition in the Addendum shall control with respect to services governed by the Virginia Medicaid Program.

"Covered Services" means services for which a Medicaid Member is eligible to receive coverage under the Virginia Managed Medicaid Program.

"DMAS" means the Virginia Department of Medical Assistance Services. DMAS is also referred to as the "Department" throughout this Addendum.

"Medicaid Contract" means the Payor's contract with DMAS.

"Medicaid Member" means a covered individual enrolled under any contract a Payor may have with DMAS during the term of this Agreement. Medicaid members include individuals enrolled through Virginia's Cardinal Care program.

"Payor" shall mean a carrier, health insurer, health maintenance organization (HMO), managed care entity or an organization that has entered into an agreement with CARECENTRIX to arrange home care services for the Payor's Medicaid Members.

CARECENTRIX and Provider agree to abide by all applicable provisions of the Medicaid Contract. No terms of this Addendum to the Agreement are valid which terminate the legal liability of the Payor in the Medicaid Contract. Provider compliance with the Medicaid Contract specifically includes but is not limited to the following requirements to the extent applicable to the Agreement:

1. Provider must have a National Provider Identifier (NPI) number, and must be screened, enrolled (including signing a Department Medicaid provider participation agreement), and periodically revalidated in the Department's Medicaid Enterprise System (MES) Provider Services Solution (PRSS). This rule applies to all provider types and specialties. Per 42 CFR §438.608(b), this provision does not require CARECENTRIX's network providers to render services to Fee For Service (FFS) beneficiaries. If Provider only provides services to Dual Eligible Special Needs Plan (DSNP) members, Provider is not required to enroll in PRSS.

2. Provider shall meet CARECENTRIX's standards for licensure, certification, and credentialing as specified in the Agreement and Provider Manual.

3. Provider shall comply with all applicable Federal and State laws and regulations including Title VI of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act of 1990 as amended; Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards, Section 1557 of the

Patient Protection and Affordable Care Act (including but not limited to, reporting overpayments pursuant to state or federal law) and the Deficit Reduction Act of 2005 (DRA) requiring that emergency services be paid in accordance with the DRA provisions [Pub. L. No. 109- 171, Section 6085], and as explained in CMS State Medicaid Director SMD #06- 010, Further, Provider agrees to comply with all non-discrimination requirements in the Medicaid Contract.

4. Provider shall maintain records for ten (10) years from the close of the Agreement. For children under age 21 enrolled in the CCC Plus Waiver, records must be retained for the greater period of a minimum of ten (10) years or at least six (6) years after the minor has reached 21 years of age per 12 VAC 30-120-1730.

5. As applicable, Provider agrees to ensure confidentiality of family planning services in accordance with the Medicaid Contract, except to the extent required by law, including, but not limited to, the Virginia Freedom of Information Act.

6. Provider shall provide copies of Medicaid Member records and access to its premises to representatives of CARECENTRIX and Payor, as well as duly authorized agents or representatives of the Department, the U.S. Department of Health and Human Services, and the State Medicaid Fraud Unit. Provider agrees to preserve the full confidentiality of medical records in accordance with the Medicaid Contract.

7. Provider shall maintain and provide a copy of a Medicaid Member's medical records, in accordance with 42 CFR § 438.208(b)(5), to the Medicaid Member and their authorized representatives as required by CARECENTRIX or the Payor and within no more than 10 business days of CARECENTRIX, the Payor, or the Medicaid Member's request.

8. Provider shall disclose the required information, at the time of application, credentialing, and/or re-credentialing, and/or upon request, in accordance with 42 CFR § 455, Parts 101 through 106 for definitions, percentage calculations, and requirements for disclosure of ownership, business transactions, and information on persons convicted of crimes related to any Federal health care programs.

9. Provider shall screen its directors, officers, employees, and contractors initially and on an ongoing monthly basis to determine whether any of its directors, officers, employees, or contractors have been excluded from participation in Medicare, Medicaid, SCHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded or debarred. Provider shall be required to immediately report to CARECENTRIX any exclusion information discovered. Civil monetary penalties may be imposed against Provider if Provider employs or enters into contracts with excluded individuals or entities to provide items or services to Medicaid Members.

10. Provider shall submit utilization data for enrolled Medicaid Members in the format specified by CARECENTRIX, consistent with either CARECENTRIX's obligations or the Payor's obligations to the Department as related to quality improvement and other assurance programs as required in this Agreement.

11. Provider agrees to participate in and contribute required data to CARECENTRIX and Payor's quality improvement and other assurance programs as required in the Medicaid Contract.

12. As applicable, Provider agrees to abide by the terms of the Medicaid Contract for the timely provision of emergency and urgent care. Where applicable, the Provider agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required

hospital/emergency department Memorandums of Understanding signed by the applicable Payor in accordance with the Medicaid Contract.

13. Provider agrees not to create barriers to access to care by imposing requirements on Medicaid Members that are inconsistent with the provision of medically necessary and Covered Services.

14. Provider agrees to clearly specify referral approval requirements to its providers and in any sub-subcontracts. Additionally, Provider agrees to hold Medicaid Members harmless for charges for any Medicaid Covered Service. This includes those circumstances where Provider fails to obtain necessary referrals, preauthorization, or fails to perform other required administrative functions.

15. Provider shall promptly provide or arrange for the provision of all services required under the Agreement. This provision shall continue to be in effect for contract periods for which payment has been made even if Provider becomes insolvent until such time as Medicaid Members are withdrawn from assignment to Provider.

16. Provider shall comply with corrective action plans initiated by CARECENTRIX or the Payor.

17. Payors and, as applicable, CARECENTRIX shall follow prior authorization procedures pursuant to the Code of Virginia § 38.2-3407.15:2. Such requirements are specified in the Agreement, CARECENTRIX Provider Manual, and Provider Portal. Payors and, as applicable, CARECENTRIX must accept telephonic, facsimile, or electronic submissions of pharmacy service authorization requests that are delivered from e-prescribing systems, electronic health records, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards for service authorization requests.

18. Referral approval requirements are set forth in the Agreement, Provider Manual, and Provider Portal.

19. In accordance with 42 CFR § 447.15, Provider shall accept CARECENTRIX's payment as payment in full except for patient pay amounts for Long Term Support and Services (LTSS) as established by the local Department of Social Services and shall not bill or balance bill a Medicaid Member for Medicaid Covered Services provided during the Medicaid Member's period of Payor enrollment. The collection or receipt of any money, gift, donation or other consideration from or on behalf of a Cardinal Care Medicaid Member for any Medicaid Covered Service provided is expressly prohibited. This includes those circumstances where Provider fails to obtain necessary referrals, service authorization, or fails to perform other required administrative functions.

20. Should an audit by CARECENTRIX, the Payor, or an authorized state or federal official result in disallowance of amounts previously paid to Provider, Provider will reimburse CARECENTRIX upon demand. Provider shall not bill the Medicaid Member in these instances.

21. Provider agrees not to bill Medicaid Members for medically necessary Covered Services provided during the Medicaid Member's period of Payor enrollment. This provision shall continue to be in effect even if CARECENTRIX or the Payor becomes insolvent. However, if a Medicaid Member agrees in advance of receiving the service and in writing to pay for a non-Covered Service, then Provider, CARECENTRIX, or the Payor can bill.

22. Any conflict in the interpretation of CARECENTRIX's or the Payor's policies and the Agreement shall be resolved in accordance with Federal and Virginia laws and regulations. Provider shall comply with Federal contracting requirements described in 42 CFR Part 438.3, including identification of/non-payment of provider-preventable conditions, conflict of interest

safeguards, inspection and audit of records requirements, physician incentive plans, recordkeeping requirements, etc.

23.

a. Clean claims must be submitted to CARECENTRIX within three (3) months from the date of service. If the Medicaid Member has other coverage, the timeframe for submission begins on the date of payment from the primary payer.

b. Provider and CARECENTRIX mutually agree that Provider will be paid for clean claims for Covered Services rendered to Medicaid Members within 60 days of receipt by CARECENTRIX of a clean claim from Provider. Interest shall only be payable on late paid claims to the extent required by law with respect to contracted providers**.**

c. In accordance with 42 CFR §438.602(b), 42 CFR §438.608(b), and 42 CFR §455.100-106, 42 CFR §455.400-470, and Section 5005(b)(2) of the 21st Century Cures Act, CARECENTRIX does not pay claims to any network providers who are not enrolled in Provider Services Solution (PRSS) module or out-of-network providers who are not registered in PRSS, other than claims from Providers that participate in a D-SNP network that only provide Medicare services.

d. In accordance with 42 CFR§ 457.1201, CARECENTRIX does not avoid costs for Covered Services by referring Medicaid Members to publicly supported health care resources.

24. Under 42 CFR § 434.6(a)12(i), CARECENTRIX and Payors are prohibited from making a payment to Provider for provider-preventable conditions (PPC) that meet the criteria outlined in 42 CFR § 447.26(b). Provider shall report to CARECENTRIX all PPCs or health care acquired conditions (HCACs) associated with claims. No reduction in payment for a PPC shall be imposed on Provider when the condition defined as a PPC or that meets the definition of a HCAC for a particular Medicaid Member that existed prior to the initiation of treatment for that Medicaid Member by the Provider.

25. The CARECENTRIX Provider Manual supplements and is part of the Agreement, and Provider must comply with the terms and conditions of the Provider Manual. In the event of a conflict between the terms in the CARECENTRIX Provider Manual and the Agreement, the terms of the Agreement shall control.

26. As applicable, Provider shall use DMAS established billing codes as described in the Cardinal Care Coverage Chart.

27. As applicable, Provider shall comply with the CMS HCBS Settings Rule detailed in 42 CFR 441.301(c)(4)-(5).

28. Provider agrees to comply with all record retention requirements.

ADDENDUM FOR THE STATE OF WASHINGTON

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Washington regarding provider contracts with providers rendering health care services in the State of Washington. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, a health carrier or health maintenance organization as defined in applicable Washington law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Payor shall establish a mechanism by which Provider can obtain timely information on Member eligibility for Covered Services and health plan benefits, including any limitations or conditions on such services or benefits. Nothing contained in the Agreement may have the effect of modifying benefits, terms, or conditions contained in the Member's health plan. In the event of any conflict between the Agreement and the Member's health plan, the benefits, terms, and conditions of the health plan shall govern with respect to Covered Services provided to the Member. Wash. Admin. Code [WAC] 284-170-421 (1)(2).

2. As required by the hold harmless and insolvency provisions of WAC 284-170-421(3)

    a. Provider hereby agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency, or breach of the Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Member or a person acting on a Member's behalf, other than Payor, for services provided pursuant to the Agreement. This provision shall not prohibit collection of deductibles, copayments, coinsurance, and/or non-Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Members in accordance with the terms of the Member's health plan.

    b. Provider agrees, in the event of Payor's insolvency, to continue to provide Covered Services to Members of such Payor's plan for the duration of the period for which premiums on behalf of the Member were paid to such Payor or until the Member's discharge from inpatient facilities, whichever time is greater.

    c. Notwithstanding any other provision of the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Member's health plan.

    d. Provider may not bill the Member for Covered Services, except for deductibles, copayments, or coinsurance, where Payor denies payments because Provider has failed to comply with the terms or conditions of the Agreement.

    e. Provider further agrees that: (i) the provisions of subsections (a), (b), (c), and (d) of this section shall survive termination of the Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Payor's Members, and (ii) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Members or persons acting on their behalf.

    f. If Provider contracts with other providers or facilities who agree to provide Covered Services to Members of Payor with the expectation of receiving payment directly or indirectly from Payor, such providers or facilities must agree to abide by the provisions of subsections (a), (b), (c), (d), and (e) of this section.

3. Provider is hereby informed that willfully collecting or attempting to collect an amount from a Member knowing that collection to be in violation of the Agreement constitutes a class C felony under Wash. Rev. Code [RCW] 48.80.030(5). WAC 284-170-421(4).

4. Payor or CARECENTRIX, as applicable, shall notify Provider of Provider's responsibilities with respect to Payor's or CARECENTRIX's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any applicable federal or State requirements. WAC 284-170-421(5).

5. To the extent required by law, Provider must be given reasonable notice of not less than sixty (60) days of changes that affect Provider's compensation and that affect health care service delivery, unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible. Subject to any termination and continuity of care provisions of the Agreement, Provider may terminate the Agreement without penalty if Provider does not agree with such changes. No change to the Agreement may be made retroactive without the express consent of Provider. WAC 284-170-421(6).
6. Payor or CARECENTRIX may not in any way preclude or discourage Provider from informing Members of the care they require, including various treatment options, and whether in Provider's view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the Member's plan. Payor or CARECENTRIX may not prohibit, discourage, or penalize Provider otherwise practicing in compliance with the law from advocating on behalf of a Member with Payor or CARECENTRIX. Nothing in this section shall be construed to authorize Provider to bind Payor or CARECENTRIX in any way to pay for any service. Payor may not preclude or discourage Members or those paying for Members' coverage from discussing the comparative merits of different health carriers with Provider. This prohibition specifically includes prohibiting or limiting Provider from participating in those discussions even if critical of Payor or CARECENTRIX. RCW 48.43.510(6)-(7); WAC 284-170-421(7).

7. Provider shall make health records available to appropriate State and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of Members subject to applicable State and federal laws related to the confidentiality of medical or health records. WAC 284-170-421(8).

8. Provider and CARECENTRIX shall provide at least sixty (60) days' written notice to each other before terminating the Agreement without cause. If the Agreement provides for a longer notice period for termination without cause, such longer notice period shall govern. WAC 284-170-421(9).

9. Provider shall furnish Covered Services to Members without regard to the Member's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when Provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions. WAC 284-170-421(11).

10. Provider shall not be penalized because Provider, in good faith, reports to State or federal authorities any act or practice by Payor or CARECENTRIX that jeopardizes patient health or welfare or that may violate State or federal law. WAC 284-170-421(12).

11. Notwithstanding any other provision of law, Payor may not prohibit directly or indirectly its Members from freely contracting at any time to obtain any health care services outside the Members' health care plan on any terms or conditions the Members choose; provided, however, that nothing in this section shall be construed to bind Payor in any way for any services delivered outside the Member's health plan. RCW 48.43.085.

12. To the extent required by WAC 284-170-431, the standards set forth in this section shall apply to the prompt payment of amounts owed by Payor to Provider for Covered Services provided to Members under the Agreement, to the extent applicable and not otherwise preempted by federal law:

    a. For purposes of this section, "clean claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

    b. For Covered Services provided to Members, Payor shall pay Provider in accordance with the following standards:

        i. Ninety-five percent (95%) of the monthly volume of clean claims shall be paid within thirty (30) days of receipt by Payor or agent of Payor; and

        ii. Ninety-five percent (95%) of the monthly volume of all claims shall be paid or denied within sixty (60) days of receipt by Payor or agent of Payor, except as agreed to in writing by the parties on a claim-by-claim basis.

    c. The receipt date of a claim is the date that Payor or Payor's agent receives either written or electronic notice of the claim.

    d. Payor shall establish a reasonable method for confirming receipt of claims and responding to Provider's inquiries about claims.

    e. If Payor fails to pay claims within the standards established under subsection (b) of this section, Payor shall pay interest on undenied and unpaid clean claims more than sixty-one (61) days old until Payor meets the standards under subsection (b) of this section. Interest shall be assessed at the rate of one percent (1%) per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Payor shall add the interest payable to the amount of the unpaid claim without the necessity of Provider submitting an additional claim. Any interest paid under this section shall not be applied by Payor to a Member's deductible, copayment, coinsurance, or any similar obligation of the Member.

    f. When Payor issues payment in Provider's and the Member's names, Payor shall make claim checks payable in the name of Provider first and the Member second.

    g. Denial of a claim must be communicated to Provider and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then Payor upon request of Provider must also promptly disclose the supporting basis for the decision.

    h. Payor shall be responsible for ensuring that any person acting on behalf of or at the direction of Payor, or acting pursuant to Payor standards or requirements, complies with the billing and claim payment standards set forth in this section.

    i. The standards set forth in this section do not apply to claims about which there is substantial evidence of fraud or misrepresentation by Provider, other providers, facilities, or Members, or instances where Payor, Payor's agent, or CARECENTRIX has not been granted reasonable access to information under Provider's control.

    j. Provider, Payor, and CARECENTRIX are not required to comply with the provisions of this section if the failure to comply is occasioned by any act of God, bankruptcy, act of a governmental authority responding to an act of God or other emergency, or the result of a strike, lockout, or other labor dispute.

13. To the extent applicable and not otherwise preempted by federal law, Payor may not unreasonably delay payment of a claim through the application of a coordination of benefits provision, as further specified in the time limits set forth in WAC 284-51-215.

14. To the extent required by WAC 284-170-433, the following requirements apply to the Agreement to the extent applicable and not otherwise preempted by Federal law:

    a. Provider shall be reimbursed for Covered Services provided to Member through telemedicine or store and forward technology if: (i) The plan provides Covered Services when provided in person by Provider; (ii) the Covered Service is medically necessary; (iii) the Covered Service is a service recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act in effect on January 1, 2015, RCW 48.43.005 and 48.43.715; (iv) The Covered Service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the Covered Service meets the standards required by state and federal laws governing the privacy and security of protected health information; and (v) effective 1/1/2023, for audio only telemedicine, the Member has an established relationship with Provider.

    b. Provider must be reimbursed for a Covered Service provided to a Member through telemedicine as provided in RCW 48.43.735(1) or WAC 284-170-433(1) the same amount of compensation that would be payed to Provider if the Covered Service was provided in person, except for hospitals, hospital systems, telemedicine companies, and provider groups consisting of 11 or more providers that may elect to negotiate an amount of compensation for telemedicine services that differs from the amount of compensation for in-person services. The number of providers in a provider group refers to all providers within the group, regardless of a provider's location.

    c. An originating site for a telemedicine health care service subject to WAS 284-170-433(1) includes a: (i) Hospital; (ii) Rural health clinic; (iii) Federally qualified health center; (iv) Physician's or other provider's office; (v) Licensed or certified behavioral health agency; (vi) Skilled nursing facility; (vii) Home or any location determined by the Member receiving the service including, but not limited to, a pharmacy licensed under chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825. If the site chosen by the Member receiving Covered Service is in a state other than the state of Washington, the Provider's ability to conduct a telemedicine encounter in that state is determined by the Provider's licensure status and the Provider licensure laws of the other state; or (viii) Renal dialysis center, except an independent renal dialysis center.

       Except for a home or any location determined by the Member receiving the service including, but not limited to, a pharmacy licensed under chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825 and a hospital that is an originating site for an audio-only telemedicine encounter, any originating site may charge a facility fee for infrastructure and preparation of the Member. Reimbursement for a facility fee must be subject to a negotiated agreement between the originating site and the Payor or CARECENTRIX. A distant site, a hospital that is an originating site for an audio-only telemedicine encounter, or any other site not identified in this subsection may not charge a facility fee.

    d. If Provider intends to bill a Member or a Member's plan for an audio-only telemedicine service, Provider must obtain patient consent from the Member for the billing in advance of the Covered Service being delivered, consistent with the requirements of WAS 284-170-433(6) and state and federal laws applicable to obtaining patient consent.

    e. Access to telemedicine services is inclusive for Members who may have disabilities or limited-English proficiency and for whom the use of telemedicine technology may be more challenging, consistent with Payor's obligations under WAC 284-43-5940 through 284-43-5965 with respect to design and implementation of plan benefits.

15. To the extent required by WAC 284-170-460, the following audit guidelines shall apply to the Agreement, to the extent applicable and not otherwise preempted by federal law: (i) Payor and CARECENTRIX may not access health information and other similar records unrelated to Members, provided that, this provision shall not limit Payor's or CARECENTRIX's right to ask for and receive information relating to the ability of Provider to deliver health care services that meet the accepted standards of medical care prevalent in the community; (ii) to the extent that Payor or CARECENTRIX accesses medical records for audit purposes, such access shall be limited to only those records that are necessary to perform the audit; and (iii) any billing audit standards set forth in the Agreement shall apply mutually to the parties.

16. If Provider subcontracts with other providers or facilities to deliver Covered Services to Members under the Agreement, Provider shall require each such subcontracted provider or facility to satisfy the requirements of Section 2 of WAC 284-170-401, and to comply with the terms and conditions of the Agreement and this Addendum. WAC 284-170-401.Notwithstanding the foregoing, nothing in this section shall authorize Provider to subcontract, delegate, or assign any of Provider's services or obligations under the Agreement to another provider or facility without the prior written consent of CARECENTRIX, which consent shall not be unreasonably withheld or delayed.

17. To the extent required by law, retrospective reviews conducted pursuant to the utilization management program under the Agreement shall comply with the following requirements, to the extent applicable and not otherwise preempted by federal law: (i) retrospective review determinations must be based solely on the medical information available to the attending physician or order provider at the time the health service was provided; (ii) coverage shall not be retrospectively denied for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered, unless the prior authorization was based upon a material misrepresentation by Provider; and (iii) a review conducted pursuant to a "postservice review request" must be completed within thirty (30) calendar days of receipt of all necessary information. RCW 48.43.525; WAC 284-43-2000.

18. a. To the extent required by RCW 48.43.600, if applicable and not otherwise preempted by federal law, Payor may not, except in the case of fraud:

    i. Request a refund from Provider of a payment previously made to satisfy a claim unless Payor does so in writing to Provider within twenty-four (24) months after the date that the payment was made; or

    ii. If doing so for reasons related to coordination of benefits (COB) with another carrier or entity responsible for payment of a claim, request a refund from Provider of a payment previously made to satisfy a claim unless Payor does so in writing to Provider within thirty (30) months after the date that the payment was made; or

    iii. Request that a contested refund be paid any sooner than six (6) months after receipt of the request.

    b. Any request pursuant to subsection (a) of this section must specify why Payor believes that Provider owes the refund. If made for reasons related to COB, such request must include the name and mailing address of the entity that has primary responsibility for payment of the claim.

    c. If Provider fails to contest the request in writing to Payor within thirty (30) days of receipt of such request, the request is deemed accepted and the refund must be paid. This section is not applicable to subrogation claims.

    d. Payor may at any time request a refund from Provider of a payment previously made to satisfy a claim if: (1) a third party, including a government entity, is found responsible for satisfaction of the claim as

a consequence of liability imposed by law, such as tort liability; and (2) Payor is unable to recover directly from the third party because the third party has either already paid or will pay Provider for the health services covered by the claim.

19. a. To the extent required by RCW 48.43.605, if applicable and not otherwise preempted by federal law, Provider may not, except in the case of fraud:

    i. Request additional payment from Payor to satisfy a claim unless Provider does so in writing to Payor within twenty-four (24) months after the date that the claim was denied or payment intended to satisfy the claim was made; or

    ii. If doing so for reasons related to coordination of benefits (COB) with another carrier or entity responsible for payment of a claim, request additional payment from Payor to satisfy a claim unless Provider does so in writing to Payor within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made; or

    iii. Request that the additional payment be made any sooner than six (6) months after receipt of the request.

    b. Any request pursuant to subsection (a) of this section must specify why Provider believes that Payor owes the additional payment. If made for reasons related to COB, such request must also include the name and mailing address of any entity that has disclaimed responsibility for payment of the claim. This section is not applicable to subrogation claims.

20. To the extent required by law, the "Arbitration" section of the Agreement is hereby deleted in its entirety and is replaced by the dispute resolution provisions set forth in this Addendum for the fair resolution of disputes between the parties arising out of the Agreement. Notwithstanding any provision to the contrary in the Agreement, the Provider Manual, or CARECENTRIX's administrative policies and procedures, disputes between the parties arising out of the Agreement shall not be subject to binding arbitration. Unless otherwise required by a specific federal or State statute or regulation governing dispute resolution, or otherwise preempted by federal law, such disputes shall be subject to the applicable provisions set forth in Sections 19 through 23 of this Addendum. WAC 284-170-421(13), WAC 284-170-440.

21. In accordance with Section 20 of this Addendum, the dispute resolution procedures in this section shall apply to disputes arising out of the Agreement with respect to **claims payment** issues:

    a. Request for Reconsideration. In the event that Provider wishes to request reconsideration of a claim payment under the Agreement, Provider must either notify the CARECENTRIX Provider Resolution Team verbally by calling the toll-free telephone number at 877-725-6525, or submit a request for reconsideration in writing by using the Claim Reconsideration Form that is found on the CARECENTRIX provider portal website at www.carecentrixportal.com. The completed Claim Reconsideration Form must be submitted to CARECENTRIX at the following address:

    CareCentrix
    Request for Reconsideration
    20 Church Street
    Hartford, CT 06103

    Provider's request for reconsideration must be received by CARECENTRIX **within forty-five (45) days after the date of CARECENTRIX's explanation of payment (EOP)**, or within the period of time required by applicable law if longer. After receipt of Provider's completed request for reconsideration, CARECENTRIX will research Provider's concern and respond to Provider as soon as possible. If the request for reconsideration is resolved in Provider's favor, the claim will be reprocessed, and an EOP issued. If the request for reconsideration is not resolved in Provider's favor,

Provider will be advised to submit an appeal in writing according to the procedures set forth in subsection (b) of this section.

b. Appeal. In the event that the request for reconsideration under subsection (a) of this section is not resolved in Provider's favor, Provider must submit an appeal in writing by using the Appeal Form that is found on the CARECENTRIX provider portal website at www.carecentrixportal.com. The completed Appeal Form, together with a copy of the claim, must be submitted to the CARECENTRIX Appeals Unit at the following address:

CareCentrix
Appeals Unit
20 Church Street
Hartford, CT 06103

Provider's appeal must be received by CareCentrix **within thirty (30) calendar days** from the date that CARECENTRIX orally advised Provider or, for written requests for reconsideration, the date of CARECENTRIX's written notice (EOP, letter, etc.) advising Provider that Provider's request for reconsideration was not resolved in Provider's favor, or within the period of time required by law if longer. CARECENTRIX's Appeals Unit will endeavor to complete the review of Provider's appeal within thirty (30) calendar days of the date that the Appeals Unit receives all information necessary to review Provider's appeal. CARECENTRIX will communicate the results of its review of Provider's appeal in writing, which may include, when payment is issued, a check along with an explanation of payment.

c. Dispute Resolution. In the event that Provider is not satisfied with the decision rendered on appeal under subsection (b) of this section, Provider may request in writing, within sixty (60) days of the date of the appeal decision letter, that the parties attempt in good faith to resolve the dispute promptly by negotiation between representatives of the parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of the date of Provider's written request for such negotiation, Provider and/or CARECENTRIX may proceed in accordance with subsection (d) of this section.

d. Judicial Remedies. The dispute resolution procedures specified in subsections (a), (b), and (c) of this section do not exclude judicial remedies, but such procedures are required prior to judicial remedies. WAC 284-170-440(4).

e. Survival. The provisions of this section shall survive any termination of the Agreement.

22. In accordance with Section 20 of this Addendum, the dispute resolution procedures in this section shall apply to disputes arising out of the Agreement with respect to **termination** of the Agreement:

a. Appeal. In the event that Provider wishes to appeal the termination of the Agreement, Provider must submit a written request to appeal such termination, along with supporting documentation, to Provider's designated CARECENTRIX Network Manager. Provider's written request must be received by CARECENTRIX within thirty (30) days from the date of CARECENTRIX's termination notice, or the period of time required by law if longer. Provider's appeal will be handled in accordance with any appeal processes required by applicable law. CARECENTRIX will endeavor to complete its review of Provider's appeal within thirty (30) calendar days after the date of receipt of Provider's written appeal. CARECENTRIX will communicate the results of its review of Provider's appeal in writing.

b. Dispute Resolution. In the event that Provider is not satisfied with the decision rendered on appeal under subsection (a) of this section, Provider may request in writing, within sixty (60) days of the date of the appeal decision letter, that the parties attempt in good faith to resolve the dispute promptly

by negotiation between representatives of the parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of the date of Provider's written request for such negotiation, Provider and/or CARECENTRIX may proceed in accordance with subsection (c) of this section.

c. Judicial Remedies. The dispute resolution procedures specified in subsections (a) and (b) of this section do not exclude judicial remedies, but such procedures are required prior to judicial remedies. WAC 284-170-440(4).

d. Survival. The provisions of this section shall survive any termination of the Agreement.

23. In accordance with Section 20 of this Addendum, the dispute resolution procedures in this section shall apply to **other disputes** arising out of the Agreement which are not covered by Sections 20 or 21 of this Addendum:

a. Dispute Resolution. If, after exhausting the CARECENTRIX appeal process, Provider is not satisfied with the resolution of a dispute, or in the event of a dispute arising out of the Agreement which is not covered by such appeal process, a party wishes to submit the dispute for resolution, that party must first request in writing that the parties attempt in good faith to resolve the dispute promptly by negotiation between representatives of the parties who have authority to settle the dispute. If the matter is not resolved within sixty (60) days of such written request for negotiation, either party or both parties may proceed in accordance with subsection (b) of this section.

b. Judicial Remedies. The dispute resolution procedures specified in subsection (a) of this section do not exclude judicial remedies, but such procedures are required prior to judicial remedies. WAC 284-170-440(4).

c. Survival. The provisions of this section shall survive any termination of the Agreement.

24. To the extent required by RCW 48.43.055 and applicable to Provider, CARECENTRIX shall provide reasonable means allowing Provider to be heard after submitting a written request for review of a complaint arising under the Agreement. If CARECENTRIX fails to grant or reject a request for review of such complaint by Provider within thirty (30) days after it is made, Provider may proceed as if the complaint had been rejected. A complaint that has been rejected by CARECENTRIX may be submitted to nonbinding mediation. Mediation shall be conducted under the Uniform Mediation Act, as set forth in Title 7, Chapter 7.07, of the Revised Code of Washington, or any other rules of mediation agreed to by the parties. This section applies solely to the resolution of complaints by Provider. Complaints by, or on behalf of, a Member are subject to the grievance processes in RCW 48.43.530, which shall be administered by the Payor or the Payor's designee for the Member's plan.

ADDENDUM FOR THE STATE OF WEST VIRGINIA

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of West Virginia regarding provider contracts with providers rendering health care services in the State of West Virginia. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, health maintenance organization, or managed care plan, as those terms are defined in applicable West Virginia law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization ("HMO") plan, the following provisions shall be added to the Agreement to the extent required by law and applicable to Provider:

   a. In the event that Payor or CARECENTRIX fails to meet its obligations under the Agreement to pay fees for Covered Services rendered by Provider to a Member, the Member shall not be liable to Provider for such fee or fees. Provider or its agent or representative shall not: (i) collect or attempt to collect from a Member any money for Covered Services; or (ii) maintain any action at law against a Member to collect money owed to Provider by Payor or CARECENTRIX. The Member shall not be liable to Provider for any Covered Services. This provision shall not be construed to apply to the amount of any deductible or copayment which is not covered by the Member's plan. W. Va. Code § 33-25A-7a(1) to (5).

   b. Provider shall give sixty (60) days' advance written notice to CARECENTRIX and the West Virginia Commissioner of Insurance before canceling the Agreement for any reason. Nonpayment for goods or services rendered by Provider to Members is not a valid reason for avoiding the sixty (60) day advance notice of cancellation. To the extent that the Agreement provides for a longer notice of termination period, such longer notice period shall apply. Upon receipt by CARECENTRIX of a sixty (60) day cancellation notice from Provider, CARECENTRIX may, if requested by Provider, terminate the Agreement in less than sixty (60) days if Payors are not financially impaired or insolvent. W. Va. Code § 33-25A-7a(7).

   c. CARECENTRIX or Payor shall not give Provider an incentive or disincentive plan that includes specific payment made directly or indirectly, in any form, to Provider as an inducement to deny, release, limit, or delay specific, medically necessary and appropriate services provided with respect to a specific Member or groups of Members with similar medical conditions. W. Va. Code § 33-25C-4(b); W. Va. C.S.R. § 114-53-4.

   d. Nothing in the Agreement shall be construed to place restrictions on Provider which would serve to limit the communication of medical advice or options available to the Member, or would act in any way to limit the communication between Provider and its patient. Nothing in the Agreement shall prevent Provider from advising a Member as to whether or not a treatment is covered by the HMO plan. W. Va. C.S.R. § 114-53-4.

   e. Provider shall participate in quality improvement activities as described in the Agreement and the Provider Manual. Provider shall allow CARECENTRIX and Payor access to Members' medical records. Nothing in the Agreement shall be construed to prevent open communication between Provider and the patient regarding appropriate treatment alternatives, or to penalize Provider for discussing medically necessary or appropriate care for the patient. W. Va. C.S.R. § 114-53-5.

f. Provider shall not be required to indemnify Payor or hold Payor harmless for the acts or conduct of Payor that are set forth in W. Va. Code § 33-25C-7.

2. To the extent required by law, Payor and CARECENTRIX shall adhere to and comply with the minimum fair business standards in the processing and payment of claims for health care services as set forth in W. Va. Code § 33-45-2.

3. To the extent that the Agreement permits amendments to the Agreement by written notice to Provider, and requires Provider to terminate the Agreement within a specified time period to avoid the amendment, Provider shall have twenty (20) business days from the date of receipt of such amendment to notify CARECENTRIX in writing of Provider's intention to terminate the Agreement at the earliest date thereafter permitted under the Agreement. W. Va. Code § 33-45-2(a)(9). This section shall not apply to amendments required by legislative, regulatory, or other legal authority, as provided under the Agreement.

4. CARECENTRIX shall not terminate or fail to renew the Agreement or otherwise penalize Provider for invoking any of Provider's rights under W. Va. Code §§ 33-45-1 to 33-45-8 or under the Agreement. W. Va. Code § 33-45-4.

ADDENDUM FOR THE STATE OF WISCONSIN

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of Wisconsin regarding provider contracts with providers rendering health care services in the State of Wisconsin. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer, defined network plan, preferred provider plan, or health maintenance organization, as those terms are defined in applicable Wisconsin law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. Nothing in the Agreement shall be construed to limit Provider's ability to disclose information, to or on behalf of a Member, about the Member's medical condition or treatment options. Provider may discuss, with or on behalf of a Member, all treatment options and any other information that Provider determines to be in the best interest of the Member and within the scope of Provider's professional license. Neither CARECENTRIX nor Payor shall: (i) penalize Provider or terminate the Agreement because Provider makes referrals to other participating providers or discusses medically necessary or appropriate care with or on behalf of a Member; or (ii) retaliate against Provider for advising a Member of treatment options that are not covered benefits under the Member's plan. Wis. Stat. § 609.30; Wis. Admin. Code Ins. § 9.36.

2. The following continuity of care provisions shall apply to the Agreement to the extent required by Wis. Stat. § 609.24 and Wis. Admin. Code Ins. § 9.35:

    a. Except as provided in subsection b. of this section, a Member who is undergoing a course of treatment with Provider on the date of termination of the Agreement shall be permitted to continue to receive Covered Services from Provider for the following period of time:

        i. For the remainder of the course of treatment or for ninety (90) days after the effective date of termination of the Agreement, whichever is shorter; or

        ii. If maternity care is the course of treatment, and the Member is a woman who is in the second (2nd) or third (3rd) trimester of pregnancy when the Agreement terminates, until the completion of postpartum care for the woman and infant.

    b. The coverage required under this section shall not apply if: (i) Provider no longer practices in the applicable geographic service area; or (ii) the Agreement is terminated by CARECENTRIX because of misconduct on the part of Provider.

    c. The same reimbursement rates, terms, and conditions that applied under the Agreement prior to its termination shall apply to Covered Services rendered by Provider to a Member under this section.

    d. Nothing in this section shall preclude the application of any provisions related to medical necessity that are generally applicable under the Member's plan.

    e. To the extent that Provider receives or is due reimbursement for Covered Services provided to a Member under this section, Provider shall be subject to the hold harmless requirements of Wis. Stat. § 609.91 with respect to the Member, regardless of whether Provider is a participating provider in the Member's plan and regardless of whether the Member's plan is a health maintenance organization.

3. Provider shall promptly provide CARECENTRIX with the information necessary to respond to complaints and grievances filed with Payor. Provider shall cooperate with CARECENTRIX and Payor to promptly respond to such complaints and grievances to facilitate resolution. Wis. Admin. Code Ins. § 18.03(2)(c).

4. To the extent provided by Wis. Stat. § 628.35, nothing in the Agreement shall be construed to require Provider to participate in the CARECENTRIX provider network on an exclusive basis, or to prevent or materially inhibit Provider from entering into a contract or other arrangement with an insurer to participate in the insurer's provider network.

5. Provider acknowledges receipt of the Notice, in the form attached as "Appendix A" to this Addendum, as required by Wis. Stat. § 609.94(1) (the "Notice"). The Notice summarizes the statutory limitations and requirements in Wis. Stat. §§ 609.91 to 609.935, and § 609.97(1), with respect to holding harmless the Members of a health maintenance organization insurer from the recovery of health care costs. Provider agrees to comply with the applicable requirements of such Wisconsin statutes in accordance with the Notice. Wis. Admin. Code Ins. § 9.13; Wis. Admin. Code Ins. 9, Appendix C.

ATTACHMENT – Appendix A: Notice

APPENDIX A

Addendum for the State of Wisconsin

NOTICE

THIS NOTICE DESCRIBES HOLD-HARMLESS PROVISIONS WHICH AFFECT YOUR ABILITY TO SEEK RECOURSE AGAINST HEALTH MAINTENANCE ORGANIZATION INSURER ENROLLEES FOR PAYMENT FOR SERVICES

Section 609.94, Wis. Stats., requires each health maintenance organization insurer ("HMO insurer"), to provide a summary notice to all of its participating providers of the statutory limitations and requirements in §§ 609.91 to 609.935, and § 609.97 (1), Wis. Stats.

SUMMARY

Under Wisconsin law a health care provider may not hold HMO insurer enrollees or policyholders ("enrollees") liable for costs covered under an HMO insurer policy if the provider is subject to statutory provisions which "hold harmless" the enrollees. For most health care providers application of the statutory hold-harmless is "mandatory" or it applies unless the provider elects to "opt-out." A provider permitted to "opt-out" must file timely notice with the Wisconsin Office of the Commissioner of Insurance ("OCI").

Some types of provider care are subject to the hold-harmless statutes only if the provider voluntarily "opts-in."

An HMO insurer may partially satisfy its regulatory capital and surplus requirements if health care providers elect to remain subject to the statutory hold-harmless provisions.

This notice is only a summary of the law. Every effort has been made to accurately describe the law. However, if this summary is inconsistent with a provision of the law or incomplete, the law will control.

Filings for exemption with OCI must be on the prescribed form in order to be effective.

HOLD HARMLESS

A health care provider who is subject to the statutory hold-harmless provisions is prohibited from seeking to recover health care costs from an enrollee. The provider may not bill, charge, collect a deposit from, seek remuneration or compensation from, file, or threaten to file with a credit reporting agency or have any recourse against an enrollee or any person acting on the enrollee's behalf, for health care costs for which the enrollee is not liable. The prohibition on recovery does not affect the liability of an enrollee for any deductibles or copayments, or for premiums owed under the policy or certificate issued by the HMO insurer.

A. MANDATORY FOR HOLD HARMLESS.

An enrollee of an HMO insurer is not liable to a health care provider for health care costs that are covered under a policy issued by that HMO insurer if any of the following are met:

1. Care is provided by a provider who is an affiliate of the HMO insurer, owns at least 5% of the voting securities of the HMO insurer, is directly or indirectly involved with the HMO insurer through direct or indirect selection of or representation by one or more board members, or is an Individual Practice Association ("IPA") and is represented, or an affiliate is represented, by one of at least three HMO insurer board members who directly or indirectly represent one or more IPAs or affiliates of IPAs.

2. Care is provided by a provider under a contract with or through membership in an organization identified in 1.

3. To the extent the charge exceeds the amount the HMO insurer has contractually agreed to pay the provider for that health care service.

4. The care is provided to an enrolled medical assistance recipient under a Department of Health Services prepaid health care policy.

5. The care is required to be provided under the requirements of s. Ins 9.35, Wis. Adm. Code.

B. "OPT-OUT" HOLD HARMLESS.

If the conditions described in A do not apply, the provider will be subject to the statutory hold harmless unless the provider files timely election with OCI to be exempt if the health care meets any of the following:

1. Provided by a hospital or an IPA.

2. A physician service, or other provider services, equipment, supplies or drugs that are ancillary or incidental to such services and are provided under a contract with the HMO insurer or are provided by a provider selected by the HMO insurer.

3. Provided by a provider, other than a hospital, under a contract with or through membership in an IPA that has not elected to be exempt. Note that only the IPA may file election to exempt care provided by its member providers from the statutory hold harmless. (See Exemptions and Elections, No. 4.)

C. "OPT-IN" HOLD HARMLESS.

If a provider of health care is not subject to the conditions described in A or B, the provider may elect to be subject to the statutory hold-harmless provisions by filing a notification with OCI stating that the provider elects to be subject with respect to any specific HMO insurer. A provider may terminate such a notice of election by stating the termination date in that notice or in a separate notification.

CONDITIONS NOT AFFECTING IMMUNITY

An enrollee's immunity under the statutory hold harmless is not affected by any of the following:

1. Any agreement entered into by a provider, an HMO insurer, or any other person, whether oral or written, purporting to hold the enrollee liable for costs (except a notice of election or termination permitted under the statute).

2. A breach of or default on any agreement by the HMO insurer, an IPA, or any other person to compensate the provider for health care costs for which the enrollee is not liable.

3. The insolvency of the HMO insurer or any person contracting with the HMO insurer, or the commencement of insolvency, delinquency, or bankruptcy proceedings involving the HMO insurer or other persons which would affect compensation for health care costs for which an enrollee is not liable under the statutory hold harmless.

4. The inability of the provider or other person who is owed compensation to obtain compensation for health care costs for which the enrollee is not liable.

5. Failure by the HMO insurer to provide notice to providers of the statutory hold-harmless provisions.

6. Any other conditions or agreement existing at any time.

EXEMPTIONS AND ELECTIONS

Hospitals, IPAs, and providers of physician services who may "opt-out" may elect to be exempt from the statutory hold harmless and prohibition on recovery of health care costs under the following conditions and with the following notifications:

1. If the hospital, IPA, or other provider has a written contract with the HMO insurer, the provider must within thirty (30) days after entering into that contract provide a notice to OCI of the provider's election to be exempt from the statutory hold-harmless and recovery limitations for care under the contract.

2. If the hospital, IPA, or other provider does not have a contract with an HMO insurer, the provider must notify OCI that it intends to be exempt with respect to a specific HMO insurer and must provide that notice for the period January 1, 1990, to December 21, 1990, at least sixty (60) days before the health care costs are incurred; and must provide that notice for health care costs incurred on and after January 1, 1991, at least ninety (90) days in advance.

3. A provider who submits a notice of election to be exempt may terminate that election by stating a termination date in the notice or by submitting a separate termination notice to OCI.

4. The election by an IPA to be exempt from the statutory provisions, or the failure of an IPA to so elect, applies to costs of health care provided by any provider, other than a hospital, under contract with or through membership in the IPA. Such a provider, other than a hospital, may not exercise an election separately from the IPA. Similarly, an election by a clinic to be exempt from the statutory limitations and restrictions, or the failure of the clinic to elect to be exempt, applies to costs of health care provided by any provider through the clinic. An individual provider may not exercise an election to be exempt separate from the clinic.

5. The statutory hold-harmless "opt-out" provision applies to physician services only if the services are provided under a contract with the HMO insurer or if the physician is a selected provider for the HMO insurer, unless the services are provided by a physician for a hospital, IPA, or clinic which is subject to the statutory hold-harmless "opt-out" provision.

NOTICES

All notices of election and termination must be in writing and in accordance with rules promulgated by the Commissioner of Insurance. All notices of election or termination filed with OCI are not affected by the renaming, reorganization, merger, consolidation, or change in control of the provider, HMO insurer, or other person. However, OCI may promulgate rules requiring an informational filing if any of these events occur.

Notices to the Office of the Commissioner of Insurance must be written, on the prescribed form, and received at the Office's current address:

P. O. Box 7873,
Madison, WI 53707-7873

HMO INSURER CAPITAL AND SECURITY SURPLUS

Each HMO insurer is required to meet minimum capital and surplus standard ("compulsory surplus requirements"). These standards are higher if the HMO insurer has fewer than 90% of its liabilities covered by the statutory hold-harmless. Specifically, beginning January 1, 1992, the compulsory surplus requirement shall be at least the greater of $750,000 or 6% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are less than 90%, or 3% of the premiums earned by the HMO insurer in the last 12 months if its covered liabilities are 90% or more. In addition to capital and surplus, an HMO insurer must also maintain a security surplus in the amount set by the Commissioner of Insurance.

FINANCIAL INFORMATION

An HMO insurer is required to file financial statements with OCI. You may request financial statements from the HMO insurer. OCI also maintains files of HMO insurer financial statements that can be inspected by the public.

ADDENDUM FOR THE STATE OF WYOMING

The provisions in this Addendum are added to the Agreement to comply with legislative and regulatory requirements of the State of South Wyoming regarding provider contracts with providers rendering health care services in the State of South Wyoming. To the extent that Provider also renders health care services in any other state(s), the provisions of the applicable regulatory addendum as to such state(s) as set forth at the CARECENTRIX provider portal at www.carecentrixportal.com shall also be added to the Agreement to comply with such state(s)' legislative and regulatory requirements. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions in the applicable Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For purposes of this Addendum, the term "Member" shall mean an individual who is eligible under a plan insured and/or administered by a Payor, and the term "Covered Services" shall mean services that are covered under any such plan. The term "Payor" shall mean, as applicable, an insurer or health maintenance organization, as those terms are defined in applicable Wyoming law. References to Provider herein shall mean the provider listed on the signature page of the Agreement to which this Addendum relates.

1. To the extent that Covered Services are rendered to Members enrolled in a health maintenance organization (HMO) plan, the following provisions shall be added to the Agreement in accordance with the requirements of applicable law:

    a. CARECENTRIX or Payor shall not refuse to contract with or compensate Provider for Covered Services solely because Provider has in good faith communicated with one or more current, former, or prospective patients regarding the provisions, terms, or requirements of Payor's plans as they relate to the needs of Provider's patients. Wyo. Stat. § 26-34-117(f).

    b. CARECENTRIX or Payor shall not prohibit or restrict Provider from disclosing to any Member any medically appropriate health care information that Provider deems appropriate regarding the: (i) nature of treatment, risks, or alternatives; (ii) decision to authorize or deny services; or (iii) process used to authorize or deny health care services or benefits. Wyo. Stat. § 26-34-117(g).

    c. In the event that Payor fails to pay for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by Payor or CARECENTRIX. Provider shall not collect or attempt to collect from the Member sums owed by Payor or CARECENTRIX. Neither Provider nor or any agent, trustee, or assignee of Provider, shall maintain any action at law against a Member to collect sums owed by Payor or CARECENTRIX. Wyo. Stat. § 26-34-114(o), (p), (q).

    d. In the event of Payor's insolvency, Provider shall continue to provide Covered Services to Members for the duration of the contract period after Payor's insolvency for which premiums have been paid and, with respect to a Member who is confined in an inpatient facility on the date of insolvency, until the Member's discharge from the inpatient facility or expiration of benefits. Wyo. Stat. § 26-34-114(r).

    e. In the event that Provider elects to terminate the Agreement, Provider shall give CARECENTRIX at least sixty (60) days' advance written notice of the termination. Wyo. Stat. § 26-34-114(s). Notwithstanding the foregoing, if the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, the longer notification period will apply.