EXHIBIT C
COORDINATING PROVISIONS: STATE LAW,
ACCREDITATION STANDARDS AND GEOGRAPHIC EXCEPTIONS

I. INTRODUCTION:

1.1 Scope: To the extent of any conflict between the Agreement, including the administrative handbook as herein incorporated by reference, and this Exhibit, this Exhibit shall supersede, govern and control to the extent required by federal and/or state law and to the extent that MultiPlan, Inc., d/b/a/ Claritev, Inc., on behalf of itself and its subsidiaries (collectively "Claritev"), Provider and/or Client are subject to such federal or state law.

1.2 Terms: The terms used in this exhibit are the defined terms as specified in the applicable federal and/or state law. The specific form Agreement between the parties may utilize defined terms other than those noted in the federal and/or state law(s). Unless otherwise defined by applicable state/federal law, for purposes of this exhibit, Provider means a licensed facility or licensed, registered or certified health care professional(s) contracted to provide health care services under this Agreement.

1.3 Citations: The citations are current as of the date of this Exhibit. Recodification of statutory and/or regulatory citations does not nullify the intent of a provision.

II. STATE LAW COORDINATING PROVISIONS:

The following states have no State Law Coordinating Provisions at this time:

Alabama	Indiana	Minnesota	Wyoming
Arizona	Iowa	Missouri	
Arkansas	Kansas	Montana	
Delaware	Maine	Pennsylvania	
Idaho	Michigan	South Carolina	

For those states that require Coordinating Provisions, where the statutory requirement is an additional obligation not otherwise specified in the Agreement, the parties agree that the statutory requirement will be added as an obligation. Where the statutory requirement specifically conflicts with a current obligation, the statutory requirement will take precedence and replace the existing obligation as to the statutory requirement only, and will not void any other valid provision of this Agreement. The statutory requirements identified for each state below apply for any Agreement involving the delivery of health care services in that specific state and are limited to only those entities specifically covered by the statute.

STATE LAW COORDINATING PROVISIONS: ALASKA

2.1 As required by AS § 21.07.010(a)(3), the termination rights are as stated in the underlying Agreement. In the event the underlying Agreement includes a discretionary termination provision, such provision shall be equitably applied to both parties.

2.2 As required by AS § 21.07.010(a)(4), the dispute resolution process is as stated in the underlying Agreement. In the event the underlying agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook. Such process shall at a minimum comply with AS § 21.07.010(a)(4).

2.3 As required by AS § 21.07.010(a)(5), health care provider may not be penalized or the health care provider's contract terminated by the health care insurer because the health care provider acts as an advocate for a covered person in seeking appropriate, medically necessary medical care services.

2.4 As required by AS § 21.07.010(a)(6), health care provider may communicate openly with a covered person about all appropriate diagnostic testing and treatment options.

STATE LAW COORDINATING PROVISIONS: CALIFORNIA

2.1 As required by 10 CCR § 2538.3(d), provider shall comply with insurer's Health Care Language Assistance Program requirements in accordance with 10 CCR §§ 2538.1 - 2538.8. Provider shall contact insurer to obtain information on such Insurer's Health Care Language Assistance Program requirements.

2.2 As required by 10 CCR 2240.4(b)(2), network providers shall not make any additional charges for rendering network services except as provided for in the contract between the insurer and the insured.

2.3 As required by 10 CCR § 2240.4(b)(4), provider's primary consideration shall be the quality of the health care services rendered to covered persons.

2.4 As required by 10 CCR § 2240.4(b)(5), provider shall not discriminate against any insured in the provision of contracted services on the basis of sex, marital status, sexual orientation, race, color, religion, ancestry, national origin, disability, health status, health insurance coverage, utilization of medical or mental health or substance use disorder services or supplies, or other unlawful basis including without limitation, the filing by such insured of any complaint, grievance, or legal action against a provider.

2.5 As required by Cal.Ins.Code § 10120.35, a health insurer, including a specialized health insurer and a health insurer that issues, sells, renews, or offers a contract covering dental services, shall reimburse its contracting health care providers for business expenses to prevent the spread of diseases causing public health emergencies declared on or after January 1, 2022. For purposes of this section, "business expenses" means personal protective equipment, additional supplies, materials, and clinical staff time over and above those expenses usually included in an office visit or other non-facility service or services if performed during a public health emergency, as defined by law, due to respiratory-transmitted infectious disease. A health insurer shall reimburse a contracting health care provider pursuant to this section for each individual patient encounter, limited to one encounter per day per insured for the duration of the public health emergency.

2.6 As required by Cal.Ins.Code § 10133.15(j)(1) provider shall inform the insurer within five business days when either of the following occur: (a) the provider is not accepting new patients; or (b) if the provider had previously not accepted new patients, the provider is currently accepting new patients.

2.7 As required by Cal.Ins.Code § 10133.15(n)(1), provider groups or contracting specialized health insurers shall provide information to the insurer that is required by the insurer to satisfy the requirements of Cal.Ins.Code § 10133.15 for each of the providers that contract with the provider group or contracting specialized health insurer.

2.8 As required by Cal.Ins.Code § 10123.855(a)(1), the health insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

2.9 As required by West's Ann.Cal.Bus. & Prof.Code § 511.1(b)(1), the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents. Payors or contracting agents may include workers' compensation insurers or automobile insurers.

2.10 As required by West's Ann.Cal.Bus. & Prof.Code § 511.1(b)(3), payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

STATE LAW COORDINATING PROVISIONS: COLORADO

2.1 As required by C.R.S. §10-16-121(1)(a), neither the provider nor the carrier is prohibited from protesting or expressing disagreement with a medical decision, medical policy, or medical practice of the carrier or provider.

2.2 As required by C.R.S. §10-16-121(1)(b)(I), carrier may not take an adverse action against a provider because the provider expresses disagreement with a carrier's decision to deny or limit benefits to a covered person or because the provider assists the covered person to seek reconsideration of the carrier's decision or because a provider discusses with a current, former, or prospective patient any aspect of the patient's medical condition, any proposed treatments or treatment alternatives, whether covered by the plan or not, policy provisions of a plan, or a provider's personal recommendation regarding selection of a health plan based on the provider's personal knowledge of the health needs of such patients.

2.3 As required by C.R.S. §10-16-121(1)(b)(II), carrier may not take an adverse action against a provider because the provider, acting in good faith:

(A) communicates with a public official or other person concerning public policy issues related to health care items or services;
(B) files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of the carrier the provider believes might negatively affect the quality of, or access to, patient care;
(C) provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of this section;
(D) reports what the provider believes to be a violation of law to an appropriate authority; or
(E) participates in any investigation into a violation or possible violation of any provision of this section.

2.4 As required by C.R.S. § 10-16-121(1)(c), carrier shall comply with § 10-16-106.5(3) – (5), as applicable.

2.5 As required by C.R.S. § 10-16-121(1)(d), provider shall not be subjected to financial disincentives based on the number of referrals made to participating providers in the health plan for covered benefits so long as the provider making the referral adheres to the carrier's or the carrier's intermediary's utilization review policies and procedures.

2.6 As required by C.R.S. § 10-16-705(3), covered persons shall, in no circumstances, be liable for money owed to participating providers by the plan and that in no event shall a participating provider collect or attempt to collect from a covered person any money owed to the provider by the carrier. Nothing in this section shall prohibit a participating provider from collecting coinsurance, deductibles, or copayments as specifically provided in the covered person's contract with the managed care plan.

2.7 As required by C.R.S. § 10-16-705(4), Each managed care plan shall allow covered persons to continue receiving care for sixty days from the date a participating provider is terminated by the plan without cause when proper notice as specified in C.R.S. § 10-16-705(7) has not been provided to the covered person. In the circumstance that coverage is terminated for any reason other than nonpayment of the premium, fraud, or abuse, every managed care plan shall provide for continued care for covered persons being treated at an in-patient facility until the patient is discharged.

2.8 As required by C.R.S. § 10-16-705(9), participating providers shall not discriminate, with respect to the provision of medically necessary covered benefits, against covered persons that are participants in a publicly financed program.

2.9 As required by C.R.S. § 10-16-705(14), the sole responsibility for obtaining any necessary preauthorization rests with the participating provider that recommends or orders said services, treatments, or procedures, not with the covered person. A covered person may receive a standing referral for medically necessary treatment pursuant to C.R.S. § 10-16-705(14)(b).

2.10 As required by C.R.S. § 25-37-108(2)(c), this Agreement applies to network rental arrangements and is for the purpose of assigning, allowing access to, selling, renting, or giving the person's or entity's rights to the health care provider's services.

2.11 As required by C.R.S. § 25-37-111(2), for a contract with a duration of less than two years each party shall have a right to terminate the contract without cause as stated in the underlying agreement, but in no event upon less than ninety days' written notice. For a contract with a duration of two or more years each party shall have the right to terminate the contract without cause as stated in the underlying agreement, but in no event upon less than sixty days' written notice as required by C.R.S. § 10-16-705(7).

Colorado Summary Disclosure Form

As required by C.R.S. § 25-37-103, this Summary Disclosure Form is for informational purposes only and shall not be a term or condition of the Agreement.

1. Compensation or Payment Terms: Article V and Contract Rate Exhibit
2. Category of Coverage: Definition of Program
3. Duration of the Contract: Article II
4. Contract Termination: Article II
5. Person/Entity Responsible for Processing Claims: Article V
6. Dispute Resolution: Article V and Article VIII
7. Subject and Order of Addenda:

   A. Amendment Exhibit (if applicable)
   B. Network Participation Requirements
   C. Coordinating Provisions State/Federal Law and Accreditation Standards
   D. Contract Rates
   E. List of Locations (if applicable)
   F. Service Requirements (if applicable)

STATE LAW COORDINATING PROVISIONS: CONNECTICUT

2.1 As required by C.G.S.A. § 38a-477g(b)(1)(A), "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, the insolvency of the health carrier or intermediary, or a breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the

evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care provider who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier does not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

2.2 As required by C.G.S.A. § 38a-477g(b)(1)(B), in the event of a health carrier or intermediary insolvency or other cessation of operations, the participating provider's obligation to deliver covered health care services to covered persons without requesting payment from a covered person other than a coinsurance, copayment, deductible or other out-of-pocket expense for such services will continue until the earlier of (i) the termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment, as set forth in § 38a-472f(2)(g), or are totally disabled, or (ii) the date the contract between the health carrier and the participating provider would have terminated if the health carrier or intermediary had remained in operation, including any extension of coverage required under applicable state or federal law for covered persons who are in an active course of treatment or are totally disabled.

2.3 As required by C.G.S.A. § 38a-477g(b)(1)(C), a participating provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care provided to, or investigating grievances or complaints of, covered persons. Participating provider shall comply with applicable state and federal laws related to the confidentiality of medical and health records and a covered person's right to view, obtain copies of or amend such covered person's medical and health records.

2.4 As required by C.G.S.A. § 38a-477g(b)(1)(D), for purposes of C.G.S.A. § 38a-477g(c)(2), unless otherwise specified in the underlying Agreement:

(i) Material Change shall mean any change to the Agreement (including provider documents) that have a material adverse impact on provider; and

(ii) Timely Notice shall mean at least ninety (90) days prior notice to the provider.

2.5 As required by C.G.S.A. § 38a-478h, § 38a-472f(g)(1)(A) and Regs. Conn. State Agencies § 38a-472f-2, health carrier and participating provider shall provide at least ninety days' written notice to each other before the health carrier removes a participating provider from the network or the participating provider leaves the network. Each participating provider that receives a notice of removal or issues a departure notice shall provide to the health carrier, not later than thirty (30) days after receipt of the notice of termination, a list of such participating provider's patients who are covered persons under a network plan of such health carrier.

2.6 As required by C.G.S.A § 38a-472f(g)(1)(C) if participating provider is a hospital, as defined in section 38a-493, or a parent corporation of a hospital, and the contract is not renewed or is terminated by either the health carrier or the participating provider, the health carrier and the participating provider shall continue to abide by the terms of such contract, including reimbursement terms, for a period of sixty days from the date of termination or, in the case of a nonrenewal, from the end of the contract period. Except as otherwise agreed between such health carrier and such participating provider, the reimbursement terms of any contract entered into by such health carrier and such participating provider during said sixty-day period shall be retroactive to the date of termination or, in the case of a nonrenewal, the end date of the contract period. This subparagraph shall not apply if the health carrier and participating provider agree, in writing, to the termination or nonrenewal of the contract and the health carrier and participating provider provide the notices required under subparagraphs (A) and (B) of this subdivision.

2.7 As required by C.G.S.A § 38a-479aa(l), if the preferred provider network fails to pay for health care services as set forth in the contract, the enrollee shall not be liable to the participating provider for any sums owed by the preferred provider network or any sums owed by the managed care organization because of nonpayment by the managed care organization, insolvency of the managed care organization or breach of contract between the managed care organization and the preferred provider network.

2.8 As required by the Chairman of the Workers' Compensation Commission, pursuant to the authority granted by C.G.S.A § 31-279(d), Claritev, on behalf of medical care plan, may not terminate the services of any provider without cause.

STATE LAW COORDINATING PROVISIONS: DISTRICT OF COLUMBIA

2.1 As required by 26-A DCMR § 4704.3, "Provider hereby agrees that in no event, including, but not limited to, non-payment by Corporation or entity with access to this Agreement by virtue of a contract with Corporation for any reason, including a determination that the services furnished were not Medically Necessary, Corporation's insolvency,

provider's failure to submit claims within the time period specified or breach of this Agreement, will provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Members or persons other than Corporation for Covered Services furnished pursuant to this Agreement. This provision will not prohibit collection of applicable copayments, coinsurance or deductibles billed in accordance with the terms of Corporation's agreements with Members."

Provider further agrees that this provision will survive the termination of this Agreement regardless of the cause giving rise to such termination and will be construed to be for the benefit of Members. Finally, this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between provider and Members or persons acting on their behalf.

Any modifications, additions, or deletions to the provisions of this hold harmless clause will become effective on a date no earlier than thirty (30) days after the Commissioner has received written notice of such proposed changes."

2.2 As required by 26-A DCMR § 4704.5, in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing will continue until the earlier of:

(a) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms, or applicable District or federal law for covered persons who are in an active course of treatment or totally disabled; or

(b) The date the contract between the carrier and the provider would have terminated if the carrier or intermediary had remained in operation, including any required extension for covered persons in an active course of treatment.

2.3 As required by 26-A DCMR § 4704.15, health carrier shall provide at least sixty (60) days written notice to a participating provider before the provider is removed from the network without cause.

2.4 As required by 26-A DCMR § 4704.21, facilities, as applicable, shall comply with written disclosure or notice provisions of 26-A DCMR § 4704.21.

STATE LAW COORDINATING PROVISIONS: FLORIDA

2.1 If Network Provider participates in a discount medical plan organization as required by Fla. Stat. § 636.214(2)(c), provider will not charge members more than the discounted rates.

2.2 As required by Fla. Stat. § 627.64731(2), contracting entity may sell, lease, rent, or otherwise grant access to the health care services of a participating provider under this health care contract. This health care contract applies to network rental arrangements and one purpose of this contract is selling, renting, or giving the contracting entity rights to the services of the participating provider, including other preferred provider organizations. Contracting entity may sell, lease, rent, or otherwise grant access to the participating provider's services only to a third party that is:

(a) A payor or a third-party administrator or other entity responsible for administering claims on behalf of the payor;

(b) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider and that is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement; or

(c) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payor or third-party administrator and that complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

STATE LAW COORDINATING PROVISIONS: GEORGIA

2.1 As required by O.C.G.A. § 33-20A-61, in the event that a physician's contract is terminated affecting any enrollee's opportunity to continue receiving health care services from that physician under the plan, any such enrollee who is suffering from and receiving active health care services for a chronic or terminal illness or who is an inpatient shall have the right to continue to receive health care services from that physician for a period of up to sixty (60) days from the date of the termination of the physician's contract. Any enrollee who is pregnant and receiving treatment in connection with that pregnancy at the time of the termination of that enrollee's physician's contract shall have the right to continue receiving health care services from that physician throughout the remainder of that pregnancy, including six weeks' post-delivery care. During such continuation of coverage period, the physician shall continue providing such services in accordance with the terms of the contract applicable at the time of the termination, and the carrier, plan, network, panel, and all agents thereof shall continue to meet all obligations of such physician's contract.

The enrollee shall not have the right to the continuation provisions provided in this section if the physician's contract is terminated because of the suspension or revocation of the physician's license or if the carrier, plan, network, panel, or any agent thereof determines that the physician poses a threat to the health, safety, or welfare of enrollees.

2.2 As required by Ga. Comp. R. & Regs. 120-2-44-.04, an insured shall be held harmless for provider utilization review decisions over which he has no control.

STATE LAW COORDINATING PROVISIONS: HAWAII

2.1 As required by HRS § 431:26-104(b), "Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or a person other than the health carrier or intermediary, as applicable, acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons; provided that a provider shall not bill or collect from a covered person or a person acting on behalf of a covered person any charges for non-covered services or services that do not meet the criteria in section 432E-1.4, Hawaii Revised Statutes, unless an agreement of financial responsibility specific to the service is signed by the covered person or a person acting on behalf of the covered person and is obtained prior to the time services are rendered. This agreement does not prohibit a provider, except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue services solely at the expense of the covered person; provided that the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

2.2 As required by HRS § 431:26-104(c), in the event of a health carrier or intermediary insolvency or other cessation of operations, the provider's obligation to deliver covered services to covered persons without balance billing shall continue until the earlier of:

(1) The termination of the covered person's coverage under the network plan, including any extension of coverage provided under the contract terms or applicable state or federal law for covered persons who are in an active course of treatment or totally disabled; or
(2) The date the contract between the carrier and the provider, including any required extension for covered persons in an active course of treatment, would have terminated if the carrier or intermediary had remained in operation.

2.3 As required by HRS § 431:26-104(k), provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of, or amend the person's medical and health records.

STATE LAW COORDINATING PROVISIONS: ILLINOIS

2.1 As required by 50 Ill. Adm. Code 2051.295(a), and if the provider participates in the workers' compensation network, add the following language to the preamble "This Agreement conforms to the requirements of Section 8.1a of the Illinois Workers' Compensation Act."

2.2 As required by 50 Ill. Adm. Code 2051.290(b) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(c) provider shall comply with applicable administrative policies and procedures of the administrator including, but not limited to credentialing or recredentialing requirements; and, except for DHCSP administrators, utilization review requirements, and referral procedures.

2.3 As required by 50 Ill. Adm. Code 2051.290(c) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(d), when payments are due to the provider for services rendered to a beneficiary, the provider must maintain and make medical records available:

(a) To the administrator and/or insurer for the purpose of determining, on a concurrent or retrospective basis, the medical necessity and appropriateness of care provided to beneficiaries;
(b) To appropriate State and federal authorities and their agents involved in assessing the accessibility and availability of care or investigating member grievances or complaints; and
(c) To show compliance with the applicable State and federal laws related to privacy and confidentiality of medical records.

2.4 As required by 50 Ill. Adm. Code 2051.290(d) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(e) provider shall be licensed by the State of Illinois and shall notify the administrator immediately whenever there is a change in licensure or certification status.

2.5 As required by 50 Ill. Adm. Code 2051.290(e) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(f), physician providers licensed to practice medicine in all its branches to have admitting privileges in at least one hospital with which the administrator has a written provider contract. The administrator shall be notified immediately of any changes in privileges at any hospital or admitting facility. Reasonable exceptions shall be made for physicians who, because of the type of clinical specialty, or location or type of practice, do not customarily have admitting privileges.

2.6 As required by 50 Ill. Adm. Code 2051.290(f) and 215 ILCS 124/15, and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(g), the contract may be terminated by either party without cause or for nonrenewal upon not less than 60 days prior written notice. The administrator may immediately terminate the provider contract for cause, including but not limited to when a provider license has been disciplined by a State licensing board or when there is reasonable cause to believe direct imminent physical harm may occur to patients under provider's care. If applicable, a provider, acting as primary care physician under plans requiring a gatekeeper option, must provide the administrator with a list of all patients using that provider as a gatekeeper within five (5) working days after the date that the provider either gives or receives notice of termination.

2.7 As required by 50 Ill. Adm. Code 2051.290(g) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(h), the continuing obligations are as stated in the Agreement, in the event the Agreement does not include any continuing obligations, they are as follows:

(a) Upon the termination of this Agreement by either party for any reason, all rights and obligations hereunder shall cease, except (i) any confidentiality or dispute resolution rights and obligations; and (ii) those rights, obligations, and liabilities incurred prior to the date of termination.

(b) Upon termination of this Agreement for any reason, termination of any Network in which provider participates, under the terms of this Agreement, provider will:

(i) continue to provide health care services to members who are receiving treatment on the effective date of termination (1) until the course of treatment is completed; (2) for a period of ninety (90) days or through the current period of active treatment for those members undergoing active treatment for a chronic or acute medical condition, whichever time period is shorter; (3) throughout the second and third trimester of pregnancy and/or through postpartum care, if requested by the member; or (4) until provider makes reasonable and medically appropriate arrangements to transfer the member to the care of another provider, making such transfer to a provider whenever appropriate (except as specified in subsections (2) and (3) herein);

(ii) accept payment made pursuant to the Agreement, as payment in full, for covered services rendered in accordance with this Section; and

(iii) inform members seeking health care services that provider is no longer a network provider.

2.8 As required by 50 Ill. Adm. Code 2051.290(h) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(i), the rights and responsibilities under the contract cannot be sold, leased, assigned, assumed or otherwise delegated by either party without the prior written consent of the other party. The provider's written consent must be obtained for any assignment or assumption of the provider contract whenever an administrator or insurer is bought by another administrator or insurer. A clause within the provider contract allowing assignment will be deemed consent so long as the assignment is in accordance with the terms of the contract. The assignee must comply with all the terms and conditions of the contract being assigned, including all appendices, policies and fee schedules.

2.9 As required by 50 Ill. Adm. Code 2051.290(i) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(j), preferred provider has and will maintain adequate professional liability and malpractice coverage, through insurance, self-funding, or other means satisfactory to the administrator. The administrator must be notified within no less than 10 days after the provider's receipt of notice of any reduction or cancellation of the required coverage.

2.10 As required by 50 Ill. Adm. Code 2051.290(j) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(k), provider will provide health care services without discrimination against any beneficiary on the basis of participation in the preferred provider program, source of payment, age, sex, ethnicity, religion, sexual preference, health status or disability.

2.11 As required by 50 Ill. Adm. Code 2051.290(k) preferred provider shall collect applicable copayments, coinsurance and/or deductibles from beneficiaries as provided by the beneficiary's health care services contract and provide notice to beneficiaries of their personal financial obligations for non-covered services. DHCSP providers may not charge

beneficiaries more than any applicable discounted rates in accordance with payment terms and provisions contained in a DHCSP agreement signed by a beneficiary.

2.12 As required by 50 Ill. Adm. Code 2051.290(l) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(n), if provider is a physician, provider shall ensure that medical and health care services are available to beneficiaries 24 hours a day, 7 days a week. Reasonable exceptions may be made for the provider who, because of type of clinical specialty, or location or type of practice, does not customarily offer such availability.

2.13 As required by 50 Ill. Adm. Code 2051.290 (n) & (o) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(p) & (q), the administrator shall make its administrative handbook and operational procedures available to provider.

2.14 As required by 50 Ill. Adm. Code 2051.290(p) and if the provider participates in the workers' compensation network, as required by 50 Ill. Adm. Code 2051.295(r), the dispute resolution rights are as stated in the in the underlying Agreement. In the event the underlying Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook.

2.15 As required by 50 Ill. Adm. Code 2051.295(l) if the provider participates in the workers' compensation network preferred provider shall provide notice to beneficiaries of their personal financial obligations for non-covered services.

2.16 As required by 50 Ill. Adm. Code 2051.295(m), if the provider participates in the workers' compensation network, provider may charge covered employees for those services that are determined to be not compensable under the Workers' Compensation Act.

2.17 As required by 50 Ill. Adm. Code 2051.295(m), if the provider participates in the workers' compensation network, the employer shall make payment and providers shall submit bills and records in accordance with the provisions of Section.820 ILCS 305/8.2(d).

STATE LAW COORDINATING PROVISIONS: KENTUCKY

2.1 As required by K.R.S § 304.17A-270 and K.R.S § 304.17A-525(4), insurer, or its designee, may not terminate this Agreement without cause.

2.2 As required by K.R.S. § 304.17A-527(1)(a) and (1)(c), provider shall not bill, charge, collect a deposit, seek compensation, remuneration, or reimbursement from the subscriber, dependent of subscriber, enrollee, or any persons acting on their behalf, with respect to services provided in accordance with this Agreement under any circumstance including, but not limited to the managed care plans nonpayment of sums due to provider, the managed care plans insolvency, or breach of this Agreement. This section shall not prohibit collection of co-payments, deductibles, and/or co-insurance, and amounts for noncovered services. This provision shall survive the termination of this Agreement.

2.3 As required by K.R.S § 304.17A-527(1)(b) and (1)(c), in the event this Agreement is terminated, other than for quality of care or fraud, insurer shall continue to provide services and the plan shall continue to reimburse the provider pursuant to this Agreement until the subscriber, dependent of the subscriber, or the enrollee is discharged from an inpatient facility, or the active course of treatment is completed, whichever time period is greater; and (ii) through the end of the post-partum period if a pregnant woman is in her fourth or later month of pregnancy at the time this Agreement is terminated. This provision shall survive the termination of this Agreement.

2.4 As required by K.R.S § 304A-527(1)(d), the insurer issuing the managed care plan, or its designee, will, upon request of a participating provider, will provide or make available to the participating provider, when contracting or renewing an existing Agreement with such provider, the payment or fee schedules or other information sufficient to enable the provider to determine the manner and amount of payments under the Agreement for provider's services prior to the final execution or renewal of the Agreement. The insurer issuing the managed care plan, or its designee, shall provide any change in schedules at least ninety (90) days prior to the effective date of the amendment pursuant to K.R.S. § 304.17A-577.

2.5 As required by K.R.S. § 304.39-245 and Kentucky Department of Insurance Bulletin 2013-04, this Agreement applies to Kentucky no-fault benefits.

2.6 As required by K.R.S § 304.17A-527(1)(e), in the event provider subcontracts with another provider to provide their licensed health care services to the subscriber, dependent of the subscriber, or enrollee of a managed care plan where the subcontracted provider will bill the managed care plan or subscriber or enrollee directly for the subcontracted services, the subcontract agreement must meet all the requirements of K.R.S § 304A-527, and shall be filed with the Commissioner in accordance with K.R.S § 304A-527.

2.7 In the event a client/user has been certified by the Commonwealth of Kentucky as a Workers' Compensation Managed Health Care System pursuant to K.R.S. § 342.020, and as applicable to those providers that participate in the Workers' Compensation Network the provider shall:

(a) File any grievance defined by 803 KAR 25.110 Section 10 with the Managed Health Care System within thirty (30) days of the occurrence giving rise to the dispute;
(b) Such grievance shall be in writing setting forth the nature of the complaint and the remedial action requested by the provider; and;
(c) Include the provider's name and address; office contact and phone number; the Managed Health Care System and address; date of the occurrence; and employee's name and address.

Unless an alternate resolution process is provided by the Managed Health Care System, the Managed Health Care System will render a written decision within thirty (30) days of receipt by Managed Health Care System of a written grievance. It shall maintain records for two (2) years of each formal grievance which shall include the following:

(a) A description of the grievance;
(b) The employee's name and address;
(c) Names and addresses of the provider relevant to the grievance;
(d) The Managed Health Care System's and employer's name and address; and
(e) A description of the Managed Health Care System's findings, conclusions, and disposition of the grievance.

A provider dissatisfied with the Managed Health Care System's resolution of a grievance may apply for review by an administrative law judge by filing a request for resolution within thirty (30) days of the date of the Managed Health Care System's final decision. Upon review by an administrative law judge the provider shall be required to prove that the Managed Health Care System's final decision is unreasonable or otherwise fails to conform with K.R.S. Chapter 342.

2.8 In the event a client/user has been certified by the Commonwealth of Kentucky as a Workers' Compensation Managed Health Care System pursuant to K.R.S. § 342.020, and as applicable to those Network Providers that participate in the Workers' Compensation Network the following shall apply:

The Workers' Compensation Managed Health Care System administrator shall provide a spreadsheet biannually by April 15 and October 15 that will state any changes in a provider's availability since the Workers' Compensation Managed Health Care System's plan/network was approved. Name, address, phone number, and disposition of the provider shall be provided. This includes any providers added or removed from the network provider directory.

2.9 In the event a client/user has been certified by the Commonwealth of Kentucky as a Workers' Compensation Managed Health Care System pursuant to K.R.S. § 342.020, and as applicable to those providers that participate in the Workers' Compensation Network the employer, insurer, or payment obligor acting on behalf of the employer, shall make all payments for services rendered to an employee directly to the provider of the services within thirty (30) days of receipt of a statement for services. The commissioner shall promulgate administrative regulations establishing conditions under which the thirty (30) day period for payment may be tolled. The provider shall submit the statement for services within forty-five (45) days of the day treatment is initiated and every forty-five (45) days thereafter, if appropriate, as long as medical services are rendered.

STATE LAW COORDINATING PROVISIONS: LOUISIANA

2.1 As required by LSA-R.S. 22:1007(J)(1), provider is not required, as a condition of participation or continuation in the provider network of one or more health benefit plans of the managed care organization, to serve in the provider network of all or additional health benefit plans of the managed care organization. The managed care organization is prohibited from terminating provider agreement based on the provider's refusal to serve in its network for such additional plans.

STATE LAW COORDINATING PROVISIONS: MARYLAND

2.1 As required by MD Code, Insurance, § 15-125(c)(3), Health care provider has the right to elect not to serve on a provider panel for workers' compensation services.

2.2 As required by MD Code, Insurance, § 15-123(d) each carrier shall make the definition of experimental medical care available on their website or upon provider's request.

STATE LAW COORDINATING PROVISIONS: MASSACHUSETTS

2.1 As required by 211 CMR 52.03, Emergency Medical Condition means a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt

medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of a 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. § 1395dd(e)(1)(B).

2.2 As required by 211 CMR 52.11(1), carrier shall not refuse to contract with or compensate for covered services an otherwise eligible health care provider solely because such provider has in good faith:

(a) communicated with or advocated on behalf of one or more of his prospective, current or former patients regarding the provisions, terms or requirements of the carrier's health benefit plans as they relate to the needs of such provider's patients; or
(b) communicated with one or more of his prospective, current or former patients with respect to the method by which such provider is compensated by the carrier for services provided to the patient.

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

2.4 As required by 211CMR 52.11(6), neither the carrier nor the provider has the right to terminate the contract without cause.

2.5 As required by 211CMR 52.11(7), carrier shall provide a written statement to a provider of the reason or reasons for such provider's involuntary disenrollment.

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

2.7 As required by 211 CMR 52.11(9), providers shall not bill patients for charges for covered services other than for deductibles, copayments, or coinsurance.

2.8 As required by 211 CMR 52.11(10), health care providers shall not bill patients for nonpayment by the carrier of amounts owed under the contract due to the insolvency of the carrier. This requirement shall survive the termination of the contract for services rendered prior to the termination of the contract, regardless of the cause of the termination.

2.9 As required by 211 CMR 52.11(11) provider shall comply with the carrier's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

2.10 As required by 211 CMR 52.11(15), Nurse Practitioners and Physician Assistants acting within the scope of their professional license are recognized as Participating Providers under applicable terms of this Agreement.

2.11 As required by Mass. Gen. Laws Ch.176I § 2, within forty-five (45) days after the receipt by the organization of completed forms for reimbursement to the health care provider, the organization shall (i) make payments for the provision of such services, (ii) notify the provider in writing of the reason or reasons for nonpayment, or (iii) notify the provider in writing of what additional information or documentation is necessary to complete said forms for such reimbursement. If the organization fails to comply with the provisions of this paragraph for any claims related to the provision of health care services, said organization shall pay, in addition to any reimbursement for health care services provided, interest on such benefits, which shall accrue beginning forty-five (45) days after the organization's receipt of request for reimbursement at the rate of 1.5 per cent per month, not to exceed 18 per cent per year. The provisions of this paragraph relating to interest payments shall not apply to a claim that the organization is investigating because of suspected fraud.

2.12 As required by the Massachusetts Division of Insurance, provider shall provide advance disclosure or notification to the carrier of any arrangements to charge an annual fee to members as a condition to continue to be a part of a providers' panel of patients.

STATE LAW COORDINATING PROVISIONS: MISSISSIPPI

2.1 As required by 19 Miss. Admin. Code Pt. 3, R. 14.6 B., "Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a covered person or a person (other than the health carrier or intermediary) acting on behalf of the covered person for services provided pursuant to this agreement. This agreement does not prohibit

the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider (except for a health care professional who is employed full-time on the staff of a health carrier and has agreed to provide services exclusively to that health carrier's covered persons and no others) and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

2.2 As required by 19 Miss. Admin. Code Pt. 3, R. 14.6 C., in the event of a health carrier or intermediary insolvency or other cessation of operations, covered services to covered persons will continue through the period for which a premium has been paid to the health carrier on behalf of the covered person or until the covered person's discharge from an inpatient facility, whichever time is greater. Covered benefits to covered persons confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until their continued confinement in an inpatient facility is no longer medically necessary.

2.3 As required by MS ST § 83-9-5(1)(h) and (8)(d), upon request by an insured and/or by a provider submitting a claim, the insurer shall provide a written list of the information and the documentation required for the insurer to deem a claim to be clean, and the insurer shall then be bound to such list.

STATE LAW COORDINATING PROVISIONS: NEBRASKA

2.1 As required by R.R.S. Neb. § 44-7106(2)(j), provider shall make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and comply with the applicable state and federal laws related to the confidentiality of medical or health records.

STATE LAW COORDINATING PROVISIONS: NEVADA

2.1 As required by N.R.S. 687B.690, Provider of health care agrees that in no event, including but not limited to, nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary or breach of this agreement, shall the provider of health care bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against, a covered person or a person (other than the health carrier) acting on behalf of the covered person for health care services provided pursuant to this agreement. This agreement does not prohibit the provider of health care from collecting coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. This agreement does not prohibit a provider of health care (except for a provider of health care who is employed full-time on the staff of the health carrier and has agreed to provide health care services exclusively to the health carrier's covered persons and no others) and a covered person from agreeing to continue health care services solely at the expense of the covered person, as long as the provider of health care has clearly informed the covered person that the health carrier may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this agreement does not prohibit the provider of health care from pursuing any available legal remedy.

2.2 As required by N.R.S. 687B.700, in the event of the insolvency of the health carrier or any applicable intermediary, or in the event of any other cessation of operations of the health carrier or intermediary, the participating provider of health care must continue to deliver health care services covered by the network plan to a covered person without billing the covered person for any amount other than coinsurance, deductibles or copayments, as specifically provided in the evidence of coverage, until the earlier of:

(a) The date of the cancellation of the covered person's coverage under the network plan pursuant to NRS 687B.310, including, without limitation, any extension of coverage provided pursuant to:
  (i) The terms of the contract between the covered person and the health carrier;
  (ii) NRS 689A.04036, 689B.0303, 695B.1901, 695C.1691 and 695G.164, as applicable; or
  (iii) Any applicable federal law for covered persons who are in an active course of treatment or totally disabled; or

(b) The date on which the contract between the health carrier and the provider of health care would have terminated if the health carrier or intermediary, as applicable, had remained in operation, including, without limitation, any extension of coverage provided pursuant to:
  (i) The terms of the contract between the covered person and the health carrier;
  (ii) NRS 689A.04036, 689B.0303, 695B.1901, 695C.1691 and 695G.164, as applicable; or
  (iii) Any applicable federal law for covered persons who are in an active course of treatment or totally disabled.

2.3 As required by N.R.S. 687B.720, written notice must be provided to the participating provider of health care as soon as practicable in the event (1) that a court determined the health carrier or any applicable intermediary to be insolvent; or (2) of any other cessation of operations of the health carrier or any applicable intermediary.

2.4 As required by N.R.S. 687B.760, participating provider of health care must make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of covered persons, and comply with the applicable state and federal laws related to the confidentiality of medical and health records and the covered person's right to see, obtain copies of or amend their medical and health records.

2.5 As required by N.R.S. 687B.770, neither the health carrier nor the participating provider of health care may assign or delegate the rights and responsibilities of either party under the contract without the prior written consent of the other party.

2.6 As required by N.R.S. 687B.830, unless otherwise stated in the underlying Agreement,
(i) Material Change shall mean any change to the Agreement (including provider documents) that have a material adverse impact on provider; and
(ii) Timely Notice shall mean at least thirty (30) days prior notice to the provider.

STATE LAW COORDINATING PROVISIONS: NEW HAMPSHIRE

2.1 As required by N.H. Rev. Stat. § 420-J:8 (I)(a):

(a) Provider agrees that in no event, including but not limited to nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek payment or reimbursement from, or have recourse against a covered person or a person acting on behalf of the covered person (other than the health carrier or intermediary) for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider and a covered person from agreeing to continue services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific service or services. Except as provided in N.H. Stat. § 420-J:8, this agreement does not prohibit the provider from pursuing any available legal remedy.

(b) Provider further agrees that (1) 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 covered person; and (2) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between provider and covered person or persons acting on their behalf.

2.2 As required by N.H. Rev. Stat. § 420-J:8(X) health carrier may not remove a health care provider from its network or refuse to renew the health care provider with its network for participating in a covered person's internal grievance procedure or external review.

2.3 As required by N.H. Rev. Stat. § 420-J:8(XI) covered persons will have continued access to the provider in the event that the contract is terminated for any reason other than unprofessional behavior. The continued access to providers shall be made available for 60 days from the date of termination of the contract and shall be provided and paid for in accordance with the terms and conditions of the covered person's health benefit plan and the prior contract between a health carrier and a health care provider. Within 5 business days of the contract termination, the health carrier shall provide written notice to affected covered persons explaining their continued access rights.

2.4 As required by N.H. Rev. Stat. § 420-J:8(XVIII) health care provider must notify a health carrier when the health care provider is no longer accepting new patients. Notification shall take place no more than 30 days after the date the health care provider is no longer accepting new patients.

STATE LAW COORDINATING PROVISIONS: NEW JERSEY

2.1 As required by N.J.A.C. 11:24B-5.2(a)(1), any provision of this Agreement that conflicts with State or Federal law is hereby amended to conform to such applicable State or Federal or law.

2.2 As required by N.J.A.C. 11:24B-5.2(a)(2), provider shall comply with the appeal rights specific to denial of additional provider compensation as stated in the underlying Agreement. In the event the underlying Agreement does not state such appeal rights, the provider may appeal a decision denying the provider additional compensation to which provider believes he or she is entitled under the terms of the provider agreement.

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

2.4 As required by N.J.A.C. 11:24B-5.2(a)(4), provider shall comply with the quality assurance program of the ODS and/or carrier, as applicable, and as stated in the underlying Agreement. In the event the underlying Agreement does not contain information regarding the quality assurance program, provider shall observe the quality assurance protocols contained in the administrative handbook. ODS shall be responsible for the day to day administration of its quality assurance program. If provider has a complaint regarding the quality assurance program, provider may follow the complaint process in the underlying Agreement. In the event the underlying Agreement does not include a mechanism to lodge a complaint, provider may contact Claritev's Service Operations Department.

2.5 As required by N.J.A.C. 11:24B-5.2(a)(5) & (6), provider shall comply with the carrier's utilization management ("UM") program. Carrier is responsible for the day-to-day operation of its UM program. Provider may contact carrier via the phone number or website indicated on covered persons identification for information regarding UM decisions, appeals and protocols as required by N.J.A.C. 11:24B-5.2 (a)(5)(ii)-(iv). Provider may rely upon the written or oral authorization for a service if made by carrier. Services shall not be retroactively denied as not medically necessary except in cases of material misrepresentation of the facts or fraud to carrier. In the event that an appeal instituted by a provider on behalf of a covered person will be entertained as a member utilization management appeal without covered person's consent, the appeal will not be eligible for the Independent Health Care Appeals Program, established pursuant to N.J.S.A. 26:2S-11, until the covered person's specific consent to the appeal is obtained.

2.6 As required by N.J.A.C. 11:24B-5.2(a)(7), this Agreement is governed by New Jersey law with respect to health care services rendered in the State of New Jersey.

2.7 As required by N.J.A.C. 11:24B-5.2(a)(8), the term of this Agreement is as stated in the underlying Agreement. In the event the underlying Agreement does not state the term of this Agreement, then this Agreement will become effective on the effective date of the underlying Agreement and will continue in effect for a period of one (1) year ("Initial Term"). Unless otherwise terminated, this Agreement shall renew automatically for consecutive one (1) year terms ("Renewal Term") on each anniversary of the effective date ("Renewal Date").

2.8 As required by N.J.A.C. 11:24B-5.2(a)(9) and N.J.A.C. 11:24B-5.3 (a), the termination rights are as stated in the underlying Agreement. In the event the underlying Agreement does not include any termination rights, the termination rights are as follows:

Discretionary Termination. After the expiration of the Initial Term, this Agreement may be terminated in the sole discretion of either party, by the provision of written notice at least ninety (90) days prior to the Renewal Date, such termination to be effective on the Renewal Date.

Termination for Material Breach.

(a) This Agreement may be terminated by ODS upon written notice to provider if (i) any action is taken which requires provider to provide ODS with notice; (ii) in the sole discretion of ODS, if provider fails to comply with the quality management and/or credentialing/recredentialing program(s) specified in the administrative handbook(s); or (iii) provider fails to comply with any applicable state and/or federal law related to the delivery of health care services.
(b) In the event that one party commits a material breach of this Agreement (the "Breaching Party") this Agreement will terminate upon the provision of at least thirty (30) days written notice to the Breaching Party specifying the material breach. The Breaching Party may cure the breach within such thirty (30) day period, provided however, that failure to cure said breach will result in termination as of the date specified in the notice.

Network Participation Termination. Either party may terminate this Agreement as to any of the networks in which provider participates by the provision of at least ninety (90) days prior written notice to the other party provided however, provider maintains participation in at least one network. Termination of a Network will not terminate this Agreement as to any other Networks in which provider participates.

2.9 As required by N.J.A.C. 11:24B-5.2(a)(10), provider shall not bill or otherwise pursue payment from a carrier's covered person for the costs of services or supplies rendered in-network that are covered, or for which benefits are payable, under the covered person's health benefits plan, except for copayment, coinsurance or deductible amounts set forth in the health benefits plan, regardless of whether the provider agrees with the amount paid or to be paid, for the services or supplies rendered.

2.10 As required by N.J.A.C. 11:24B-5.2(a)(11), provider shall cooperate and comply with the terms of the credentialing/recredentialing program(s) and otherwise be eligible to participate in various programs, as appropriate. Initial Credentialing shall be completed prior to provider's participation in a network and recredentialing shall be completed every three (3) years thereafter or as otherwise required by ODS policy.

2.11 As required by N.J.A.C. 11:24B-5.2(a)(12), provider will maintain professional liability insurance as required by the underlying Agreement, but such amount shall not be less than $1,000,000 per occurrence and $3,000,000 in the aggregate per year.

2.12 As required by N.J.A.C. 11:24B-5.2(a)(13), provider will render medical and health care services in a manner which assures availability, adequacy, and continuity of care to covered persons. Health care services means health care treatment and supplies rendered by a provider and provided to a covered person for which a carrier is responsible for payment pursuant to the terms of a health benefits plan.

2.13 As required by N.J.A.C. 11:24B-5.2(a)(14), provider has the right and obligation to communicate openly with covered persons regarding diagnostic tests and treatment options.

2.14 As required by N.J.A.C. 11:24-5.2(a)(15), provider shall not be terminated or otherwise penalized because of complaints or appeals that the provider files on his or her own behalf, or on behalf of a covered person, or for otherwise acting as an advocate for covered persons in seeking appropriate, medically necessary health care services covered under the covered person's health benefits plan.

2.15 As required by N.J.A.C. 11:24B-5.2(a)(16), provider shall not discriminate in his or her treatment of a carrier's covered persons.

2.16 As required by N.J.A.C. 11:24B-5.2(a)(17) and N.J.A.C. 11:22-3.4, all providers shall file claims for payment unless the patient, at his or her option, files the claim directly. Where a claim is being filed by the provider on behalf of the patient without an assignment of benefits, the provider shall file the claim within 60 days of the last date of service of that course of treatment. Where the provider is filing a claim under an assignment of benefits from the patient, the provider shall file the claim within 180 days of the last date of service of the course of treatment. If the carrier or its agent fails to pay a clean claim within the time limits set forth in N.J.A.C. 11:22-1.5, the carrier shall include simple interest on the claim amount at the rate of 10 percent per year and shall either add the interest amount to the claim amount when paying the claim or issue an interest payment within 14 days of the payment of the claim. Interest shall accrue beginning thirty (30) or forty (40) days, as applicable, from the date all information and documentation required to process the claim is received by the carrier. The carrier may aggregate interest amounts up to $ 25.00, with the consent of the provider. In no event shall provider be required to request payment of such interest from, as applicable, as a condition of receiving such interest payment.

2.17 As required by N.J.A.C. 11:24B-5.2(a)(17) and N.J.A.C. 11:22-3.4, in the event a provider does not file the claim within one hundred eighty (180) days of the last date of service of a course of treatment, the carrier shall in accordance with N.J.A.C. 11:22-1.6 reserve the right to deny or dispute the claim and the provider shall be prohibited from seeking payment in whole or in part directly from the patient. Carrier shall advise provider that payment of the claim, in whole or in part, will be made based upon consideration of the following factors that shall be addressed by the provider: (i) the good faith use of information provided by the patient to the provider with respect to the identity of the patient's health benefits payer; (ii) delays encountered in filing a claim related to the coordination of benefits among third party payers; (iii) whether the provider has previously filed untimely claims or has an established pattern of untimely claim practices; (iv) any prejudice to the rights of the patient and/or the health benefits provider in determination of the medical necessity of the services and care being billed for; and (v) potential adverse impact to the public.

2.18 As required by N.J.A.C. 11:24B-5.2 (a)(17) and N.J.A.C. 11:22-3.4, providers failing to file a claim within one hundred eighty (180) days in accordance with N.J.A.C. 11:22-3.4(d) whose claim for payment has been denied in whole or in part may, in the discretion of a Judge of the Superior Court, be permitted to refile the claim where there has not been substantial prejudice to the health benefit payer. Application to the Superior Court for permission to refile a claim shall be made within 14 days of the notification of denial of payment and shall be made upon motion based upon affidavit(s) showing sufficient reason(s) for the failure to file the claim with the third party payer within the required time.

2.19 As required by N.J.A.C. 11:24B-5.2(a)(18), the dispute resolution process is as stated in the underlying Agreement. In the event the underlying Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook. Provider may submit and seek resolution of a complaint or grievance, separate and apart from submitting complaints and grievances on behalf of covered person(s), and complaints addressing compensation of claims issues to ODS at MultiPlan, Inc., d/b/a Claritev, Inc., Service Operations Department, 16 Crosby Drive Bedford, MA 01730. Such resolution shall not exceed thirty (30) calendar days

following the receipt of the complaint or grievance. In the event provider is not satisfied with the resolution of the complaint or grievance, provider may submit the complaint or grievance to the New Jersey Department of Banking and Insurance or the New Jersey Department of Human Services, depending on the issue involved.

2.20 As required by N.J.A.C. 11:24B-5.2(a)(19), all information and materials provided by ODS or carrier to provider will remain proprietary to ODS or carrier, respectively. Provider will not disclose any of such information or materials or use them except as may be required to carry out its respective obligations under this Agreement. Provider shall comply with the confidentiality of medical and billing records as stated in the underlying Agreement. In the event, the underlying Agreement does not contain a provision with respect to the confidentiality of medical and billing records then provider will comply with all state and federal laws and the requirements specified in the ODS administrative handbook(s) pertaining to the confidentiality of medical and billing records, and will keep confidential, and take all precautions to prevent the unauthorized disclosure of any and all medical and billing records.

2.21 As required by N.J.A.C. 11:24B-5.2(c)(8), nothing in this Agreement shall require provider to assure that it never charges ODS or carrier a rate that is greater than the least amount charged to another entity with which the provider contracts for similar services.

2.22 As required by N.J.A.C. 11:24B-5.3(a)(2), in the event provider believes that a carrier has repeatedly failed to comply with requirements specified in this Agreement with respect to the timely payment of claims to provider or otherwise failed to abide by the requirements for access to this Agreement, provider shall notify ODS and carrier immediately in writing and may request that such carrier be excluded from access under this Agreement. Within thirty (30) days of receipt of such notice from provider, or within such extended time period to which the parties mutually agree ("Resolution Time Period"), ODS will attempt to resolve the matter, pursuant to the Agreement, to the reasonable satisfaction of provider such that the carrier will not be excluded from access under this Agreement. At the end of the Resolution Time Period, if ODS finds that the carrier failed to adequately abide by the requirements for access to this Agreement and cannot resolve the matter to the reasonable satisfaction of provider, ODS shall exclude such carrier from access under this Agreement effective thirty (30) days after the expiration of the Resolution Time Period.

2.23 As required by N.J.A.C. 11:24B-5.3(c), if the provider is a health care professional, when the provider's status as a participating provider in a network is being terminated, written notice shall be issued to the provider no less than 90 days prior to the date of termination, except that the 90-day prior notice requirement need not apply when the contract is being terminated upon its date of renewal, or upon its anniversary date, if no annual renewal date is specified, or is being terminated because of breach, alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare. The health care professional shall receive a written statement setting forth the reason(s) for the termination, and the procedures for obtaining such a written statement, in the event that the written notice of termination does not include a statement setting forth the reason(s) for the termination.

2.24 As required by N.J.A.C. 11:24B-5.3(d), the health care professional shall have the right to request a hearing following a notice that the health care professional's status as a participating provider with a carrier is being terminated, except that the right to a hearing may not apply when the termination occurs on the date of renewal of the contract, or upon the contract's anniversary date, if no annual renewal date is specified, or termination is based on breach or alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

2.25 As required by N.J.A.C. 11:24B-5.3(e), provider may submit a request for a hearing as outlined in the letter of termination sent by ODS when a health care professional is terminated from participation in the ODS's network. The hearing procedures shall be consistent with the requirements of N.J.A.C. 11:24-3.6 or 11:24A-4.9, as appropriate.

2.26 As required by N.J.A.C. 11:24B-5.3(f) and (g), when a provider's status as a participating provider is terminated, or when the contract between the ODS and the provider terminates, regardless of the party initiating the termination, the provider, if a physician, shall remain obligated to provide services for covered persons in accordance with the following:

1. For up to four months following the effective date of the termination in cases where it is medically necessary for the covered person to continue treatment with the health care professional, except as 2 through 5 below applies;
2. In cases of the pregnancy of a covered person, through the postpartum evaluation of the covered person, up to six weeks after delivery;
3. In the case of post-operative care, up to six months following the effective date of the termination;
4. In the case of oncological treatment, up to one year following the effective date of the termination; and
5. In the case of psychiatric treatment, up to one year following the effective date of the termination.

The above referenced obligations for provider to continue to provide care, and for the carrier or its designee to pay for services rendered by the provider following the effective date of termination do not apply when the termination is

based on breach or alleged fraud, or because, in the opinion of the medical director of either the ODS or the carrier, if different, the health care professional presents an imminent danger to one or more covered persons, or the public health, safety or welfare.

2.27 As required by N.J.A.C. 11:24C-4.3(c)(5), carrier may enter into an agreement with third parties allowing the third parties to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

2.28 In the event that provider is offering services or supplies to a covered person for a carrier or intermediary that has been approved by the State of New Jersey as a Workers' Compensation Managed Care Organization pursuant to N.J.A.C. 11:6-2.3 then as required by N.J.A.C. 11:6-2.10(d)(4), provider shall hold such covered person harmless for the cost of any services or supplies under the carrier's or intermediary's program for workers' compensation, whether or not the provider believes its compensation for services or supplies from the carrier or intermediary is made in accordance with the reimbursement provisions of this Agreement, or is otherwise inadequate.

STATE LAW COORDINATING PROVISIONS: NEW MEXICO

2.1 As required by Subsection C of 13.10.22.12 NMAC, "Health care professional/health care facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall health care professional/health care facility bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a subscriber, enrollee, covered person, or person acting on behalf of the covered person, for health care services provided pursuant to this agreement. This does not prohibit health care professional/health care facility from collecting co-insurance, deductibles, 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 the health insuring corporation or its successor."

2.2 As required by Subsection D of 13.10.22.12 NMAC, contracted health care professionals and health care facilities, shall comply with administrative policies and programs in the administrative handbook, including, but not limited to, payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs.

2.3 As required by Subsection E of 13.10.22.12 NMAC, health care professionals and health care facilities shall maintain and make available health records to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the medical necessity and appropriateness of health care services provided to covered persons. Health care professional or health care facility shall make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of covered persons. Health care professional or health care facility shall comply with applicable state and federal laws related to the confidentiality of medical or health records.

2.4 As required by Subsection F of 13.10.22.12 NMAC, the contractual rights and responsibilities of this agreement may not be assigned or delegated by the provider without the prior written consent of the contracting Managed Health Care Plan.

2.5 As required by Subsection G of 13.10.22.12 NMAC, health care professional or health care facility shall maintain adequate professional liability and malpractice insurance. Health care professional or health care facility shall notify the health care insurer or Managed Health Care Plan not more than ten days after the provider's receipt of notice of any reduction or cancellation of such coverage.

2.6 As required by Subsection H of 13.10.22.12 NMAC, health care professional or health care facility shall observe, protect, and promote the rights of covered persons as patients.

2.7 As required by Subsection I of 13.10.22.12 NMAC, health care professional or health care facility shall provide health care services without discrimination on the basis of a patient'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 health care services rendered to a patient. This requirement shall not apply to circumstances when the health care professional or health care facility appropriately does not render services due to limitations arising from the health care professional's or health care facility's lack of training, experience, or skill, or due to licensing restrictions. Health care insurer or Managed Health Care Plan shall provide interpreters for limited English proficient (LEP) individuals and interpretative services for patients who qualify under the Americans with Disabilities Act (ADA). Such interpretive services will be made available to provider's office at no cost to the provider.

2.8 As required by Subsection J of 13.10.22.12 NMAC , health care professional or health care facility will ensure that covered health care services are available twenty-four hours per day, seven days per week.

2.9 As required by Subsection K of 13.10.22.12 NMAC, the dispute resolution process is as stated in the underlying Agreement. In the event that the agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook.

2.10 As required by Subsection L of 13.10.22.12 NMAC , the hold harmless provision required by Subsection C of 13.10.22.12 NMAC shall survive the termination of the contract regardless of the reason for the termination, including the insolvency of the health care insurer or Managed Care Health Plan.

2.11 As required by Subsection M of 13.10.22.12 NMAC, those terms used in the contract and that are defined by New Mexico statutes and division regulations will be used in the contract in a manner consistent with any definitions contained in said laws or regulations.

2.12 As required by Subsection O of 13.10.22.12 NMAC, Managed Health Care Plans ("MHCP") failing to pay a health care professional or failing to pay a covered person for out of pocket covered expenses within forty-five (45) days after a clean claim has been received by the MHCP shall be liable for the amount due and unpaid with interest on that amount at the rate of one and one half times the rate established by a bulletin entered by the superintendent in January of each calendar year.

STATE LAW COORDINATING PROVISIONS: NEW YORK

2.1 As required by NY CLS Ins § 3217-b(e), the dispute resolution process is stated in the underlying Agreement. In the event that the Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook. In addition, either party to the contract may seek resolution of a dispute arising pursuant to the payment terms of the contracts through a proceeding under article seventy-five of the civil practice law and rules.

2.2 As required by NY CLS Ins § 3217-b(m), health care provider shall have in place business processes to ensure the timely provision of provider directory information to the insurer. A health care provider shall submit such provider directory information to an insurer, at a minimum, when a provider begins or terminates a network agreement with an insurer, when there are material changes to the content of the provider directory information of the health care provider, and at any other time, including upon the insurer's request, as the health care provider determines to be appropriate. "Provider directory information" shall include the name, address, specialty, telephone number, and digital contact information of such health care provider; whether the provider is accepting new patients; for mental health and substance use disorder services providers, any affiliations with participating facilities certified or authorized by the office of mental health or the office of addiction services and supports, and any restrictions regarding the availability of the individual provider's services; and in the case of physicians, board certification, languages spoken, and any affiliations with participating hospitals.

2.3 As required by NY CLS Ins § 3217-b(n,) provider shall reimburse the insured for the full amount paid by the insured in excess of the in-network cost-sharing amount, plus interest at an interest rate determined by the superintendent in accordance with 42 U.S.C. § 300gg-139(b), for the services involved when the insured is provided with inaccurate network status information by the insurer in a provider directory or in response to a request that stated that the provider was a participating provider when the provider was not a participating provider. In the event the insurer provides inaccurate network status information to the insured indicating the provider was a participating provider when such provider was not a participating provider, the insurer shall reimburse the provider for the out-of-network services regardless of whether the insured's coverage includes out-of- network services.

2.4 As required by NY CLS Ins § 3224-a(g), the timeframe for submission of claims is as stated in the underlying Agreement. If there is no timeframe stated, then except as otherwise provided by law, health care claims must be initially submitted by health care providers within one hundred twenty days after the date of service to be valid and enforceable against an insurer.

2.5 As allowed by NY CLS Ins § 3224-a(h)(2),an insurer may reduce the reimbursement due to a health care provider for an untimely claim that otherwise meets the requirements of NY CLS Ins § 3224-a(h)(1) by an amount not to exceed twenty-five percent of the amount that would have been paid had the claim been submitted in a timely manner; provided, however, that nothing in NY CLS Ins § 3224-a(h)(2) shall preclude a health care provider and an insurer or organization or corporation from agreeing to a lesser reduction. The provisions of this subsection shall not apply to any claim submitted three hundred sixty-five days after the date of service, in which case the insurer or organization or corporation may deny the claim in full.

STATE LAW COORDINATING PROVISIONS: NORTH CAROLINA

II. DEFINITIONS:

Depending upon the specific form of the Agreement, the following terms may be utilized in the Agreement and are intended to be defined as provided for in the Agreement:

2.1 Billed Charges may be referred to as Regular Billing Rates;
2.2 Client may be referred to as Payor;
2.3 Contract Rates may be referred to as Preferred Payment Rates;
2.4 Covered Services may be referred to as Covered Care;
2.5 Network Provider may be referred to as Preferred Provider;
2.6 Participant may be referred to as Covered Individual; and
2.7 Program or Benefit Program may be referred to as Contract.

For purposes of this Exhibit, the term Network Provider is inclusive of Participating Professional and all Network Providers.

3.1 As required by the North Carolina Department of Insurance, Emergency Medical Condition is defined pursuant to N.C.G.S. § 58-3-190(g)(1) to mean 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:
a. 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.
b. Serious impairment to bodily functions.
c. Serious dysfunction of any bodily organ or part.

3.2 As required by the North Carolina Department of Insurance, Emergency Services is defined pursuant to N.C.G.S. § 58-3-190(g)(2) to mean health care items and services furnished or required to be screened for or treated an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

3.3 As required by the North Carolina Department of Insurance, Medical Necessity is defined pursuant to N.C.G.S. § 58-3-200(b) to mean covered services or supplies that are:
(a) Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease.
(b) Not for experimental, investigational, or cosmetic purposes, except as allowed by N.C.G.S. § 58-3-255.
(c) Necessary for, and appropriate to, the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
(d) Within generally accepted standards of medical care in the community.
(e) Not solely for the convenience of the Participant, the Participant's family, or the Network Provider.

3.4 As required by N.C.G.S. § 58-3-200(c), in the event Client or User, or an authorized representative of Client or User, as applicable, determines that services, supplies, or other items are covered under its Program, including any determination under N.C.G.S. § 58-50-61, Client/User shall not subsequently retract its determination after the services, supplies, or other items have been provided, or reduce payment for such services furnished in reliance on such a determination, unless the determination was based upon a material misrepresentation about the Participant's health condition that was knowingly made by the Participant or Network Provider who provided the service, supply, or other item.

3.5 As required by N.C.G.S. § 58-3-225(b), (d), and (f), Network Provider shall submit claims for payment within one hundred eighty (180) calendar days of furnishing health care services. In the event the claim is not a Clean Claim, Client or User, as applicable, shall, within thirty (30) calendar days, notify Network Provider that such claim is incomplete. In the event Client/User requires additional information to process the claim, Client/User shall allow Network Provider ninety (90) business days to submit such additional information. Unless otherwise agreed to, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for Network Provider to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of Participant, later than one year from the time submittal of the claim is otherwise required.

3.6 As required by N.C.G.S. § 58-3-225(h), Network Provider may collect underpayments or nonpayments by Client or User, as applicable, for a time period of up to two (2) years. Client or User, as applicable, may recover overpayments or offset future payments for a time period of up to two (2) years after the date of the original claim payment unless Client or User, as applicable, has reasonable belief of fraud or other intentional misconduct by Network Provider.

3.7 As required by N.C.G.S. § 58-50-270(1), "Amendment" means any change to the terms of this Agreement, including terms incorporated by reference, that modifies fee schedules. A change required by federal or State law, rule, regulation, administrative hearing, or court order is not an Amendment.

3.8 As required by N.C.G.S. § 58-50-275(b), all notices provided under this Agreement shall be one or more of the following, calculated as (i) five (5) business days following the date the notice is placed, first class postage prepaid, in the United States mail; (ii) on the day the notice is hand delivered; (iii) for certified or registered mail, the date on the return receipt; or (iv) for commercial courier service the date of delivery. Notwithstanding the foregoing, nothing in N.C.G.S. § 58-50-275(b) prohibits the use of electronic medium for a communication other than an Amendment if agreed to by the parties.

3.9 As required by N.C.G.S. § 58-50-280(a), Claritev shall send any proposed Amendment to the notice contact of Network Provider. The proposed Amendment shall be dated and labeled "Amendment," signed by a representative of Claritev and include an effective date for the proposed Amendment.

3.10 As required by N.C.G.S. § 58-50-280(b), upon receipt of a proposed Amendment, Network Provider shall be given at least sixty (60) days to object to such proposed Amendment. If Network Provider fails to object in writing to the proposed Amendment within such sixty (60) day time period, the Amendment shall be effective.

3.11 As required by N.C.G.S. § 58-50-280(c), in the event Network Provider provides written notice to Claritev objecting to a proposed Amendment within the sixty (60) day time period, the proposed Amendment will not become effective and Claritev has the right to terminate this Agreement.

3.12 As required by N.C.G.S. § 58-50-280(d), nothing in N.C.G.S. § 58-50-280 prohibits Network Provider and Claritev from negotiating terms that provide for mutual consent to an Amendment, a process for reaching mutual consent, or alternative notice contacts.

3.13 As required by N.C.G.S. § 58-50-285(a), Client/User or Claritev, as applicable, shall provide copies of its policies and procedures to Network Provider prior to execution of a new or amended agreement and annually to all contracted Network Providers. Such policies and procedures may be provided to Network Provider in hard copy, CD, or other electronic format, and may also be provided by posting the policies and procedures on the website of the Client/User or Claritev.

3.14 As required by N.C.G.S. § 58-50-285(b), the policies and procedures of Client/User or Claritev, as applicable, shall not conflict with or override any term of this Agreement, including fee schedules. In the event of a conflict between the policy and procedure and the language in this Agreement, the Agreement shall prevail.

3.15 As required by 11 N.C.A.C. 20.0202(5)(a), in the event this Agreement is terminated or Client/User or Claritev becomes insolvent, Network Provider shall ensure that any administrative duties and records regarding Participants shall be transitioned as requested by Client/User or Claritev.

3.16 As required by 11 N.C.A.C. 20.0202(6), Network Provider shall maintain licensure, accreditation, and credentials sufficient to meet Claritev's credential verification program requirements and shall notify Claritev of any subsequent changes in any information relating to Network Provider's professional credentials.

3.17 As required by 11 N.C.A.C. 20.0202(7), Network Provider shall notify Claritev of any changes in Network Provider's professional liability insurance.

3.18 As required by 11 N.C.A.C 20.0202(9), Network Provider shall arrange for call coverage or other back-up to provide service in accordance with Client's/User's and/or Claritev's provider accessibility standards.

3.19 As required by 11 N.C.A.C. 20.0202(10), Client shall provide a mechanism that allows Network Provider to verify Participant eligibility, based on current information held by Client, before rendering health care services.

3.20 As required by 11 N.C.A.C. 20.0202(11), Network Provider shall maintain the confidentiality of Participant medical records and personal information as required by N.C.G.S. 58, Article 39, and other health records as required by law. Network Provider shall maintain adequate medical and other health records according to industry, Claritev, and Client/User standards. Network Provider shall make copies of such records available to Client/User and the North Carolina Department of Insurance ("DOI"), in conjunction with the DOI's regulation of Client/User.

3.21 As required by 11 N.C.A.C. 20.0202(12), Network Provider shall cooperate with Participants in all grievance processes.

3.22 As required by 11 N.C.A.C. 20.0202(13), Network Provider shall not discriminate against Participants on the basis of race, color, national origin, gender, age, religion, marital status, health status, or health insurance coverage.

3.23 As required by 11 N.C.A.C. 20.0202(15), Claritev, Client or User, as applicable, shall provide Network Provider with information on (i) benefit exclusions; (ii) credential verification program; (iii) quality assessment programs; (iv) provider sanction programs; (v) administrative requirements; and (vi) utilization review. In the event the preceding information is revised, Claritev, Client or User, as applicable, shall notify Network Provider and shall allow Network Provider time to comply with such revisions.

3.24 As required by 11 N.C.A.C. 20.0202(16), Network Provider shall comply with Client's/User's or Claritev's, as applicable, (i) utilization management program; (ii) credential verification program; (iii) quality management program; and (iv) provider sanctions program. None of these shall override the professional and ethical responsibility of Network Provider or interfere with Network Provider's ability to provide information or assistance to Participants.

3.25 As required by 11 N.C.A.C. 20.0202(17), Network Provider authorizes Client/User to include such Network Provider in Client's/User's provider directory. Client/User shall include such Network Provider in its provider directory that Client/User distributes to Participants.

3.26 As required by 11 N.C.A.C. 20.0202(19), Network Provider's duties and obligations under this Agreement shall not be assigned, delegated, or transferred without the prior written consent of Claritev. Claritev shall notify Network Provider, in writing of any duties or obligations that are to be delegated or transferred.

3.27 As required by 11 N.C.A.C. 20.0204, in the event Network Provider is an IPA, Network Provider shall:
(i) ensure that all provider contracts utilized by Network Provider with its Participating Providers, i.e. Participating Professional and/or Participating Facility, shall comply with and include the applicable provisions of 11 N.C.A.C. 20.0202;
(ii) retain its legal responsibility to monitor and oversee the offering of services to its members and financial responsibility to its members;
(iii) not subcontract for its services without Claritev's written permission;
(iv) ensure that Claritev has the right to approve or disapprove of participation of Participating Providers;
(v) make available for review by the North Carolina Department of Insurance, all provider contracts and subcontracts held by such Network Provider;
(vi) comply with all applicable statutory and regulatory requirements that apply to the functions delegated by Network Provider to its Participating Providers.

3.28 As required by the North Carolina Department of Insurance, for the PHCS or Primary Network in North Carolina, Claritev contracts on behalf of itself and its wholly owned subsidiary Private Healthcare Systems, Inc.

STATE LAW COORDINATING PROVISIONS: NORTH DAKOTA

2.1 As required by N.D. Cent. Code, § 26.1-53-04, providers offering medical services to members under a discount medical plan will not charge members more than the discounted rates.

STATE LAW COORDINATING PROVISIONS: OHIO

2.1 As required by RC § 1751.13(C)(2), "Provider/Health Care Facility agrees that in no event, including but not limited to nonpayment by the health insuring corporation, insolvency of the health insuring corporation, or breach of this agreement, shall Provider/Health Care Facility 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 covered enrollee, for health care services provided pursuant to this agreement. This does not prohibit Provider/Health Care Facility from collecting co-insurance, deductibles, 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 the health insuring corporation or its successor."

2.2 As required by RC § 175113(C)(3), provider or health care facility shall continue to provide covered health care services to enrollees in the event of the health insuring corporation's insolvency or discontinuance of operations. Provider or health care facility shall continue to provide covered health care services to enrollees as needed to complete any medically necessary procedures commenced but unfinished at the time of the health insuring corporation's insolvency or discontinuance of operations. The completion of a medically necessary procedure shall include the rendering of all covered health care services that constitute medically necessary follow-up care for that procedure. If an enrollee is receiving necessary inpatient care at a hospital, provision of covered health care services relating to that inpatient care may be limited in accordance with division (D)(3) of section 1751.11 of the Revised Code, and may also be limited to the period ending thirty days after the health insuring corporation's insolvency or discontinuance of operations.

2.3 As required by RC § 175113(C)(4), the rights and responsibilities of the health insuring corporation, and of the contracted providers and health care facilities, with respect to administrative policies and programs, including, but not limited to, payments systems, utilization review, quality assurance, assessment, and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs are as stated in the underlying Agreement and/or the Administrative Handbook.

2.4 As required by RC § 1751.13(C)(5), provider and health care facilities shall make available and keep confidential of those health records maintained by providers and health care facilities to monitor and evaluate the quality of care, to conduct evaluations and audits, and to determine on a concurrent or retrospective basis the necessity of and appropriateness of health care services provided to enrollees. Provider or health care facility shall make these health records available to appropriate state and federal authorities involved in assessing the quality of care or in investigating the grievances or complaints of enrollees, provider or health care facility shall comply with applicable state and federal laws related to the confidentiality of medical or health records.

2.5 As required by RC § 1751.13(C)(6), contractual rights and responsibilities may not be assigned or delegated by the provider or health care facility without the prior written consent of the health insuring corporation.

2.6 As required by RC § 1751.13(C)(7), provider or health care facility to maintain adequate professional liability and malpractice insurance in accordance with the underlying Agreement. Provider or health care facility shall notify the health insuring corporation not more than ten days after the provider's or health care facility's receipt of notice of any reduction or cancellation of such coverage.

2.7 As required by RC § 1751.13(C)(8), provider or health care facility shall observe, protect, and promote the rights of enrollees as patients.

2.8 As required by RC § 1751.13(C)(9), provider or health care facility shall provide health care services without discrimination on the basis of a patient's participation in the health care plan, age, sex, ethnicity, religion, sexual preference, health status, or disability, and without regard to the source of payments made for health care services rendered to a patient. This requirement shall not apply to circumstances when the provider or health care facility appropriately does not render services due to limitations arising from the provider's or health care facility's lack of training, experience, or skill, or due to licensing restrictions.

2.9 As required by RC § 1751.13(C)(10), a primary care provider shall provide, or arrange for the provision of, covered health care services twenty-four hours per day, seven days per week.

2.10 As required by RC § 1751.13(C)(11), the dispute resolution process is as stated in the underlying Agreement. In the event the underlying Agreement does not include a dispute resolution process, the dispute resolution process is as stated in the administrative handbook.

2.11 As required by RC § 1751.13(C)(12), the hold harmless provision required by RC §1751.13(C)(2) shall survive the termination of the contract with respect to services covered and provided under the contract during the time the contract was in effect, regardless of the reason for the termination, including the insolvency of the health insuring corporation.

2.12 As required by RC § 1751.13(C)(13), those terms that are used in the contract and that are defined by RC §1751.01, shall be used in the contract in a manner consistent with those definitions.

2.13 As required by RC § 1751.13(F)(2), health insuring corporation is a third-party beneficiary to the agreement.

2.14 As required by RC § 1751.13(F)(3), health insuring corporation may approve or disapprove the participation of any provider or health care facility with which the intermediary organization contracts.

2.15 As required by RC § 1751.13(G), health insuring corporation has statutory responsibility to monitor and oversee the offering of covered health care services to its enrollees.

2.16 As required by RC § 3963.02(A)(1)(c), this Agreement applies to network rental arrangements and one purpose of the Agreement is selling, renting, or giving the contracting entity's rights to the services of the participating provider, including other preferred provider organizations, and the third party accessing the participating provider's services is any of the following:

(i) A payer or a third-party administrator or other entity responsible for administering claims on behalf of the payer;
(ii) A preferred provider organization or preferred provider network that receives access to the participating provider's services pursuant to an arrangement with the preferred provider organization or preferred provider network in a contract with the participating provider that is in compliance RC § 3963.02(A)(1)(c), and is required to comply with all of the terms, conditions, and affirmative obligations to which the originally contracted primary participating provider network is bound under its contract with the participating provider, including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.
(iii) An entity that is engaged in the business of providing electronic claims transport between the contracting entity and the payer or third-party administrator and complies with all of the applicable terms, conditions, and affirmative obligations of the contracting entity's contract with the participating provider including, but not limited to, obligations concerning patient steerage and the timeliness and manner of reimbursement.

2.17 As required by RC § 3961.02(B)(3), provider, participating in a discount medical plan, will not charge members more than the discounted rates agreed upon in this Agreement.

OHIO SUMMARY DISCLOSURE FORM

IMPORTANT INFORMATION - PLEASE READ CAREFULLY

The information provided in this Summary Disclosure Form is a guide to the attached Health Care Contract as defined in section 3963.01(G) of the Ohio Revised Code. The terms and conditions of the attached Health Care Contract constitute the contract rights of the parties.

Reading this Summary Disclosure Form is not a substitute for reading the entire Health Care Contract. When you sign the Health Care Contract, you will be bound by its terms and conditions. These terms and conditions may be amended over time pursuant to section 3963.04 of the Ohio Revised Code. You are encouraged to read any proposed amendments that are sent to you after execution of the Health Care Contract.

Nothing in this Summary Disclosure Form creates any additional rights or causes of action in favor of either party.

1. Compensation terms: Article V and Contract Rate Exhibit
2. Manner of payment: Fee for Service
3. Fee Schedule Available at: 800-546-3887
4. Products or networks covered by this contract: Definition of Program
5. Term of this contract: Article II
6. Contracting entity or payer responsible for processing payment available at: 800-546-3887
7. Dispute Resolution: Article V and Article VIII
8. Subject and Order of Addenda:
   A. Amendment Exhibit (if applicable)
   B. Network Participation Requirements
   C. Coordinating Provisions State/Federal Law and Accreditation Standards
   D. Contract Rates
   E. List of Locations (if applicable)
   F. Service Requirements (if applicable)
9. Telephone number to access a readily available mechanism, such as a specific web site address, to allow a participating provider to receive the above information: 800-546-3887

STATE LAW COORDINATING PROVISIONS: OKLAHOMA

2.1 As required by 36 OK ST § 1219.4(G)(2), a health care provider offering medical services to members under a discount medical plan will not charge members more than the discounted rates.

STATE LAW COORDINATING PROVISIONS: OREGON

2.1 As required by O.R.S. § 743B.405(2)(a), provider shall participate in and observe the protocols of the quality management program outlined in the administrative handbook.

2.2 As required by O.R.S. § 743B.405(2)(b), the criteria for termination or nonrenewal are as stated in the underlying agreement. In the event the underlying agreement does not contain criteria for termination or nonrenewal, those rights are as follows:

Discretionary Termination. After the expiration of the Initial Term, this Agreement may be terminated in the sole discretion of either party, by the provision of written notice at least ninety (90) days prior to the Renewal Date, such termination to be effective on the Renewal Date.

Termination for Material Breach.

(a) This Agreement may be terminated by insurer upon written notice to provider if (i) any action is taken which requires provider to provide insurer with notice; (ii) in the sole discretion of insurer, if provider fails to comply with the quality management and/or credentialing/recredentialing program(s) specified in the administrative handbook(s); or (iii) provider fails to comply with any applicable state and/or federal law related to the delivery of health care services.

(b) In the event that one party commits a material breach of this Agreement (the "Breaching Party") this Agreement will terminate upon the provision of at least thirty (30) days written notice to the Breaching Party specifying the material breach. The Breaching Party may cure the breach within such thirty (30) day period, provided however, that failure to cure said breach will result in termination as of the date specified in the notice.

Network Participation Termination. Either party may terminate this Agreement as to any of the networks in which provider participates by the provision of at least ninety (90) days prior written notice to the other party provided however, provider maintains participation in at least one network. Termination of a Network will not terminate this Agreement as to any other Networks in which provider participates.

2.3 As required by O.R.S. § 743B.405(2)(c) provider is entitled to an annual accounting accurately summarizing the financial transactions between provider and insurer for that year.

2.4 As required by O.R.S. § 743B.405(2)(d), provider may withdraw from the care of a patient when, in the professional judgment of the provider, it is in the best interest of the patient to do so.

2.5 As required by O.R.S. § 743B.405(2)(e), a doctor of medicine or doctor of osteopathy licensed under ORS chapter 677 shall be retained by the other party to the medical services contract and shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the medical services contract.

2.6 As required by O.R.S. § 743B.405(2)(f), a physician, as defined in ORS 677.010, who is practicing in conformity with ORS 677.095 may advocate a decision, policy or practice without being subject to termination or penalty for the sole reason of such advocacy.

2.7 As required by O.R.S. § 743B.405(2)(h), when continuity of care is required to be provided under a health benefit plan by ORS 743B.225, the insurer and the individual provider shall provide continuity of care to enrollees as provided in ORS 743B.225.

2.8 As required by O.R.S. § 742.424(2)(c), for providers offering services under a discount medical plan, provider agrees not to charge plan members more for medical and ancillary services than the amount listed in the provider's price schedule or an amount that reflects the application of the provider's discount rate.

STATE LAW COORDINATING PROVISIONS: RHODE ISLAND

2.1 As required by 230-RICR-20-30-9.9(A)(1)(a), beneficiary shall be held harmless from any financial liability beyond in-network cost shares attributable to the failure of a referring network provider to adhere to the referral process, including by failing to submit the required network plan's referral documents according to the health care entity requirements when there is evidence that the beneficiary sought and received a referral from the network provider. This section is not applicable in cases where the beneficiary has self-referred.

2.2 As required by 230-RICR-20-30-9.9(A)(1)(b), in no event, including but not limited to non-payment by the health care entity or intermediary, insolvency of the health care entity or one of its delegates or breach of the health care entity's agreement with a network plan provider, shall the network plan provider bill, charge, collect a deposit from, or seek compensation, remuneration or reimbursement from a beneficiary to include but not limited to facility or administrative fees added to a beneficiary for covered services by the provider.

2.3 As required by 230-RICR-20-30-9.9(A)(1)(c), no beneficiary shall be liable to any provider for charges for covered benefits, except for the amounts due for co-payments, deductibles and/or coinsurance, when provided or made available to enrolled participants by a licensed health maintenance organization, as that term is defined in R.I. Gen. Laws § 27-41-2(t), during a period in which premiums were paid by or on behalf of the enrollee.

2.4 As required by 230-RICR-20-30-9.9(A)(2), in the event of a provider contract termination:

a. The beneficiary shall be held harmless for covered benefits except for amounts due for co-payments, coinsurance, and deductibles, for the duration of an active course of treatment or up to one year, whichever is earlier, subject to all the terms and conditions of the terminated provider contract, unless the provider is able to safely transition the patient to a network provider; and
b. For this period of active treatment, the beneficiary shall only be responsible for in-network cost shares provided for under the beneficiaries' coverage documents and not otherwise prohibited by state or federal laws or regulations.

2.5 As required by 230-RICR-20-30-9.9(B)(4), termination due to a material modification, as defined in 230-RICR-20-30-9.3, in a professional provider contract shall not affect the method of payment or reduce the amount of reimbursement to the provider by the health care entity for any beneficiary in active treatment for an acute medical condition at the time the beneficiary's provider terminates until the active course of treatment is concluded or, if earlier, one year after the termination.

2.6 As required by 230-RICR-20-30-9.9(G), neither party shall terminate this Agreement without cause.

STATE LAW COORDINATING PROVISIONS: SOUTH DAKOTA

2.1 As required by SDCL § 58-17E-27, providers participating in a discount medical plan will not charge members more than the discounted rates.

2.2 As required by SDCL § 58-17F-11(6), a provider shall make health records available to the carrier 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 person that is provided records pursuant to this section shall maintain the confidentiality of such records and may not make such records available to any other person who is not legally entitled to the records.

STATE LAW COORDINATING PROVISIONS: TENNESSEE

2.1 Assignability. As required by T.C.A. § 50-6-215(c), the list of contracted medical providers may be sold, leased, transferred, or conveyed to other payors or agents, including workers' compensation insurers or self-insureds. Workers' compensation payors to whom the list of contracted medical providers may be sold, leased, transferred, or conveyed may be permitted to pay a medical provider's contracted rate if less than the workers' compensation fee schedule.

STATE LAW COORDINATING PROVISIONS: TEXAS

2.1 As required by Tex. Ins. Code § 1301.059(b) and 28 TAC § 3.3703(a)(15), an insurer may not engage in quality assessment except through a panel of at least three physicians selected by the insurer from among a list of physicians contracting with the insurer. The physicians contracting with the insurer in the applicable service area shall provide the list of physicians to the insurer.

2.2 As required by Tex. Ins. Code § 1301.062, for a provider that is a podiatrist licensed by the Texas State Board of Podiatric Medical Examiners:

(a) the podiatrist may request a copy of the coding guidelines and payment schedules applicable to the compensation that the podiatrist will receive under the contract for services;
(b) the insurer shall provide a copy of the coding guidelines and payment schedules not later than the 30th day after the date of the podiatrist's request;
(c) the insurer may not unilaterally make material retroactive revisions to the coding guidelines and payment schedules; and
(d) the podiatrist may, practicing within the scope of the law regulating podiatry, furnish x-rays and nonprefabricated orthotics covered by the health insurance policy.

2.3 As required by Tex. Ins. Code § 1301.064, subject to Subchapter C of Tex. Ins. Code § 1301, payment to a physician or health care provider for health care services and benefits provided to an insured under the contract and to which the insured is entitled under the terms of the contract shall be made not later than: (1) the 45th day after the date on which a claim for payment is received with the documentation reasonably necessary to process the claim; or (2) if applicable, within the number of calendar days specified by written agreement between the physician or health care provider and the insurer.

2.4 As required by Tex. Ins. Code § 1301.136,

(a) the preferred provider may request a description and copy of the coding guidelines, including any underlying bundling, recoding, or other payment process and fee schedules applicable to specific procedures that the preferred provider will receive under the contract;
(b) the insurer or the insurer's agent will provide the coding guidelines and fee schedules not later than the 30th day after the date the insurer receives the request;
(c) the insurer or the insurer's agent will provide notice of changes to the coding guidelines and fee schedules that will result in a change of payment to the preferred provider not later than the 90th day before the date the changes take effect and will not make retroactive revisions to the coding guidelines and fee schedules; and
(d) the contract may be terminated by the preferred provider on or before the 30th day after the date the preferred provider receives information requested under this subsection without penalty or discrimination in participation in other health care products or plans.

2.5 As required by 28 TAC § 3.3703(a)(8), the dispute resolution rights are as stated in the underlying Agreement. In the event the underlying Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook. The dispute resolution process shall comply with 28 TAC § 3.3706(b)(2) as applicable.

2.6 As required by 28 TAC § 3.3703(a)(10), preferred provider agrees to bill the insured only on the discounted fee as agreed to in this Agreement and not the full charge.

2.7 As required by 28 TAC § 3.3703(a)(11), insurer shall comply with all applicable statutes and rules pertaining to prompt payment of clean claims with respect to payment to the provider for covered services rendered to insureds.

2.8 As required by 28 TAC § 3.3703(a)(12), provider shall comply with the Insurance Code §§ 1301.152 - 1301.154, which relates to Continuity of Care. In accordance with Tex. Ins. Code § 1301.153(b) the termination of the physician's or provider's participation in a preferred provider benefit plan, except for reason of medical competence or professional behavior, shall not: (1) release the physician or health care provider from the generally recognized obligation to: (a) treat an insured whom the physician or provider is currently treating; and (b) cooperate in arranging for appropriate referrals; and (2) release the insurer from the obligation to reimburse the physician or health care provider or, if applicable, the insured, at the same preferred provider rate if, at the time a physician's or provider's participation is terminated, an insured whom the physician or provider is currently treating has special circumstances in accordance with the dictates of medical prudence.

2.9 As required by 28 TAC § 3.3703(a)(18), in the event provider voluntarily terminates the contract, provider shall provide reasonable notice to the insured, and insurer shall provide assistance to the provider as set forth in the Insurance Code § 1301.160(b).

2.10 As required by 28 TAC § 3.3703(a)(19), insurer shall provide written notice of termination of the contract to the provider, and in the case of termination of a physician or practitioner, the notice must include the provider's right to request a review, as specified in § 3.3706(d) of this title.

2.11 As required by 28 TAC § 3.3703(a)(20), preferred provider is entitled upon request to all information necessary, in accordance with 28 TAC § 3.3703(a)(20), to determine that the preferred provider is being compensated in accordance with the contract. The insurer is required to provide the fee schedules and other required information by the 30th day after the date the insurer receives the preferred provider's request.

2.12 As required by 28 TAC § 3.3703(a)(25), preferred provider shall comply with all applicable requirements of the Insurance Code § 1661.005 (relating to refunds of overpayments from enrollees).

2.13 As required by 28 TAC § 3.3703(a)(26), a provider that is a facility shall give notice to the insurer of the termination of a contract between the facility and a facility-based physician group that is a preferred provider for the insurer as soon as reasonably practicable, but not later than the fifth business day following termination of the contract.

2.14 As required by 28 TAC § 3.3703(a)(27), except for instances of emergency care as defined under Insurance Code § 1301.155(a), a physician or provider referring an insured to a facility for surgery must: (a) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; (b) notify the insurer that surgery has been recommended; and (c) notify the insurer of the facility that has been recommended for the surgery.

2.15 As required by 28 TAC § 3.3703(a)(28), except for instances of emergency care as defined under Insurance Code § 1301.155(a), facility, when scheduling surgery must: (a) notify the insured of the possibility that out-of-network providers may provide treatment and that the insured can contact the insurer for more information; and (b) notify the insurer that surgery has been scheduled.

STATE LAW COORDINATING PROVISIONS: UTAH

2.1 As required by U.C.A. § 31A-45-301, if the managed care organization (a) fails to pay for health care services as set forth in the contract, the enrollee is not liable to the health care provider for any sums owed by the managed care organization; and (b) becomes insolvent, the rehabilitator or liquidator may require the network provider to:

(i) continue to provide health care services under the contract between the network provider and the managed care organization until the earlier of:

(A) ninety (90) days after the date of the filing of a petition for rehabilitation or a petition for liquidation; or

(B) the date the term of the contract ends; and

(ii) subject to § 31A-45-301(3) reduce the fees the network provider is otherwise entitled to receive from the managed care organization under the contract between the network provider and the managed care organization during the time period described in § 31A-45-301(1)(b)(i).

2.2 As required by U.C.A. 1953 § 31A-45-303(b), network provider shall accept payment as specified in this Agreement as payment in full, relinquishing the right to collect amounts other than copayments, coinsurance, and deductibles from the enrollee.

STATE LAW COORDINATING PROVISIONS: VERMONT

2.1 As required by Vt. Admin. Code 4-5-3:5.3(E), the requirements and responsibilities of the managed care organization and contracted providers with respect to administrative policies and programs, including but not limited to payment terms, utilization review, quality improvement programs, chronic care programs, credentialing, grievance procedures, data reporting requirements, confidentiality requirements, and any other applicable provisions required by federal or state law are as stated in the Administrative Handbook. The provider may participate in the managed care organization's quality management program, dispute resolution process, and utilization management program. Contracted providers shall notify the managed care organization of any changes that would impact the provider's credentialing status or ongoing availability to members.

2.2 As required by Vt. Admin. Code 4-5-3:5.3(F), provider shall ensure availability and confidentiality necessary to monitor and evaluate the quality of care, and to conduct medical and other health care evaluations and audits to determine, on a concurrent or retrospective basis, the necessity and appropriateness of care provided to members. Provider shall make health records available as required by law to appropriate state and federal authorities involved in assessing the quality of care or investigating the grievances or complaints of members, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

2.3 As required by Vt. Admin. Code 4-5-3:5.3(I), "Provider agrees that in no event, including nonpayment by the managed care organization, insolvency of the managed care organization, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or a person (other than the managed care organization) acting on behalf of the member for services provided pursuant to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles or copayments, as specifically provided in the certificate of coverage, or fees for uncovered services delivered on a fee-for-service basis to members. This agreement does prohibit the provider from requesting payment from a member for any services that have been confirmed by independent external review obtained through the Department of Financial Regulation pursuant to Vermont law to be medically unnecessary, experimental, investigational or a medically inappropriate off-label use of a drug."

2.4 As required by Vt. Admin. Code 4-5-3:5.3(J), in the event of the managed care organization's insolvency or other cessation of operations, covered services to a member will continue through the period for which a premium has been paid to the managed care organization on behalf of the member or until the member's discharge from an inpatient facility, whichever period is greater. Covered benefits 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 the facility is no longer medically necessary.

2.5 As required by Vt. Admin. Code 4-5-3:5.3(O), unless otherwise stated in the underlying Agreement,
(i) Material Change shall mean any change to the Agreement (including provider documents) that have a material adverse impact on provider; and
(ii) Timely Notice shall mean at least thirty (30) days prior notice to the provider.

2.6 As required by 18 V.S.A. § 9418c(a)(1), contracting entity shall provide participating health care providers information sufficient for the participating provider to determine the compensation or payment terms for health care services.

2.7 As required by 18 V.S.A. § 9418c(4)(C), the term of this Agreement is as stated in the underlying Agreement. In the event the underlying Agreement does not state the term of this Agreement, then this Agreement will become effective on the effective date of the underlying Agreement and will continue in effect for a period of one (1) year ("Initial Term"). Unless otherwise terminated, this Agreement shall renew automatically for consecutive one (1) year terms ("Renewal Term") on each anniversary of the effective date ("Renewal Date").

2.8 As required by 18 V.S.A. § 9418c(4)(D), the termination rights are as stated in the underlying Agreement. In the event the underlying Agreement does not include any termination rights, the termination rights are as follows:

Discretionary Termination. After the expiration of the Initial Term, this Agreement may be terminated in the sole discretion of either party, by the provision of written notice at least ninety (90) days prior to the Renewal Date, such termination to be effective on the Renewal Date.

Termination for Material Breach.

(a) This Agreement may be terminated by contracting entity upon written notice to provider if (i) any action is taken which requires provider to provide contracting entity with notice; (ii) in the sole discretion of contracting entity, if provider fails to comply with the quality management and/or credentialing/recredentialing program(s) specified in the administrative handbook(s); or (iii) provider fails to comply with any applicable state and/or federal law related to the delivery of health care services.
(b) In the event that one party commits a material breach of this Agreement (the "Breaching Party") this Agreement will terminate upon the provision of at least thirty (30) days written notice to the Breaching Party specifying the

material breach. The Breaching Party may cure the breach within such thirty (30) day period, provided however, that failure to cure said breach will result in termination as of the date specified in the notice.

Network Participation Termination. Either party may terminate this Agreement as to any of the networks in which provider participates by the provision of at least ninety (90) days prior written notice to the other party provided however, provider maintains participation in at least one network. Termination of a Network will not terminate this Agreement as to any other Networks in which provider participates.

2.9 As required by 18 V.S.A. § 9418c(4)(F), the dispute resolution process is as stated in the underlying Agreement. In the event the underlying Agreement does not include a dispute resolution process, the dispute resolution process is as stated in the administrative handbook.

2.10 As required by 18 V.S.A. § 9418f(d)(1), contracting entity may enter into an agreement with a third party, allowing the third party to obtain the contracting entity's rights and responsibilities under the provider network contract as if the third party were the contracting entity. The third party accessing the provider network contract is contractually obligated to comply with all applicable terms, limitations, and conditions of the provider network contract.

VERMONT SUMMARY DISCLOSURE FORM

This Summary Disclosure Form is being provided pursuant to 18 V.S.A. § 9418c. This Summary Disclosure Form is merely a guide to your health care contract. The terms and conditions of your health care contract constitute the actual contract rights of the parties. Reading this Summary Disclosure Form is not a substitute for reading the entire health care contract. By signing the health care contract, the participating provider will be bound by the health care contract's terms and conditions. The terms and conditions of the health care contract may be amended pursuant to 18 V.S.A. § 9418d and the participating provider is encouraged to read any proposed amendments sent after execution of your health care contract.

1. Compensation or Payment Terms: Article V and Contract Rate Exhibit
2. Manner of Payment: Fee-for-Service
3. Contact Information to Request Fee Schedule: 1 (800) 950-7040
4. Website Address: www.multiplan.com
5. List of Products: Definition of Program
6. Term of the Health Care Contract: Article II
7. Termination Notice Period and Reasons for Termination: Article II
8. Processing of Participating Provider's Compensation or Payment: Article V
9. Dispute Resolution Mechanism: Article V and Article VIII
10. List of Addenda:
    A. Amendment Exhibit (if applicable)
    B. Network Participation Requirements
    C. Coordinating Provisions State/Federal Law and Accreditation Standards
    D. Contract Rates
    E. List of Locations (if applicable)
    F. Service Requirements (if applicable)

STATE LAW COORDINATING PROVISIONS: VIRGINIA

2.1 As required by subsection B 1 of Va. Code Ann. § 38.2-3407.15, a carrier shall pay any claim within forty (40) days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

(a) the claim is determined by the carrier 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 the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or
(b) the claim was submitted fraudulently.

Carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim

shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2.2 As required by subsection B 2 of Va. Code Ann. § 38.2-3407.15, carrier shall, within thirty (30) days after receipt of a claim, notify the person submitting the claim of any defect or impropriety that prevents the carrier from deeming the claim a clean claim and request the information that will be required to process and pay the claim. Upon receipt of the additional information necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with Va. Code Ann. § 38.2-3407.15. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7 of of subsection B of Va. Code Ann. § 38.2-3407.15. Beginning no later than January 1, 2026, all notifications and information required under this subdivision shall be delivered electronically.

2.3 As required by subsection B 3 of Va. Code Ann. § 38.2-3407.15, any interest owing or accruing on a claim under § 38.2-3407.1 or § 38.2-4306.1, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within sixty (60) days thereafter.

2.4 As required by subsection B 4 a of Va. Code Ann. § 38.2-3407.15, carrier shall establish and implement reasonable policies to permit provider (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If carrier routinely, as a matter of policy, bundles or downcodes claims submitted by provider, the carrier shall clearly disclose on its website the specific bundling and downcoding policies that carrier reasonably expects to be applied to provider or provider's services on a routine basis as a matter of policy. Provider may also request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, carrier shall provide the requesting provider with such policies within ten (10) business days following the date the request is received.

2.5 As required by subsection B 4 b of Va. Code Ann. § 38.2-3407.15, carrier shall make available to a provider requesting copies of policies pursuant to subsection B 4 a of Va. Code Ann. § 38.2-3407.15 within ten (10) business days of receipt of the request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

2.6 As required by subsection B 5 of Va. Code Ann. § 38.2-3407.15, carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

(a) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;
(b) The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or,
(c) During the post-service claims process, it is determined that the claim was submitted fraudulently.

2.7 As required by subsection B 6 of Va. Code Ann. § 38.2-3407.15, in the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure provider

discovers clinical evidence prompting provider to perform a less or more extensive or complicated procedure than was previously authorized, then carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

2.8 As required by subsection B 7 of Va. Code Ann. § 38.2-3407.15, carrier shall not impose any retroactive denial of a previously paid claim or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought, the carrier has provided a written explanation of why the claim is being retroactively adjusted, and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed twelve (12) months. Notwithstanding the provisions of clause (iii), a provider and a carrier may agree in writing that recoupment of overpayments by withholding or offsetting against future payments may occur after such 12-month limit for the imposition of the retroactive denial. A carrier shall notify a provider at least thirty (30) days in advance of any retroactive denial or recovery or refund of a previously paid claim.

2.9 As required by subsection B 8 of Va. Code Ann. § 38.2-3407.15, this contract includes (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subsection B 4 of Va. Code Ann. § 38.2-3407.15) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

2.10 As required by subsection B 9 of Va. Code Ann. § 38.2-3407.15, no amendment to this contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least sixty (60) calendar days before the effective date and the provider has failed to notify the carrier within thirty (30) calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

2.11 As required by subsection B 10 of Va. Code Ann. § 38.2-3407.15, in the event that the carrier's provision of a policy required to be provided under subsection B 8 or 9 of Va. Code Ann. § 38.2-3407.15 would violate any applicable copyright law, the carrier may instead comply with subsection B of Va. Code Ann. § 38.2-3407.15 by providing a clear, written explanation of the policy as it applies to the provider.

2.12 As required by subsection B 11 of Va. Code Ann. § 38.2-3407.15, the dispute resolution process is as stated in the Agreement. In the event the underlying Agreement does not contain a dispute resolution process, the dispute resolution process is as stated in the administrative handbook. If a carrier's claim denial is overturned following completion of a dispute review, the carrier shall, on the day the decision to overturn is made, consider the claims impacted by such decision as clean claims. All applicable laws related to the payment of a clean claim shall apply to the payments due.

2.13 As required by subsection B 12 of Va. Code Ann. § 38.2-3407.15, provider shall not discriminate against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in subsection B 12 of Va. Code Ann. § 38.2-3407.15 shall require provider to treat an enrollee who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

2.14 As required by subsection B 1 of VA Code Ann. § 38.2-3407.15:2, carrier, in a method of its choosing, is required to accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards.

2.15 As required by subsection B 2 of VA Code Ann. § 38.2-3407.15:2, carrier is required to communicate to the prescriber or his designee within twenty-four (24) hours, including weekend hours, of submission of an urgent prior authorization request to the carrier, if submitted telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or requires supplementation.

2.16 As required by subsection B 3 of VA Code Ann. § 38.2-3407.15:2, carrier is required to communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two (2) business days of submission of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation.

2.17 As required by subsection B 4 of VA Code Ann. § 38.2-3407.15:2, carrier is required to communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two (2) business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied.

2.18 As required by subsection B 5 of VA Code Ann. § 38.2-3407.15:2, if a prior authorization request is approved for prescription drugs and such prescription drugs have been scheduled, provided, or delivered to the patient consistent with the authorization, the carrier shall not revoke, limit, condition, modify, or restrict that authorization unless (i) there is evidence that the authorization was obtained based on fraud or misrepresentation; (ii) final actions by the U.S. Food and Drug Administration, other regulatory agencies, or the manufacturer remove the drug from the market, limit its use in a manner that affects the authorization, or communicate a patient safety issue that would affect the authorization alone or in combination with other authorizations; (iii) a combination of drugs prescribed would cause a drug interaction; or (iv) a generic or biosimilar is added to the prescription drug formulary. Nothing in this section shall require a carrier to cover any benefit not otherwise covered or cover a prescription drug if the enrollee is no longer covered by a health plan on the date the prescription drug was scheduled, provided, or delivered.

2.19 As required by subsection B 6 of VA Code Ann. § 38.2-3407.15:2, if a prior authorization request is denied, the carrier shall communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by subsection B 3 or 4 of VA Code Ann. § 38.2-3407.15:2, as applicable, the reasons for the denial.

2.20 As required by subsection B 7 of VA Code Ann. § 38.2-3407.15:2, prior authorization approved by another carrier is required to be honored, upon the carrier's receipt from the prescriber or his designee of a record demonstrating the previous carrier's prior authorization approval or any written or electronic evidence of the previous carrier's coverage of such drug, at least for the initial ninety (90) days of a member's prescription drug benefit coverage under a new health plan, subject to the provisions of the new carrier's evidence of coverage and any exception listed in subsection B 5 of VA Code Ann. § 38.2-3407.15:2.

2.21 As required by subsection B 8 of VA Code Ann. § 38.2-3407.15:2, carrier is required to use a tracking system for all prior authorization requests and the identification information must be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon the carrier's response to the prior authorization request.

2.22 As required by subsection B 9 of VA Code Ann. § 38.2-3407.15:2, the carrier's prescription drug formularies, all drug benefits subject to prior authorization by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms accepted by the carrier are required to be made available through one central location on the carrier's website and such information must be updated by the carrier within seven (7) days of approved changes.

2.23 As required by subsection B 10 of VA Code Ann. § 38.2-3407.15:2, carrier is required to honor a prior authorization issued by the carrier for a drug, other than an opioid, regardless of changes in dosages of such drug, provided such drug is prescribed consistent with U.S. Food and Drug Administration-labeled dosages.

2.24 As required by subsection B 11 of VA Code Ann. § 38.2-3407.15:2, carrier is required to honor a prior authorization issued by the carrier for a drug regardless of whether the covered person changes plans with the same carrier and the drug is a covered benefit with the current health plan.

2.25 As required by subsection B 12 of VA Code Ann. § 38.2-3407.15:2, when requiring a prescriber to provide supplemental information that is in the covered individual's health record or electronic health record, carrier shall identify the specific information required.

2.26 As required by subsection B 13 of VA Code Ann. § 38.2-3407.15:2, carrier will not require prior authorization for at least one drug prescribed for substance abuse medication-assisted treatment, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine.

2.27 As required by subsection B 14 of VA Code Ann. § 38.2-3407.15:2, when any carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization shall be required by the carrier, provided that (i) the drug is a covered benefit; (ii) the prescription does not exceed the FDA-labeled dosages; (iii) the prescription has been continuously issued for no fewer than three months; and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. Nothing in this subdivision shall

prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription for the drug is issued.

2.28 As required by subsection B 15 of VA Code Ann. § 38.2-3407.15:2, carrier shall honor a prior authorization issued by the carrier for a drug regardless of whether the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision 14

2.29 As required by subsection B 16 of VA Code Ann. § 38.2-3407.15:2, beginning July 1, 2025 and notwithstanding the provisions of subsection B 1 of VA Code Ann. § 38.2-3407.15:2 or any other provision of this section, carrier shall establish and maintain an online process that (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests (a) for which no additional information is needed by the carrier to process the prior authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for approval; and (iv) links directly to real-time patient out-of-pocket costs for the office visit, considering copayment and deductible, and (v) otherwise meets the requirements of this section. No carrier shall (a) impose a fee or charge on any person for accessing the online process as required by subsection B 16 of VA Code Ann. § 38.2-3407.15:2. or (b) access, absent provider consent, provider data via the online process other than for the enrollee. No later than July 1, 2024, a carrier, upon request from a provider, shall provide contact information of any third-party vendor or other entity the carrier will use to meet the requirements of this subdivision or the requirements of VA Code Ann. § 38.2-3407.15:7. A carrier that posts such contact information on its website shall be considered to have met this requirement.

2.30 As required by subsection B 17 of VA Code Ann. § 38.2-3407.15:2, beginning July 1, 2025, participating health care provider shall ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollee's health record has the ability to access, at the point of prescribing, the electronic prior authorization process established by a carrier as required by subsection B 16 of VA Code Ann. § 38.2-3407.15:2 and the real-time patient-specific benefit information, including out-of-pocket costs and more affordable medication alternatives made available by a carrier pursuant to VA Code Ann. § 38.2-3407.15:7. A provider may request a waiver of compliance for undue hardship for a period specified by the appropriate regulatory authority with the Health and Human Resources Secretariat

STATE LAW COORDINATING PROVISIONS: WASHINGTON

The terms used in this exhibit are the defined terms as specified in the applicable federal and/or state law. The specific form Agreement between the parties may utilize defined terms other than those noted in the federal and/or state law(s). For purposes of this exhibit, participating provider means a licensed facility or licensed, registered or certified health care professional(s) contracted to provide health care services under this Agreement.

2.1 As required by WAC 284-43-2050, all prior authorization requests must be submitted to the carrier or the carrier's designee. Carriers must have a current and accurate secure online prior authorization process. A participating provider or facility may appeal a prior authorization denial by contacting the carrier or the carrier's designee. Participating providers and facilities may contact the carrier for information regarding the carrier's prior authorization process and how to access the online prior authorization process, which must be consistent with WAC 284-43-2050.

2.2 As required by WAC 284-170-240(1)(a), carriers regulated by the Office of the Insurance Commissioner in Washington may not elect to use less than one hundred percent of the subcontracted network or networks in its service area.

2.3 As required by WAC 284-170-380, carriers must allow a contracted network provider to arrange for a substitute provider for at least sixty days during any calendar year. A carrier must grant an extension if a contracted network provider demonstrates that exceptional circumstances require additional time away from his or her practice.

2.4 As required by WAC 284-170-411(4), an issuer must make its selection standards for participating providers and facilities available for review upon request by the commissioner.

2.5 As required by WAC 284-170-421(1), an issuer must establish a mechanism by which participating providers and facilities can obtain timely information on patient eligibility for health care services and health plan benefits, including any limitations or conditions on services or benefits. Participating providers and facilities may obtain patient eligibility, benefit coverage, prior authorization, and utilization management information from carrier by contacting the number on the patient's identification card or other identifying information provided by carrier to patient consistent with the terms of this Agreement.

2.6 As required by WAC 284-170-421(2), nothing contained in this Agreement will have the effect of modifying benefits, terms, or conditions contained in the health plan. In the event of any conflict between this Agreement and the health plan, the benefits, terms, and conditions of the health plan will govern with respect to coverage provided to enrollees.

2.7 As required by WAC 284-170-421(3)(a), "Participating provider or facility hereby agrees that in no event, including, but not limited to nonpayment by issuer, issuer's insolvency, or breach of this contract will participating provider or facility bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against an enrollee or person acting on their behalf, other issuer, for services provided pursuant to this contract. This provision does not prohibit collection of deductibles, copayments, coinsurance, and/or payment for noncovered services, which have not otherwise been paid by a primary or secondary issuer in accordance with regulatory standards for coordination of benefits, from enrollees in accordance with the terms of the enrollee's health plan."

2.8 As required by WAC 284-170-421(3)(b), "Participating provider or facility agrees, in the event of issuer's insolvency, to continue to provide the services promised in this contract to enrollees of issuer for the duration of the period for which premiums on behalf of the enrollee were paid to issuer or until the enrollee's discharge from inpatient facilities, whichever time is greater."

2.9 As required by WAC 284-170-421(3)(c), "Notwithstanding any other provision of this contract, nothing in this contract shall be construed to modify the rights and benefits contained in the enrollee's health plan."

2.10 As required by WAC 284-170-421(3)(d), "Participating provider or facility may not bill the enrollee for covered services (except for deductibles, copayments, or coinsurance) where issuer denies payments because the provider or facility has failed to comply with the terms or conditions of this contract."

2.11 As required by WAC 284-170-421(3)(e), "Participating provider or facility further agrees (i) that the provisions of (a), (b), (c), and (d) of this subsection shall survive termination of this contract regardless of the cause giving rise to termination and shall be construed to be for the benefit of issuer's enrollees, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between participating provider or facility and enrollees or persons acting on their behalf."

2.12 As required by WAC 284-170-421(3)(f), "If participating provider or facility contracts with other providers or facilities who agree to provide covered services to enrollees of issuer with the expectation of receiving payment directly or indirectly from issuer, such providers or facilities must agree to abide by the provisions of (a), (b), (c), (d), and (e) of this subsection."

2.13 As required by WAC 284-170-421(4), willfully collecting or attempting to collect an amount from an enrollee knowing that collection to be in violation of this Agreement constitutes a class C felony under RCW 48.80.030(5).

2.14 As required by WAC 284-170-421(5), an issuer or its designee will notify participating providers and facilities of their responsibilities with respect to the health issuer's applicable administrative policies and programs, including but not limited to payment terms, utilization review, quality assessment and improvement programs, credentialing, grievance, appeal and adverse benefit determination procedures, data reporting requirements, pharmacy benefit substitution processes, confidentiality requirements and any applicable federal or state requirements.

2.15 As required by WAC 284-170-421(6):

(a) Participating provider and facility must be given reasonable notice of not less than sixty days of changes that affect participating provider and facility compensation or that affect health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice must be provided as soon as possible.

(b) (i) Subject to any termination and continuity of care provisions of the contract, participating provider and facility may terminate the contract without penalty if participating provider and facility does not agree with the changes, subject to the requirements of WAC 284-170-421(9); and (ii) A material amendment to a contract may be rejected by participating provider and facility. The rejection will not affect the terms of the existing contract. A material amendment has the same meaning as in RCW 48.39.005.

(c) No change to the contract may be made retroactive without the express written consent of the participating provider and facility.

2.16 As required by WAC 284-170-421(7)(a), "No health carrier subject to the jurisdiction of the state of Washington may in any way preclude or discourage their providers from informing patients of the care they require, including various treatment options, and whether in their view such care is consistent with medical necessity, medical appropriateness, or otherwise covered by the patient's service agreement with the health carrier. No health carrier may prohibit, discourage, or penalize a provider otherwise practicing in compliance with the law from advocating on behalf of a

patient with a health carrier. Nothing in this section shall be construed to authorize providers to bind health carriers to pay for any service."

2.17 As required by WAC 284-170-421(7)(b), "No health carrier may preclude or discourage patients or those paying for their coverage from discussing the comparative merits of different health carriers with their providers. This prohibition specifically includes prohibiting or limiting providers participating in those discussions even if critical of a carrier."

2.18 As required by WAC 284-170-421(8), subject to applicable state and federal laws related to the confidentiality of medical or health records, participating provider and facility will make health records available to appropriate state and federal authorities involved in assessing the quality of care or investigating complaints, grievances, appeals, or review of any adverse benefit determinations of enrollees. Participating provider and facility will cooperate with audit reviews of encounter data in relation to the administration of health plan risk adjustment and reinsurance programs.

2.19 As required by WAC 284-170-421(9), issuer, or its designee, and participating provider must provide at least sixty days' written notice to each other before terminating the contract without cause.

2.20 As required by WAC 284-170-421(11), participating providers and facilities will furnish covered services to each enrollee without regard to the enrollee's enrollment in the plan as a private purchaser of the plan or as a participant in publicly financed programs of health care services. This requirement does not apply to circumstances when the provider should not render services due to limitations arising from lack of training, experience, skill, or licensing restrictions.

2.21 As required by WAC 284-170-421(13), the dispute resolution process is as stated in the Agreement and/or the administrative handbook (http://www.multiplan.com/providers/education). Except as otherwise required by a specific federal or state statute or regulation governing dispute resolution, no process for the resolution of disputes shall be considered fair under RCW 48.43.055 unless the process meets all the provisions of WAC 284-170-440.

2.22 As required by WAC 284-170-431(2)(a), for health services provided to covered persons, a carrier shall pay participating provider and facility as soon as practical but subject to the following minimum standards:

(i) Ninety-five percent of the monthly volume of Clean Claims shall be paid within thirty days of receipt by the responsible carrier or agent of the carrier; and
(ii) Ninety-five percent of the monthly volume of all claims shall be paid or denied within sixty days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by the parties on a claim-by-claim basis.

2.23 As required by WAC 284-170-431(2)(b), the receipt date of a claim is the date the responsible carrier or its agent receives either written or electronic notice of the claim.

2.24 As required by WAC 284-170-431(2)(c), carrier shall establish a reasonable method for confirming receipt of claims and responding to provider and facility inquiries about claims.

2.25 As required by WAC 284-170-431(2)(d), any carrier failing to pay claims within the standard established under WAC 284-170-431(2) shall pay interest on undenied and unpaid Clean Claims more than sixty-one days old until the carrier meets such standard. Interest shall be assessed at the rate of one percent per month, and shall be calculated monthly as simple interest prorated for any portion of a month. Carrier shall add the interest payable to the amount of the unpaid claim without the necessity of the provider or facility submitting an additional claim. Any interest paid under this section shall not be applied by carrier to a covered person's deductible, copayment, coinsurance, or any similar obligation of the covered person.

2.26 As required by WAC 284-170-431(2)(e), when the carrier issues payment in either participating providers and the covered person names, the carrier shall make claim checks payable in the name of the participating provider or facility first and the covered person second.

2.27 As required by WAC 284-170-431(3), "Clean Claim" means a claim that has no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim under this section.

2.28 As required by WAC 284-170-431(4), denial of a claim must be communicated to participating provider or facility and must include the specific reason why the claim was denied. If the denial is based upon medical necessity or similar grounds, then carrier upon request of the participating provider or facility must also promptly disclose the supporting basis for the decision.

2.29 As required by WAC 284-170-460(1), this Agreement does not grant the carrier access to health information and other similar records unrelated to covered persons. This provision shall not limit the carrier's right to ask for and receive information relating to the ability of the provider or facility to deliver health care services that meet the accepted standards of medical care prevalent in the community.

2.30 As required by WAC 284-170-460(2), if the Agreement grants the carrier or its designee access to medical records for audit purposes such access is limited to only that necessary to perform the audit.

2.31 As required by WAC 284-170-460(3), any billing audit standards defined in the Agreement shall be deemed mutual, giving equivalent billing audit rights to carriers and providers or facilities.

2.32 As required by WAC 284-170-470(7), issuer will authorize an emergency fill by the dispensing pharmacist and approve the claim payment.

2.33 As required by WAC 284-170-480, all participating provider and facility agreements will be filed with the commissioner for prior approval and comply with the requirements in WAC 284-170-480 and RCW 48.43.730.

2.34 As required by RCW 48.43.083, if a participating provider agreement is offered to a chiropractor within a single practice organized as a sole proprietorship, partnership, or corporation, the same participating provider agreement must be offered to any other chiropractor within that practice providing services at the same location. Either party may terminate the agreement without cause.

2.35 As required by RCW 48.43.190, a health carrier may not pay a chiropractor less for a service or procedure identified under a particular physical medicine and rehabilitation code, evaluation and management code, or spinal manipulation code, as listed in a nationally recognized services and procedures code book such as the American medical association current procedural terminology code book, than it pays any other type of provider licensed under Title 18 RCW for a service or procedure under the same or substantially similar code, except as provided in RCW 48.43.190(1)(b) of this subsection.

2.36 As required by RCW 48.43.505, health carriers and insurers shall adopt policies and procedures that conform administrative, business, and operational practices to protect an enrollee's and protected individual's right to privacy or right to confidential health care services granted under state or federal laws.

2.37 As required by RCW 48.43.515(7), each carrier must cover services of a primary care provider whose contract with the plan or whose contract with a subcontractor is being terminated by the plan or subcontractor without cause under the terms of that contract for at least sixty days following notice of termination to the enrollees or, in group coverage arrangements involving periods of open enrollment, only until the end of the next open enrollment period. The provider's relationship with the carrier or subcontractor must be continued on the same terms and conditions as those of the contract the plan or subcontractor is terminating, except for any provision requiring that the carrier assign new enrollees to the terminated provider.

2.38 As required by RCW 48.43.525(1), a carrier that offers a health plan shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered.

2.39 As required by RCW 48.43.600(1) and RCW 48.43.605(1), except in the case of fraud, or as provided in Article II, sections 40 and 41 below, a carrier or a health care provider may not (a) request a refund of a payment previously made to satisfy a claim or request additional payment unless doing so in writing to the provider or carrier, as applicable, within twenty-four months after the date that the claim was denied or payment intended to satisfy the claim was made; or (b) request that a contested refund or additional payment be paid any sooner than six months after receipt of the request. Any such request must specify why the carrier or health care provider believes the other party owes the refund or additional payment. If a provider fails to contest a request from a carrier for a refund in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

2.40 As required by RCW 48.43.600(2) and RCW 48.43.605(2), a carrier or health care provider may not, if doing so for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim: (a) request a refund of a payment previously made to satisfy a claim or request additional payment from a health care provider or carrier to satisfy a claim unless doing so in writing to the health care provider or carrier within thirty months after the date the claim was denied or payment intended to satisfy the claim was made; or (b) request a contested refund or that the additional payment be made any sooner than six months after receipt of the request. Any such request must specify why the carrier or health care provider believes the health care provider or carrier owes the refund or additional payment, and include the name and mailing address of any entity that has primary responsibility or disclaimed responsibility for payment of the claim. If a health care provider fails to contest the request in writing to the carrier within thirty days of its receipt, the request is deemed accepted and the refund must be paid.

2.41 As required by RCW 48.43.600(3), a carrier may at any time request a refund from a health care provider of a payment previously made to satisfy a claim if: (a) A third party, including a government entity, is found responsible for satisfaction of the claim as a consequence of liability imposed by law, such as tort liability; and (b) the carrier is unable to recover directly from the third party because the third party has either already paid or will pay the provider for the health services covered by the claim.

2.42 As required by RCW 48.43.600(4) and RCW 48.43.605(3), if Article II, sections 39, 40, and 41 above, conflict with RCW 48.43.600 or RCW 48.43.605, RCW 48.43.600 and/or RCW 48.43.605 shall prevail. However, nothing in RCW 48.43.600 or RCW 48.43.605 prohibits a health care provider or a carrier from choosing at any time to refund a carrier or a health care provider any payment previously made to satisfy a claim.

2.43 As required by RCW 48.43.600(5), "refund" means the return, either directly or through an offset to a future claim, by a carrier, of some or all of a payment already received by a health care provider.

2.44 As required by RCW 48.43.600(6), RCW 48.43.600 neither permits nor precludes a carrier from recovering from a subscriber, enrollee, or beneficiary any amounts paid to a health care provider for benefits to which the subscriber, enrollee, or beneficiary was not entitled under the terms and conditions of the health plan, insurance policy, or other benefit agreement.

2.45 As required by WAC 284-170-433(1)(a), a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine or store and forward technology if: (i) The plan provides coverage of the health care service when provided in person by the provider; (ii) The health care service is medically necessary; (iii) The health care service is a service recognized as an essential health benefit under section 1302(b) of the federal Patient Protection and Affordable Care Act in effect on January 1, 2015, RCW 48.43.005 and 48.43.715; (iv) The health care service is determined to be safely and effectively provided through telemedicine or store and forward technology according to generally accepted health care practices and standards, and the technology used to provide the health care service meets the standards required by state and federal laws governing the privacy and security of protected health information. Beginning January 1, 2023, for audio-only telemedicine, the covered person has an established relationship with the provider.

2.46 As required by WAC 284-170-433(2)(a) and RCW 48.43.735, except as otherwise permitted under RCW 48.43.735, a health carrier shall reimburse a provider for a health care service provided to a covered person through telemedicine the same amount of compensation the carrier would pay the provider if the health care service was provided in person by the provider.

2.47 As required by WAC 284-170-433(3)(a), provide that an originating site for a telemedicine health care service subject to subsection (1) of this section includes a: (i) Hospital; (ii) Rural health clinic; (iii) Federally qualified health center; (iv) Physician's or other provider's office; (v) Licensed or certified behavioral health agency; (vi) Skilled nursing facility; (vii) Home or any location determined by the individual receiving the service including, but not limited to, a pharmacy licensed under chapter 18.64 RCW or a school-based health center as defined in RCW 43.70.825. If the site chosen by the individual receiving service is in a state other than the state of Washington, a provider's ability to conduct a telemedicine encounter in that state is determined by the licensure status of the provider and the provider licensure laws of the other state; or (viii) Renal dialysis center, except an independent renal dialysis center.

2.48 As required by WAC 284-170-433(6)(a), if a provider intends to bill a covered person or the covered person's health plan for an audio-only telemedicine service, the provider must obtain patient consent from the covered person for the billing in advance of the service being delivered, consistent with the requirements of this subsection and state and federal laws applicable to obtaining patient consent.

2.49 As required by WAC 284-170-433(9), access to telemedicine services shall be inclusive for those patients who may have disabilities or limited-English proficiency and for whom the use of telemedicine technology may be more challenging, consistent with carriers' obligations under WAC 284-43-5940 through 284-43-5965 with respect to design and implementation of plan benefits.

2.50 As required by RCW 48.43.750, a health carrier shall make a determination approving or denying a credentialing application submitted to the carrier no later than ninety days after receiving a complete application from a health care provider. All determinations made by a health carrier in approving or denying credentialing applications must average no more than sixty days. If a carrier approves a health care provider's credentialing application, upon completion of the credentialing process, carrier must reimburse health care provider in accordance with RCW 48.43.757.

2.51 As required by RCW 48.43.761, health plans and providers and facilities offering behavioral health and substance use disorder services must comply with the applicable requirements outlined in RCW 48.43.761 and WAC 284-43-2000.

2.52 As required by RCW 48.43.775, a carrier may not require a provider or facility participating in a qualified health plan under RCW 41.05.410 to, as a condition of participation in a qualified health plan under RCW 41.05.410, accept a reimbursement rate for other health plans offered by the carrier at the same rate as the provider or facility is reimbursed for a qualified health plan under RCW 41.05.410.

STATE LAW COORDINATING PROVISIONS: WEST VIRGINIA

2.1 As required by W. Va. Code § 33-45-2(a)(1), insurer shall either pay or deny a clean claim within forty days of receipt of the claim if submitted manually and within thirty days of receipt of the claim if submitted electronically, except in the following circumstances: (i) another payor or party is responsible for the claim; (ii) the insurer is coordinating benefits with another payor; (iii) the provider has already been paid for the claim; (iv) the claim was submitted fraudulently; or (v) there was a material misrepresentation in the claim.

2.2 As required by W. Va. Code § 33-45-2(a)(2), insurer shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect the record on request and to rely on that record or on any other relevant evidence as proof of the fact of receipt of the claim. If insurer fails to maintain an electronic or written record of the date a claim is received, the claim shall be considered received three business days after the claim was submitted based upon the written or electronic record of the date of submittal by the person submitting the claim.

2.3 As required by W. Va. Code § 33-45-2(a)(3), insurer shall, within thirty days after receipt of a claim, request electronically or in writing from the person submitting the claim any information or documentation that insurer reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Insurer shall use all reasonable efforts to ask for all desired information in one request, and shall if necessary, within fifteen days of the receipt of the information from the first request, only request or require additional information one additional time if such additional information could not have been reasonably identified at the time of the original request or to specifically identify a material failure to provide the information requested in the initial request. Upon receipt of the information requested under this subsection which insurer reasonably believes will be required to adjudicate the claim or to determine if the claim is a clean claim, insurer shall either pay or deny the claim within thirty days. No insurer may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if insurer fails to timely notify the person submitting the claim within thirty days of receipt of the claim of the additional information requested unless such failure was caused in material part by the person submitting the claims.

2.4 As required by W. Va. Code § 33-45-2(a)(4), interest, at a rate of ten percent per annum, accruing after the forty-day period provided in W. Va. Code § 33-45-2(a)(1), owing or accruing on any claim under any provider contract or under any applicable law, shall be paid and accompanied by an explanation of the assessment on each claim of interest paid, without necessity of demand, at the time the claim is paid or within thirty days thereafter.

2.5 As required by W. Va. Code § 33-45-2(a)(5), insurer shall establish and implement reasonable policies to permit any provider with which there is a provider contract:

(a) To promptly confirm in advance during normal business hours by a process agreed to between the parties whether the health care services to be provided are a covered benefit; and
(b) To determine insurer's requirements applicable to provider (or to the type of health care services which provider has contracted to deliver under provider's contract) for: (i) precertification or authorization of coverage decisions; (ii) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim; (iii) Provider-specific payment and reimbursement methodology; and (iv) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim.
(c) Insurer shall make available to provider within twenty business days of receipt of a request, reasonable access either electronically or otherwise, to all the policies that are applicable to provider or to particular health care services identified by provider. In the event the provision of the entire policy would violate any applicable copyright law, insurer may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to provider and to any health care services identified by provider.

2.6 As required by W. Va. Code § 33-45-2(a)(6), insurer shall pay a clean claim if insurer has previously authorized the health care service or has advised provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

(a) The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or
(b) Insurer's refusal is because: (i) another payor or party is responsible for the payment; (ii) Provider has already been paid for the health care services identified on the claim; (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the insurer by provider, enrollee, or other person not related to insurer; (iv) the person receiving the health care services was not eligible to receive them on the date of service and insurer did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status (v) there is a dispute regarding the amount of charges submitted; or (vi) the service provided was not a covered benefit and insurer did not know, and with the exercise of reasonable care could not have known, at the time of the certification that the service was not covered.

2.7 As required by W. Va. Code § 33-45-2(a)(7)(A) & (C), insurance company may not retroactively deny a previously paid claim unless: (i) The claim was submitted fraudulently; (ii) the claim contained material misrepresentations; (iii) The claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services were not delivered by provider; (iv) Provider was not entitled to reimbursement; (v) the service provided was not covered by the health benefit plan; or (vi) the insured was not eligible for reimbursement. A health plan may retroactively deny a claim for the reasons set forth in W. Va. Code §33-45-2(a)(7)(A)(iii), (iv), (v) and (vi) for a period of one year from the date the claim was originally paid. There shall be no time limitations for retroactively denying a claim for the reasons set forth W. Va. Code § 33-45-2(a)(7)(A)(i) and (ii).

2.8 As required by W. Va. Code § 33-45-2(a)(7)(B), a provider to whom a previously paid claim has been denied by a health plan in accordance with W. Va. Code § 33-45-2(a)(7) upon receipt of notice of retroactive denial by the plan, shall notify the health plan within forty days of the provider's intent to pay or demand written explanation of the reasons for the denial.

(i) Upon receipt of explanation for retroactive denial, provider shall reimburse the plan within thirty days for allowing an offset against future payments or provide written notice of dispute.
(ii) Disputes shall be resolved between the parties within thirty days of receipt of notice of dispute.
(iii) Upon resolution of dispute, provider shall pay any amount due or provide written authorization for an offset against future payments.

STATE LAW COORDINATING PROVISIONS: WISCONSIN

2.1 As required by Wis. Admin. Code § Ins 9.35(1)(1m), participating provider shall notify all plan enrollees of the enrollees' rights under Wis. Stat. § 609.24 if the provider's participation terminates for reasons other than provided in Wis. Admin. Code § Ins 9.35(2)(a) or (b). Participating provider shall post a notification of termination with the plan no later than 30 days prior to the termination or fifteen (15) days following the date the insurer received the provider's termination notice, whichever is later, and describe each enrollee's options for receiving continued care from the terminated provider.

2.2 As required by Wis. Adm. Code § Ins 18.03(2)(c)2., provider shall promptly provide the insurer with the information necessary to respond to complaints or grievances described in Wis. Admin. Code § Ins 18.03(2)(c).

2.3 As required by Wis. Stat. § 609.24(1)(e)1., except as provided in Wis. Stat. § 609.24(1)(d), provider shall accept payment made pursuant to the underlying Agreement, as payment in full, for services rendered pursuant to Wis. Stat. § 609.24(1)(c).

III. ACCREDITATION STANDARDS COORDINATING PROVISIONS:

There are no Accreditation Standards Coordinating Provisions at this time.

IV. GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS:

The following states have no Geographic Exceptions Coordinating Provisions at this time:

Alabama	Georgia	Massachusetts	Ohio	Virginia
Alaska	Hawaii	Minnesota	Oregon	Washington
Arizona	Illinois	Montana	Rhode Island	West Virginia
California	Iowa	Nevada	South Dakota	Wisconsin
Connecticut	Kentucky	New Jersey	Tennessee	
Delaware	Maryland	New Hampshire	Utah	
District of Columbia	Maine	North Carolina	Vermont	

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: ARKANSAS

4.1 In the event provider is subject to the protection granted by A.C.A. § 21-9-301 *et seq*. (Liability of Political Subdivisions), provider may not be required to carry liability insurance. In order to waive the liability insurance requirements of this Agreement, provider shall provide Claritev with proof of such political subdivision status upon the execution of this Agreement.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: COLORADO

4.1 Professional Liability and Comprehensive General Liability Insurance. As allowed by C.R.S. § 24-10-106, if Network Provider is a public entity, as defined by C.R.S. § 24-10-103, and operates a public hospital, Network Provider will maintain professional liability insurance and comprehensive general liability insurance in an amount necessary to

cover its statutory liability. Network Provider's statutory liability is limited to the amounts set out in C.R.S. § 24-10-114.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: FLORIDA

4.1 Professional Liability Insurance. As allowed by Claritev, if Network Provider is a practitioner, other than a medical doctor ("MD") or doctor of osteopathy ("DO"), such Network Provider will maintain professional liability insurance or an unexpired, irrevocable letter of credit at minimum levels of $100,000 per occurrence and $300,000 in the aggregate.

4.2 Professional Liability Insurance. Per Fla. Stat. § 458.320, if Network Provider is a physician licensed and compliant under Ch. 458, Fla. Stat. such Network Provider may waive the minimum levels of professional liability insurance.

4.3 As required by Fla. Stat. § 458.320, if Network Provider meets the requirements stated in Section VI.2 herein, Network Provider shall post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all Participants or provide a written statement to a Participant. The statement shall be as follows:

"Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law."

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: IDAHO

4.1 Professional Liability Insurance. As allowed by I.C. § 6-919 *et seq*., if provider is a governmental entity, as defined by I.C. § 6-902, such provider will maintain professional liability insurance and comprehensive general liability insurance at minimum levels of $500,000 per occurrence, unless such provider purchases additional insurance coverage.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: INDIANA

4.1 As allowed by I.C. § 34-18-4-1 *et seq*., if provider participates in the Indiana Patient Compensation Fund, provider will maintain professional liability insurance at one of the following minimum levels of coverage:
(i) if provider is a health care provider, as defined by Indiana code § 34-18-2-14, at least the amount specified in I.C. § 34-18-14-3(b) per occurrence, and three (3) times that amount in the annual aggregate.
(ii) if provider is a health facility, as defined by I.C. § 34-18-2-15, with no more than one hundred (100) beds, at least the amount specified in I.C. § 34-18-14-3(b) per occurrence, with a minimum aggregate amount of three (3) times the amount specified in I.C. § 34-18-14-3(b).
(iii) if provider is a health facility, as defined by I.C. § 34-18-2-15, with more than one hundred (100) beds, at least the amount specified in I.C. § 34-18-14-3(b) per occurrence, with a minimum aggregate amount of five (5) times the amount specified in I.C. § 34-18-14-3(b).
(iv) if provider is a hospital, as defined by I.C. § 34-18-2-16, with no more than one hundred (100) beds, at least the amount specified in I.C. § 34-18-14-3(b) per occurrence, with a minimum aggregate amount of twenty (20) times the amount specified in I.C. § 34-18-14-3(b).
(v) if provider is a hospital, as defined by I.C. § 34-18-2-16, with more than one hundred (100) beds, at least the amount specified in I.C. § 34-18-14-3(b) per occurrence, with a minimum aggregate amount of thirty (30) times the amount specified in I.C. § 34-18-14-3(b)

4.2 Pursuant to I.C. § 34-18-14-3(b) a health care provider is not liable for an amount in excess of the following:
(i) Two hundred fifty thousand dollars ($250,000) for an act of malpractice that occurs after June 30, 1999 and before July 1, 2017.
(ii) Four hundred thousand dollars ($400,000) for an act of malpractice that occurs after June 30, 2017 and before July 1, 2019.
(iii) Five hundred thousand dollars ($500,000) for an act of malpractice that occurs after June 30, 2019.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: KANSAS

4.1 As allowed by Claritev, providers professional liability insurance limits will be acceptable so long as provider participates in the Kansas Health Care Stabilization Fund and maintains minimum professional liability insurance levels in accordance with K.S.A. § 40-3402 *et seq*.

4.2 As allowed by Claritev, if provider is an allied health professional, such provider will maintain professional liability insurance at minimum levels of $1,000,000 per occurrence and $2,000,000 in the aggregate.

4.3 Per the Kansas Tort Claims Act, K.S.A. § 75-6101 *et seq*., if provider is a hospital owned by a municipality or charitable health care provider, such provider will maintain professional liability insurance and comprehensive general liability at minimum levels of $500,000 per occurrence. Nothing herein shall prevent such provider from obtaining additional professional liability insurance and additional comprehensive general liability insurance.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: LOUISIANA

4.1 Professional Liability Insurance. As allowed by LSA-R.S. 40:1231.2, if provider participates in the Patient Compensation Fund, provider will maintain professional liability insurance at minimum levels of $100,000 per occurrence. In the event provider self-insures, such provider shall demonstrate financial responsibility at minimum levels of $125,000.

4.2 Professional Liability and Comprehensive General Liability Insurance. Per LSA-R.S. 39:1538, if provider is a member of the state agencies, as defined by LSA-R.S. 39:1527, such provider will maintain professional liability insurance in the minimum amount of $500,000 per occurrence and comprehensive general liability insurance in the minimum amount of $500,000 per occurrence.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: MICHIGAN

4.1 Professional Liability Insurance. As allowed by Claritev, provider will maintain professional liability insurance at minimum levels of $100,000 per occurrence and $300,000 in the aggregate.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: MISSISSIPPI

4.1 As allowed by Miss. Code Ann. § 11-46-1 *et seq*. if provider is a governmental entity, as defined by Miss. Code Ann. § 11-46-1, such provider will maintain professional liability insurance and comprehensive general liability at minimum levels of $500,000 per occurrence. Nothing herein shall prevent such provider from obtaining additional professional liability insurance and additional comprehensive general liability insurance.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: MISSOURI

4.1 Professional Liability Insurance. As allowed by Claritev, provider will maintain professional liability insurance at minimum levels of $500,000 per occurrence and $1,000,000 in the aggregate.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: NEBRASKA

4.1 Professional Liability Insurance. As allowed by Neb.Rev.St. § 44-2824 *et seq*., if Network Provider is a physician or certified registered nurse anesthetist and participates in the Excess Liability Fund, Network Provider will maintain professional liability insurance at minimum levels of $500,000 per occurrence and $1,000,000 in the aggregate. Notwithstanding the foregoing, if Network Provider is a facility and participates in the Excess Liability Fund, such Network Provider will maintain professional liability insurance in the minimum levels of $500,000 per occurrence and $3,000,000 in the aggregate.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: NEW MEXICO

4.1 Professional Liability Insurance. As allowed by N.M. Stat. § 41-5-5, if Network Provider is other than a hospital or facility and participates in the New Mexico Medical Malpractice Act, such Network Provider will maintain professional liability insurance at minimum levels of $200,000 per occurrence and $600,000 in the aggregate.

4.2 Professional Liability Insurance. As allowed by N.M. Stat. § 41-5-5, if Network Provider is a hospital or facility and participates in the New Mexico Medical Malpractice Act, such Network Provider will maintain professional liability insurance in an amount determined by the Superintendent of Insurance.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: NEW YORK

4.1 Professional Liability Insurance. In the event provider is a nurse practitioner, such Network Provider shall maintain professional liability insurance at minimum levels of $500,000 per occurrence and $1,500,000 in the aggregate.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: NORTH DAKOTA

4.1 Liability Insurance. As allowed by NDCC § 32-12.1-03, in the event Network Provider is a political subdivision as define by NDCC § 32-12.1-02, Network Provider shall maintain the comprehensive liability limits in the amounts set forth in NDCC § 32-12.1-03.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: OKLAHOMA

4.1 Professional Liability Insurance. As allowed by Claritev, Network Provider will maintain professional liability insurance at minimum levels of $1,000,000 per occurrence and $1,000,000 in the aggregate.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: PENNSYLVANIA

4.1 Professional Liability Insurance. As allowed by 40 P.S. § 1303.711 *et seq*., if provider participates in the Medical Care Availability and Reduction of Error plan, provider will maintain professional liability insurance at minimum levels as set out in 40 P.S. § 1303.712.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: SOUTH CAROLINA

4.1 Professional Liability Insurance. As allowed by S.C. Code Ann. § 15-78-120, if provider is a governmental entity, as defined by SC Code Ann. § 15-78-30, provider will maintain professional liability insurance in an amount necessary to cover its statutory liability. Pursuant to S.C. Code Ann. § 15-78-120, such provider's statutory liability is limited to $1,200,000 per occurrence.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: TEXAS

4.1 As allowed by Claritev, if provider is an individual practitioner or group provider, such provider will maintain through a policy of insurance or a self-funded arrangement, coverage for professional liability insurance at minimum levels of $100,000 per occurrence and $300,000 in the aggregate.

4.2 As allowed by Claritev, if provider is an urgent care center, such provider will maintain through a policy of insurance or a self-funded arrangement, coverage for professional liability at minimum levels of $200,000 per occurrence and $600,000 in the aggregate.

4.3 As allowed by Tex. Civ. Prac. & Rem. Code Ann. § 101.001 *et seq*., if provider is governmental unit, as defined by Tex. Civ. Prac. & Rem. Code Ann. §101.001, such provider will maintain professional liability insurance and comprehensive general liability insurance in accordance with Tex. Civ. Prac. & Rem. Code Ann. § 101.023. Pursuant to Tex. Civ. Prac. & Rem. Code Ann. § 101.027, Claritev and provider acknowledge and agree that if provider is a unit of state government, as defined by Tex. Civ. Prac. & Rem. Code Ann. § 101.001, such provider may only maintain professional liability and comprehensive general liability insurance if authorized or required to do so by law. In the event such provider, who is also a unit of state government, is authorized or required by law to maintain professional liability and comprehensive general liability insurance, such provider will maintain professional liability insurance and comprehensive general liability insurance in accordance with Tex. Civ. Prac. & Rem. Code Ann. § 101.023.

GEOGRAPHIC EXCEPTIONS COORDINATING PROVISIONS: WYOMING

4.1 Professional Liability Insurance. As allowed by Wyo. Stat. Ann. § 26-33-101 *et seq*., if provider participates in the Medical Liability Compensation Account, provider will maintain professional liability insurance at minimum levels of $50,000 per occurrence.