

## **STATE-SPECIFIC COORDINATION PROVISIONS**

Pursuant to applicable state law, ValueOptions is required to comply with specific state law provisions as it pertains to health maintenance organizations (“HMO”), preferred provider organizations (“PPO”), point of service (“POS”), exclusive provider organizations (“EPO”), open access (“OA”), and other contractual arrangements with providers. As such, the following is a list of state coordinating provisions that shall hereby be included in your provider agreement applicable to HMO and/or PPO member services.

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### **ALABAMA STATE PROVISIONS**

1. The Agreement is amended by the following defined term:

The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Clean Claim” means a claim for payment of covered health care expenses that is submitted on the appropriate claim form or in the appropriate electronic data format which contains substantially all of the required data elements necessary for accurate adjudication, without obtaining additional information from the provider of the service or from a third party.

2. Claim Payment. To the extent any provision of the Agreement conflicts with the requirements of Ala. Code § 27-1-17, or its successor provision regarding payment of claims, those provisions shall be amended hereby for both parties to comply with that law. To the extent required by Applicable Law, each party agrees to comply with the provisions of Ala. Code § 27-1-17.

3. Refund of Overpayments. ValueOptions shall provide notice specifying the reasons for the action taken with respect to retroactive denials, adjustments of claims, including any recoupment or refund of a paid claim. If Provider contests the basis for ValueOptions’ action, Provider shall notify ValueOptions within thirty (30) days following the receipt of ValueOptions notice. Notwithstanding the foregoing, Provider shall have an additional period of six months from the date of receipt of ValueOptions notice to file a revised claim or request a reconsideration to consider additional medical records or information. Such revised claim or reconsideration shall be processed in accordance with Applicable Law. ValueOptions shall not retroactively deny, adjust a claim, or seek recoupment or a refund of a paid claim after the expiration of one year from the date that the initial claim was paid except in cases of fraud, coordination of benefits, or for duplicate payments on claims received from ValueOptions.

### **ALASKA STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:

(a) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means health care services that are provided by a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention would reasonably be expected by a prudent person who possesses an average knowledge of health and medicine to result in: (i) the placing of the Member’s health in serious jeopardy; (ii) a serious impairment to bodily functions; or (iii) a serious dysfunction of a bodily organ or part.

(b) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law: “Clean Claim” means a claim that does not have a defect, impropriety or circumstance requiring special treatment that precludes timely payment on the claim.

2. Termination of Agreement. To the extent that the Agreement contains a provision allowing discretionary termination of the Agreement, such provision shall apply equitably to both Provider and ValueOptions.
3. Dispute Resolution. Any dispute resolution provisions in the Agreement shall be replaced by the following to the extent applicable and to the extent the Agreement does not contain a dispute resolution provision, the following shall be added as a provision to the Agreement. In the event of a dispute between ValueOptions and Provider, a fair, prompt and mutual dispute resolution process shall be used. Provider and ValueOptions will hold an initial meeting at which Provider and ValueOptions are present or are represented by individuals with authority regarding the matters in dispute. The meeting shall be held within ten (10) working days after ValueOptions receives written notice of the dispute or gives written notice to Provider, unless Provider and ValueOptions agree in writing to a different schedule. If, within thirty (30) days following the initial meeting, ValueOptions and Provider have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to ValueOptions and Provider and who is not regularly under contract to or employed by either ValueOptions or Provider. Each party shall bear its proportionate share of the cost of mediation, including the mediator fees. If, after a period of sixty (60) days following commencement of mediation, ValueOptions and Provider are unable to resolve the dispute, either party may seek other relief allowed by law. ValueOptions and Provider agree to negotiate in good faith at the initial meeting and in mediation.
4. Provider / Patient Relationship. In accordance with Alaska Stat. § 21.07.010(a)(5), ValueOptions shall not penalize Provider or terminate Agreement because Provider acts as an advocate of a Member in seeking appropriate, medically necessary health care services. ValueOptions shall not interfere with Provider's ability to openly communicate with a Member about all appropriate diagnostic testing and treatment options.
5. No Financial Incentives. In accordance with Alaska Stat. section 21.07.010(b)(1), this Agreement shall not be interpreted to contain direct financial incentives to Provider for withholding Covered Services that are medically necessary. Nothing herein, however, shall be construed to prohibit incentives to Provider for efficient management of the utilization and cost of Covered Services.
6. Product Participation and Compensation From ValueOptions. Nothing in this Agreement shall be interpreted to require Provider to contract for all products currently offered or that may be offered in the future by ValueOptions. Nothing in this Agreement shall be interpreted to require Provider to accept from ValueOptions the same rate of compensation for Covered Services rendered as that which Provider has contracted for with another managed care entity.
7. Indemnification. To the extent required by Alaska Stat. section 21.07.010(c), nothing in this Agreement shall require Provider to indemnify or hold harmless ValueOptions for the acts or conduct of ValueOptions.
8. Continuity of Care. If a Member is pregnant or being actively treated by Provider on the date of termination of this Agreement, the Member may continue to receive Covered Services from Provider as described herein and this Agreement shall remain in force with respect to the continuing treatment. The Member shall be treated for the purposes of benefit determination or claim payment as if Provider were still under Agreement with ValueOptions. However, treatment is required to continue only while the Member's coverage remains in effect and 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 ("terminal" means a life expectancy of less than one year) or for the period that is the longest of the following: (i) the end of the current plan year; (ii) up to 90 days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or, (iii) through completion of postpartum care, if the Member is pregnant on the date of termination. This provision shall not supersede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.
9. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with Alaska Stat. §§ 21.51.120, 21.54.020, & 21.54.050.

10. Covered Services. Upon request, ValueOptions shall forward information to Provider, which sets forth Covered Services.

## ARIZONA STATE PROVISIONS

### I. The Agreement is amended by the following defined terms:

(a) *The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means health care services that are provided to a Member in a licensed hospital emergency facility by a provider after the recent onset of a medical condition that manifests itself by symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in any of the following: (i) serious jeopardy to the Member’s health; (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily organ or part.*

(b) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law: “Clean Claim” means a written or electronic claim for health care services or benefits that may be processed without obtaining additional information from the health care provider or from a third party, except in cases of fraud.

### II. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members:

1. Provider / Patient Relationship. In accordance with ARS Section 20-1061.B., ValueOptions shall not 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. Additionally, ValueOptions shall not terminate this Agreement or refuse to renew this Agreement with 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 a reconsideration of a decision by ValueOptions to deny coverage for a Covered Service; or (c) reports a violation of law to an appropriate authority.

2. No Financial Incentives. In accordance with ARS section 20-1061.C., this Agreement shall not be interpreted to contain financial incentives that include a specific payment made to or withheld from Provider as an inducement to deny, reduce, limit or delay medically necessary care. Nothing herein prohibits an arrangement for payment between ValueOptions and Provider that uses 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.

3. Member Hold Harmless. If ValueOptions fails to pay for Covered Services, Member shall not be liable to Provider for any amounts owed by ValueOptions and Provider shall not bill or otherwise attempt to collect from Member the amount owed by ValueOptions. No Provider, agent, trustee or assignee of Provider may maintain an action at law against Member to collect any amounts owed by ValueOptions for which Member is not liable to Provider. Nothing herein impairs the right of Provider to charge, collect from, attempt to collect from or maintain an action at law against a Member for any of the following: (a) copayment or coinsurance amounts; (b) health care services which are not Covered Services, including out of area claims that are not paid by an organization on behalf of a Member; (c) health care services rendered after the termination of this Agreement between ValueOptions and Provider, unless the health care services were rendered during confinement in an inpatient facility and the confinement began prior to the date of termination, or unless Provider has assumed post-termination treatment obligations under this Agreement. Nothing herein prohibits a Member from seeking health care services from a contracting or noncontracting provider and accepting financial responsibility for these services. If Member accepts financial responsibility for a service, Provider may not charge a Member more than the amount the Provider contracted to charge the Member pursuant to this Agreement. Nothing herein prohibits any person from informing a Member of either the cost of health care services performed or the status of any bill submitted to an organization in connection with health care services provided to a Member. Any information provided to a Member pursuant to this provision shall include a statement that the information is not a bill and is for the Member’s information only. The

statement shall include the following disclosure prominently displayed at the top of the page in all capital letters: "Do not pay this statement. This is not a bill. The information provided below is for information purposes only." This provision shall not supercede provisions in the Agreement that provide additional protections for Member if such provisions are permitted by Applicable Law.

4. Continuity of Care. Provider shall provide Covered Services to Members at the same rates and subject to the same terms and conditions established in this Agreement for the duration of the period after ValueOptions is declared insolvent, until the earliest of the following: (a) the duration of the contract period under the Member's health care plan or for sixty (60) days from the date insolvency is declared, whichever is longer; (b) for Members who are confined in an inpatient facility on the date of insolvency, until the Member's discharge; (c) a notification from the receiver that the plan for the risk of insolvency is inadequate to pay the cost of continuation of benefits under paragraphs (a) and (b) above or a determination by a court that ValueOptions cannot provide adequate assurance that it will be able to pay contract providers' claims for Covered Services that were rendered after ValueOptions is declared insolvent; (d) a determination by a court that ValueOptions is unable to pay contracted providers' claims for Covered Services that were rendered after ValueOptions is declared insolvent; (e) a determination by a court that continuation of the contract would constitute undue hardship to Provider; and/or (f) a determination by a court that ValueOptions has satisfied its obligations to all Members under its health care plans. This provision shall not supersede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

III. The following provision is added to the Agreement and is applicable to Providers rendering services to either insured or HMO Members:

Claim Payment. To the extent required by Applicable Law, ValueOptions and Provider shall comply with Ariz. Rev. Stat. § 20-3102 and State of Arizona, Department of Insurance Circular Letter 2000-15. Except in cases of fraud, ValueOptions or Provider shall not adjust or request adjustment of the payment of a claim more than one year after ValueOptions has paid that claim.

### **ARKANSAS STATE PROVISIONS**

1. The Agreement is amended by the following defined term:

The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Clean Claim" means a claim for payment of health care expenses that is submitted on a HCFA 1500, on a UB92, in a format required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), or on ValueOptions' standard claim form with all required fields completed. A Clean Claim shall not include a claim for which ValueOptions needs additional information in order to resolve one or more issues preventing payment or a claim for payment of expenses incurred during a period of time for which health benefit plan premiums are delinquent. References in the Agreement to "claims" shall be construed to mean "Clean Claims" to the extent required by Applicable Law.

2. Continuation of Care. In accordance with Ark. Code Ann. § 23-99-408, upon termination of the Agreement, Provider shall continue to treat Members until the current episode of treatment for an acute condition is complete or for a period of ninety (90) days, whichever occurs first. During such time that Provider continues to provide Covered Services to Members in accordance with this provision, Provider shall be deemed to be a participating provider by complying with the Agreement for purposes of reimbursement, utilization management, and quality of care. Except for applicable copays, deductibles, and coinsurance, Provider shall not bill Members for Covered Services provided pursuant to this provision. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

3. Provider/Patient Relationship. Nothing in the Agreement shall be construed to prohibit, restrict or otherwise penalize Provider from disclosing to any Member health care information that the Provider deems appropriate regarding the nature of treatment, risks, or alternatives, the availability of alternate therapies, consultations or tests,

the decisions of utilization reviewers, the process used to authorize or deny services, or information regarding financial incentives used by ValueOptions.

4. Claim Payment. To the extent required by Applicable Law, if any provision of the Agreement conflicts with the requirements of Ark. Ins. Dept. Reg. No. 43, or any successor provision regarding payment of claims, those provisions shall be amended hereby for both parties to comply with that rule. To the extent applicable, each party agrees to comply with the provisions of Ark. Ins. Dept. Reg. No. 43.

6. Claims Recoupments. To the extent required, any adjustments to payments, including any recoupment process utilized by ValueOptions, shall be administered in accordance with Ark. Code Ann. § 23-104-101 et seq., and any applicable regulations adopted thereunder. To the extent applicable, each party agrees to comply with the provisions of Ark. Code Ann. § 23-104-101 et seq.

## **CALIFORNIA STATE PROVISIONS**

### I. The Agreement is amended by the following defined terms:

(a) For insured and HMO (HCSP) business, the term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the Member’s health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily part or organ.

(b) For HMO (HCSP) business, “Risk-bearing Organization” means a professional medical corporation, other form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure or another lawfully organized group of physicians that delivers, furnishes or otherwise arranges for or provides Covered Services, but does not include an individual or health care service plan and that does all of the following:

- (i) Contracts directly with ValueOptions or arranges for Covered Services to be provided to ValueOptions Members.
- (ii) Receives compensation for those services on any capitated or fixed periodic payment basis.
- (iii) Is responsible for the processing and payment of claims made by providers for services rendered by those providers on behalf of ValueOptions that are covered under the capitation or fixed periodic payment made by ValueOptions to the risk-bearing organization.

### II. The following provisions are added to the Agreement and are applicable to Providers rendering services to HMO (HCSP) Members only.

1. Member Hold Harmless. In the event that ValueOptions fails to pay for Covered Services as set forth in the Member’s health benefit plan, the Member shall not be liable to Provider for any sums owed by ValueOptions. If ValueOptions learns that Provider is charging Member a surcharge or a fee for sums owed by ValueOptions for Covered Services, ValueOptions shall take appropriate action against Provider. Provider shall not invoice or balance bill Member for the difference between Provider’s billed charges and the reimbursement paid by ValueOptions for Covered Services provided to Member. This provision does not prohibit Provider from collecting copayments, coinsurance, deductibles for Covered Services provided to Member, or fees for noncovered services delivered to Members. Provider shall fully advise Members of their financial responsibility prior to rendering any services that are not covered. Provider shall report to ValueOptions all surcharge and copayments paid by Members directly to Provider in accordance with Section 1385 of the California Health and Safety Code. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

2. Continuity of Care. Upon termination of the Agreement, Provider shall continue to provide services to Members in accordance with Cal. Health & Safety Code § 1373.96. At a Member’s request, Provider shall continue to provide Covered Services to a Member receiving such services from Provider at the time of termination as follows:

- (a) acute conditions, through the duration of the acute condition;
- (b) a serious chronic condition, for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider, as determined by ValueOptions in consultation with the Member and Provider, consistent with good professional practice. Completion of such services shall not exceed 12 months from the termination date or 12 months from the effective date of coverage for a new Member;
- (c) a terminal illness, for the duration of the terminal illness;
- (e) newborn child, for the time period between birth and age 36 months, but not to exceed 12 months from the termination date or 12 months from the effective date for a new Member; and
- (f) any procedure that is authorized by ValueOptions as part of a documented course of treatment, if the such services have been recommended and documented by Provider to occur within 180 days of termination or within 180 days of the effective date for a new Member

During the period in which Provider renders such continued care, Provider shall be subject to all contractual terms and conditions in the Agreement, including, but not limited to, credentialing, hospital privileges, utilization review, peer review, and quality assurance requirements. During the time period through which Provider renders Covered Services pursuant to this section, the amount of and requirements for payment of applicable Member copayments, deductibles, and coinsurance shall remain the same as if Provider continued to be a contracted provider. If Provider refuses to agree to abide by the terms of the Agreement, ValueOptions shall not be obligated to continue such services through Provider.

ValueOptions shall not be obligated to allow Members to continue care with Provider if the Agreement is terminated for reasons relating to a medical disciplinary cause or reason, or fraud or other criminal activity.

Compensation for Covered Services rendered pursuant to this section shall be in accordance with Cal. Health & Safety Code § 1373.96 (d) and Applicable Law

This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this Amendment and are permitted by Applicable Law. The obligations of this section shall survive termination of the Agreement regardless of the cause giving rise to the termination and will be construed for the benefit of Members. In the event of ValueOptions insolvency, Provider shall continue to provide Covered Services in accordance with Applicable Law.

3. Accessibility of Services. Provider shall provide Covered Services to Members during reasonable hours of operation. Provider shall make available Emergency health care services within the service area twenty-four hours a day, seven days a week. ValueOptions shall periodically monitor and evaluate the accessibility of Provider's care by evaluating waiting time and appointment scheduling times and by addressing problems that develop.

4. Maintenance of Records.

- (a) Provider shall maintain in the State of California such records, books and papers, and provide such information to ValueOptions, or make such records, books and papers open during normal business hours to inspection by the Director of the California Department of Managed Health Care, as may be necessary for compliance by ValueOptions with the provisions of the Knox-Keene Health Care Service Plan Act of 1975 and the rules thereunder. Provider agrees to retain such records for a period of at least five years unless a longer period is required under the terms of the Agreement. This obligation does not terminate upon the termination of Agreement.
- (b) ValueOptions shall have access, at reasonable times upon demand, to the books, records, and papers of Provider relating to the Covered 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.

5. Grievance System. ValueOptions' grievance system shall comply with the requirements of 28 Cal. Code Regs. § 1300.68. Provider agrees to cooperate in resolving all grievances relating to the provision of medical services to Members in accordance with procedures established by ValueOptions or the department. Provider agrees to participate in and provide assistance and information as may be necessary or helpful to ValueOptions to ensure

compliance with the rule, to include those grievances where Provider is advocating for or submitting a grievance on behalf of a Member.

6. Quality Assurance Program. ValueOptions' quality assurance program shall comply with the requirements of 28 Cal. Code Regs. § 1300.70. Provider shall comply with ValueOptions' quality assurance programs, policies or procedures, including updates thereto, as required by the Agreement, to include obligations to comply with ValueOptions oversight programs, policies or procedures pursuant to the delegation of quality assurance activities.

7. Risk-bearing Organization Disclosure Requirements. If Provider is a Risk-bearing Organization:

- (a) Provider must furnish financial information to ValueOptions or to ValueOptions designated agent and shall meet any other financial requirements that will assist ValueOptions in maintaining the financial viability of its arrangements with Provider for the provision of Covered Services. Provider shall comply with any provision of the Agreement, or any ValueOptions policy or mechanism, which is required by ValueOptions in accordance with 28 Cal. Code Regs. § 1300.70(b)(2)(H), to ensure that Provider has the administrative and financial capacity to meet the obligations of the Agreement.
- (b) Nothing in this Agreement shall require a Provider to take financial risk for the provision of Covered Services unless the contractual provision relating to such risk has been negotiated and agreed to by and between ValueOptions and Provider. The assumption of risk for certain injectables identified in 28 Cal. Code Regs. § 1375.8 shall be allowed only on written request from Provider presented at the time of initial contracting or renewal. Nothing in this provision shall be interpreted to require Provider to request such assumption of risk as a prerequisite to entering this Agreement.
- (c) ValueOptions shall provide payment for all risk arrangements, excluding capitation, within 180 days after the close of ValueOptions' fiscal year.
- (d) ValueOptions shall disclose information to Provider that enables Provider to be informed regarding the financial risk assumed under the Agreement. ValueOptions shall disclose to Provider the information specified in 28 Cal. Code Regs. § 1300.75.4.1(a). Additionally, ValueOptions shall disclose, on or before the Agreement anniversary date, the amount of payment for each and every service to be provided under the Agreement, including any fee schedules or other factors or units used in determining the fees for each and every service in accordance with 28 Cal. Code Regs. § 1300.75.4.1(b). ValueOptions shall disclose, on or before the Agreement anniversary date, in the case of capitated payment, the amount to be paid per enrollee per month in accordance with 28 Cal. Code Regs. § 1300.75.4.1(c). ValueOptions shall disclose upon contracting and annually on or before the Agreement anniversary date, and upon request from Provider, such detailed claims payment policies and rules as are applicable to Provider in accordance with 28 Cal. Code Regs. § 1300.71(o).
- (e) Provider shall provide on ValueOptions request, pursuant to and within seven (7) calendar days of a request from the California Department of Managed Health Care, pro forma copies of such documents required in accordance with 28 Cal. Code Regs. § 1300.71(n).

8. Economic Profiling. If ValueOptions uses Economic Profiling, ValueOptions shall provide, upon request, a copy of the Economic Profiling information to Provider. If Provider is a medical group or an individual practice association that uses Economic Profiling of individual providers, Provider shall provide, upon request, a copy of the individual Economic Profiling information to the individual providers who are profiled. The Economic Profiling information provided pursuant to this section shall be provided in accordance with Section 1367.02 of the Knox-Keene Act of 1975 and its amendments (the "Act").

9. Claim Payment. To the extent required by Applicable Law, ValueOptions shall process claim payments in accordance with, and both parties shall comply with, Section 1371, et seq. of the Act and any other Applicable Law. Unless contested or denied by ValueOptions, claims shall be reimbursed no later than 45 days after receipt of the claim. Compensation shall be in accordance with the terms and conditions as set forth under the applicable Exhibit contained in the Agreement, which shall remain confidential within the meaning of 28 Cal. Code Reg. § 1300.67.8(a).

10. Amendments. ValueOptions and Provider shall comply with Cal. Health & Safety Code § 1375.7. In accordance with that law, ValueOptions shall not have the authority to change a material term of the Agreement unless the change has first been negotiated and agreed to by Provider and ValueOptions or the change is necessary to comply with Applicable Law or any accreditation requirements of a private sector accreditation organization. If ValueOptions amends a material term of any manual, policy, or procedure document referenced in the Agreement,

ValueOptions shall provide Provider forty-five (45) business days notice, and provider shall have the right to negotiate and agree to the amendment. If Provider and ValueOptions cannot agree as to such amendment, Provider may terminate the Agreement by providing ValueOptions with notice as set forth in the termination provisions of the Agreement and this Amendment. If Provider exercises its right to terminate the Agreement, the amendment shall not be implemented.

11. Acceptance of Additional Patients. Nothing in the Agreement shall require Provider to accept additional patients beyond the contracted number as specified in the Agreement or in the absence of a number, if in the reasonable professional judgment of Provider, accepting additional patients would endanger patients' access to or continuity of care. Provider agrees to use best efforts to provide notice to ValueOptions of at least thirty (30) days prior to closing a practice or no longer accepting new patients.

12. Compliance with Quality Improvement or Utilization Management Programs or Procedures. Provider shall cooperate fully with ValueOptions quality improvement and utilization management programs, policies or procedures including updates thereto as required by the Agreement. Nothing in the Agreement shall require Provider to comply with quality improvement or utilization management programs, policies or procedures of ValueOptions, unless the requirements are fully disclosed to Provider at least 15 business days prior to Provider executing the Agreement or in accordance with the requirements of Section 1375.7(b)(1)(A) of the Act. However, ValueOptions may make changes to the quality improvement or utilization management programs, policies or procedures 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.

13. Member Confidentiality. Nothing in the Agreement shall permit Provider or ValueOptions access to Member information in violation of federal and state laws and regulations concerning the confidentiality of Member information.

14. Waiting Room Notices. To the extent required by Applicable Law, including but not limited to 28 Cal. Code Regs. § 1300.67.8, Provider shall post such notices to Members as may be required by the Department of Managed Health Care regulations.

15. Provisions Governing Capitated Providers and Provider Groups. As required by 28 Cal. Code Regs. § 1300.71(c), to the extent Provider is reimbursed on a capitated basis and performs claims payment functions on behalf of ValueOptions, Provider shall pay claims and resolve provider disputes as required by Applicable Law.

- (a) Provider agrees to accept and adjudicate claims in accordance with the laws of the State of California and the regulations adopted by the Department of Managed Health Care;
- (b) ValueOptions retains the right, subject to any corrective action plan agreed upon, to assume responsibility for processing and paying provider claims if Provider fails to timely and accurately pay claims to include interest and penalties;
- (c) Where the ValueOptions has delegated the function, Provider agrees to establish and administer a provider dispute resolution mechanism in accordance with Applicable Law;
- (d) ValueOptions retains the right to assume responsibility for the administration of the dispute resolution mechanism if Provider fails to timely resolve provider disputes, to include issuing the written dispute determination;
- (e) Provider shall ensure any provider using the dispute resolution mechanism the unconditional right to appeal a claim dispute involving an issue of medical necessity or utilization review to ValueOptions for a de novo review and resolution within sixty (60) working days of the date of the written dispute determination;
- (f) Provider shall make available to ValueOptions and the Department of Managed Health Care all records, notes and documents regarding the provider dispute resolution mechanism and the resolution of its provider disputes;
- (g) Provider shall submit quarterly claims reports, signed by an officer, within thirty (30) days of the close of each quarter disclosing its compliance status and all other information as required by Applicable Law;
- (h) Nothing in this provision shall be construed to relieve ValueOptions of any of its obligations under Applicable Law.

16. Dispute Resolution. ValueOptions and Provider will administer and attempt to resolve Provider disputes as required by of the Cal. Health & Safety Code § 1367 and 28 Cal. Code Regs. § 1300.71.38. This provision shall not be construed to supercede any contract provisions that do not directly conflict with the terms of the regulation. Provider shall direct all calls regarding a dispute under this provision to the Provider Solutions Unit at 1-888-663-

8081, and shall direct all correspondence regarding a dispute to the mailing address specified in the Agreement for notices required to be given pursuant to the Agreement.

17. Hospital and Provider Group Termination. If Provider is a general acute care hospital or provider group, Provider or ValueOptions, as applicable, shall provide not less than one hundred twenty (120) days notice of any intention to nonrenew or otherwise terminate the Agreement and shall provide such information as required by ValueOptions in order to fulfill ValueOptions' obligations under Cal. Health & Safety Code § 1373.65. Provider agrees to provide reasonable notice pursuant to Cal. Health & Safety Code § 1255.1 of any elimination or reduction of emergency services. If the Agreement contains a provision requiring specific notice, such specific notice shall apply. Where the ValueOptions has delegated the Member notification requirements of Section 1373.65, Provider agrees to comply with the requirements of the Act, including, but not limited to, the content and information requirements of Section 1373.65(f) for Member notifications. If Provider is a provider group, Provider shall provide notice in accordance with this section for any termination of an individual provider from the group. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

18. Claims Recoupment. To the extent required, any adjustment to payments, including any recoupment process utilized by ValueOptions, shall be administered in accordance with Health and Safety Code § 1371.1 and California Department of Managed Health Care Rule 1300.71, or other Applicable Law. Except where an overpayment was caused in whole or in part by fraud or misrepresentation on the part of Provider, ValueOptions shall not request reimbursement for an overpayment of a claim unless the ValueOptions sends a written request for reimbursement to Provider within 365 days of the date of payment on the over paid claim.

III. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members only.

1. Continuity of Care. Upon the termination of Agreement for any cause, ValueOptions shall, at the request of Member, arrange for the continuation of Covered Services rendered by a Provider whose Agreement has terminated, in accordance with Cal. Ins. Code § 10133.56. ValueOptions shall not be required to provide for such continuity of care unless Member is undergoing a course of treatment from terminated Provider for an acute condition, serious chronic condition, a high-risk pregnancy, a terminal illness, the care of a newborn up to age thirty-six (36) months, or the performance of surgery or other procedure at the time of termination of the Agreement. ValueOptions shall not be required to provide for such continuity of care if the reason for termination of Provider's Agreement relates to a medical disciplinary cause or reason, fraud or other criminal activity. This section shall not require ValueOptions to cover services or provide benefits that are not otherwise covered under the terms and conditions of the Member's health benefit plan.

2. Economic Profiling. If ValueOptions uses Economic Profiling, ValueOptions shall provide, upon request, a copy of the Economic Profiling information to Provider. If Provider is a medical group that uses Economic Profiling of individual providers who may be seen by Members, Provider shall provide, upon request, a copy of the individual Economic Profiling information to the individual providers who are profiled. The Economic Profiling information provided pursuant to this section shall be provided in accordance with Cal. Ins. Code § 10123.36.

3. Claim Payments. To the extent required by Applicable Law, ValueOptions shall process claim payments in accordance with, and both parties shall comply with, Cal. Ins. Code §§ 10123.13, 10123.145, & 10123.147 and any other Applicable Law.

4. Amendments. In accordance with Cal. Ins. Code § 10133.65, ValueOptions may make a material change to this Agreement provided ValueOptions gives Provider at least 45 business days' notice of such change and Provider has the right to terminate Agreement prior to implementation of the change.

5. Compliance with Quality Improvement or Utilization Management Programs or Procedures. Nothing in the Agreement shall require Provider to comply with quality improvement or utilization management programs or procedures of ValueOptions, unless the requirements are fully disclosed to Provider at least 15 business days prior to Provider executing the Agreement. However, ValueOptions may make changes to the quality improvement or utilization management programs or procedures 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. Such changes shall be made in accordance with Cal. Ins. Code § 10133.65(c).

6. Member Confidentiality. Nothing in the Agreement shall permit Provider or ValueOptions access to Member information in violation of federal and state laws and regulations concerning the confidentiality of Member information.

## **COLORADO STATE PROVISIONS**

### I. The Agreement is amended by the following defined terms:

1. The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law: “Clean Claim” means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to law with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a Clean Claim. “Clean Claim” does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.

2. The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means the sudden, and at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy. “Emergency” shall also mean any event that a prudent lay person would believe threatens his or her life or limb in such a manner that a need for immediate medical care is created to prevent death or serious impairment of health.

3. For the purposes of this Amendment, “Subcontractor” means a person authorized by health care providers to negotiate and execute provider contracts with ValueOptions on behalf of such subcontracted providers.

4. For the purposes of this Amendment, “Standing Referral” means a referral by the Member’s primary care provider to a specialist or specialized treatment center participating in ValueOptions’ network for ongoing treatment of the Member.

### II. The following provisions are added to the Agreement:

1. Member's Financial Responsibility. Provider is responsible for collecting applicable copayments, coinsurance or deductibles, if any, from Members. Additionally, Provider shall notify Members of their financial obligation to pay for services which are not Covered Services.

2. Standing Referrals and Authorizations. Members are entitled to a Standing Referral from ValueOptions for medically necessary treatment to a specialist or specialized treatment center participating in ValueOptions network in accordance with the requirements of Section 10-16-705(14)(b), C.R.S.

3. Member Hold Harmless. Provider agrees that in no event, including but not limited to, non-payment by ValueOptions, insolvency of ValueOptions 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 ValueOptions) acting on Member's behalf for services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting copayments, coinsurance, deductibles or fees for noncovered services delivered to Members.

(i) Provider agrees that this provision shall survive the termination of this Agreement for authorized services rendered prior to the termination of this 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 this Agreement has been terminated.

(ii) Provider agrees that this provision supersedes any oral or written contrary agreement now or existing

hereafter entered into between Provider and Member or persons acting on Member's behalf insofar as such contrary agreement relates to liability for payment of services provided under the terms and conditions of this Agreement.

- (iii) Any modification, addition, or deletion to this provision shall become effective on a date no earlier than thirty (30) days after Colorado's Commissioner of Insurance has received written notification of proposed changes.
- (iv) This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

4. Continuity of Care.

- (i) In the event that ValueOptions or Provider terminates this Agreement without cause in accordance with the termination provisions of this Agreement and notice of such termination has not been given to Members who are patients of Provider, such Members may continue to receive care from Provider for a period of sixty (60) days from the date of notice of termination to Members or from the date of termination, whichever occurs earlier.
- (ii) In the event that a Member's coverage is terminated for any reason other than nonpayment of premium, fraud or abuse and Member is being treated at an inpatient facility, ValueOptions shall provide for continued care for that Member at the facility until he/she is discharged.
- (iii) These continuity of care provisions shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with these provisions and are permitted by Applicable Law.

5. Termination. Either party may terminate this Agreement for any reason by giving at least sixty (60) written notice to the other party. Within five (5) working days after the date that the Provider either gives or receives notice of termination of this Agreement, Provider shall supply ValueOptions with a list of those patients of the Provider who are Members of ValueOptions. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

6. Noninterference with Medical Decisions.

- (i) Provider shall not be prohibited from protesting or expressing disagreement with a policy or medical practice of ValueOptions or an entity representing or working for ValueOptions.
- (ii) ValueOptions or an entity representing or working for ValueOptions shall not be prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of Provider.
- (iii) ValueOptions shall not terminate this Agreement because:
- (iv) Provider expresses disagreement with a decision by ValueOptions or an entity representing or working for ValueOptions to deny or limit benefits to a Member or because Provider assists Members to seek reconsideration of ValueOptions decision to deny or limit benefits; or
- (v) 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 ValueOptions 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 patient.
- (vi) Provider is precluded from making, publishing, disseminating or circulating directly or indirectly or aiding, abetting or encouraging the making, publishing, disseminating or circulating of any oral or written statement or any pamphlet, circular, article or literature that is false or maliciously critical of ValueOptions and calculated to injure ValueOptions.
- (vii) If Provider is a Subcontractor, Subcontractor shall include provisions 6.A. through D. above in each of its underlying contracts with the health care providers who have authorized Subcontractor to negotiate and execute provider contracts on its behalf with ValueOptions.

7. Nondiscrimination. Provider does not discriminate, with respect to the provision of medically necessary Covered Services, against Members who are participants in a publicly financed healthcare program.

8. Subcontractors. If Provider is a Subcontractor, Subcontractor agrees to the following:

- (i) Subcontractor will comply and shall require its providers with whom it contracts (subcontracted providers) to comply with all of the applicable requirements of Section 10-16-705, C.R.S.
- (ii) ValueOptions is responsible for ensuring that its subcontracted providers have the capacity and legal authority to furnish Covered Services.

- (iii) ValueOptions has the right to approve or disapprove participation status of subcontracted providers in its own or a contracted network for the purpose of delivering Covered Services to its Members.
- (iv) ValueOptions shall maintain copies of all Subcontractors health care subcontracts.
- (v) If applicable, Subcontractor shall transmit utilization documentation and claims paid documentation to ValueOptions. ValueOptions shall monitor the timeliness and appropriateness of payments made to providers and health care services rendered to Members.
- (vi) If applicable, Subcontractor shall maintain books, records, financial information and documentation of services provided to Members at the Subcontractor's place of business in the State of Colorado.
- (vii) Subcontractor shall allow the Commissioner of Insurance access to the Subcontractor's books, records, financial information and any documentation of services provided to Members as necessary to determine compliance with the law.
- (viii) ValueOptions shall have the right, in the event of Subcontractor's insolvency, to require the assignment to ValueOptions of the provisions of a provider's subcontract addressing the provider's obligations to furnish Covered Services.

9. No Financial Disincentives. Provider shall not be subject to financial disincentives based on the number of referrals made to participating providers for Covered Services; provided that Provider, in making referrals, adheres to ValueOptions' utilization review policies and procedures.

10. Reimbursement Arrangements. Provider understands the reimbursement arrangements as agreed to by and between Provider and ValueOptions. Provider is capable of undertaking any financial risks assumed in such reimbursement arrangement, if any.

11. Assignment. Provider shall not assign nor delegate rights or responsibilities under this Agreement without the prior written consent of ValueOptions, and any subcontracts shall comply with Part 7 of Title 10, Article 16 of the Colorado Revised Statutes. This provision shall not supercede additional provisions in the Agreement related to assignment and/or delegation if such provisions do not conflict with this provision and are permitted by Applicable Law.

12. Provider's Responsibility for Obtaining Authorizations. It shall be the sole responsibility of Provider, not Member, to obtain any necessary authorization from ValueOptions when recommending, ordering or referring Members for services.

13. Provider Dispute Resolution. ValueOptions and Provider will administer and attempt to resolve Provider disputes in accordance with Division of Insurance Regulation 4-2-23. This provision shall not be construed to supercede any contract provisions that do not directly conflict with the terms of the regulation.

14. Telemedicine. ValueOptions does not require face-to-face contact between Provider and Member residing in a county with one hundred fifty thousand or fewer residents for services appropriately provided through telemedicine if such county has the technology necessary for the provision of telemedicine. Any health benefits provided through telemedicine shall meet the same standards of care as for in-person care. This provision does not require the use of telemedicine when in-person care by Provider is available to Member within ValueOptions' network and within Member's geographic area. Provider shall not require ValueOptions to pay for consultation provided by Provider when using a telephone or facsimile.

15. Claim Payments.

- (i) To the extent required by Applicable Law, ValueOptions and Provider shall comply with Section 10-16-106.5, C.R.S. and Division of Insurance regulation 4-2-24.
- (ii) Claims paid by ValueOptions shall be considered final unless adjustments are made. Claim payment adjustments shall not exceed twelve months after the date of the original explanation of benefits.

## CONNECTICUT STATE PROVISIONS

1. The Agreement is amended by the following defined term:

The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a medical condition such that a prudent layperson, acting reasonably, would believe that emergency medical treatment is needed, and includes a life or limb-threatening emergency where the Member believes that immediate medical care is required to prevent death or serious impairment of health.

2. Provider/Patient Relationship. Nothing in the Agreement or this Amendment should be construed to prohibit Provider from discussing with a Member any treatment option or services available in or out of network, including experimental treatments, nor from disclosing to a Member who inquires the method ValueOptions uses to compensate Provider. ValueOptions shall not threaten nor take any action against Provider for Provider’s assistance to a Member in filing any complaint or grievance against ValueOptions.

3. Member Rights. Nothing in the Agreement shall be construed as prohibiting or limiting any cause of action or contract rights a Member otherwise has.

4. Termination. The parties may terminate the Agreement, with or without cause, by giving sixty (60) days advance written notice to the other party. This provision shall not apply in cases where the termination is necessary for the health or safety of Members, if Provider is found to have entered into this Agreement based on fraud or material misrepresentation, or if Provider engages in any fraudulent activity related to the terms of the Agreement. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

5. Indemnification. Nothing in this Agreement shall be construed as requiring Provider to indemnify ValueOptions for any expenses and liabilities including, without limitation, judgments, settlements, attorney’s fees, court costs, and any associated charges incurred in connection with any claim or action brought against ValueOptions on the basis of its determination of medical necessity or appropriateness of health care services if the information provided by Provider used in making the determination is accurate and appropriate at the time given. This provision shall not be construed to relieve any liability associated with Provider’s professional actions and any related liability.

6. Claim Payment. To the extent required by Applicable Law, if any provision of the Agreement conflicts with the requirements of Conn. Gen. Stat. § 38a-816(15) or any successor provision regarding payment of claims, those provisions shall be amended hereby for both parties to comply with that law. To the extent applicable, each party agrees to comply with the provisions of Conn. Gen. Stat. § 38a-816(15).

7. Overpayment Recovery. ValueOptions shall have the right to recoup any overpayment to the Provider in accordance with Conn. Regs. § 38a-480-4 regarding coordination of benefits in the event of an overpayment where the Member is covered under more than one health benefit plan.

#### **DELAWARE STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:

(a) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “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 substantially prevents timely payments from being made on the claim.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means the sudden onset of a medical or behavioral condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, such that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual afflicted with such condition, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part, or, serious disfigurement of such person.

2. Provider/Patient Relationship. To the extent required by Applicable Law, ValueOptions shall not refuse to contract with or compensate Provider for Covered Services solely because Provider has in good faith communicated with one or more of Provider's current, former, or prospective patients regarding the provisions, terms or requirements of ValueOptions' products or services as they relate to the needs of Provider's patients.
3. Termination. ValueOptions shall give Provider a minimum of sixty (60) days written notice prior to terminating this Agreement. Such notice will include a statement of Provider's right to request a written explanation, and the right to request an internal administrative review within twenty (20) days of receipt of the notice to terminate the Agreement. This shall not apply to cases where the termination is based upon breach of contract, loss of professional liability insurance, indictment, arrest or conviction for a felony crime or moral turpitude, final disciplinary action by a hospital, licensing board or other governmental agency that impairs the Provider's ability to practice or clinical privileges, failure to meet the minimum requirements for participation in ValueOptions' network, fraud, or cases involving imminent harm to patient care, in which case ValueOptions may terminate the Agreement immediately. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.
4. Claim Payment. To the extent required by Applicable Law, if any provision of the Agreement conflicts with the requirements of Code of Del. Reg. § 18-1300-1310 (formerly Ins. Rule 80) or any successor provision regarding payment of claims, those provisions shall be amended hereby for both parties to comply with that law. To the extent applicable, each party agrees to comply with the provisions of Code of Del. Reg. § 18-1300-1310.

#### **DISTRICT OF COLUMBIA PROVISIONS**

1. The Agreement is amended by the following defined terms:
  - (a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Clean Claim" means a claim that has no material defect or impropriety, including any lack of reasonably required substantiating documentation, which substantially prevents timely payment from being made on the claim, or a claim for which ValueOptions failed to notify the Provider submitting the claim of any such defect or impropriety within thirty (30) days after ValueOptions' receipt of the claim. For the purposes of this provision, the term "material defect" means an imperfection in the submission of a claim consisting in the omission of information that is essential to process the claim in accordance with ValueOptions' claims filing requirements. The requirements for electronic claim submissions shall be consistent with regulations promulgated by Secretary of Health and Human Services. References in the Agreement to "claims" shall be construed to mean "Clean Claims" to the extent required by Applicable Law.
  - (b) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means the sudden onset or sudden worsening of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent lay person, who possesses an average knowledge of health and medicine, to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
2. Non-exclusivity of Agreement. Nothing in the Agreement shall be construed to require as a condition of participating in one of ValueOptions' provider panels that the Provider participate in any other provider panel owned or operated by ValueOptions. The Provider shall have the right to refuse participation in one or more of the other provider panels at the time the Agreement is executed or renewed. The status of the Provider's participation on other existing provider panels owned or operated by ValueOptions shall not be adversely affected by Provider's exercise of the right to refuse participation.
3. Termination. Provider shall notify ValueOptions at least ninety (90) days prior to terminating participation on any specific provider panel owned or operated by ValueOptions. Provider agrees to continue to provide Covered Services to any affected Member for at least ninety (90) days after the date Provider's notice of termination is received by ValueOptions. This provision shall not supercede a longer notice provision for termination or additional provisions regarding continuity of care in the Agreement if such provisions are permitted by Applicable Law.

4. Financial Inducements or Incentives. Nothing in the Agreement shall be construed to penalize or otherwise reduce or limit the reimbursement of Provider, or provide incentives to induce Provider to provide care to a Member in a manner inconsistent with the requirements of D.C. Code § 31-3835 pertaining to women's rights to certain health insurance benefits.

5. Claims Payment. To the extent required by Applicable Law, if any provision of the Agreement conflicts with the requirements of D.C. Code § 31-3131, or any successor provision regarding payment of claims, those provisions shall be amended hereby for both parties to comply with that law. To the extent applicable, each party agrees to comply with the provisions of D.C. Code § 31-3131.

## **FLORIDA STATE PROVISIONS**

### **I. The Agreement is amended by adding the following terms:**

(a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term: "Clean Claim means, " as defined by Applicable Law, a claim for reimbursement submitted to ValueOptions (on paper or electronically for institutional Providers) which has no defect or impropriety, including the lack of any required substantiating documentation, or particular circumstances requiring special treatment which prevent timely payment from being made on the claim. References in this Agreement to "claims" shall be construed to mean "Clean Claims" in accordance with Applicable Law.

(b) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term: "Emergency" means, as defined by Applicable Law, a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain or other acute symptoms) such that a reasonably prudent layperson having average knowledge of health and medicine would believe that the absence of immediate medical attention could seriously jeopardize the Member's health or result in serious impairment to bodily functions, or dysfunction of any bodily organ or part; or with respect to a pregnant woman, transfer to another hospital cannot be safely effectuated or poses a serious threat to the health of the patient or fetus, or there is evidence that the patient is in active labor (persistent uterine contractions, or rupture of the membranes).

### **II. The Agreement is amended by adding the following provisions in accordance with Applicable Law:**

#### **1. Termination.**

- (i) Provider shall have the right to cancel or terminate this Agreement, with or without cause, upon sixty (60) days advance written notice to ValueOptions and to the Department of Insurance.
- (ii) ValueOptions will provide sixty (60) days advance written notice to Provider and the Department of Insurance before terminating the Agreement without cause, except in a case in which a Member's health is subject to imminent danger or Provider's ability to practice medicine is effectively impaired by an action by the Board of Medicine or other governmental agency.
- (iii) Before terminating the Agreement, the terminating party shall provide the other party with a written explanation for the termination, which may include termination for business reasons. ValueOptions may terminate the Agreement in less than sixty (60) days, upon Provider request, if ValueOptions is not financially impaired or insolvent.
- (iv) These provisions shall not supercede longer notice periods set forth in the Agreement if such provisions are permitted by Applicable Law.

2. Continuity of Care. In the event this Agreement is terminated for any reason other than for cause, Provider agrees to continue care and provide Covered Services, when medically necessary, to any Member receiving Covered Services at the time of the termination, through completion of treatment for a condition for which the Member was receiving care, until the Member selects another treating provider, or during the next open enrollment period offered, whichever is longer, but not longer than six (6) months after termination of the Agreement in accordance with the terms of the Agreement. Nothing in this section should be construed as preventing Provider from refusing to

continue to provide care to a Member who is abusive, noncompliant, or in arrears in payments for services provided. Any changes made within thirty (30) days before termination of this Agreement are effective only if agreed to by both Parties. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

3. Member Hold Harmless. In accordance with Applicable Law:

- (i) Except for applicable deductibles, coinsurance, copayments or non-Covered Services, Member is not liable to Provider for any services for which ValueOptions is liable.
- (ii) ValueOptions is liable for services rendered to Member by Provider if Provider has followed the precertification or referral procedures and receives authorization for a Covered Service, unless Provider has provided information with willful intent to misinform ValueOptions.
- (iii) Provider agrees that in no event, including but not limited to, nonpayment by payor, the insolvency of payor or ValueOptions, or termination or breach of this Agreement, shall Provider, or any agent of Provider, regardless of whether Provider is under contract with ValueOptions, collect or attempt to collect money from, maintain any action at law against, or report to a credit agency any Member for payment of Covered Services for which ValueOptions is liable. This provision applies during the pendency of any claim for payment made by Provider, or any legal proceedings or dispute resolution process, or in any case in which ValueOptions has admitted liability for payment, or a judgment has been entered against ValueOptions by a court of competent jurisdiction, or an agency or department has made a final determination of liability against ValueOptions.
- (iv) This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

4. Payment of Claims. To the extent required, both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to Fla. Stat. §§ 641.3155, 627.613 and 627.6131. To the extent any provision of this Agreement conflicts with the requirements of Applicable Law, those provisions are hereby amended to comply with that law.

5. Retroactive Denials. To the extent required, retroactive denial of claims, including any recoupment process utilized by ValueOptions, shall be administered in accordance with Applicable Law.

6. Consumer Notice. Provider will post a consumer assistance notice, prominently displayed in a reception area clearly noticeable to all Members, which contains the addresses and toll-free phone numbers for the Agency for Health Care Administration, the Statewide Provider and Subscriber Assistance Program, and the Department of Insurance, in accordance with state law.

7. PROVIDER/PATIENT RELATIONSHIP. Nothing in this Agreement shall be construed as imposing any restriction on Provider's ability to communicate with 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 Member's health.

8. Non-Exclusivity. Nothing in the Agreement shall be construed to restrict or prohibit Provider from entering into a commercial contract with any other health maintenance organization or to require Provider to accept the terms of ValueOptions' contracts with other health care providers or any other health maintenance organization affiliated with ValueOptions, unless Provider participates in a group practice. Nothing in this Agreement shall be construed to restrict ValueOptions from entering into a commercial contract with any other health care provider.

9. Hospital Services. Nothing in this Agreement shall be construed as prohibiting Provider from providing inpatient services in a contracted hospital to a Member if such services are determined by ValueOptions to be medically necessary and Covered Services.

## **GEORGIA STATE PROVISIONS**

I. The Agreement is amended by the following defined terms:

1. *The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means those health care services that are*

*provided for a condition of recent onset and sufficient severity, including, but not limited to, severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health, to believe that his or her condition, sickness or injury is of such a nature that failure to obtain immediate medical care could result in: (i) Placing the patient's health in serious jeopardy; (ii) Serious impairment to bodily functions; or (iii) Serious dysfunction of any bodily organ or part.*

2. For the purposes of this Amendment, the term "Prospective Authorization" shall mean receiving prior approval or authorization from ValueOptions to evaluate and treat a Member.

**II. The following provision is added to the Agreement and is applicable to Providers rendering services to insured Members only:**

Hold Harmless. Members shall be held harmless for Provider utilization review decisions over which Member has no control.

**III. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured and HMO Members:**

1. **Prospective Authorization/Pre-certification.** Pre-certification is a determination in accordance with ValueOptions' Utilization Management program which consists of a review of proposed treatment involving inpatient or day admissions for surgical, medical, obstetric, pediatric, psychiatric and substance abuse cases. For services requiring Pre-Certification, Provider must obtain such Pre-Certification from ValueOptions. ValueOptions will determine whether to certify the services based on whether the services meet the criteria established in the Agreement, the Utilization Management Program, or policies and procedures in the Provider Handbook, including updates thereto.

2. **Continuity of Care.**

- (a) In the event that ValueOptions or Provider terminates Provider's Agreement, any Member who is suffering from and receiving Covered Services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from Provider for a period of up to sixty (60) days from the date of the termination of Provider's Agreement.

- (b) During the continuation of coverage periods described in A. and B. above, Provider shall continue providing such Covered Services in accordance with the terms of this Agreement applicable at the time of termination, and ValueOptions shall continue to meet all obligations of Provider's Agreement.

- (c) Member shall not have the right to the continuation provisions herein if Provider's Agreement is terminated because of the suspension or revocation of the Provider's license or for reasons related to the quality of health care services rendered or issues related to the health, safety or welfare of Members.

- (d) These provisions shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with these provisions and are permitted by Applicable Law.

3. **No Penalties or Financial Incentives.** In accordance with OCGA section 30-20A-6 and OCGA section 30-20A-7, nothing in the Agreement shall be construed to:

- (a) **penalize a Provider for considering, studying or discussing Medically Necessary or appropriate care with or on behalf of his or her patient;**

- (b) **penalize Provider for providing testimony, evidence, records or any other assistance to an enrollee who is disputing a denial, in whole or in part, of a health care treatment or service or claim therefor;**

- (c) **create a financial incentive or disincentive that directly or indirectly compensates Provider for ordering or providing less than medically necessary and appropriate care to his or her patients or for**

**denying, reducing, limiting or delaying such care. This paragraph shall not prohibit ValueOptions from using a capitated payment arrangement.**

4. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with O.C.G.A. section 33-24-59.5.

5. Refund of Overpayments. To the extent required by Applicable Law, retroactive denial of claims, including any recoupment process utilized by ValueOptions, shall be processed in accordance with O.C.G.A. § 33-20A-62.

## **HAWAII STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:

(a) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Clean Claim” means a claim in which the information received adequately indicates that the claim is for a Covered Service provided by an eligible health care provider to a Member covered under a group subscriber contract, where the claim has no material defect or impropriety, there is no dispute regarding the amount claimed, and there is no reason to believe the claim was submitted fraudulently. The term does not include claims for expenses incurred during a period of time when premiums were delinquent, fraudulent claims, or claims based upon material misrepresentations. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a condition manifesting symptoms of sufficient severity that a layperson could reasonably expect, in the absence of medical treatment, to result in placing the person’s health or condition in serious jeopardy, serious impairment of bodily functions, serious dysfunction of any bodily organ or part, or death.

2. Provider/Patient Relationship. Nothing in this Agreement shall be construed as ValueOptions imposing any kind 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 that are not Covered Services. In accordance with Applicable Law, in order for Members to be informed fully prior to making any treatment, benefit, or non-treatment decision, Provider shall discuss all treatment options with a Member, discuss all risks, benefits, and consequences to treatment, and provide Members with disabilities an effective means of communication with Provider and ValueOptions. Provider shall discuss with a Member and the Member’s immediate family both living wills and durable powers of attorney in relation to medical treatment.

3. Performance Measurement and Data Reporting. In accordance with ValueOptions’ obligations under Haw. Rev. Stat. § 432E-10, Provider agrees to comply with ValueOptions requests for any information necessary for ValueOptions to comply with the plan performance measurement and data reporting including information relevant to effectiveness, appropriateness, access and availability of care, Member satisfaction, Member utilization, and any other such information as required to comply with Applicable Law.

4. Claims Payment. To the extent required by Applicable Law, if any provision of the Agreement conflicts with the requirements of Haw. Rev. Stat. § 431:13-108, or any successor provision regarding payment of claims, those provisions shall be amended hereby for the parties to comply with that law. To the extent applicable, each party agrees to comply with the provisions of Haw. Rev. Stat. § 431:13-108.

## **IDAHO STATE PROVISIONS**

1. The Agreement is amended by the following defined term:

The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in placing a person’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ.

2. Termination. In the event Provider breaches any term of the Agreement, ValueOptions shall provide written notice to Provider setting forth any breach of the Agreement for which ValueOptions proposes that the Agreement be terminated or not renewed. ValueOptions will provide a period of thirty (30) days for Provider to cure such breach prior to termination or nonrenewal of the Agreement. ValueOptions may terminate this Agreement immediately without a period of time to cure any breach, if ValueOptions determines that the breach is willful, an act of fraud, or poses an immediate danger to the public health or safety. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

3. Provider/Patient Relationship. Nothing in the Agreement shall be construed to permit ValueOptions to refuse to contract with Provider or compensate Provider for Covered Services solely because Provider has in good faith communicated with any current, former, or prospective Members regarding the provisions, terms, or requirements of ValueOptions’ products as they relate as they relate to the Member’s needs, including the provision of non-covered services at the Member’s election, and the Provider’s participation in ValueOptions’ provider network. ValueOptions will not terminate or otherwise penalize Provider who is practicing in conformance with community standards for advocating on behalf of a Member.

4. Indemnification. Nothing in this Agreement shall be construed to require Provider to indemnify or hold ValueOptions harmless so long as ValueOptions also agrees to indemnify and hold harmless the Provider under comparable circumstances.

5. Information Referred to or Adopted by the Agreement. ValueOptions will provide upon Provider’s request and within a reasonable time any documents referred to or adopted by reference in the Agreement. Information that is proprietary, constitutes a trade secret, or is a confidential personnel record shall be excluded from disclosure under this provision.

6. Incentives to Withhold Care. To the extent required by Idaho Code § 41-3928, nothing in the Agreement shall be construed to constitute an incentive plan that includes a specific payment made, in any type or form, to the provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services covered by the health benefit plan and provided with respect to a specific Member or group of Members with similar medical conditions.

7. Collection from Members. In accordance with Idaho Admin. Code § 18.01.26.004, Provider shall not bill or charge any Member for the difference between the amount specified in the fee schedule for a Covered Service and the amount normally charged by Provider for the particular service. This provision shall not preclude the Provider from collecting the specified coinsurance, copayment, or applicable deductible under the Member’s health benefit plan. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

8. Adjustment of Fee Schedule Amounts. Nothing in the Agreement shall be construed to require Provider to accept the unnegotiated adjustment of or to enter into negotiations to reduce the Provider’s contractual reimbursement rate to equal the lowest reimbursement rate Provider has agreed to charge any other payor; or, to require Provider to disclose to ValueOptions the contractual reimbursement rate with other payors.

9. Claim Payment. Effective January 1, 2005 and to the extent any provision of the Agreement conflicts with the requirements of Idaho Code § 41-5602, or its successor provision regarding payment of claims, those provisions shall be amended hereby to comply with that law. To the extent required by Applicable Law, each party agrees to comply with the provisions of Chapter 56 of Title 41 of the Idaho Code regarding payment of claims.

## **ILLINOIS STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:

The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to potentially result in: (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

2. Claims Payments. To the extent required by Applicable Law, claims shall be processed in accordance with § 215 ILCS 5/368a and § 215 ILCS 370a and any other Applicable Law. Each party agrees to comply with the provisions of § 215 ILCS 5/368a and § 215 ILCS 370a.

3. Transfer of Liability. To the extent required by Applicable Law, nothing in the Agreement shall be construed to transfer or appear to transfer to Provider by indemnification, hold harmless, or contribution requirements concerning any liability relating to activities, actions, or omissions that ValueOptions, its officers, employees or agents incurs. Nothing in this Agreement shall be construed to limit, restrict or waive any right set forth under Applicable Law.

4. Provider/Patient Relationship. Nothing in the Agreement or this Amendment shall be construed as prohibiting or imposing any restriction on Provider’s ability to discuss with a Member any health care services and health care providers, utilization review and quality assurance policies, terms and conditions of plans and plan policy with Members, prospective Members, providers, or the public. Nothing in the Agreement or this Amendment shall be construed as prohibiting or imposing any restriction on Provider’s ability to advocate for appropriate health care services for patients. ValueOptions will not financially or otherwise penalize a Provider for so advocating as permitted by Applicable Law.

5. Continuity of Care. If Provider terminates this Agreement for any reason or ValueOptions terminates the Agreement without cause or for any cause except situations involving imminent harm to a patient or a final disciplinary action by a regulatory agency, then a Member shall be allowed to continue care as follows: (1) a Member under active treatment for a particular injury or sickness may continue to receive Covered Services from Provider for such injury or sickness for a period of ninety (90) days from the date of notice of termination; (2) a Member in the third trimester of pregnancy may continue to receive Covered Services from Provider until completion of postpartum care directly related to the delivery. The foregoing shall only apply if Provider agrees to continue to be bound by the terms, conditions, and reimbursement rates contained in this Agreement. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this Amendment and are permitted by Applicable Law.

6. Termination.

(a) With respect to the HMO product, Provider may terminate the Agreement for cause upon at least sixty (60) days notice to ValueOptions, and without cause upon at least ninety (90) days notice to ValueOptions. With respect to any insured product, Provider may terminate the Agreement for cause upon at least sixty (60) days notice to ValueOptions, and without cause upon at least ninety (90) days notice to ValueOptions.

(b) With respect to any insured product, ValueOptions may terminate the Agreement with or without cause by providing at least sixty (60) days notice to Provider and to Members served by Provider. ValueOptions may terminate the Agreement immediately upon notice to Provider if Provider’s license has been disciplined by a state licensing board. Notice under this subsection will include a name and address to whom Provider or Members may direct comments or concerns regarding the nonrenewal or termination and the availability of transitional services.

(c) This section shall not supercede a longer notice period set forth in the Agreement if such notice provision is permitted by Applicable Law.

7. State Quality Assurance Programs. Provider and any provider subcontracted for the provision of services to Members, will provide, arrange for, or participate in the quality assurance programs mandated by Applicable Law and the Illinois Department of Public Health.

## INDIANA STATE PROVISIONS

I. The Agreement is amended by the following defined terms:

(a) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Clean Claim” means, unless otherwise defined by Applicable Law, a properly completed claim for payment for Covered Services submitted by Provider to ValueOptions that has no defect, impropriety or particular circumstances requiring special treatment preventing payment, and requires no further information, documentation, adjustment or alteration by Provider in order to be processed and paid. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means, unless otherwise defined by Applicable Law, the sudden unexpected onset of bodily injury or a serious illness of sufficient severity to cause a prudent layperson having average knowledge of health and medicine and acting reasonably to believe that, if not treated immediately, could result in serious medical complications, loss of life, or serious impairment to bodily functions or serious dysfunction of a bodily organ or part.

II. The following provisions are added to the Agreement and are applicable only to Providers rendering services to insured Members as required by Applicable Law:

1. Amendments. ValueOptions will provide written notice of any amendment to this Agreement not less than forty-five (45) days before the effective date of the amendment. Provider may terminate this Agreement without penalty if Provider does not approve any amendment to this Agreement and provides written notice of such disapproval not later than 15 days after receipt of ValueOptions’ notice of amendment. Such termination will be effective ninety (90) days after ValueOptions has received Provider’s notice, or earlier if mutually agreed upon. Provider will not be bound by the terms of the proposed amendment after providing notice of disapproval and termination. If Provider terminates this Agreement under this section, Provider shall inform Members of the termination before providing Covered Services. This section does not apply to an amendment required for compliance with Applicable Law.

2. Claim Payments. To the extent required by law, ValueOptions shall pay Clean Claims and administer such claims payment programs in accordance with applicable state or federal law or regulation, including IC § 27-8-5.7-5 and 27-8-5.7-6. Each party agrees to comply with the provisions of IC § 27-8-5.7-5 and 27-8-5.7-6.

3. Professional Responsibility. Nothing in the Agreement nor this Amendment shall be construed as imposing any restriction on Provider’s ability to disclose to a Member the terms of this Agreement as it relates to: (1) financial incentives to Provider; or, (2) treatment options available to a Member, including those not covered under the benefit plan. ValueOptions will not financially or otherwise penalize a Provider for making any disclosure under this section.

III. The following provisions are added to the Agreement and are applicable to Providers rendering services to HMO Members as required by Applicable Law:

1. Termination. Provider may terminate this Agreement with or without cause upon at least sixty (60) days advance written notice to ValueOptions unless Provider provides thirty (30) percent or more of ValueOptions’ covered services, in which case Provider must give ValueOptions at least one hundred twenty (120) days advance written notice. These provisions shall not supercede longer notice periods set forth in the Agreement if such provisions are permitted by Applicable Law.

2. Continuity of Care. If Provider terminates this Agreement with or without cause, or ValueOptions terminates this Agreement without cause or for any cause except a quality of care issue, Provider shall continue to render care to a Member as follows: (1) upon request of a Member, Provider may continue to provide Covered Services for up to sixty (60) days following the termination of the Agreement; (2) a Member in the third trimester of pregnancy may continue to receive Covered Services from Provider throughout the term of the pregnancy; (3) a Member being treated by an inpatient facility may remain at the facility until the Member is released from inpatient status or sixty (60) days, whichever is less. The foregoing shall only apply if Provider agrees to continue to be bound by the terms, conditions, and reimbursement rates contained in this Agreement. Provider may not bill Member for any amounts in excess of any applicable deductible, coinsurance, or copay. This provision shall not supercede additional provisions

in the Agreement providing for continuity of care if such provisions do not conflict with this Amendment and are permitted by Applicable Law.

3. Hold Harmless. In the event that ValueOptions fails to pay for Covered Services, Provider shall not hold a Member liable for any sums owed by ValueOptions. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.
4. Claims Payments. To the extent required by law, ValueOptions shall pay Clean Claims and administer such claims payment programs in accordance with applicable state or federal law or regulation, including IC § 27-13-36.2-2.3 and 27-13-36.2-2.4. Each party agrees to comply with the provisions of IC § 27-13-36.2-2.3 and 27-13-36.2-2.4.
5. Disclosures to Members. Nothing in the Agreement nor this Amendment shall be construed as imposing any restriction on Provider's ability to disclose to a Member the terms of this Agreement as it relates to financial or other incentives to limit medical services or medical care or treatment options available to a Member, including treatments not covered under the Group Subscriber contract. ValueOptions will not financially or otherwise penalize a Provider for making any disclosure under this section.
6. Amendments. ValueOptions will provide written notice of any amendment to this Agreement not less than forty-five (45) days before the effective date of the amendment. Provider may terminate this Agreement without penalty if Provider does not approve any amendment to this Agreement and provides written notice of such disapproval not later than 15 days after receipt of ValueOptions' notice of amendment. Such termination will be effective ninety (90) days after ValueOptions has received Provider's notice, or earlier if mutually agreed upon. Provider will not be bound by the terms of the proposed amendment after providing notice of disapproval and termination. If Provider terminates this Agreement under this section, Provider shall inform Members of the termination before providing Covered Services. This section does not apply to an amendment required for compliance with Applicable Law.

## **IOWA STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:
  - (a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Clean Claim" means a properly completed paper or electronic billing instrument containing all reasonably necessary information, that does not involve coordination of benefits for third-party liability, preexisting condition investigations, or subrogation, and that does not involve the existence of particular circumstances requiring special treatment that prevents a prompt payment from being made.
  - (b) The term "Emergency Medical Condition" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that absence of immediate medical attention to result in one of the following: (1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
2. Provider/Patient Relationship. In accordance with 191 Iowa Admin. Code § 27.8(514F), nothing in the Agreement shall be construed to restrict, penalize, or prohibit Provider's communication with a Member concerning treatment options, and advocating on a Member's behalf in the grievance or utilization review processes. The Provider shall not be penalized under this Agreement in the event that the Provider reports in good faith to a state or federal authority any act or practice by ValueOptions that in the Provider's opinion jeopardizes the Member's health or welfare.
3. Payment of Claims. To the extent any provision of the Agreement conflicts with Iowa Code § 507B.4 (10B) and any successor provisions regarding payment of claims, those provisions shall be amended for both parties to

comply with that law. This provision shall be construed with Applicable Law to determine whether that law applies to a particular claim.

## **KANSAS STATE PROVISIONS**

### **I. The Agreement is amended by the following defined terms:**

(a) To the extent required by Applicable Law, the term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law: “Clean Claim” means a claim that has no defect or impropriety, including any lack of required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim under the Kansas health care prompt payment act.

(b) To the extent required by Applicable Law, the term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

### **II. The following provisions are added to the Agreement:**

1. **Continuity of Care for HMO Members.** In accordance with K.S.A. Section 40-3230, upon termination of the Agreement, Provider shall continue to treat Members for a period of ninety (90) days where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence, as well as where the Member has special circumstances, such as a disability, or a life threatening illness. During such time that Provider continues to provide Covered Services to Members in accordance with this provision, all terms of this Agreement, including compensation, will remain in effect. Except for applicable copays, deductibles, and coinsurance, Provider shall not bill Members for Covered Services provided pursuant to this provision. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this Amendment and are permitted by Applicable Law.

2. **HMO Member Hold Harmless.** In accordance with K.S.A. Section 40-3209(b), in the event ValueOptions fails to pay Provider for Covered Services rendered to Members, Members shall not be liable to Provider for any amounts owed by ValueOptions to Provider, and Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on a Member’s behalf for Covered Services provided pursuant to this Agreement. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

3. **Provider/Patient Relationship.** In accordance with K.S.A. Section 40-4604, nothing in the Agreement shall be construed to prohibit or restrict Provider from discussing with or disclosing to any Member 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 by ValueOptions to approve or deny health care services, the availability of alternate therapies, consultations, or tests, or from advocating on behalf of Members within the utilization review or grievance processes established by ValueOptions.

4. **Compensation not an Inducement.** In accordance with K.S.A. Section 40-4605, the compensation paid to Provider pursuant to this Agreement shall not directly or indirectly serve as an inducement to reduce or limit the delivery of medically necessary services with respect to a Member.

5. **Medicaid Coverage is Last Resort.** Pursuant to K.S.A. Section 40-3208, the parties agree that if a service constitutes a Covered Service for an HMO Member, Medicaid coverage shall be the source of last resort of any payment to Provider.

6. **Claim Payment.** To the extent any provision of the Agreement conflicts with the requirements of K.S.A. Section 40-2442, those provisions shall be amended hereby to comply with that law. Each party agrees to comply with the provisions of K.S.A. Section 40-2442.

## KENTUCKY STATE PROVISIONS

1. The Agreement is amended by the following defined terms:

(a) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Clean Claim” means a properly completed billing instrument, paper or electronic, including the required health claim attachments, submitted in the format set forth in Ky. Rev. Stat. § 304.17A-700(3). References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson would reasonably have cause to believe constitutes a condition that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) with respect to a pregnant woman who is having contractions, (i) a situation in which there is inadequate time to effect a safe transfer to another hospital before delivery; or (ii) a situation in which transfer may pose a threat to the health or safety of the woman or the unborn child.

2. Hold Harmless. In accordance with Ky. Rev. Stat. Ann. § 304-17A-527(1)(a), the Provider agrees that in no event, including but not limited to nonpayment by ValueOptions, insolvency of ValueOptions, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member or the Member’s authorized representative, for health care services provided pursuant to this Agreement. This provision shall not prohibit Provider from collecting deductibles, coinsurance, or copayments as specifically provided by the Member’s benefit plan, or fees for noncovered health care services. This provision shall survive the termination of the Agreement. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law

3. Continuity of Care. In the event that ValueOptions or Provider terminates the Agreement for any reason other than for a quality of care issue or fraud, Provider shall continue to provide Covered Services and ValueOptions shall reimburse the provider in accordance with the Agreement until the Member is discharged from an inpatient facility, or until the active course of treatment is completed, whichever time is greater. If applicable, ValueOptions shall provide notice to the Member in the event that ValueOptions terminates participation of the Member’s primary care provider. This provision shall survive the termination of the Agreement. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

4. Provider/Patient Relationship. Nothing in the Agreement shall be construed to limit Provider’s ability to disclose information to the Member or the Member’s authorized representative about the Member’s medical condition or any treatment options, or any other information that Provider determines to be in the best interest of the Member. ValueOptions shall not terminate or otherwise penalize Provider because Provider discusses medically necessary or appropriate care with the Member or the Member’s authorized representative. Neither shall any provision in the Agreement be construed to Penalize the Provider for discussing with the Member financial arrangements between Provider and ValueOptions.

5. Provider Reimbursement Rate. Nothing in the Agreement shall be construed as a “most-favored-nation provision” where ValueOptions would be entitled to a better rate than the Provider’s most favorable negotiated rate with other health insurance issuers. This provision shall not preclude ValueOptions and Provider from negotiating payment rates and performance-based terms that would result in ValueOptions receiving a rate that is as favorable, or more favorable, than the rates negotiated between Provider and other health insurance issuers.

6. Availability of Claims Payment Information. ValueOptions shall, upon request from Provider, provide the specific reimbursement amount for billing codes that are applicable to the compensation that Provider will receive under the Agreement within thirty (30) days of such request.

7. Claim Payment. To the extent required by Applicable Law, any provision of the Agreement that conflicts with payment of health claims under Kentucky State Law, those provisions shall be amended to comply with Ky. Rev. Stat. Ann. §§ 304.17A-700 to -730, and 205.593, 304.14-135, 304.99-123; 806 Ky. Admin. Reg. § 17:360 or any successor provisions regarding payment of claims. To the extent required by Applicable Law, ValueOptions shall accept uniform health claim forms as set forth in Ky. Rev. Stat. Ann. § 304.14-135.
8. Claims Recoupment. ValueOptions shall give written notice to provider making a request for a refund or giving notice of its intent to recoup an overpayment in cases where services were either non-covered or the individual was not eligible. ValueOptions shall request a refund or give notice of its intent to seek recoupment for overpayments and overpayments resulting from an error in the payment rate or method within twenty-four (24) months from the date that ValueOptions paid the claim. Recovery of any overpayment or any recoupment process utilized by ValueOptions will conform to the notice and dispute resolution requirements in accordance with Ky. Rev. Stat. §§ 304.17A-708, 712, and 714.
9. Provider Subcontracting. Provider agrees to execute subcontracts that bind the subcontracted provider to the terms and conditions contained in the Agreement and subtitle 17A of the Kentucky Insurance Code for any subcontracted responsibilities under the Agreement to provide Covered Services to Members. Provider shall give ValueOptions thirty (30) days prior notice in the event that any responsibilities under this Agreement are subcontracted.
10. Use of Hospitalists. Nothing in the Agreement shall be construed as requiring the Provider to use a hospitalist. For the purpose of this provision, hospitalist means a physician of record at a hospital for a patient of a Provider and who may return the care of the patient to the Provider at the end of the hospitalization.
11. Non-exclusivity. Nothing in the Agreement shall be construed as restricting Provider's ability to enter into commercial contracts with other insurers. Nothing in the Agreement shall be construed as requiring Provider to participate in any other ValueOptions health benefit plans as a condition of participating in a health benefit plan. ValueOptions shall compensate Provider according to the fee schedule for the products and markets described in the appropriate provision or exhibit(s) of the Agreement.

## **LOUISIANA STATE PROVISIONS**

1. The Agreement is amended by the adding the following defined terms:
  - (a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Clean Claim" means a correctly completed standardized claim form as required under Regulation 48 adopted by the Louisiana Department of Insurance (La. Admin. Code tit. 37, § 2301, *et seq.*).
  - (b) The term "Emergency Medical Condition" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency Medical Condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson, acting reasonably and possessing an average knowledge of health and medicine, to believe that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) placing the health of the individual in serious jeopardy; (b) with respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy; (c) serious impairment to bodily function; or, (d) serious dysfunction of any bodily organ or part.
2. Provider/Patient Relationship. In accordance with La. Rev. Stat. § 22:215.18, nothing in the Agreement shall be construed to interfere with Provider's communication with a Member concerning health care, treatment options, medical alternatives, or other coverage arrangements. Nothing in this Agreement shall be construed as prohibiting or restricting the Provider from advocating to ValueOptions on the Member's behalf of a particular course of treatment or for the provision of health care services. The Provider shall not be penalized under this Agreement solely on the basis of communications with the Member in terms of ValueOptions' refusal to renew the Agreement, or by canceling, restricting, or otherwise terminating the Agreement. . Nothing in this Agreement may be construed to prohibit or restrict the Provider from filing a complaint, making a report or commenting to an appropriate

governmental entity regarding the policies or practices of ValueOptions which may negatively impact upon the quality of, or access to, Member care.

3. Indemnification. The following shall be added to any existing provision in the Agreement regarding indemnification if applicable.

This provision is not intended to transfer to the Provider any liability relating to activities, actions, and omissions of ValueOptions.

4. Incentives to Withhold Medically Necessary Services. In accordance with La. Rev. Stat. § 22:215.19, nothing in this Agreement shall be construed as an incentive or specific payment made directly in any form to the Provider as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided to the Member or groups of Members with similar medical conditions.

5. Payment of Claims. To the extent any provision of the Agreement conflicts with La. Admin. Code Tit. 37, § 6001 (“Regulation 74”) or any successor provisions regarding payment of claims, those provisions shall be amended for both parties to comply with that law. This provision shall be construed with Applicable Law to determine whether that law applies to a particular claim.

6. Recoupment of Claim Payments. In accordance with La. Rev. Stat. 22:250.38 any recoupment by ValueOptions of a claim for payment of medical services, shall be preceded by written notice from ValueOptions including the Member’s name, date(s) of service, and an explanation for the recoupment. The Provider shall have thirty (30) days following the receipt of such notice to appeal ValueOptions’ action. Upon acceptance of the recoupment, ValueOptions may accept payment from the Provider or may deduct the agreed upon amount from future payments to the Provider. In the event that the Provider disputes the recoupment action, the dispute shall be resolved in accordance with the Agreement.

## MAINE STATE PROVISIONS

1. The Agreement is amended by adding the following term:

The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. “Emergency” means a medical condition, that manifests itself by acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to seriously jeopardize the Member’s health, physical or mental, or result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part; or, with respect to a pregnant woman, seriously jeopardize the health of the woman or her unborn child; or, if the woman is having contractions, there is inadequate time to effect a safe transfer to another hospital before delivery or, a transfer may pose a threat to the health or safety of the woman or unborn child.

2. Continuity of Care After Termination. In the event the Agreement is terminated without cause, Provider agrees to provide Covered Services to a Member who is undergoing a course of treatment with Provider for a period of at least sixty (60) days from the date of the notice to Member of Provider’s termination. If Member is in the second trimester of a pregnancy at the time of Provider’s termination, Provider agrees to continue to provide Covered Services until the completion of postpartum care directly related to the pregnancy. During such time that Provider continues to provide Covered Services in accordance with this provision, all terms and conditions of the Agreement applicable at the time of termination, including compensation and adherence to ValueOptions policies and procedures, including those governing Quality Assurance, will remain in effect. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision.

3. Provider/Patient Relationship. ValueOptions shall not terminate, discipline or otherwise penalize Provider for advocating for medically appropriate health care, or restrict Provider from disclosing to any Member any information Provider determines appropriate regarding the nature of treatment and any risks or alternatives to treatment, the availability of other therapy, consultations or tests, or ValueOptions’ decision to authorize or deny health care services or benefits.

4. Claim Payment. To the extent required, both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to 24-A Maine Revised Statute § 2436. To the extent any provision of the Agreement conflicts with the requirements of Applicable Law, those provisions shall be amended hereby to comply with that law.
5. Retrospective Denials. To the extent required by Applicable Law, retrospective denial of any previously paid claims, including any recoupment process utilized by ValueOptions, shall be administered in accordance with Applicable Law.
6. Notice of Amendment to Agreement. In accordance with Applicable Law, ValueOptions shall provide Provider with at least sixty (60) days prior written notice of any proposed amendment to this Agreement that has substantial impact on the rights and obligations of the Provider, including but not limited to material changes to fee schedules, unless the parties mutually agree to waive this 60-day notice requirement. To the extent not already agreed upon in the Agreement, the proposed amendment shall become effective and binding upon the parties, subject to any applicable termination provision in the Agreement, after the expiration of the 60 day notice period, unless either party objects to the proposed amendment.
7. No Financial Incentives or Penalties. Nothing in the Agreement or this Amendment shall be construed to 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 covered under a group subscriber contract. This provision shall not be construed to prohibit general payments such as capitation payments or risk-sharing agreements.
8. Indemnification. Nothing in this Agreement shall be construed to require Provider to indemnify ValueOptions or hold ValueOptions harmless for any expenses or liabilities arising from or in connection with any coverage decision, negligent act or omission or intentional misconduct of ValueOptions. ValueOptions 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 others.
9. Termination. ValueOptions may not terminate or not renew this Agreement, for any reason, with or without cause, unless Provider has been provided with at least sixty (60) days notice of termination or non-renewal and a written explanation prior to the termination or nonrenewal of the reasons for the proposed termination or nonrenewal, and an opportunity for a review or hearing, in accordance with Applicable Law. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.
10. Credentialing. Provider will notify ValueOptions within ten (10) days of any changes to the information required by ValueOptions' credentialing program. ValueOptions shall maintain an appeals procedure and ensure Provider's right to a hearing for any Provider concern relating to the denial of credentialing for not meeting the objective credentialing standards of ValueOptions.
11. Dispute Resolution. In accordance with Applicable Law, Provider shall have the right to appeal and the right to a hearing concerning any contractual dispute between ValueOptions and Provider.

## **MARYLAND STATE PROVISIONS**

### **I. Definitions.**

- (a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Clean Claim" means a properly completed claim for reimbursement submitted to ValueOptions by Provider for Covered Services that contains data elements and attachments required under Applicable Law in order to be processed or paid by ValueOptions. References in the Agreement to "claims" shall be construed to mean "Clean Claims" to the extent required by Applicable Law.
- (b) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement shall be added as a new term. "Emergency" means as defined by Applicable Law, a medical

condition that manifests itself by symptoms of sufficient severity, including severe pain, such that a reasonably prudent layperson, who possesses an average knowledge of health and medicine, would believe that the absence of immediate medical attention could seriously jeopardize the Member's health, or result in serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(c) The Agreement is amended by the following defined term "Experimental Medical Care" means a drug, device, medical treatment or procedure which: (1) cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) or other governmental agency and such approval has not been granted at the time of its use or proposed use; or (2) is the subject of a current investigational new drug or new device application on file with the FDA; or (3) is being provided pursuant to: a Phase I or Phase II clinical trial or, as the experimental or research arm of a Phase III clinical trial, or a written protocol which describes among its objectives, determinations of safety, toxicity, effectiveness, or effectiveness in comparison to conventional alternatives; or (4) is being delivered, or should be delivered pursuant to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations particularly those of the FDA or the Department of Health and Human Services; or (5) in the predominant opinion of experts: as expressed in the published, authoritative literature, is substantially confined to use in research settings, is subject to further research in order to define safety, toxicity, effectiveness, or effectiveness compared with conventional alternatives, or, is experimental, investigational, unproven or is not generally acceptable medical practice; or (6) is not a covered service under Medicare because it is considered investigational or experimental as determined by the Health Care Financing Administration (HCFA) or HHS; or (7) is provided concomitantly to a treatment, procedure, device or drug which is experimental, investigational, unproven treatment; or (8) has not been performed at least ten (10) times and reported on in the United States peer review medical literature. This provision shall not supercede provisions in the Agreement that expand or restrict the meaning of the term if such expanded or restricted meaning is permitted by Applicable Law:

II. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members only:

1. Continuity of Care after Termination. In the event of termination of the Agreement, unless such termination is due to fraud, patient abuse, incompetency, suspension, revocation or other loss of licensure status, Provider agrees to continue care and provide Covered Services upon request, to any Member receiving Covered Services, for a period of up to ninety (90) days after the date of the notice of termination in accordance with the terms of the Agreement applicable at the time of termination. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.
2. Termination. Either party shall have the right to terminate the Agreement, with or without cause, upon ninety (90) days prior written notice to the other party, unless the termination is for reasons related to provider fraud, patient abuse, incompetency or loss of licensure status. This termination provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.
3. Provider/Patient Relationship.
  - (a) The Agreement in no manner prohibits or restricts Provider from engaging in discussions or communications with a Member that: are necessary or appropriate for the delivery of health care services; including communications that: (1) relate to treatment alternatives; (2) are necessary or appropriate to maintain the provider-patient relationship while the Member is under Provider's care; (3) relate to a Member's right to appeal a benefit coverage determination; or (4) pertain to public policy issues. This provision does not restrict ValueOptions' right to prohibit tortious interference with a contract as recognized under Applicable Law.
  - (b) ValueOptions may not terminate or otherwise penalize Provider for advocating the interests of a Member pursuant to ValueOptions' internal complaint, appeal or grievance system, or for filing an appeal or grievance as permitted under Applicable Law.
4. Claim Payments. Both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to Maryland Insurance Code §15-1005. To the extent that any provision of the Agreement conflicts with Applicable Law, those provisions are hereby amended and shall be construed in compliance with Applicable Law.

5. Retroactive Denial of Reimbursement. To the extent required, ValueOptions may retroactively deny reimbursement of a claim in accordance with Applicable Law.
6. Non-Exclusivity of Agreement. Nothing in this Agreement shall be construed to restrict Provider's right to enter into contracts with other organizations or insurers, or to require Provider, as a condition of participation or continuation on a provider panel, to serve on another provider panel of ValueOptions.
7. Indemnification. Nothing in this Agreement shall be construed to require Provider to indemnify ValueOptions or hold ValueOptions harmless from a coverage decision or negligent act of ValueOptions.

## **MASSACHUSETTS STATE PROVISIONS**

### **I. Definitions:**

(a) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. "Emergency" 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 the 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).

(b) For the purposes of this Amendment, "Medical Necessity" or "Medically Necessary" means health care services that are consistent with generally accepted principles of professional medical practice as determined by whether 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, is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes, or for services and interventions not in widespread use, is based on scientific evidence.

(c) For the purposes of this Amendment, "Participating Provider" means a primary care physician, specialty care physician, ancillary provider, facility, hospital, Subcontractor or other health care provider who has entered into an agreement with ValueOptions or its affiliates or subcontractor to provide health care services to Members with an expectation of receiving payment, other than coinsurance, copayments or deductibles, directly or indirectly from ValueOptions.

(d) For the purposes of this Amendment, "Utilization Review" means the processes or techniques, used to monitor or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings including but not limited to, ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning or retrospective review, and/or case management standards established by ValueOptions or payors.

### **II. The following provisions are added to the Agreement and are applicable only to Providers rendering services to HMO and insured Members as required by Applicable Law:**

1. Provider/Patient Relationship. Nothing in the Agreement shall be construed to prohibit Provider from freely communicating with Members regarding the treatment options available to them, including alternative medications, regardless of benefit coverage. ValueOptions shall not refuse to contract with or compensate Provider for Covered Services provided to Members because Provider has in good faith communicated with or advocated on behalf of a Member regarding the provisions, terms or requirements of ValueOptions' health benefit plans as they relate to the needs of the Member, or with respect to the method by which Provider is compensated for Covered Services provided to the Member.

2. Third Party Liability. Nothing in the Agreement shall be construed to make ValueOptions, Provider, or their respective agents or representatives, liable to persons not parties hereto. Nor will anything herein be construed as, or be deemed to create, any rights or remedies in any third party, including, but not limited to, any Members or

hospitals. Notwithstanding the preceding, a contract between ValueOptions and a payor may, by its express terms, grant a payor rights to enforce the terms of this Agreement and other third party beneficiary rights with respect to those group subscriber contracts adopted, sponsored, maintained or administered by such payor. Each party will indemnify and hold the other harmless from and against any and all losses and liabilities (including reasonable attorneys' fees and related legal expenses) arising from any third party claim, action, cause of action, contest or dispute to the extent the losses or liabilities are the result of the indemnifying party's negligent or intentional act or omission. Provider is not required to indemnify ValueOptions for any expenses and liabilities, including, without limitation, judgments, settlements, attorney's fees, court costs and any associated charges, incurred in connection with any claim or action brought against ValueOptions based on ValueOptions' management decisions, utilization review provisions or other policies, guidelines or actions.

3. Financial Incentives. ValueOptions does not offer nor shall the Provider interpret the compensation program under the Agreement to be a financial incentive program that directly compensates a provider for ordering or providing less than medically necessary and appropriate care to Members, nor shall Provider profit from the provision of Covered Services that are not medically necessary or medically appropriate. Nor shall ValueOptions profit from the denial or withholding of Covered Services that are medically necessary or medically appropriate.

4. Termination. This Agreement may be terminated by either party upon ninety (90) days prior written notice. However, in the event that a longer notice period is set forth in the Agreement, this provision shall not supercede such provision if permitted by Applicable Law. ValueOptions will provide Provider a written statement of the reasons for any involuntary termination under this Agreement. Neither ValueOptions nor Provider may terminate this Agreement without cause.

5. Continuity of Care. Following the effective date of termination of this Agreement, this Agreement will be of no further force or effect except that each party will remain liable for any obligations or liabilities arising from activities undertaken prior to the effective date of termination. Upon any termination or withdrawal of the Provider, whether by termination of this Agreement or otherwise for reasons other than those related to quality or fraud, ValueOptions shall continue to be liable to pay compensation for Covered Services in accordance with the terms of the Agreement and the fee schedule in effect immediately prior to such termination for Covered Services rendered by the Provider under the terms and conditions of this Agreement to any Member who is under the care of the Provider at the time of such termination or withdrawal. Provider shall continue to provide such Covered Services until the current episode of care is completed or at least thirty (30) days after the effective date of termination, unless reasonably and medically appropriate arrangements for the assumption of such care by another provider are made. For a Member undergoing treatment for a terminal illness, Provider shall continue treatment consistent with the terms of this Agreement and the group subscriber contract until the Member's death. For a Member in her second or third trimester of pregnancy, Provider shall continue to provide treatment consistent with the terms of this Agreement and the group subscriber contract for the period up to and including the Member's first postpartum visit. Such continuing care obligations are subject to Provider's agreement to accept reimbursement from ValueOptions at the rate applicable prior to the notice of termination as payment in full, Provider's agreement not to impose cost sharing with respect to the Member in an amount that would exceed the cost sharing permitted under the group subscriber contract and this Agreement, and continued adherence to policies and procedures contained in the provider handbook in effect immediately prior to termination. Provider shall make reasonable and medically appropriate arrangements for the assumption by other providers for the care of Members who are under the care of any terminated or withdrawn Provider. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision.

6. Information to Contracting Provider. ValueOptions will provide information to Provider on Covered Services, benefit exclusions, administrative and utilization management requirements, preventive health services programs, credential verification programs, quality assessment programs and provider sanction policies, or any policy, procedure or requirement that has a substantial impact on the rights or responsibilities of Provider. ValueOptions will notify Provider in writing of any changes in these requirements sixty (60) days before the effective date, or a date mutually agreed upon in the Agreement or otherwise, and will allow reasonable time for Provider to comply with such changes.

7. Balance Billing.

(a) Provider will not bill any Member for charges for Covered Services rendered pursuant to this Agreement other than applicable deductibles, coinsurance or copayments specified in the applicable group subscriber

contract.

(b) Notwithstanding anything in this Agreement to the contrary, in the event of insolvency of ValueOptions, Provider will not bill any Member for nonpayment of any amounts owed to Provider by ValueOptions or payor under this Agreement. This provision will survive the termination of this Agreement regardless of the cause giving rise to the termination.

8. Compliance with ValueOptions' Programs and Requirements. Provider will cooperate and comply fully with ValueOptions' utilization review program, quality assurance/management program, credentialing and program requirements concerning the delivery of preventative health care services, and policies and procedures in the provider handbook, including updates thereof

9. Claims Payment. To the extent required, both parties agree to comply with Applicable Law with respect to the administration of claims including but not limited to M.G.L. c. 176G § 6. In accordance with the claims payment requirements set forth by Applicable Law, ValueOptions will, within forty-five (45) days after the receipt of a Clean Claim for payment for Covered Services, either (1) make payments to Provider for such services provided, (2) notify the Provider of the reason (s) for nonpayment, or (3) notify the Provider of the additional information or documentation that is necessary to process the claim for payment. If ValueOptions fails to pay a clean claim or notify Provider as required under Applicable Law, ValueOptions will, in addition to payment for services provided, pay interest at a rate established under said Applicable Law.

10. Member Access Fees. In the event that Provider decides to charge Members or require a fee of any amount and covering any period of time as a condition for a Member to be part of Provider's panel of patients, or for a Member to otherwise be able to receive health care services from Provider (sometimes referred to as a boutique or concierge practice), Provider will provide ValueOptions with at least ninety (90) days written notice prior to the implementation of such fee.

#### **MICHIGAN STATE PROVISIONS**

1. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with MCLS section 500.2006.

2. Prudent Purchaser Agreements. If Agreement to be amended is a Prudent Purchaser Agreement as defined by MCLS section 55.52(1), the following provisions are added to the Agreement:

(a) Provider may be removed from ValueOptions' provider panel before the expiration of the Agreement if Provider does not comply with the requirements of the Agreement.

(b) Provider shall display a notice in a conspicuous place at the entrance of Provider's facility indicating those provider panels to which Provider is a Member.

#### **MINNESOTA STATE PROVISIONS**

I. The Agreement is amended by adding the following term:

The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Clean Claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on a claim. References in the Agreement to "claims" shall be construed to mean "Clean Claims" in accordance with Applicable Law.

II. The Agreement is amended by adding the following provisions in accordance with Applicable Law:

1. Continuity of Care. Provider shall provide continued care in accordance with Applicable Law.

- (a) In the event that ValueOptions terminates this Agreement for any reason other than for cause, Provider agrees to provide Covered Services for up to one hundred twenty (120) days to any Member that requests, who is suffering from and is engaged in a current course of treatment for the following conditions: an acute condition, a life-threatening mental or physical illness, a physical or mental disability, a disabling or chronic condition that is in an acute phase, or pregnancy beyond the first trimester. A Member certified by a physician to have a life expectancy of less than one hundred eighty (180) days may, upon request, receive continued Covered Services for the rest of the Member's life. For purposes of this provision, a physical or mental disability is 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 year, or can be expected to result in death.
- (b) ValueOptions shall not be required to provide for such continuation of care if Provider's Agreement is terminated because of the suspension or revocation of the Provider's license, or for reasons related to the quality of health care services rendered, or for issues related to the health, safety or welfare of Members.
- (c) This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

2. Patient Rights. In accordance with Applicable Law, nothing in the Agreement shall be construed to:

- (a) prohibit Provider from communicating with Member with respect to the Member's health status, health care, or treatment options, including options not covered or otherwise limited by ValueOptions, if Provider is acting in good faith and within the scope of Provider's practice as defined by law;
- (b) prohibit Provider from making a recommendation regarding the suitability or desirability of a health plan ValueOptions, health insurer, or health plan coverage for Member, unless Provider has a financial conflict of interest;
- (c) prohibit Provider from providing testimony, supporting or opposing legislation, or making any other contact with governmental or regulatory officers or staff;
- (d) prohibit Provider from disclosing accurate information about whether services will be paid for by ValueOptions;
- (e) prohibit Provider from informing a Member about the reimbursement methodology used by ValueOptions to pay Provider;
- (f) permit ValueOptions to retaliate against Provider for refusal to enter into an agreement or provide services or information in a manner prohibited by law or for any action listed above, or criticizing or otherwise expressing personal disagreement regarding a treatment or coverage decision, or assisting or advocating for a Member in seeking reconsideration of such decision.
- (g) permit Provider or ValueOptions to retaliate against a Member who in good faith makes a complaint against Provider or ValueOptions.

3. Non-exclusivity of Agreement. Nothing in this Agreement shall be construed to restrict Provider's right to enter into any preferred provider contracts with other organizations or insurers. To the extent required by Applicable Law, Provider shall not be required to participate in a network under a category of coverage that differs from which this Agreement applies without the affirmative consent of Provider. ValueOptions may not terminate or fail to honor this Agreement based solely on Provider's decision not to accept any proposed new category of coverage.

4. Claims Payment. To the extent required, both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to Minnesota Statute § 62Q.75. To the extent any provision of the Agreement conflicts with the requirements of Applicable Law, those provisions shall be amended hereby to comply with that law.

5. Amendments. In accordance with Applicable Law, any amendments or change in the terms of the Agreement including the terms of reimbursement, or any written policies or procedures will be disclosed to Provider before the amendment is deemed effective.

6. Claims Recoupment. Requests for refund of overpayment of all or any portion of a claim will be made pursuant to Applicable Law.

### MISSISSIPPI STATE PROVISIONS

1. The Agreement is amended by the following defined term:

The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law: “Clean Claim” means a claim received by ValueOptions for adjudication and which requires no further information, adjustment or alteration by Provider or Member in order to be processed and paid by ValueOptions. A claim is a Clean Claim if it has no defect or impropriety, including any lack of substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made on the claim. A Clean Claim includes resubmitted claims with previously identified deficiencies corrected. A Clean Claim does not include any of the following: a) a duplicate claim, which means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim; b) claims that are submitted fraudulently or that are based upon material misrepresentations; c) claims that require information essential for ValueOptions to administer preexisting condition, coordination of benefits or subrogation provisions; or d) claims submitted by Provider more than thirty (30) days after the date of service. If Provider does not submit the claim on behalf of the Member, then a claim is not clean when submitted more than thirty (30) days after the date of billing by the Provider to the Member.

2. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with Miss. Code Ann. section 83-9-5.

### MISSOURI STATE PROVISIONS

1. The Agreement is amended by the following defined term:

The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” or “Emergency Medical Condition” means, unless otherwise defined by Applicable Law, a sudden unexpected onset of bodily injury or a serious illness of sufficient severity to cause a prudent layperson having average knowledge of health and medicine and acting reasonably to believe that, if not treated immediately, could result in serious medical complications, loss of life, serious impairment to bodily functions or serious dysfunction of a bodily organ or part, inadequately controlled pain, or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another hospital before delivery, or that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

2. Claims Submission and Payment. ValueOptions shall pay claims and administer such claims payment programs in accordance with applicable state or federal law or regulation, including § 376.383 and § 376.384 of the Revised Statutes of the State of Missouri. Each party agrees to comply with the provisions of § 376.383 and § 376.384.

### MONTANA STATE PROVISIONS

I. The Agreement is amended by the following defined terms:

(a) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a condition manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in any of the following: (a) the Member’s health would be in serious jeopardy; (b) the Member’s bodily functions would be seriously impaired; or (c) a bodily organ or part would be seriously damaged.

(b) The term “Subcontractor” means a person authorized to negotiate, execute and be a party to a contract between ValueOptions and a Provider or between ValueOptions and a network.

II. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members:

1. No Inducements. In accordance with Mont. Code Anno. Section 33-36-204(2), this Agreement shall not be interpreted to contain any provision that offers an inducement to Provider to provide less than medically necessary services to a Member.

2. Provider/Patient Relationship:

(a) In accordance with Mont. Code Anno. Section 33-36-204(3), this Agreement shall not be interpreted to contain any provision that prohibits Provider from discussing treatment options with a Member or from advocating on behalf of a Member within the utilization review or grievance processes established by ValueOptions or its designee.

(b) In accordance with Mont. Code Anno. Section 33-36-204(8), ValueOptions may not penalize Provider because Provider, in good faith, reports to state or federal authorities an act or practice by ValueOptions that may adversely affect patient health or welfare.

(c) In accordance with Mont. Code Anno. Section 33-1-803, ValueOptions may not take any of the following actions with regard to Provider because Provider made a medical communication to a Member or to the guardian or legal representative of the Member: (a) terminate the Agreement between ValueOptions and Provider; (b) reduce compensation to Provider; (c) demote Provider in regard to relative seniority within ValueOptions; or (d) take any other action against Provider in retaliation for a medical communication made by Provider to a Member.

(d) In accordance with Mont. Code Anno. Section 33-1-802, ValueOptions may not by an 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 making a medical communication to a Member. A contract, direction, requirement or financial inducement or penalty violating this prohibition is void. This prohibition does not apply to: (i) an oral or written contract, direction, requirement or financial inducement or penalty prohibiting Provider from disclosing a trade secret, as defined in Mont. Code Anno. Section 30-14-402, to the same extent as other employees or contractors of ValueOptions are prohibited from disclosing the trade secret; (ii) an oral or written contract, direction, requirement or financial inducement or penalty prohibiting Provider from referring Member to another health plan in which the provider making the referral has a direct financial interest; and (iii) the terms of an oral or written contract mutually agreed upon by ValueOptions and Provider requiring Provider to participate in and cooperate with all programs, policies, and procedures implemented by ValueOptions to ensure, review or improve the quality of health care.

3. Confidentiality and Health Records. Provider shall make available to appropriate state and federal authorities, in accordance with the Applicable Law related to 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.

4. Termination of Agreement. ValueOptions and Provider shall provide at least sixty (60) days’ written notice prior to the end of the term of the Agreement before terminating this Agreement without cause. ValueOptions and Provider may not terminate this Agreement prior to the expiration of its term except for just cause. For purposes of this provision, “just cause” means reasonable grounds for termination based on a failure to satisfactorily perform contract obligations or other legitimate business reason. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

5. Nondiscrimination. Provider shall provide Covered Services without regard to the Member’s enrollment in the health benefit plan as a private purchaser or as a participant in a publicly financed program of health care services. This requirement does not apply to circumstances in which the Provider should not render services because of Provider’s lack of training, experience, or skill or because of a restriction on the Provider’s license.

6. Provider’s Duty to Collect Applicable Copayments and Other Sums. Provider is responsible for collecting from Member any applicable copayments, coinsurance, deductibles pursuant to the Member’s health benefit plan.

Additionally, Provider is responsible for notifying Members of their personal financial obligation for services which are not Covered Services.

7. Definitions in Agreement. The definitions and other provisions in this Agreement shall not conflict with the definitions or provisions contained in the Member's health benefit plan or those contained in Montana law or regulations.

8. Hold Harmless. Provider agrees that Provider may not for any reason, including but not limited to nonpayment by ValueOptions or Subcontractor, insolvency of ValueOptions or Subcontractor, or breach of this 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 ValueOptions or Subcontractor acting on behalf of the Member for services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the Member's health benefit plan or fees for services which are not Covered Services delivered on a fee-for-service basis to the Member. This Agreement does not prohibit Provider and a Member from agreeing to continue services solely at the expense of the Member if Provider has clearly informed the Member that ValueOptions may not cover or continue to cover a specific service or services. Except as provided in this Agreement, this Agreement does not prohibit Provider from pursuing any legal remedy available for obtaining payment for services from ValueOptions. This provision shall be construed in favor of the Member, shall survive termination of this Agreement regardless of the reason for termination, including insolvency of ValueOptions and shall supersede an oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with this provision. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

9. Continuity of Care. If ValueOptions or Subcontractor becomes insolvent or otherwise ceases operations, Covered Services to Members will continue through the end of the period for which a premium has been paid to ValueOptions on behalf of the Member, but not to exceed thirty (30) days, 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 confinement in an inpatient facility is no longer medically necessary. This provision shall be construed in favor of the Member, shall survive termination of this Agreement regardless of the reason for termination, including insolvency of ValueOptions and shall supersede an oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with this provision. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

10. Indemnification. In accordance with Mont. Code Anno. Section 33-37-104(2), nothing in this Agreement shall require Provider to indemnify or hold harmless ValueOptions for the acts or conduct of ValueOptions. Any such provision in a contract entered into, amended or renewed on or after October 1, 1999 is void.

11. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with Mont. Code Anno. Section 33-18-232.

12. Subcontractors. In addition to the above provisions, if Provider is a Subcontractor, the following shall apply:

(a) ValueOptions shall have the right to approve or disapprove participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to Members.

(b) ValueOptions shall maintain copies of all Subcontractor health care subcontracts at its principal place of business or, alternatively, Provider shall ensure that ValueOptions has access to all Subcontractor subcontracts, including the right to make copies of the contracts upon twenty (20) days' prior written notice from ValueOptions. Subcontractor shall make such subcontracts available to ValueOptions in accordance with this provision.

- (c) If applicable, Subcontractor shall transmit utilization documentation and claims paid documentation to ValueOptions. ValueOptions shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Members.
- (d) Subcontractor shall maintain the books, records, financial information, and documentation of health care services provided to Members at its principal place of business in the state and preserve them for five (5) years in a manner that facilitates regulatory review.
- (e) Subcontractor shall allow the Commissioner of Insurance and the Department of Insurance for the State of Montana access to the Subcontractor's books, records, claim information, billing information and other documentation of health care services provided to Members, as necessary to determine compliance with state laws and regulations.
- (f) ValueOptions shall have the right, in the event of the Subcontractor's insolvency, to require Subcontractor to assign to ValueOptions the provisions of providers' contracts addressing providers' obligation to furnish Covered Services.

## **NEBRASKA STATE PROVISIONS**

### **I. The Agreement is amended by the following defined terms:**

- (a) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy; (b) serious impairment to such person's bodily functions; (c) serious impairment of any bodily organ or part of such person; or (d) serious disfigurement of such person.
- (b) The term "Subcontractor" means a person authorized to negotiate, execute and be a party to a contract between ValueOptions and a Provider or between ValueOptions and a network.

### **II. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members.**

1. **Hold Harmless.** Provider agrees that, in no event, including, but not limited to, nonpayment by ValueOptions or Subcontractor, insolvency of ValueOptions or Subcontractor, 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 ValueOptions or Subcontractor, acting on behalf of the Member for Covered Services provided pursuant to this Agreement. This Agreement does not prohibit Provider from collecting coinsurance, copayments, or deductibles, as specifically provided in the Member's health benefit plan or fees for services which are not Covered Services delivered on a fee-for-service basis to the Member. This Agreement does not prohibit Provider 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 ValueOptions may not cover or continue to cover a specific health care service or services. Except as provided in this Agreement, this Agreement does not prohibit Provider from pursuing any legal remedy available for obtaining payment for services from ValueOptions. This provision shall be construed in favor of the Member, shall survive termination of this Agreement regardless of the reason for termination, including insolvency of ValueOptions and shall supersede an oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with this provision. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.
2. **Continuity of Care.** If ValueOptions or Subcontractor becomes insolvent or otherwise ceases operations, Covered Services to Members will continue through the period for which a premium has been paid to ValueOptions on behalf of the Member or until the Member's discharge from an inpatient facility, whichever time is greater. Covered Services to a Member confined in an inpatient facility on the date of insolvency or other cessation of

operations will continue until the Member's continued confinement in an inpatient facility is no longer medically necessary. This provision shall be construed in favor of the Member, shall survive termination of this Agreement regardless of the reason for termination, including insolvency of ValueOptions and shall supersede an oral or written contrary agreement between Provider and a Member or the representative of a Member if the contrary agreement is inconsistent with this provision. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

3. No Inducements. In accordance with R.R.S. Neb. Section 44-7106(2)(h), this Agreement shall not be interpreted to contain any provision that offers an inducement to Provider to provide less than medically necessary services to a Member.

4. Provider/Patient Responsibility.

(a) In accordance with R.R.S. Neb. Section 44-7106(2)(i), this Agreement shall not be interpreted to contain any provision that prohibits Provider from discussing treatment options with a Member irrespective of ValueOptions' position on the treatment options or from advocating on behalf of Members within the utilization review or grievance processes established by ValueOptions or ValueOptions' designee.

(b) In accordance with R.R.S. Neb. Section 44-7106(2)(o), ValueOptions shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by ValueOptions that jeopardizes patient health or welfare.

5. Confidentiality and Health Records. Provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating grievances or complaints of Members. Provider shall comply with Applicable Law related to confidentiality of medical or health records.

6. Termination of Agreement. ValueOptions and Provider shall provide at least sixty (60) days' written notice to each other before terminating this Agreement without cause. This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

7. Assignment/Delegation. Provider shall not assign or delegate its rights or responsibilities under this Agreement without the prior written consent of ValueOptions. This provision shall not supercede additional provisions in the Agreement related to assignment and/or delegation if such provisions do not conflict with this provision and are permitted by Applicable Law.

8. Nondiscrimination. Provider shall furnish Covered Services to Members without regard to the Member's enrollment in the health benefit plan as a private purchaser or as a participant in a publicly financed program 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.

9. Provider's Duty to Collect Applicable Copayments and Other Sums. Provider is responsible for collecting from Member any applicable copayments, coinsurance, deductibles pursuant to the Member's health benefit plan. Additionally, Provider is responsible for notifying Members of their personal financial obligation for services which are not Covered Services.

10. Definitions in Agreement. The definitions and other provisions in this Agreement shall not conflict with the definitions or provisions contained in the Member's health benefit plan or those contained in Nebraska law or regulations.

11. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with Code of Nebraska Rule 210-61.

12. Subcontractors. In addition to the above provisions, if Provider is an Subcontractor, the following provisions shall apply:

- (a) ValueOptions' responsibility to monitor the offering of Covered Services to Members shall not be delegated or assigned by ValueOptions to Subcontractor.
- (b) ValueOptions shall have the right to approve or disapprove participation status of a subcontracted Provider in its own or a contracted network for the purpose of delivering Covered Services to Members.
- (c) ValueOptions shall maintain copies of all Subcontractor health care subcontracts at its principal place of business or, alternatively, Provider shall ensure that ValueOptions has access to all Subcontractor subcontracts, including the right to make copies to facilitate regulatory review upon twenty (20) days' prior written notice from ValueOptions. Subcontractor shall make such subcontracts available to ValueOptions in accordance with this provision.
- (d) If applicable, Subcontractor shall transmit utilization documentation and claims paid documentation to ValueOptions. ValueOptions shall monitor the timeliness and appropriateness of payments made to Providers and health care services received by Members.
- (e) If applicable, Subcontractor shall maintain the books, records, financial information, and documentation of health care services provided to Members at its principal place of business in the state and preserve them for five (5) years in a manner that facilitates regulatory review.
- (f) Subcontractor shall allow the Director of Insurance for the State of Nebraska access to the Subcontractor's books, records, financial information, and any documentation of health care services provided to Members, as necessary to determine compliance with state law or regulations.
- (g) ValueOptions shall have the right, in the event of the Subcontractor's insolvency, to require Subcontractor to assign to ValueOptions the provisions of providers' contracts addressing providers' obligation to furnish Covered Services.

## **NEVADA STATE PROVISIONS**

1. The Agreement is amended by the following defined term:

The term "Emergency Services" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency Services " means those health care services that are provided to a Member by a Provider after the sudden onset of a medical condition that manifests itself by symptoms of such sufficient severity that a prudent person would believe that the absence of immediate medical attention could result in: (a) serious jeopardy to the health of the Member; (b) serious jeopardy to the health of an unborn child; (c) serious impairment of a bodily function; or (d) serious dysfunction of any bodily organ or part.

2. ValueOptions' Quality Assurance Program. Provider shall provide Covered Services to Members in accordance with ValueOptions' quality assurance program. Upon execution of this Agreement, ValueOptions shall give Provider information regarding its quality assurance program requirements.

3. Provider/Patient Relationship. In accordance with NRS section 695G.400, ValueOptions shall not restrict or interfere with any communication between Provider and Member regarding any information that Provider determines is relevant to the health care of the Member. In accordance with NRS section 695G.410, ValueOptions shall not terminate this Agreement, demote Provider, 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 Member; (b) assists Member in seeking a reconsideration of a decision by ValueOptions to deny coverage for a health care service; or (c) reports a violation of law to an appropriate authority.

4. No Financial Incentives. In accordance with NRS section 695G.420, ValueOptions shall not 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 herein prohibits an arrangement for payment between ValueOptions and Provider 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.

5. Claim Forms and Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with NRS section 689B.250 and section 698B.255. ValueOptions shall, in accordance with Nevada Revised Statutes § 695G.430, provide within seven days of a request from Provider the schedule of payments applicable to Provider.

6. Continuity of Care. To the extent required by Nevada Revised Statutes § 695G.164, ValueOptions shall arrange for the continuation of Covered Services for a Member who is actively undergoing a medically necessary course of treatment for a medical condition from terminated Provider at the time of termination of the Agreement where Provider and Member agree that such continuity of care is desirable. ValueOptions shall arrange for such services for up to 120 days after the date of termination, or, if the medical condition is pregnancy, the 45<sup>th</sup> day after the date of delivery, or, if the pregnancy does not end in delivery, the date of the end of the pregnancy. Provider agrees to provide Covered Services in accordance with the terms and provisions of the Agreement as those terms and provisions existed before the termination of the Agreement, and agrees not to seek payment from Member for any Covered Services rendered pursuant to this section. ValueOptions shall not be required to provide for such continuity of care if the reason for termination of the Agreement relates to medical incompetence or professional misconduct, a disciplinary cause or reason, fraud or other criminal activity. This section shall not require ValueOptions to cover services or provide benefits that are not otherwise covered under the terms and conditions of the Member's health benefit plan.

7. Amendments. In accordance with Nevada Revised Statutes § 695G.430, this Agreement may be amended by ValueOptions at any time by giving thirty (30) days written notice to Provider. Such notice shall be conclusive evidence of receipt and acceptance of the amendments, unless, within that period, Provider provides written notice of its rejection of the amendments. If such amendment does not become effective and this Agreement is continued, Provider shall not be required to comply with such proposed amendment. Except as otherwise provided in this section, no amendment or modification will be effective unless made in writing and signed by both parties.

#### **NEW HAMPSHIRE STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:

(a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Clean Claim" means a claim for payment of Covered Services, as defined by Applicable Law, that is submitted on ValueOptions' standard claim form which contains all correct required fields, utilizing using the most current published procedural codes, and is completed with correct and complete information in accordance with Applicable Law.

(b) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Emergency" means the sudden and, at the time, unexpected onset of a health condition that requires immediate medical attention, where failure to provide medical attention would result in serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the Member's health in serious jeopardy.

2. Claim Payment. To the extent required, both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to New Hampshire Revised Statute §420 J: 8-a. To the extent that any provision of the Agreement conflicts with the requirements of Applicable law, those provisions shall be hereby amended to comply with that law.

3. Continuity of Care after Termination. Upon termination of this Agreement for any reason except unprofessional behavior, Provider shall continue to provide Covered Services to any Member who is under the care of Provider at the time of such termination for up to sixty (60) days from the date of termination of the Agreement. Compensation for Covered Services rendered pursuant to this section shall be in accordance with the terms and conditions of the Agreement. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

4. Provider/Patient Relationship. Nothing in the Agreement shall be construed to limit Provider's ability to disclose information to Members, patients or prospective patients regarding the provisions, terms or requirements of

ValueOptions' products as they relate to the needs of Members or Provider's patients, except for trade secrets of significant competitive value. ValueOptions may not terminate or not renew this Agreement or otherwise penalize Provider for participating in a Member's internal grievance procedure or external review.

5. Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by ValueOptions, insolvency of ValueOptions, 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 a person acting on behalf of the Member, for Covered Services provided pursuant to this Agreement. This 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. This provision does not prohibit Provider and a Member from agreeing to continue services solely at the expense of the Member, as long as the Provider has fully informed the Member that ValueOptions may not cover or continue to cover a specific service or services. Except as expressly contained in the Agreement, the Agreement does not prohibit Provider from pursuing any available legal remedy permitted by Applicable Law. This provision supercedes any oral or written agreement to the contrary, now existing or hereafter entered into and shall survive termination of the Agreement regardless of the reason for termination, including insolvency of ValueOptions. This provision shall not supercede provisions in the Agreement that provides additional protections for Members if such provisions are permitted by Applicable Law.

6. Recoupment of Overpayments. To the extent permitted, retroactive denial of claims, including any recoupment process utilized by ValueOptions, shall be administered in accordance with Applicable Law.

7. Amendments. Excepting amendments or modifications which are expressly permitted under the Agreement, ValueOptions will provide Provider sixty (60) days from the postmark date to review any proposed amendments or modifications to the Agreement.

8. No Inducements, Limitations or Penalties. Nothing in the Agreement shall be construed to directly or indirectly offer or create an inducement for Provider to reduce, limit or not provide medically necessary health care services to a Member. This section shall not prohibit ValueOptions from using capitated, withhold or other payment arrangements.

## NEW MEXICO STATE PROVISIONS

I. The Agreement is amended by the following defined terms:

*(a) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means health care procedures, treatments or services delivered to a Member after the sudden onset of what reasonably appears to be a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that: a. the absence of immediate medical attention could be reasonably expected by a reasonable layperson to result in jeopardy to a person's health, serious impairment of bodily functions, serious dysfunction of a bodily organ or part or disfigurement; or b. a reasonable person believes that immediate medical attention is required.*

**(b) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. References in the Agreement to "claims" shall be construed to mean "Clean Claims" to the extent required by Applicable Law: "Clean Claim" means a manually or electronically submitted claim from a participating provider that: a. contains substantially all the required data elements necessary for accurate adjudication without the need for additional information from outside of ValueOptions' system; b. is not materially deficient or improper, including lacking substantiating documentation currently required by ValueOptions; or c. has no particular or unusual circumstances requiring special treatment that prevent payment from being made by ValueOptions within thirty (30) days of the date of receipt if submitted electronically or forty-five (45) days if submitted manually.**

II. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members excluding PPO insured Members:

1. Covered Services. This Agreement sets forth the Covered Services for which Provider is responsible for providing including limitations and/or conditions on such services.
2. Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by ValueOptions, insolvency of ValueOptions, or breach of this Agreement by ValueOptions, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, person to whom health care services have been provided, or person acting on behalf of the Member, for Covered Services provided pursuant to this Agreement. This does not prohibit Provider from collecting co-insurance, deductibles or copayments as specifically provided in the evidence of coverage, or fees for services which are not Covered Services delivered on a fee-for-service basis to Members, nor from any recourse against ValueOptions or its successor. This provision shall survive termination of this Agreement regardless of the reason for termination, including insolvency of ValueOptions. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.
3. Policies and Procedures. ValueOptions is responsible for establishing, and communicating to Provider, practices and guidelines which may include policies and procedures applicable to payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements and any applicable federal or state programs.
4. Access and Confidentiality of Health Records. Provider shall make available to ValueOptions health records in order for ValueOptions to monitor and evaluate the quality of care rendered to Members, to conduct evaluations and audits, and to determine on a prospective, concurrent or retrospective basis the appropriateness of Covered Services provided to Members. Provider shall make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating grievances or complaints of Members. Provider shall comply with Applicable Law related to the confidentiality of medical or health records.
5. Assignment/Delegation of Agreement. Provider shall not assign or delegate its rights or responsibilities under the terms of this Agreement without the prior written consent of ValueOptions. This provision shall not supercede additional provisions in the Agreement related to assignment and/or delegation if such provisions do not conflict with this provision and are permitted by Applicable Law.
6. Insurance. Provider shall maintain adequate professional liability and malpractice insurance in an amount acceptable to ValueOptions. Provider shall notify ValueOptions within ten (10) days of Provider's receipt of notice of any reduction or cancellation of such coverage.
7. Member Rights. Provider shall observe, protect and promote the rights of Members as patients.
8. Nondiscrimination. 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 Member. This Agreement shall not be interpreted to apply to circumstances when the Provider appropriately does not render services due to limitations arising from the Provider's lack of training, experience, or skill or due to licensing restrictions.
9. Coverage Requirement. If Provider is a primary care physician, Provider shall be available to provide or arrange for the provision of Covered Services twenty-four (24) hours per day, seven (7) days per week.
10. Terms in Agreement. The terms used in this Agreement that are defined by New Mexico statutes and New Mexico Department of Insurance regulations will be used in this Agreement in a manner consistent with any definitions in such laws or regulations.
11. Provider/Patient Relationship. In accordance with 13 NMAC 10.13.25(N)(2), this Agreement shall not be interpreted to contain any provision that penalizes Provider for assisting a Member seeking a reconsideration of ValueOptions' decision to deny or limit benefits to the Member. In accordance with 13 NMAC 10.13.25(N)(3), this Agreement shall not be interpreted to contain any provision that prohibits Provider from advocating on behalf of Members within the utilization review or grievance processes established by ValueOptions.

III. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members:

1. Dispute Resolution. Any dispute resolution provisions in the Agreement in conflict with this provision shall be replaced by the following to the extent applicable and to the extent the Agreement does not contain a dispute resolution provision, the following shall be added as a provision to the Agreement. ValueOptions offers Provider a dispute resolution process in the event that Provider has a concern with ValueOptions regarding the operation of ValueOptions, including concerns regarding quality of and access to Covered Services, the choice of health care providers and the adequacy of ValueOptions' provider network. This process includes the right of the Provider to present his concerns to a committee responsible for the substantive area addressed by the concern. Such concern shall be conveyed to ValueOptions' governing body by the committee. ValueOptions shall forward to Provider its written decision on the dispute within twenty (20) days from the date of the committee meeting held to consider the dispute. Additionally, in the event ValueOptions terminates Provider's participation in its network for cause, ValueOptions shall offer Provider a fair hearing process that permits Provider to dispute the termination.
2. Provider/Patient Relationship. ValueOptions shall not adopt a gag rule or practice that prohibits Provider from discussing a treatment option with a Member even if ValueOptions does not approve of the option.
3. No Financial Incentives. This Agreement shall not be interpreted to contain any provision that offers an inducement, financial or otherwise, to provide less than medically necessary services to a Member.
4. Professional Responsibility. In accordance with N.M. Stat. Ann. section 59A-57-6 A.(3), this Agreement shall not be interpreted to require Provider to violate any recognized fiduciary duty of his profession or place his license in jeopardy.
5. Indemnification. In accordance with N.M. Stat. Ann. section 59A-16-21.1(D), nothing in this Agreement shall require either party to relieve the other party of liability for its actions or inactions.
6. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with N.M. Stat. Ann. section 59A-16-21.1 and for insured Members' Clean Claims excluding those of PPO insured Members, ValueOptions and Provider shall comply with 13 NMAC 10.13.25.15 and related Insurance Department Bulletins.

### **NEW YORK STATE PROVISIONS**

1. The Agreement is amended by the following defined term:

The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition placing the health of such person or others in serious jeopardy, or (b) serious impairment to such person's bodily functions; (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

2. Term and Termination. The following provision is added to the section titled "Term and Termination" and applies to health benefit plans regulated by the New York Ins. Code, Article 48, pertaining to managed care products:

(a) In no event shall termination be effective earlier than sixty (60) days from the receipt of notice of the termination or notice of non-renewal from the other party.

(b) ValueOptions shall provide in the notice of a proposed termination, the reasons for the proposed action and the right to request a hearing or review pursuant to N.Y. Ins. Law § 4803. These provisions do not apply in cases involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the Provider's ability to practice.

(c) Non-renewal of the Agreement does not constitute a termination under these provisions.

This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

3. The provision titled “Indemnification” is replaced with the following:

Responsibility for Actions and Omissions. Each party to this Agreement is responsible for its own acts and omissions in providing services pursuant to this Agreement, as well as those acts or omissions of its officers, employees and agents. Nothing in this Agreement shall be construed to place any responsibility for such acts and omissions on the other party.

4. Professional Responsibility. Nothing in the Agreement shall be construed as prohibiting or restricting the Provider from disclosing to any Member or their authorized representative any information that is deemed by the Provider to be appropriate regarding: (1) a condition or a course of treatment regarding a Member including the availability of other therapies, consultations, or tests; or (2) the provisions, terms, or requirements of ValueOptions' products as they relate to the Member; or (3) be construed as prohibiting or restricting the Provider from advocating on behalf of the Member for approval or coverage of health care services. Neither shall the Agreement be construed as prohibiting or restricting the Provider from filing a complaint, making a report, or commenting to an appropriate governmental body regarding the policies or practices of ValueOptions that the Provider believes negatively impact upon the quality of, or access to, patient care.

5. Claim Payment. To the extent any provision of the Agreement conflicts with N.Y. Ins. Law § 3224-a or its successor provision regarding payment of claims, those provisions shall be amended for both parties to comply with that law. This provision shall be construed with Applicable Law to determine whether that law applies to a particular claim.

## **NORTH CAROLINA STATE PROVISIONS**

### **I. Definitions.**

To the greatest extent possible, any definitions used in this Amendment and the Agreement are to be interpreted consistently with the definitions contained in Member's evidence of coverage and with those contained in Provider manuals. The Agreement is amended by the following defined terms:

1. The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following: (i) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (ii). Serious impairment to bodily functions, and (iii) Serious dysfunction of any bodily organ or part.

2. The term “Medically Necessary” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Medically Necessary” means those Covered Services or supplies that are: (a) Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease; and except as allowed under G.S. 58-3-225, not for experimental, investigational, or cosmetic purposes, (b) Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms, (c) Within generally accepted standards of medical care in the community, and (d) Not solely for the convenience of the Member, Member's family or the provider.

3. For the purposes of this Amendment, the term “Subcontractor” or “Subcontractor Organization” shall mean any entity that employs or contracts with health care providers for the provision of health care services and that also contracts with ValueOptions or its Subcontractor.

II. The following provisions are added to the Agreement and are applicable to Providers rendering services to HMO Members:

1. Hold Harmless. In the event ValueOptions fails to pay for Covered Services, Member shall not be liable to Provider for any sums owed by ValueOptions. No other provisions of this Agreement shall, under any circumstances, change the effect of this provision. No Provider, agent, trustee or assignee thereof, may maintain any action at law or otherwise against a Member to collect sums owed by ValueOptions. This provision shall survive termination of this Agreement for any reason, including ValueOptions’ insolvency. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

2. Continuity of Care. In the event ValueOptions is insolvent, Provider shall continue to provide Covered Services to Members for the duration of the period after ValueOptions’ insolvency for which premium payment has been made. Additionally, Provider shall continue to provide Covered Services to Members who are confined in an inpatient facility until their discharge. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

III. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members:

1. Non-Exclusivity of Agreement. In accordance with N.C. Gen. Stat. Section 58-50-56, nothing in this Agreement shall be construed to restrict Provider’s right to enter into preferred provider contracts with other organizations or insurers.

2. Information to Providers. ValueOptions shall provide to Provider information about ValueOptions and ValueOptions’ preferred provider benefit plans. This information shall include, for each preferred provider benefit plan, the benefit designs and incentives that are used to encourage Members to use preferred providers.

IV. The following provisions are added to the Agreement and are applicable to Providers rendering services to HMO and insured Members:

1. Term of Agreement. The term of this Agreement shall become effective upon execution of the Agreement or as otherwise indicated in the Agreement and will continue in effect until terminated by either party in accordance with the terms of this Agreement.

2. Continuity of Care. Upon termination of this Agreement in accordance with its terms or upon ValueOptions’ insolvency, if ValueOptions provides or arranges for delivery of Covered Services on a prepaid basis, inpatient care shall be continued for a Member until that Member is ready for discharge. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

3. Transfer of Administrative Duties and Records. Upon the effective date of termination of this Agreement or in the event of ValueOptions’ insolvency, Provider will arrange for a transition of administrative duties to the succeeding provider of Covered Services and, at the request of ValueOptions, will copy all medical files of Member and forward such files to the succeeding provider of Covered Services.

4. Licensure. Provider shall maintain appropriate licensure, accreditation and credentials sufficient to meet ValueOptions’ credentialing program requirements. The specific elements of ValueOptions’ credentialing program requirements are attached hereto as Attachment A. Provider must inform ValueOptions, in writing, of any change in the status of any information relating to Provider’s professional credentials.

5. Insurance. Provider shall procure and maintain at all times during the term of this Agreement adequate professional liability insurance in an amount acceptable to ValueOptions. Provider shall notify ValueOptions, in writing, of any change in the status of Provider's professional liability insurance coverage on a timely basis.
6. Emergency Service. Provider shall make appropriate arrangements with covering providers as necessary to assure the availability of Covered Services to Members. If Provider is a primary care physician, Provider shall be available to provide or arrange for the provision of Covered Services twenty-four (24) hours per day, seven (7) days per week, including holidays. If Provider is a hospital, Emergency services shall be available twenty-four (24) hours per day, seven (7) days per week, including holidays.
7. Verification of Member Eligibility. ValueOptions shall supply Members with an identification card or other means of identification indicating their status as a Member. Provider shall use the eligibility/benefit verification telephone number on the Member's identification card to obtain information on Member eligibility information held by ValueOptions.
8. Member Records. Provider shall prepare and maintain appropriate financial, medical and other relevant records and personal information on Members in accordance with ValueOptions' policies and procedures and in accordance with ValueOptions and industry standards. Such records shall be maintained in accordance with generally accepted medical, accounting and bookkeeping practices. Provider shall maintain the confidentiality of Member medical records and other personal and health information in accordance with Applicable Law. Upon request, Provider shall make such records available to ValueOptions and the Department of Insurance in conjunction with the Department's regulation of ValueOptions.
9. Grievance Procedures. Provider agrees to cooperate with Members in the grievance procedures adopted by ValueOptions in accordance with Applicable Law.
10. Nondiscrimination. 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. Policies and Procedures. Provider shall comply with and be bound by ValueOptions' administrative requirements, utilization management programs, credential verification programs, quality management programs and provider sanction programs, if any. ValueOptions shall give Provider data and information relating to its administrative requirements, utilization management programs, credential verification programs, quality management programs, provider sanction programs, if any, and Member benefit exclusions. However, none of these requirements and nothing in this Agreement shall override the professional or ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to their patients.
12. Use of Name. Provider authorizes ValueOptions to include and ValueOptions shall include Provider's name in ValueOptions' provider directory distributed to Members.
13. Assignment/Delegation. Provider may not assign, delegate or transfer its duties and obligations under this Agreement without the prior written consent of ValueOptions. ValueOptions shall notify Provider, in writing, of any duties or obligations that are to be delegated, assigned or transferred before the delegation, assignment or transfer. This provision shall not supercede additional provisions in the Agreement related to assignment and/or delegation if such provisions do not conflict with this provision and are permitted by Applicable Law.
14. Subcontractor Agreements. If Provider is a Subcontractor, the following additional provisions are added to the Agreement:
  - (a) ValueOptions retains legal responsibility to monitor and oversee the offering of services to Members and financial responsibility to Members;
  - (b) Provider may not subcontract for its services without ValueOptions' written permission;
  - (c) ValueOptions may approve or disapprove the participation of any individual provider contracting with Provider for inclusion in or removal from ValueOptions' own network plan;

- (d) Provider shall make available for review by the Department of Insurance all provider contracts and subcontracts held by Provider;
- (e) If Provider assumes risk from ValueOptions or pays its subcontracted providers on a risk basis or is responsible for claims payment to its subcontracted providers:
- i. Provider shall provide ValueOptions with documentation of utilization and claims payments and ValueOptions shall maintain accounting systems and records necessary to support the arrangement;
  - ii. ValueOptions shall arrange for financial protection of itself and Members through approaches such as member hold harmless language in subcontracted provider agreements, retention of signatory control of the funds to be disbursed, or financial reporting requirements by Provider; and
  - iii. To the extent provided by law, the Department of Insurance shall have access to the books, records and financial information to examine the activities performed by Provider on behalf of ValueOptions. Such books and records shall be maintained in the state of North Carolina.
  - iv. Provider shall comply with all Applicable Law that applies to the functions delegated by ValueOptions and assumed by Provider. If Provider is contracted to deliver health care services, provider contracts used by Provider shall comply with and include applicable provisions required by state regulations.

15. Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with N.C. Gen. Stat. Section 58-3-225.

16. Provider/Patient Relationship. In accordance with N.C. Gen. Stat. section 58-3-176, nothing in the Agreement shall be construed to: (a) limit Provider's ability to discuss with a Member the clinical treatment options medically available, the risks associated with the treatments, or a recommended course of treatment; (b) limit Provider's professional obligations to Members as specified under the Provider's professional license; or (c) expand or revise the scope of benefits covered by ValueOptions.

17. Information to Contracting Providers. As applicable, ValueOptions will provide information and data to Provider, including performance feedback reports related to incentive compensation, information on benefit exclusions, administrative and utilization management requirements, credential verification programs, quality assessment programs and provider sanction policies. ValueOptions will notify Provider of any changes in these requirements, and will allow a reasonable time for Provider to comply with such changes.

18. Entire Agreement. This amendment together with the Agreement, all of its exhibits, attachments and appendices as attached to this Amendment and to the Agreement constitute the entire Agreement between the parties hereto.

19. ValueOptions Fee Schedules and Claim Submission and Reimbursement Policies. In accordance with N.C. Gen. Stat. section 58-3-227, ValueOptions shall make information available to Provider as it relates to ValueOptions fee schedules and claim submission and reimbursement policies.

## **NORTH DAKOTA STATE PROVISIONS**

1. The Agreement is amended by adding the following defined term:

The term "Emergency Medical Condition" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency Medical Condition" means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious

dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

2. Provider/Patient Relationship. In accordance with N.D. Cent. Code § 26.1-04-03, nothing in the Agreement shall be construed to restrict or interfere with a Provider's communication with a Member concerning health care, treatment options, medical alternatives, or other coverage arrangements. No actions will be taken under this Agreement against the Provider: including refusal to contract or renew a contract, termination, refusal to refer Members, refusal to compensate Provider for Covered Services that are medically necessary solely on the basis of a medical communication between Provider and a Member, or on the basis of Provider's advocacy on the Member's behalf. Member advocacy means a Provider's good faith communication to state or federal authorities regarding an act or practice by ValueOptions that jeopardizes the Member's health or welfare or Provider communication on behalf of the Member related to the utilization review program or grievance procedures.

3. Balance Billing. In accordance with N.D. Cent. Code § 26.1-47-02, in the event that ValueOptions fails to pay Provider for Covered Services as set forth in the Agreement, the Member shall not be liable to Provider for any sums owed by ValueOptions. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

4. Continuity of Care. In the event of ValueOptions' insolvency, the Provider agrees to continue inpatient health care services for a Member for the period for which premium has been paid and until the Member's discharge from the inpatient facility. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

5. Indemnification. The following shall be added to any existing provision in the Agreement regarding indemnification, if applicable:

This provision is not intended to transfer to Provider any liability relating to ValueOptions' negligence, willful misconduct, or breach of contract, or require Provider to waive any right to seek legal redress against ValueOptions.

6. Incentives to Withhold Medically Necessary Care. In accordance with N.D. Cent. Code § 26.1-04-03, nothing in this Agreement shall be construed as an incentive plan or specific payment made to or withheld from Provider as an inducement to deny, reduce, limit, or delay medically necessary care covered by a Member's health benefit plan.

7. Payment of Claims. To the extent any provision of the Agreement conflicts with N.D. Cent. Code § 26.1-36-37.1 or any successor provisions regarding payment of claims, those provisions shall be amended for both parties to comply with that law. This provision shall be construed with Applicable Law to determine whether that law applies to a particular claim.

## OHIO STATE PROVISIONS

I. The agreement is amended by the following defined terms:

1. *The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following: (i) placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (ii) serious impairment to bodily functions; and (iii) serious dysfunction of any bodily organ or part.*

2. For the purposes of this Amendment, "Health Delivery Network" means any group of providers or health care: (i) facilities, or both, or any representative thereof, that have entered into an agreement to offer health; and (ii) services in a panel rather than on an individual basis.

3. For the purposes of this Amendment, “Subcontractor Organization” shall mean a health delivery network: (i) or other entity that contracts with licensed health insuring corporations or self-insured employers, or (ii) both to provide health care services and that enters into contractual arrangements with other entities for the provision of health care services for the purpose of fulfilling the terms of its contracts with health insuring corporations and self-insured employers.

II. The following provisions are added to the Agreement and are applicable to Providers rendering services to Health Insuring Corporation (HMO) Members only.

1. Provider Responsibility. The specific Covered Services for which ValueOptions holds Provider responsible for, including any limitations or conditions on such services, are contained in the Agreement, and amendments thereto and the provider manual.

2. Policies, Procedures and Programs. ValueOptions and Provider shall comply with and be bound by all applicable ValueOptions policies, procedures and programs including, but not limited to, those relating to payment systems, utilization review, quality assurance, assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs. Such policies, procedures and programs may be amended by ValueOptions from time to time. Such policies, procedures and programs may be contained in ValueOptions’ provider manual. ValueOptions shall provide Provider with such policies, procedures and programs upon request, including any amendments thereto.

3. Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by ValueOptions, insolvency of ValueOptions, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, person to whom health care services have been provided, or person acting on behalf of the Member, for health care services provided pursuant to this Agreement. This does not prohibit Provider from collecting coinsurance or copayments as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against ValueOptions or its successor. Except as specified herein, Provider shall seek compensation solely from ValueOptions. This provision shall survive termination of the Agreement with respect to Covered Services provided under the Agreement during the time the Agreement was in effect, regardless of the reason for termination, including insolvency of ValueOptions. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

4. Continuity of Care.

(a) In the event ValueOptions is insolvent or discontinues operations, Provider shall continue to provide Covered Services to Members as needed to complete any medically necessary covered services commenced but unfinished at the time of ValueOptions’ 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. If a Member is receiving necessary inpatient care at a hospital, Provider shall continue to provide care until the earlier of:

- (i) the Member’s discharge from the hospital;
- (ii) a determination by Member’s attending physician that inpatient care is no longer medically indicated for the Member;
- (iii) the Member reaching the limit for contractual benefits;
- (iv) the effective date of any new coverage; or
- (v) thirty (30) days after ValueOptions’ insolvency or discontinuance of operations.

(b) Provider shall not be required to continue to provide Covered Services after the occurrence of any of the following:

- (i) the end of the thirty (30) day period following the entry of a liquidation order against ValueOptions under Chapter 3903 of the Revised Code;
- (ii) the end of Member’s period of coverage for a contractual prepayment or premium;
- (iii) the Member obtains equivalent coverage with another plan or insurer or Member’s employer obtains such coverage for the Member;

- (iv) the Member or Member's employer terminates coverage; or
- (v) a liquidator effects a transfer of ValueOptions' obligations under the Agreement under division (A)(8) of section 3903.21 ORC.

These provisions shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with these provisions and are permitted by Applicable Law.

5. Medical Records. Provider shall make available Members' medical records to ValueOptions for the purpose of monitoring and evaluating the quality of care, to conduct evaluations and audits and to determine on a prospective, concurrent and retrospective basis the necessity of and appropriateness of health care services provided to Members. Provider shall make such medical records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating grievances or complaints of Members. ValueOptions and Provider will at all times maintain the confidentiality of Members' medical records and other protected health information regarding a Member in accordance with Applicable Law.

6. Assignment/Delegation. Provider may not assign its rights nor delegate its responsibilities under this Agreement without the prior written consent of ValueOptions. This provision shall not supercede additional provisions in the Agreement related to assignment and/or delegation if such provisions do not conflict with this provision and are permitted by Applicable Law.

7. Insurance. Provider shall procure and maintain at all times during the term of this Agreement adequate professional liability and malpractice insurance. Provider shall notify ValueOptions, in writing, not more than ten (10) days after the Provider's receipt of notice or any reduction or cancellation of such coverage.

8. Rights of Enrollees. Provider shall observe, protect, and promote the rights of Members as patients.

9. Nondiscrimination. Provider shall provide Covered Services and other health care services without discrimination on the basis of a Member's participation in ValueOptions, age, sex, ethnicity, religion, sexual preference, health status or disability and without regard to the source of payments made for Covered Services and other health care services rendered to a Member. This requirement shall not apply to circumstances when the Provider does not render services due to limitations arising from the Provider's lack of training, experience or skill or due to licensing restrictions.

10. Coverage Requirement. If Provider is a primary care physician, Provider shall be available to provide or arrange for the provision of Covered Services twenty-four (24) hours per day, seven (7) days per week.

11. Dispute Resolution. In the event of any dispute arising out of this Agreement, the parties agree to attempt in good faith to resolve the dispute.

12. No Inducements, Limitations or Penalties. In accordance with section 1751.13 ORC, 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 a Member;
- (b) penalize Provider when Provider assists a Member in seeking a reconsideration of ValueOptions' decision to deny or limit benefits to Members;
- (c) limit or otherwise restrict Provider's ethical and legal responsibility to fully advise Members about their medical condition and about medically appropriate treatment options;
- (d) penalize Provider for principally advocating for medically necessary health care services; or
- (e) penalize Provider for providing information or testimony to a legislative or regulatory body or agency. This shall not prohibit ValueOptions from penalizing Provider that provides information or testimony that is libelous or slanderous or that discloses trade secrets which Provider has no privilege or permission to disclose.

13. Health Care facilities. If Provider is a health care facility, Provider agrees that ValueOptions is responsible for monitoring and overseeing the offering of Covered Services to Members.

14. Termination of Agreement. To the extent required by law, ValueOptions shall terminate Agreement in accordance with section 1753.09 ORC. Additionally, ValueOptions shall notify affected Members of the termination of the Agreement between ValueOptions and Provider in accordance with section 1751.13 ORC if Provider is a primary care physician (PCP) or hospital.

15. Use of Name. Provider authorizes ValueOptions to include Provider in provider directories. ValueOptions shall obtain prior approval from Provider for inclusion of Provider's name and address in any other marketing materials.

16. Notice of Amendment to Agreement. To the extent required by law, ValueOptions shall provide Provider with notice of an amendment to this Agreement and to any document incorporated by reference into the Agreement in accordance with section 1753.08 ORC if the amendment of the document directly and materially affects the Provider.

17. Subcontractor Agreements. If Provider is an Subcontractor Organization, the following additional provisions are added to the Agreement:

(a) ValueOptions must approve or disapprove the participation of any provider or health care facility with which the Subcontractor Organization contracts.

(b) If Subcontractor Organization accepts compensation, Subcontractor Organization shall provide the Superintendent of the Ohio Department of Insurance with regulatory access to all books, records, financial information and documents related to the provision of health care services to Members under this Agreement. Subcontractor Organization shall maintain such books, records, financial information, and documents at its principal place of business in the state of Ohio for at least three (3) years in a manner that facilitates regulatory review.

(c) If the Subcontractor Organization is not a Health Delivery Network contracting solely with self-insured employers subcontracts with a Provider, ValueOptions is a third party beneficiary to the subcontract and must approve or disapprove the participation of any provider or health care facility with which the Subcontractor Organization contracts.

18. Terms used in agreement. Terms used in this Agreement that are defined by Ohio law shall be construed in this Agreement in a manner consistent with the law.

III. The following provision is added to the Agreement and is applicable to Providers rendering services to insured and Health Insuring Corporation (HMO) Members.

Claim Payments. To the extent required by Applicable Law, ValueOptions and Provider shall comply with OAC sections 3901-1-59 and 3901-1-60 and ORC sections 3901.38 through 3901.3814.

### **OKLAHOMA STATE PROVISIONS**

1. The Agreement is amended by the following defined terms.

(a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term: "Clean Claim" means a claim that has no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstance requiring special

treatment that impedes prompt payment. References in the Agreement to “claims” shall be construed to mean “Clean Claims” in accordance with Applicable Law.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. “Emergency” means, as defined by Applicable Law, a medical condition arising from any injury, illness, or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent layperson would believe that the absence of medical attention could result in serious jeopardy to the Member’s health, or impairment of any bodily function, or dysfunction of any bodily organ or part.

2. Provider/Patient Relationship. In accordance with 63 Okl. St. §2525.5(A)(10), nothing in this Agreement shall be construed to penalize, preclude or discourage Provider’s ability to advocate on behalf of a Member for appropriate and medically necessary health care or to inform a Member of the care a Member requires, including treatments or services not covered under Member’s benefit plan.

3. Indemnification. Nothing in this Agreement shall be construed to require Provider to indemnify ValueOptions for liability imposed by the Managed Health Care Reform and Accountability Act (36 Okl. St. §6591 *et seq.*) or any other Applicable Law.

4. Termination.

(a) Either party may terminate this Agreement for any reason by giving at least ninety (90) days written notice to the other party.

(b) ValueOptions may terminate this Agreement immediately upon written notice if ValueOptions determines, in its reasonable judgment, that Provider's continued participation may jeopardize the health or safety of Members.

(c) To the extent required by Applicable Law, ValueOptions will provide on request the reasons for any involuntary termination of this Agreement if this Agreement is terminated or not renewed for cause.

(d) This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

5. Continuity of Care after Termination.

(a) In the event that the Agreement is terminated for reasons other than cause, Provider agrees to provide continued Covered Services in accordance with Applicable Law for a period of up to ninety (90) calendar days from the date of notice to Member, for a Member who: (i) has a degenerative and disabling condition or disease; (ii) is terminally ill; or (iii) has entered the third trimester of pregnancy. Additional Covered Services shall continue through the completion of pregnancy to include at least six (6) weeks of postpartum evaluation.

(b) ValueOptions shall not be required to provide for such continuation of care, in accordance with Applicable Law, if Provider’s Agreement is terminated because of the suspension or revocation of the Provider’s license, or for reasons related to the quality of health care services rendered, or for issues related to the health, safety or welfare of Members.

(c) This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

6. Recoupment of Overpayments. To the extent permitted, refund of overpayments of all or any portion of a claim shall be made in accordance with Applicable Law.

## **OREGON STATE PROVISIONS**

I. The Agreement is amended by the following defined terms:

(a) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Clean Claim” means a claim that has no defect, impropriety, lack of any required substantiating documentation or particular circumstance requiring special

treatment that prevents timely payment. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

II. The following provisions are added to the Agreement and are applicable only to Providers rendering services to HCSC and insured Members as required by Applicable Law.

1. Appeals of Payment Denials. To the extent required by Oregon Revised Statutes § 743.807(2)(c) and any other Applicable Law, Provider shall be afforded an opportunity for a timely appeal before an appropriate medical consultant or peer review committee of any request for payment for services denied as not medically necessary or as experimental.
2. Continuity of Care. If Provider terminates this Agreement for any reason or ValueOptions terminates the Agreement without cause, then a Member undergoing an active course of treatment that is medically necessary and, Provider and Member agree that it is desirable to maintain continuity of care, the Member shall be allowed to continue care as required by Oregon Revised Statutes § 743.854 as follows: (a) a Member under active treatment for a particular injury or sickness may continue to receive Covered Services from Provider for such injury or sickness until the earlier of: (i) the day following the date on which the active course of treatment is completed; or (ii) for a period of one hundred twenty (120) days from the date of notice of termination; and (b) a Member undergoing care for a pregnancy who is in the second trimester of pregnancy may continue to receive Covered Services from Provider until the later of the 45<sup>th</sup> day after the birth or as long as the Member continues under an active course of treatment, but not later than one hundred twenty (120) days from the date of notice of termination. The foregoing shall only apply if Provider agrees to continue to be bound by the terms, conditions, and reimbursement rates contained in this Agreement. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this Amendment and are permitted by Applicable Law.
3. Provider/Patient Responsibility. Nothing in the Agreement or this Amendment shall be construed to permit ValueOptions to terminate or otherwise financially penalize Provider for communicating or providing information to a Member that is not slanderous, defamatory or intentionally inaccurate concerning any aspect of the Member’s medical condition, any proposed treatment or treatment alternatives, whether they are Covered Services or not, or Provider’s financial arrangement with ValueOptions.
4. Referrals. Nothing in the Agreement or this Amendment shall be construed to permit ValueOptions to terminate or otherwise financially penalize Provider for referring a Member to another provider, whether or not such provider had an agreement with ValueOptions; provided, however, that Provider must comply with ValueOptions’ written policies and procedures for such referrals, and Provider must inform Member that such services may not be covered by ValueOptions.
5. Member Hold Harmless. The following shall be added pursuant to Oregon Revised Statutes § 750.095: Provider agrees that in no event, including, but not limited to, nonpayment by ValueOptions, the insolvency of ValueOptions, or termination or breach of this Agreement, shall a Member be liable for any amount owing to Provider by ValueOptions, and Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on the Member’s behalf for Covered Services provided pursuant to this Agreement. Nothing in this provision shall impair the right of Provider to charge, collect from, attempt to collect from or maintain a civil action against a Member for deductible, copayment or coinsurance amounts, health care services not covered by ValueOptions or rendered after the termination of this Agreement. Nothing in this provision prohibits a Member from seeking noncovered services from Provider and accepting financial responsibility for these services nor Provider from contracting with Member for payment of services not within the scope of Covered Services. The provisions of this section shall: (i) survive the termination of this Agreement regardless of the cause giving rise to termination; (ii) be construed for the benefit of Members; and (iii) supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and any Member or persons acting on the Member’s behalf. This provision shall not supercede

provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

6. Payment of Claims. To the extent required by Applicable Law, Clean Claims will be process in accordance with Oregon Revised Statutes § 743.866 and § 743.868. Each party agrees to comply with the provisions of § 743.866 and § 743.868.

7. Indemnification. To the extent prohibited by Oregon Revised Statutes § 743.803, nothing in the Agreement shall be construed to require Provider to indemnify or hold harmless ValueOptions for tort or patent or copyright infringement liability that ValueOptions incurs, experiences, or causes by act or omission, or by act or omission of Provider to the extent the act or omission was pursuant to a directive of ValueOptions.

8. Termination Hearing. Upon the termination of Provider by ValueOptions, ValueOptions shall comply with and Provider shall be afforded such rights as are applicable under Oregon Revised Statute § 743.803(2).

9. Provider Right to Withdraw. Provider shall have the right to withdraw from the care of a Member when, in Provider's professional judgement, such withdrawal is in the best interest of the Member.

10. Recoupment. To the extent permitted under Applicable Law, retroactive denial of claims, including any recoupment process utilized by ValueOptions, will be processed in accordance with Oregon Administrative Rules 836-020-0740 and 836-020-0750. Provider shall be entitled to an annual accounting of the financial transactions between ValueOptions and Provider.

#### **PENNSYLVANIA STATE PROVISIONS**

1. The agreement is amended by the following defined terms:

(a) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means any health care service provided to a Member after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (1) placing the health of the Member or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. Emergency includes transportation and related emergency service provided by a licensed ambulance service.

(b) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Clean Claim" means a claim for payment for a health care service, which has no defect or impropriety. A defect or impropriety shall include lack of required substantiating documentation or a particular circumstance requiring special treatment which prevents timely payment from being made on the claim. The term shall not include a claim from a health care provider who is under investigation for fraud or abuse regarding that claim.

2. Claim Payment. To the extent any provision of the Agreement conflicts with 40 Pa. Stat. § 991.2166; 31 Pa. Code § 154.18 or any successor provisions regarding payment of claims, those provisions shall be amended for both parties to comply with that law. This provision shall be construed with Applicable Law to determine whether that law applies to a particular claim.

#### **RHODE ISLAND STATE PROVISIONS**

1. The agreement is amended by the following defined term:

The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Emergency" means as defined by Applicable Law, the sudden onset of a medical, mental or other substance abuse or other health condition, manifesting itself by acute symptoms of severity,

including severe pain, such that a prudent lay person, would believe that the absence of immediate medical attention could result in placing a Member's health in serious jeopardy, serious impairment to bodily or mental functions, or serious dysfunction of any bodily organ or part.

2. Actions. In accordance with Applicable Law, ValueOptions will provide due process for all adverse credentialing decisions which result in a change of Provider's contractual privileges, except that if ValueOptions has reason to suspect that there is immediate danger to a Member, ValueOptions will notify the Director of Health immediately and take the appropriate action to protect Members. Such due process shall include the following:

(a) Provider will be notified by ValueOptions in writing of the proposed actions or immediate action and of the reasons for the proposed action;

(b) **Provider may request an appeal of the proposed actions prior to the effective date of the proposed action, in accordance with ValueOptions' internal appeal process. Provider may waive in writing any due process rights; however, such waiver is not required as a condition of this Agreement.**

3. Termination and Continuity of Care.

(a) Neither party may terminate the Agreement without cause; however, cause shall include the lack of need due to economic considerations.

(b) The Agreement may be terminated by ValueOptions upon ninety (90) days prior written notice, in the event that ValueOptions determines due to economic considerations, it no longer needs Provider as a contracting provider. Such determination shall be made at ValueOptions' sole discretion.

(c) The Agreement may be terminated by Provider as a result of a notice from ValueOptions of a proposed contractual change within sixty (60) calendar days of receipt of the notice. Such termination shall be effective fifteen (15) days from the mailing of the notice of termination.

(d) In the event that the Agreement is terminated by either party, Provider agrees to continue to provide Covered Services in accordance with the terms and conditions of this Agreement, including compensation, to any Member in active treatment for an acute medical condition at the time of the termination of this Agreement, until the active treatment is concluded or, one (1) year after the termination, whichever is earlier.

(e) These termination provisions shall not supercede longer notice periods set forth in the Agreement if such provisions are permitted by Applicable Law. Nor shall this provision supercede any additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

4. Provider/Patient Relationship. ValueOptions shall not refuse to contract with or compensate Provider for Covered Services solely because Provider has in good faith communicated with one or more of his/her patients regarding the provisions, terms, or requirements of ValueOptions' health plan, as they relate to the needs of Provider's patient.

5. Claim Payment. Both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to Rhode Island General Law §27-18-61. To the extent any provision of the Agreement conflicts with the requirements of Applicable Law, those provisions shall be amended hereby to comply with that law.

6. Amendments. In accordance with Applicable Law, the Agreement may be amended by ValueOptions upon sixty (60) days prior written notice by mail to Provider of any proposed changes to the Agreement, including but not limited to changes that affect utilization review and management activities or payment or coverage policies. Such notice shall contain an explanation of the contractual changes in non-technical terms to include the impact of the proposed changes. Provider may either agree to the proposed amendments to the Agreement or terminate the Agreement as a result of the proposed changes within sixty (60) calendar days of receipt of the notice.

7. Financial Inducements. In accordance with Applicable Law, nothing in the Agreement shall be construed to provide a specific payment directly or indirectly to Provider as an inducement or incentive to reduce or limit services, to reduce the length of stay or the use of alternative treatment settings or the use of a particular medication with respect to a Member. Notwithstanding the foregoing, this provision does not restrict the use of capitation agreements and similar risk sharing arrangements.

8. Non-Exclusivity of Agreement. In accordance with Applicable Law, nothing in the Agreement shall be construed to compel Provider to render services exclusively to Members in order to be a Participating Provider.

9. Overpayment Recoupment. To the extent permitted by Applicable Law, retroactive denial of claims, including any recoupment process utilized by ValueOptions, will be administered in accordance with Applicable Law.

## **SOUTH CAROLINA STATE PROVISIONS**

I. The Agreement is amended by the following defined term:

The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a medical condition manifesting itself acute symptoms of such sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the Member, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

II. The following provisions are added to the Agreement and are applicable to Providers rendering services to insured Members.

1. Retrospective Denials. ValueOptions will not retrospectively deny or reduce payments to Providers for Emergency medical care of a Member even if it determined that the Emergency initially presented is later identified through screening not to be an actual Emergency, except as follows: (a) material misrepresentation, fraud, omission or clerical error; (b) a payment reduction due to applicable copayments, coinsurance, or deductibles which may be the responsibility of the Member; (c) cases in which the Member does not meet the Emergency definition, unless the Member has been referred to the emergency department by the Member’s primary care physician or other agent acting on behalf of ValueOptions.

2. Liability for Negligent Acts or Omissions. In accordance with S.C. Code Ann. section 38-71-1740 (A)(1), Provider shall be liable for any and all legal consequences and costs of its acts or omissions, or both, and is not responsible for the acts or omissions, or both, of ValueOptions. ValueOptions shall be liable for any and all legal consequences and costs of its acts or omissions, or both, and is not responsible for the acts or omissions, or both, of Provider.

3. Provider/Patient Relationship. In accordance with S.C. Code Ann. section 38-71-1740 (A)(2), this Agreement in no way limits Provider’s ability to discuss with a Member the treatment options available to the Member, risks associated with treatments, utilization management decisions, and recommended courses of treatment. Additionally, this Agreement does not limit a Provider’s legal obligation to a Member as specified under the Provider’s professional license. ValueOptions, however, prohibits Provider from disclosing trade secrets. Additionally, nothing herein is intended to subject ValueOptions to liability for clinical decisions made solely by Provider and nothing herein limits the ability of ValueOptions to prudently administer this Agreement.

## **SOUTH DAKOTA STATE PROVISIONS**

1. The Agreement is amended by the adding the following defined terms:

(a) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Clean Claim” means a claim for which there is no need for additional information to determine eligibility or adjudicate the claim. The term, clean claim, does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law or a claim for which fraud is suspected.

(b) The term “Emergency Medical Condition” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency Medical Condition” means a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person’s health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

2. Provider/Patient Relationship. In accordance with S.D. Codified Laws § 58-17C-14, ValueOptions shall not prohibit or penalize Provider from discussing treatment options with Members, irrespective of ValueOptions’ position on the treatment options, from advocating on behalf of Members within the utilization review or grievance processes established by ValueOptions, or from reporting to state or federal authorities in good faith any act or practice by ValueOptions that jeopardized a Member’s health or welfare.

3. Hold Harmless. In accordance with S.D. Codified Laws § 58-17C-14, in no event shall Provider collect or attempt to collect from a Member any money owed to Provider by ValueOptions nor may Provider have any recourse against Members for any Covered Services in excess of the copayment, coinsurance, or deductible amounts specified in the Member’s health benefit plan. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

4. Continuity of Care. In the event of termination of the Agreement without cause, ValueOptions agrees to permit a Member to continue an ongoing course of treatment for ninety (90) days following the effective date of termination, upon request of the Member or Provider. The Provider agrees to be bound by the terms of the Agreement during the ongoing course of treatment. In the case of a Member who has entered the second trimester of pregnancy on the effective date of termination, the continuation of coverage shall extend to the provision of postpartum care that is directly related to the delivery. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

5. Confidentiality and Health Records. Provider shall make health records available to ValueOptions upon request, but only those 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. Any individual provided records under this provision shall maintain the confidentiality of such records and may not make such records available to any other person who is not legally entitled to such records.

6. Payment of Claims. To the extent any provision of the Agreement conflicts with S.D. Codified Laws § 58-12-20 or any successor provisions regarding payment of claims, those provisions shall be amended for both parties to comply with that law. This provision shall be construed with Applicable Law to determine whether that law applies to a particular claim.

## TENNESSEE STATE PROVISIONS

### I. The Agreement is amended by the following defined terms:

1. The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law: “Clean Claim” means a claim received by ValueOptions that requires no further information, adjustment or alteration by Provider in order to be processed and paid by ValueOptions. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstance requiring special treatment that prevents the claim from being timely paid.

2. The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to

potentially result in: (1) placing the person's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

II. The following provisions shall be added to the Agreement.

1. Emergency services shall be covered in accordance with Applicable Law, including T.C.A. Section 56-7-2355.
2. To the extent required by Applicable Law, Clean Claims shall be processed in accordance with T.C.A. Sections 56-7-109 and 56-32-226, and the parties shall each comply with the requirements contained therein.
3. To the extent required by T.C.A. Section 56-2-124, nothing in the Agreement shall be construed to require Provider to indemnify or hold harmless ValueOptions for tort or patent or copyright infringement liability that ValueOptions incurs, experiences, or causes by act or omission, or by act or omission of Provider to the extent the act or omission was pursuant to a directive of ValueOptions.
4. The following shall be added pursuant to T.C.A. Section 56-32-205:

Provider agrees that in no event, including, but not limited to, nonpayment by ValueOptions or Payor, the insolvency of Payor or ValueOptions, or termination or breach of this Agreement, shall a Member be liable for any amount owing to Provider by Payor, and Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on the Member's behalf for Covered Services provided pursuant to this Agreement. The provisions of this section shall: (i) survive the termination of this Agreement regardless of the cause giving rise to termination; (ii) be construed for the benefit of Members; and (iii) supersede any oral or written contrary agreement now existing or hereafter entered into between Provider and any Member or persons acting on the Member's behalf. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

5. Nothing in this Agreement shall be construed as prohibiting Provider from disclosing to a Member the existence of financial arrangements with ValueOptions that reward Provider for reducing or limiting the range and amount of medically necessary and appropriate services rendered to Members.

6. This Agreement shall be construed to comply with T.C.A. Sections 56-32-230 and 56-7-2349 regarding member communications and provider protections.

7. If Provider terminates this Agreement for any reason or ValueOptions terminates the Agreement without cause, then a Member shall be allowed to continue care as required by T.C.A. Section 56-7-2358 as follows: (1) a Member under active treatment for a particular injury or sickness may continue to receive Covered Services from Provider for such injury or sickness for a period of one hundred twenty (120) days from the date of notice of termination; (2) a Member in the second trimester of pregnancy may continue to receive Covered Services from Provider until completion of postpartum care; (3) a Member being treated by an inpatient facility may remain at the facility until the Member is discharged. The foregoing shall only apply if Provider agrees to continue to be bound by the terms, conditions, and reimbursement rates contained in this Agreement. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

8. Effective January 1, 2004, to the extent required by Applicable Law, retroactive denial of claims, including any recoupment process utilized by ValueOptions, shall be processed in accordance with T.C.A. § 56-7-110 (Chapter 257 of the Public Acts of 2003).

### **TEXAS STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:

- (a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Clean Claim" means a non-electronic claim submitted

by Provider for health care services rendered to a Member that includes the required data elements set forth in 28 Tex. Admin. Code § 21.2803(b) and, if applicable, the amount paid by the primary plan or other valid coverage pursuant to 28 Tex. Admin. Code § 21.2803(c); and, means an electronic claim submitted by Provider for health care services rendered to a Member using the ASC X12N 837 format and in compliance with all Applicable Law related to electronic health care claims, including applicable implementation guides, companion guides, and trading partner agreements. References in the Agreement to “claims” shall be construed to mean “Clean Claims” to the extent required by Applicable Law.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: “Emergency” means a medical condition of a recent onset that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care attention to potentially result in: (1) placing the person’s health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or, (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

2. Provider/Patient Relationship. Nothing in this Agreement shall be construed to discourage or prohibit Provider from discussing or communicating in good faith with a Member or a Member’s authorized representative information or opinions regarding Member’s health care, including but not limited to Member’s medical condition or treatment options, or information or opinions regarding the provisions, terms, requirements or services of the health care plan, including out-of-network referral requirements, as they relate to the medical needs of the Member; or the status of Provider’s participation in ValueOptions’ network. ValueOptions shall not in any way penalize, terminate, or refuse to compensate Provider for Covered Services for discussing any matter pursuant to this provision with a Member or the Member’s authorized representative. ValueOptions shall not engage in any kind of retaliatory action, including termination of or refusal to renew a contract, against Provider because Provider has, on behalf of a Member, reasonably filed a complaint or has appealed a ValueOptions decision.

3. The provision titled or relating to “Indemnification,” if applicable, is amended to also contain the following:

This provision shall not be construed to require Provider to indemnify ValueOptions for any liability in tort resulting from an act or omission of ValueOptions.

4. The following provisions are added to the section titled “Term and Termination” or other comparable provisions:

ValueOptions may terminate this Agreement by written notice to Provider at least ninety (90) days prior to the effective date, except in cases of imminent harm to the Member’s health, adverse actions against the Provider’s license to practice, or fraud as defined in the Texas Insurance Code, where termination of the Agreement shall be immediate. ValueOptions shall provide a written explanation to Provider of the reasons for termination.

(a) Within thirty (30) days of the receipt of the notice of termination, Provider shall be entitled, on request, to a review of ValueOptions’ proposed termination by an advisory review panel. Provider shall not be entitled to a review by an advisory panel under the following circumstances: (1) cases involving imminent harm to the Member’s health, (2) the Provider’s fraud or malfeasance, (3) an action by a state medical or dental board, or other licensing board or other government agency that effectively impairs Provider’s ability to render services under this Agreement. The advisory review panel shall be composed of physicians and providers who are appointed to serve on ValueOptions’ standing quality assurance committee or utilization management committee, including at least one representative in Provider’s specialty or a similar specialty, if available. ValueOptions shall consider the recommendation of the advisory review panel but will not be bound by its recommendation. Upon Provider’s request, ValueOptions shall provide a copy of the recommendation of the advisory review panel and ValueOptions’ determination.

(b) Provider shall be entitled to an expedited review of a proposed termination by ValueOptions upon ValueOptions’ receipt of the Provider’s request.

(c) ValueOptions shall provide notice to Members currently receiving treatment from Provider at least thirty (30) days before the effective date of the termination. ValueOptions may notify such Members immediately if Provider is terminated for reasons related to imminent harm. Provider shall provide reasonable advance notice

to Members currently receiving treatment from Provider in cases where the Provider voluntarily terminates the Agreement.

(d) This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

5. Continuity of Care. Following termination of the Agreement, Provider shall continue to provide Covered Services and ValueOptions shall continue to reimburse Provider for Covered Services rendered to a Member of special circumstance, which shall include a Member who has a disability, acute condition, or life-threatening illness or is past the twenty-fourth (24<sup>th</sup>) week of pregnancy. For the purposes of this provision, “special circumstance” means a condition identified by Provider such that Provider reasonably believes that discontinuing care by Provider could cause harm to the Member. Provider shall request that a Member be permitted to continue treatment under Provider’s care and disputes regarding the necessity for continued treatment shall be resolved in accordance with the procedures described in the Agreement and the provider handbook. This provision does not extend ongoing treatment of a Member beyond ninety (90) days after the effective date of the termination, or beyond nine months in the case of a Member who at the time of the termination has been diagnosed with a terminal illness. If the Member is past the twenty-fourth (24<sup>th</sup>) week of pregnancy at the time of the effective date of termination, ValueOptions shall reimburse Provider for services provided to the Member through the delivery of the child to include immediate postpartum care and a follow-up checkup within the first six weeks of the delivery. Provider and ValueOptions agree to follow the terms of the Agreement following the effective date of termination with respect to continuation of such Covered Services. This provision shall not apply in cases where the termination is for reasons of medical competence or professional behavior. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

6. Claims Submission and Payment. To the extent required by Applicable Law, Clean Claims shall be processed by ValueOptions and submitted by Provider in accordance with Tex. Ins. Code § 1301.101 through § 1301.110, §§ 843.336-.346; 28 Tex. Admin. Code §§ 21.2801-.2825, or any successor provisions regarding payment of claims. Provider shall submit claims for Covered Services within ninety-five (95) days after Covered Services were rendered and claims submitted after this claims submission period are subject to forfeiture. ValueOptions agrees that it will, no later than the forty-fifth (45<sup>th</sup>) day after the date of receipt of a Clean Claim from the Provider in a non-electronic format or the thirtieth (30<sup>th</sup>) day following the receipt of a Clean Claim in an electronic format, make a determination of whether the claim is payable; and, (i) pay the total amount of the claim in accordance with the Agreement if the entire claim is payable; or, (ii) pay the portion of the claim that is not in dispute and notify Provider in writing why the remaining portion of the claim will not be paid; or, (iii) notify Provider in writing why the claim will not be paid if ValueOptions determines that the claim is not payable. ValueOptions reserves the right to audit a Clean Claim, and request additional information from Provider or other sources, and will furnish the appropriate appeal rights due under Applicable Law for disputes under this provision.

7. Availability of Claims Payment Information. Pursuant to Tex. Ins. Code art. 3.70-3C, sec. 3H, § 843.319; 28 Tex. Admin. Code §§ 3.3703(a)(20), 11.901(11), ValueOptions will provide within thirty (30) days of receipt of a reasonable and verifiable request from Provider all information necessary for Provider to determine that Provider is being compensated in accordance with the Agreement, to include applicable fee schedules, addenda, exhibits or policies, coding guidelines, bundling processes, downcoding policies, and the publisher, product name, edition and model version of the software used to determine bundling and unbundling of claims (collectively referred to herein as “Claims Payment Information”). ValueOptions shall provide Claims Payment Information at a level of detail sufficient to enable a reasonable person with sufficient training, experience and competence in claims processing to determine the payment to be made in accordance with the Agreement.

(a) ValueOptions shall provide Claims Payment Information by any reasonable method at its discretion whether via e-mail, computer disks, paper, or via access to an electronic database.

b) ValueOptions shall provide at least ninety (90) days written notice of any change to Claims Payment Information, identifying with specificity the amendment or revision. ValueOptions may not make retroactive changes to Claims Payment Information. Nothing in this paragraph supercedes any provision in the Agreement governing amendments to the Agreement that require mutual consent.

(c) Provider may terminate the Agreement without penalty or discrimination on or before the thirtieth (30<sup>th</sup>) day after Provider receives the information requested above.

(d) Provider receiving information pursuant to this section may only use or disclose the Claims Payment Information for the purpose of practice management, billing activities and other business operations, or disclose the information to a governmental agency involved in the regulation of health care or insurance. Claims Payment Information may not be relied upon as a representation that a Member is covered for a particular health care service. Provider shall not use Claims Payment Information received pursuant to this section to knowingly submit a claim for payment that does not accurately represent the level, type or amount of services that were actually provided to a Member or to misrepresent any aspect of the services; and shall not rely upon such information about a service as a representation that a Member is covered for that service under the terms of the Member's group subscriber contract.

(e) Nothing in this section shall be construed to require ValueOptions to violate any applicable copyright law or licensing agreement.

8. Recoupment of Claims. ValueOptions may recover an overpayment to Provider if ValueOptions provides written notice that includes the basis and the specific reasons for the request for recovery to Provider within 180 days following the Provider's receipt of payment. Provider shall make arrangements to repay the requested funds within forty-five (45) days of the receipt of ValueOptions' request. If Provider disagrees with the request, ValueOptions shall provide an appeal to Provider if notice is received by ValueOptions of the intent to appeal within forty-five (45) days of ValueOptions' request and ValueOptions shall not recover the funds until all appeal rights are exhausted. Any recoupment process described in this subsection, will be processed by ValueOptions in accordance with Tex. Ins. Code art. 3.70-3C, sec. 3D, and § 843.350.

9. Coordination of Payment. Provider shall retain in the Provider's records updated information concerning other health benefit plan coverage of Members and shall provide the information to ValueOptions on the applicable form used to submit a claim to ValueOptions. This provision shall not be construed to require Provider to investigate coordination of other health benefit plan coverage, except as provided herein. In the event that Provider submits a claim for health care services to more than one health maintenance organization or insurer, Provider shall provide written notice on the claim submitted to each the identity of each other health maintenance organization or insurer with which the same claim is being filed. On receipt of written notice from Provider, ValueOptions shall coordinate and determine the appropriate payment for each health maintenance organization or insurer to make to the Provider. If ValueOptions overpays the claim as the secondary payor under circumstances where the primary payor also paid the claim, ValueOptions may recover the amount of overpayment under the provisions of the Agreement regarding overpayments to the Provider. If ValueOptions processes an electronic claim as a secondary payor, it shall rely on the primary payor information submitted on the claim by the Provider.

The Agreement is amended by the following provisions, which are applicable to Members receiving services under a health maintenance organization policy:

1. Notice of Complaint and Grievance Procedures. Provider shall post a notice to Members in the Provider's office that describes the process for resolving complaints with ValueOptions, and shall include the Texas Department of Insurance's toll free telephone number for filing a complaint.

2. Hold Harmless. Provider agrees that in no event, including, but not limited to non-payment by ValueOptions, ValueOptions' 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 the Member or the Member's authorized representative for services provided pursuant to this Agreement. This provision shall not prohibit collection of deductibles, coinsurance, or copayments on ValueOptions' behalf made in accordance with the terms of the Member's health benefit plan. The 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 Member; and,

(b) This provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and the Member or the Member's authorized representative. Any modifications, addition, or deletion to the provisions of this clause shall be effective on a date no earlier than fifteen (15) days after the commissioner of the Texas Department of Insurance has received written notice of such proposed changes.

This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

3. Payment of Capitation. To the extent ValueOptions employs capitation as a method of payment to the Provider, payment of capitated amounts to the primary care physician shall begin no later than sixty (60) days following the selection or assignment of the primary care physician. ValueOptions shall notify Provider of the selection of Provider as a primary care physician within thirty (30) days of the selection or assignment. This provision shall not be construed as restricting the Member's right under Tex. Ins. Code § 843.315 to reject and select another primary care physician or other rights conferred under those provisions. Capitation means a method of compensating the Provider for arranging for or providing a defined set of health care services to Members that is based on a predetermined payment per Member for the specified period, without regard to the quantity of services actually provided.

The Agreement is amended by the following provisions, which are applicable to Members receiving services under a non- health maintenance organization health insurance policy:

1. Exclusivity of Preferred Provider Agreements. Nothing in this Agreement shall be construed to restrict the Provider's right to enter into preferred provider contracts with other preferred provider organizations, health maintenance organizations, or insurers.

2. Financial Incentives. Nothing in the Agreement shall be construed to create a financial incentive or disincentive 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. This provision shall not be construed to prohibit the savings from cost-effective utilization of health services by Provider from being shared with health care providers in the aggregate.

3. Resolution of Complaints. To the extent required by 28 Tex. Admin. Code § 3.3706, complaints under the Agreement shall be resolved in accordance with the appeal procedures described in the Agreement or in the provider handbook. Such procedures shall afford Provider a review of the complaint by an advisory review panel composed of not less than three individuals selected by ValueOptions from its network in the applicable service area. At least one of the three individuals on the advisory review panel shall be a provider in the same or similar specialty as the Provider requesting review unless there is no network provider in the same or similar specialty.

4. Hold Harmless. Provider agrees in accordance with 28 Tex. Admin. Code § 3.3703(10) that in no event may it bill, charge, seek compensation, remuneration, or reimbursement from a Member or the Member's authorized representative for any amounts in excess of the discounted fee contained in the fee schedule of the Agreement based upon the Provider's full billed charge. This provision shall not preclude Provider from collecting the applicable co-payment, deductible, or coinsurance specified in the Member's benefit plan. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

5. Quality of Care. To the extent that ValueOptions engages in quality assessment, defined as a program of evaluating, monitoring, or improving the quality and effectiveness of the medical care delivered by Providers to Members to ensure that care is delivered consistent with that of an ordinary, reasonable, prudent provider under the same or similar circumstances, ValueOptions acknowledges its obligation to comply with Tex. Ins. Code § 1301.059 requiring that quality assessment activities utilize a panel of not less than three network providers in the applicable service area.

## **UTAH STATE PROVISIONS**

1. The Agreement is amended by the following defined term:

The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term: "Emergency" means, as defined by Applicable Law, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson, having an

average knowledge of medicine and health, would believe that the absence of immediate medical attention could result in placing a Member's health in serious jeopardy, serious impairment to bodily functions, serious dysfunction of any bodily organ or part; or seriously jeopardize the health of the woman or her unborn child.

2. Provider/Patient Relationship. Nothing in the Agreement or this Amendment shall be construed to limit Provider's ability to advise Members fully about treatment options or other issues that affect the health care of the Member.
3. Continuity of Care. In the event of the insolvency of ValueOptions, Provider shall continue to provide Covered Services to Members for a period of ninety (90) days after the date of the filing of the petition for rehabilitation or liquidation, or after the date the term of this Agreement ends, whichever is earlier, where the continuation of such care is medically necessary and in accordance with the dictates of medical prudence, as well as where the Member has special circumstances, such as a disability, a life threatening illness, or is in the third trimester of pregnancy. During such time that Provider continues to provide Covered Services to Members in accordance with this provision, all terms of the Agreement, including compensation, will remain in effect. Except for applicable copayments, deductibles, and coinsurance, Provider shall not bill Members for Covered Services provided pursuant to this provision. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision.
4. Member Hold Harmless. Provider agrees to accept payment for Covered Services specified in the Agreement as payment in full, and relinquishes the right to collect additional amounts from Members, other than any applicable deductibles, coinsurance or copayments specified in the applicable group subscriber contract. In the event ValueOptions fails to pay Provider for Covered Services rendered to Members, Members shall not be liable to Provider for any amounts owed by ValueOptions to Provider, and Provider shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member or persons acting on a Member's behalf for Covered Services provided pursuant to this Agreement. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.
5. Claim Payment. To the extent required, both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to Utah Code Ann. § 31A-26-301.6. To the extent any provision of the Agreement conflicts with the requirements of Applicable Law, those provisions shall be amended hereby to comply with that law.
6. Recoupment. To the extent required under Applicable Law, retroactive denial of claims, including any recoupment process utilized by ValueOptions, will be administered in accordance with Applicable Law.

#### **VERMONT STATE PROVISIONS**

1. The Agreement is amended by the following defined term:

The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means the sudden and, at the time, unexpected onset of an illness or medical condition that manifests itself by symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected by the prudent layperson, who possess an average knowledge of health and medicine, to result in placing the Member's physical or mental health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

2. Continuity of Care. Provider agrees that in the event that ValueOptions terminates this Agreement without cause, Provider shall continue to provide Covered Services for any Member in an ongoing course of treatment for a life threatening, debilitating, or degenerative condition for up to sixty (60) days from the date of termination, and in the case of a Member in her second or third trimester of pregnancy until the completion of postpartum care. Provider shall continue providing such Covered Services in accordance with the terms and condition of the Agreement. In the event of ValueOptions' insolvency or cessation of operations, Covered Services to a Member will continue through the period for which a premium has been paid to ValueOptions on behalf of the Member or until the Member's discharge from an inpatient facility, whichever period is greater. Covered Services to a Member

confined in an inpatient facility on the date of insolvency or cessation of operations will continue until the Member's continued confinement in the facility is no longer medically necessary.

This provision shall survive termination of the Agreement regardless of the reason for termination, including the insolvency of ValueOptions, and shall supercede any oral or written agreement to the contrary between Provider and Member or the Member's authorized representative. This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

3. Provider/Patient Relationship. Nothing in the Agreement shall be construed to prohibit Provider from disclosing to Members information about the Agreement or the benefit plan that may affect their health or any decision regarding their health. Nor shall the Agreement be construed as prohibiting or otherwise penalizing Provider from discussing any treatment options with Members or advocating on behalf of Members within the utilization review or grievance processes established by ValueOptions. ValueOptions shall not penalize Provider because Provider in good faith reports to state or federal authorities any act or practice that jeopardizes patient health or welfare.

4. Hold Harmless. Provider agrees that in no event, including but not limited to nonpayment by ValueOptions, insolvency of ValueOptions, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Member, or the Member's authorized representative, for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting deductibles, copayments, or coinsurance as specifically provided in the Member's benefit plan, or fees for non-covered health care services delivered on a fee-for-service basis. This provision shall survive termination of the Agreement regardless of the reason for termination, including the insolvency of ValueOptions, and shall supercede any oral or written agreement to the contrary between Provider and Member or the Member's authorized representative. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

5. Confidentiality and Member Records. ValueOptions and Provider will at all times maintain the privacy, confidentiality, and security of Member medical records in accordance with Applicable Law. Subject to such requirements, Provider will make a Member's medical records available to ValueOptions upon request in order to perform administrative functions consistent with its obligations under the Agreement including but not limited to monitoring and evaluating quality of care, and conducting health care evaluations and audits regarding the appropriateness and the necessity of care provided to Members on both concurrent and retrospective bases. To the extent required by Applicable Law, Provider shall make Member records available to state and federal authorities responsible for activities such as quality of care, Member grievances and complaints.

6. Provider Inducements. Nothing in the Agreement shall be construed as offering an inducement to Provider to forego providing medically necessary services to a Member.

7. The following provisions are added to the section titled or relating to "Term and Termination:"

(a) ValueOptions and Provider shall provide no less than sixty (60) days written notice to each other prior to terminating the Agreement without cause.

(b) Within five (5) business days of the date Provider either gives or receives notice of termination of the Agreement, either for or without cause, the Provider shall supply to ValueOptions a list of Members seen on a regular basis by Provider.

This provision shall not supercede a longer notice period set forth in the Agreement if such provision is permitted by Applicable Law.

8. Claim Payment. To the extent any provision of the Agreement conflicts with the requirements of 18 Vt. Stat. Ann. § 9418 or any successor provisions regarding payment of claims and is required by Applicable Law, those provisions shall be amended hereby for both parties to comply with that law.

9. The provision titled or relating to "Indemnification" is amended by the following:

Nothing in this Agreement shall be construed to require Provider to indemnify ValueOptions or hold ValueOptions harmless from any liability relating to activities, actions or omissions of ValueOptions as opposed to those activities, actions or omissions of Provider.

## **VIRGINIA STATE PROVISIONS**

### **I. The Agreement is amended by the following defined terms:**

(a) The term “Clean Claim” shall be replaced by the following, and to the extent not already contained in the Agreement shall be added as a new term. “Clean Claim” means a claim that has no material defect or impropriety, including the lack of any reasonably required substantiation documentation, which substantially prevents timely payment from being made on the claim or with respect to which ValueOptions has failed to timely notify Provider of any defect or impropriety. References in the Agreement to “claims” shall be construed to mean “Clean Claims” in accordance with Applicable Law.

(b) The term “Emergency” shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. “Emergency” means, as defined by Applicable Law, the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to the Member’s mental or physical health, serious impairment of bodily functions, serious dysfunction of bodily organs, or, with respect to pregnant woman, serious jeopardy to the health of the fetus.

### **II. The following provisions are added to the Agreement for those health care services policies, plans or other arrangements that are subject to the Virginia Ethics & Fairness in Carrier Business Practices Act (Virginia Insurance Code § 38.2-3407.15).**

#### **1. Claims Payment.**

(a) To the extent required, both parties agree to comply with Virginia Code §38.2-3407.15 with respect to the administration of claims. ValueOptions agrees to pay claims within forty (40) days of receipt unless: (a) the claim is determined by ValueOptions 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 carrier for all or part of a claim; (iv) the amount of the claim or the amount currently due under the claim; (v) the benefits covered; (vi) the manner in which services were accessed or provided; or (b) the claim was submitted fraudulently.

(b) ValueOptions will maintain a written or electronic record of the date of receipt of a claim. Provider will be entitled to inspect such record or request and to rely on the 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.

(c) ValueOptions will, within thirty (30) days after receipt of a claim, request electronically or in writing from Provider, or the person submitting the claim on behalf of the Provider, the information and documentation that ValueOptions reasonably believes will be required to process and pay the claim or to determine if the claim is a Clean Claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a Clean Claim, ValueOptions will make the payment of the claim in accordance with this Agreement and Applicable Law. ValueOptions will not refuse to pay a claim for Covered Services if ValueOptions fails to timely notify or attempt to notify Provider of the matters identified above, unless such failure was caused in material part by the person submitting the claim. Nothing herein will preclude ValueOptions from imposing a retroactive denial of payment of such a claim unless such a retroactive denial of payment would violate the requirements of Applicable Law.

(d) ValueOptions agrees to pay, if applicable and in accordance with Virginia Code § 38.2-3407.1 or § 38.2-4306.1, any interest owing or accruing on a Clean Claim at the same time the claim is paid or within sixty (60) days thereafter.

2. ValueOptions Policies.

(a) ValueOptions' policies will permit Provider to: (i) confirm in advance during normal business hours by free telephone or electronic means, if available, whether the services to be provided are Medically Necessary and are Covered Services; (ii) determine ValueOptions' requirements applicable to Provider for: (a) precertification or authorization or coverage decisions; (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial or 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 this Agreement, including whether a claim is a Clean Claim.

(b) ValueOptions will make available to Provider, within ten (10) business days of receipt of the request, copies of, or reasonable electronic access to all policies that are applicable to Provider. In the event that distributing the entire policy would violate applicable copyright law, existing third party agreements or other confidentiality obligations, ValueOptions will deliver to Provider a clear explanation of the policy as it applies to Provider.

3. Precertification. ValueOptions will pay a Provider's claim if ValueOptions has previously authorized the services or has advised Provider or Member in advance that the provision of the particular services are medically necessary and are Covered Services, unless: (a) the documentation for the claim fails to support the claim as originally authorized; or (b) ValueOptions' refusal is because: (i) another payor is responsible for the payment; (ii) Provider has already been paid for the services; (iii) the claim was submitted fraudulently or the authorization was based in whole or in part on erroneous information provided to ValueOptions; or (iv) the person receiving the services was not a Member at the time services were rendered.

4. Retroactive Denials. To the extent required by Applicable Law, ValueOptions will not impose a retroactive denial of a previously paid claim unless ValueOptions has provided the reason for the retroactive denial and: (i) the original claim was submitted fraudulently; (ii) the original claim payment was incorrect because Provider was already paid for the services on the claim or the services identified on the claim were not provided by Provider; or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the claim submission deadline stated in the Agreement. ValueOptions will notify Provider at least thirty (30) days in advance of any retroactive denial of a claim.

5. Fee Schedules. At the time of execution of the Agreement, ValueOptions will make available applicable fee schedules and all material schedules, agenda and policies applicable to Provider.

6. Amendments. No amendment to the Agreement will be effective unless Provider has been provided with the applicable portion of the proposed amendment and has failed to notify ValueOptions within fifteen (15) business days of receipt of the amendment of Provider's intent to terminate the Agreement in accordance with the terms thereof.

III. The following provisions are added to the Agreement and are applicable to Provider as required by Applicable Law for insured Members only:

1. Continuity of Care after Termination. In the event this Agreement is terminated for any reason other than cause, Provider agrees to provide Covered Services to:

- (a) Any Member, upon request, who is in an active course of treatment with Provider prior to the notice of termination, for a period of at least ninety (90) days;
- (b) Any Member, at the Member's option, who has entered the second trimester of pregnancy at the time of the termination, until the completion of postpartum care directly related to the delivery; and
- (c) Any Member, at the Member's option, who is determined to be terminally ill at the time of Provider's termination, for the remainder of the Member's life, for care directly related to the treatment of the terminal illness.
- (d) Provider agrees to provide Covered Services to Members under this provision upon the same terms, including reimbursement, as those contained in the Agreement before the termination.
- (e) This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision.

2. Indemnification. Nothing in this Agreement shall be construed to require Provider to indemnify ValueOptions or hold ValueOptions harmless for the negligence, willful misconduct or breach of contract by ValueOptions.
3. Legal Redress. To the extent required by Applicable Law, nothing in this Agreement shall be construed to require Provider, as a condition of participation, to waive any right to seek legal redress against ValueOptions.
4. Provider/Patient Relationship. Nothing in the Agreement shall be construed to prohibit, impede or interfere with Provider's ability to discuss medical treatment options with a Member. Provider is permitted and required to discuss medical treatment options with a Member pursuant to Applicable Law.
5. Non-Exclusivity of Agreement. Nothing in this Agreement shall be construed to restrict Provider's right to enter into contracts with other organizations or insurers. Nothing in this Agreement shall be construed to require Provider, as a condition of participation or continuation on a provider panel, to serve on another provider panel of ValueOptions. Provider has the right to refuse participation in any provider panel owned or operated by ValueOptions or an affiliate or an unaffiliated carrier whose participation terms differ materially from the terms of this Agreement.
6. Provision of Covered Services. Provider shall provide Covered Services to Members in a prompt and timely manner upon request. Provider shall maintain accessibility for medical care, as necessary, either personally or telephone coverage with an appropriate health care professional for urgent and emergency services twenty-four hours per day, seven days per week, 365 days per year.

## **WASHINGTON STATE PROVISIONS**

### I. The Agreement is amended by the following defined terms:

(a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "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. References in the Agreement to "claims" shall be construed to mean "Clean Claims" to the extent required by Applicable Law.

(b) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, the following shall be added as a new term: "Emergency" means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, would place the person's health in serious jeopardy.

### II. The following provisions are added to the Agreement and are applicable as required by Applicable Law to Providers rendering services to HCSC Members:

1. Sub-Contracting. In accordance with WAC 284-43-300, Provider shall ensure that any subcontracts it enters into with providers for the delivery of Covered Services to Members satisfy the requirements of Applicable Law.

2. Hold Harmless. The following shall be added pursuant to WAC 284-43-320:

(a) Provider hereby agrees that in no event, including, but not limited to, nonpayment by ValueOptions, ValueOptions' insolvency or breach of this Agreement will Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Member or persons acting on their behalf, other than ValueOptions, for services provided pursuant to this Agreement. This provision shall not prohibit collection of deductibles, copayments, co-insurance, and/or fees 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.

(b) Provider may not bill Member(s) for Covered Services (except for deductibles, copayments or co-insurance) where ValueOptions denies payment because Provider has failed to comply with the terms of this Agreement.

(c) Provider agrees, in the event of ValueOptions' insolvency, to continue to provide Covered Services to Members for the duration of the period for which premiums on behalf of the Members were paid to ValueOptions or until a Member's discharge from inpatient facilities, whichever time is greater.

(d) Notwithstanding any other provision of this Agreement, nothing in this Agreement shall be construed to modify the rights and benefits contained in a Member's plan.

(e) In the event Provider willfully collects or attempts to collect an amount from Member(s) knowing that collection to be in violation this Agreement, the actions of Provider may constitute a class C felony under Revised Code of Washington 48.80.030(5).

(f) The obligations set forth in this paragraph shall survive termination of this Agreement regardless of the cause giving rise to termination and shall be construed to be for the benefit of Members. 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. The provisions of this paragraph shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.

3. Compliance with Programs and Requirements. To the extent required by WAC 284-43-320(4), ValueOptions will notify Provider of Provider's responsibilities with respect to ValueOptions' administrative policies and programs, including payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and other requirements of Applicable Law.

4. Member Communications. In accordance with WAC 284-43-320(5), Provider shall not in any way be precluded or discouraged by ValueOptions from informing Member(s) 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 constitutes a Covered Service. ValueOptions shall not prohibit, discourage, or penalize Provider otherwise practicing in compliance with the law from advocating on behalf of Members with ValueOptions. Nothing in this section shall be construed to authorize Provider to bind ValueOptions to pay for any non-Covered Service.

5. Confidentiality and Medical Records. To the extent required by WAC 284-43-320(6), Provider shall, subject to Applicable Law regarding confidentiality, make accounting, administrative and medical records available upon request with reasonable notification by ValueOptions, or governmental regulatory authority to determine that the content and quality are acceptable, as well as for peer review or grievance review.

6. Termination. To the extent required by WAC 284-43-320(7) and any other Applicable Law, ValueOptions and Provider will provide at least sixty (60) days written notice to each other before terminating this Agreement without cause. If the Agreement contains a provision requiring more than sixty (60) days notice for termination without cause, such longer notice shall apply.

7. Coordination of Benefits. To the extent required by WAC 284-51-100, ValueOptions will not unreasonably delay payment to Provider as a result of the application of a coordination of benefits provision.

8. Equitable Treatment. As required by WAC 284-43-320(8), Provider shall furnish Covered Services to Members without regard to Member's enrollment in the plan as a private purchaser of the plan or as a participant in a publicly financed plan.

9. Dispute Resolution. To the extent required by WAC 284-43-320(11) and WAC 284-43-322, ValueOptions will provide fair review and consideration of all provider complaints or disputes arising from the terms of this Agreement. Except for those disputes subject to any appeals process described in the Agreement, the following shall apply: Provider shall submit such disputes to ValueOptions within thirty-one (31) days of the event giving rise to the dispute. If ValueOptions fails to acknowledge a timely filed dispute within thirty (30) days of receipt or

otherwise rejects Provider's request, Provider may submit the dispute to non-binding mediation at Provider's own expense.

10. Billing, Compensation and Claims Submissions. To the extent required by Applicable Law, each party agrees to comply with the provisions of WAC 284-43-321.

11. Amendments. To the extent required by Applicable Law, Provider will be afforded not less than sixty (60) days notice of changes to contract terms that affect Provider's compensation or the delivery of Covered Services. Provider may, pursuant to WAC 284-43-320(4), terminate this Agreement without penalty if Provider does not accept the changes in contract terms.

12. Member Eligibility. To the extent required by WAC 284-43-320(1), ValueOptions will establish a mechanism by which Provider can verify Member eligibility for Covered Services, including limitations on conditions on services or benefits.

13. Audit. As required by WAC 284-43-324 and Applicable Law, no audit provisions in the Agreement may be construed to grant ValueOptions access to health information and other similar records unrelated to Members.

14. Non-Covered Services. To the extent required by RCW § 48.43.085, ValueOptions shall not directly or indirectly prohibit Members from freely contracting at any time to obtain any health care services outside Member's plan on any terms or conditions the Member chooses. Nothing in this section shall be construed to bind ValueOptions for any non-covered services or any services delivered outside the Member's plan.

#### **WEST VIRGINIA STATE PROVISIONS**

1. The Agreement is amended by the following defined terms:

(a) The term "Clean Claim" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Clean Claim" means a claim that has no material defect or impropriety, including all reasonably required information and substantiating documentation, to determine eligibility or to adjudicate the claim; or where ValueOptions has failed to timely notify the person submitting the claim of any such defect or impropriety. References in the Agreement to "claims" shall be construed to mean "Clean Claims" to the extent required by Applicable Law.

(b) The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Emergency" means as defined by Applicable Law, a condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson could reasonably expect that the absence of immediate medical attention could result in serious jeopardy to the Member's health, or result in serious impairment to bodily functions, or serious dysfunction of any bodily part or organ, or with respect to a pregnant woman, result in serious jeopardy to the health of the unborn child.

2. Claim Payment. To the extent required, both parties agree to comply with Applicable Law with respect to the administration of claims, including but not limited to W. Va. Code § 33-45-2. To the extent that any provision of the Agreement conflicts with Applicable Law, those provisions are hereby amended and shall be construed in compliance with Applicable Law.

3. Policies and Procedures. To the extent required, ValueOptions will establish policies and procedures applicable to Provider in accordance with Applicable Law. Provider shall comply with and be bound by all such policies and procedures, including but not limited to, ValueOptions' policies relating to administrative requirements, utilization management, credentialing, quality management, payment and reimbursement, precertification and authorization of coverage decisions and claims processing.

4. Claims Recoupment. To the extent permitted under Applicable Law, retroactive denial of claims, including any recoupment process utilized by ValueOptions, will be administered in accordance with Applicable Law.

5. Amendments. No amendment to the Agreement, or to any exhibit, addenda, schedule or policy that relates to payment, delivery of care, or the range of health care services provided by Provider, shall be effective as to Provider unless Provider fails to notify ValueOptions in writing within twenty (20) business days of receipt of such amendment of Provider's intention to terminate the Agreement at the earliest date permitted under the Agreement.
6. Balance Billing. Provider shall accept as full payment such compensation as set forth in the Agreement between ValueOptions and Provider.
7. Provider Rights. Nothing in the Agreement shall be construed to permit ValueOptions to terminate or fail to renew the Agreement or otherwise penalize Provider for invoking any rights as a Provider under the Agreement or Applicable Law.

## **WISCONSIN STATE PROVISIONS**

### I. The Agreement is amended by the following defined term:

The term "Emergency" shall be replaced by the following, and to the extent not already contained in the Agreement, shall be added as a new term. "Emergency" means, as defined by Applicable Law, a medical condition that manifests itself by acute symptoms of sufficient severity, including, severe pain, such that a reasonably prudent layperson, who possesses an average knowledge of health and medicine, would believe that the absence of immediate medical attention could seriously jeopardize the Member's health or result in serious impairment to bodily functions or, serious dysfunction of any bodily organ or part, or with respect to a pregnant woman, seriously jeopardize the health of the woman or her unborn child.

### II. The following provisions are added to the Agreement and are applicable to the extent required by Applicable Law to Providers rendering services to insured Members only:

1. Provider/Patient Relationship. Nothing in this 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, or restrict Provider from discussing with or on behalf of the 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. ValueOptions may not terminate nor otherwise penalize Provider for making referrals to other participating providers or from discussing medically necessary or appropriate care with or on behalf of a Member. ValueOptions will not retaliate against Provider for advising a Member of treatment options not available under Member's plan.
2. Complaints, Grievances and Appeals. Provider agrees to respond promptly and provide ValueOptions all necessary information to permit ValueOptions to respond to any complaints, grievances or appeals filed with ValueOptions relating to Covered Services provided by Provider. If Provider subcontracts for the provision of Covered Services, Provider shall require subcontractors, to the extent required by Applicable Law, to incorporate within their contracts provisions requiring the subcontractor to promptly provide ValueOptions all necessary information to permit ValueOptions to respond to any complaints, grievances or appeals filed with ValueOptions relating to Covered Services rendered.
3. Claim Payments. To the extent required, both parties will comply with Applicable Law with respect to the administration of claims, including but not limited to Wisconsin Statute §628.46. To the extent that any provision of the Agreement conflicts with Applicable Law, those provisions are hereby amended and shall be construed in accordance with that Law.
4. Continuity of Care after Termination.
  - (a) In the event this Agreement is terminated for any reason other than when Provider no longer practices in the geographic service area, or due to misconduct, suspension or revocation of Provider's license, or for issues related to the quality of health care services rendered, or the health, safety or welfare of any Members, Provider agrees to continue care and provide Covered Services for any Member who is undergoing a course of treatment with Provider at the time of the termination for the remainder of the course of treatment or ninety (90) days after the termination of the Agreement, whichever is shorter.

- (b) Provider agrees to provide Covered Services for any Member who is in the 2<sup>nd</sup> or 3<sup>rd</sup> trimester of pregnancy until completion of postpartum care.
- (c) During the continuation of coverage periods described in this Amendment, Provider shall provide such Covered Services in accordance with the terms of this Agreement, including terms of reimbursement, applicable at the time of termination. This provision shall not supercede provisions in the Agreement that provide additional protections for Members if such provisions are permitted by Applicable Law.
- (d) Except where the termination of the Agreement is for cause, Provider shall notify all Members undergoing a course of treatment with Provider of the termination and the continuation of coverage provision in the Agreement. If Provider is a specialist, such Provider shall post a notice of the termination in all offices of Provider in which Members are seen at least thirty (30) days prior to the termination or fifteen (15) days after receipt of the notice of termination from ValueOptions.
- (e) This provision shall not supercede additional provisions in the Agreement providing for continuity of care if such provisions do not conflict with this provision and are permitted by Applicable Law.

### **WYOMING STATE PROVISIONS**

1. Provider/Patient Relationship. In accordance with Wyo. Stat. § 26-22-504, ValueOptions shall not refuse to re-contract with, or compensate Provider for Covered Services solely because Provider in good faith communicated with a Member regarding the provisions, terms, or requirements of ValueOptions' products as they relate to the needs of that Member.
2. Payment of Claims. To the extent any provision of the Agreement conflicts with Wyo. Stat. § 26-15-124 and any successor provisions regarding payment of claims, those provisions shall be amended for both parties to comply with that law. This provision shall be construed with Applicable Law to determine whether that law applies to a particular claim.