EVERNORTH BEHAVIORAL HEALTH ADMINISTRATIVE GUIDELINES

For contracted psychiatrists, psychologists, master-level therapists, hospitals, and facility-based programs

The Evernorth Behavioral Health Administrative Guidelines were previously referred to as the Medical Management Program.

EVERNORTH℠

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Introduction

Inside the guide

Welcome to Evernorth! For starters, we'd like you to know that we're committed to giving all of our customers access to quality services and benefits. That means working with you across all the aspects of today's health care world. To help us stay on the same page, we have created these Administrative Guidelines for you. It highlights the programs and policies intended to keep our relationship smooth and productive – for the sake of the people we serve together.

The Administrative Guidelines were previously referred to as the "Medical Management Program." Any agreement or document that references the Medical Management Program, the Provider Guide, the Provider Manual, or the Provider Administrative Guidelines shall all be construed to reference this document.

Your Provider Agreement and these Administrative Guidelines describe the terms under which you agree to provide services to all Participants. Those terms include the reimbursement rates applicable to Covered Services provided to Participants. However, the actual benefits payable by a Payer for Covered Services provided to a Participant in all cases are determined by the terms of the Payer's Benefit Plan.

Our commitment and mission

We also understand that a stable provider panel facilitates our goal of consistent and superior customer service. For that reason, we seek to build strong, long-standing relationships with our providers. Our policies and protocols have been developed to minimize time-consuming administrative activities, so you can spend more time providing superb service.

Evernorth Behavioral Health, Inc. is a subsidiary of Cigna and the behavioral network for customers with Cigna health plans. Note, however, we also sell behavioral health solutions to clients who may not have Cigna health plans. Evernorth provides behavioral care benefit management, employee assistance, and work/life programs to consumers through United States employers of all sizes, national and regional health maintenance organizations (HMOs), Taft-Hartley trusts, and disability insurers. With headquarters in Bloomington, Minnesota , we operate four care management centers around the United States in support of a national network of psychiatrists, psychologists and master-level therapists, clinics and facilities.

Contact us

Please contact us if you have questions about the information in this guide, or our plans and programs. The terms of your Provider Agreement supersede this guide if a conflict arises. In all circumstances, the parties shall comply with applicable law and the regulatory addendum contained herein.

Notes

Evernorth manages mental health and substance use disorder services of benefit plans sponsored and/or administered, in whole or in part, in compliance with applicable laws,

rules, and regulations, including without limitation the Federal Mental Health Parity and Addictions Equity Act, Affordable Care Act, state parity laws, and regulations.

Not all Administrative Guidelines and Program Requirements are outlined in this guide. Other guidelines and requirements or updates may be posted on the Evernorth provider website at Provider.Evernorth.com or communicated through notifications we deliver by mail, email, telephone, fax, or in person.

Regulatory addenda and state-specific information

Enclosed at the end of these Administrative Guidelines are the state-specific regulations and contract provisions applicable to the provider and which govern the Provider Agreement. These provisions are incorporated into the Provider Agreement to the extent required by law and as specified in such Addenda. The regulatory addenda shall be frequently updated to be in compliance with applicable law.

Please use the table below to access each state regulatory addendum.

Alabama (AL)	Alaska (AK)	Arizona (AZ)
Arkansas (AR)	California (CA)	Colorado (CO)
Connecticut (CT)	Delaware (DE)	Florida (FL)
Georgia (GA)	Hawaii (HI)	Idaho (ID)
Illinois (IL)	Indiana (IN)	Iowa (IA)
Kansas (KS)	Kentucky (KY)	Louisiana (LA)
Maine (ME)	Maryland (MD)	Massachusetts (MA)
Michigan (MI)	Minnesota (MN)	Mississippi (MS)
Missouri (MO) St. Louis	Montana (MT)	Nebraska (NE)
Nevada (NV)	New Hampshire (NH)	New Jersey (NJ)
New York (NY)	North Carolina (NC)	North Dakota (ND)
Ohio (OH)	Oklahoma (OK)	Oregon (OR)
Pennsylvania (PA)	Rhode Island (RI)	South Carolina (SC)
South Dakota (SD)	Tennessee (TN)	Texas (TX)
Utah (UT)	Vermont (VT)	Virginia (VA)
Virgin Islands (VI)	Washington DC Washington (WA)	West Virginia (WV)
Wisconsin (WI)	Wyoming (WY)	

Note: These requirements apply only to the extent required by applicable law and may not apply to participants covered under self-funded plans.

Important contact information

Find the contact you need for information about your patients. Please note that call, claim, and service channels may differ based on the participant's identification (ID) card.

If you want to:	Use the following:
Update your provider directory demographic information, or notify us of errors/changes to the way you are currently listed in our provider directories, including: • Name • Type/Degree • Specialty • National Provider Identifier (NPI) number • Clinic or facility affiliation • Office email address • Address • Office telephone number • Whether you are accepting new patients	Log in to Provider.Evernorth.com to use our updated online change form. If you haven't registered yet, please go to Provider.Evernorth.com and click "Register" to begin the process. **Or** Email: cforms@evernorth.com Fax: 860.687.7257 Mail: Network Operations 6625 W 78th Street, Ste. 100 Bloomington, MN 55439
Perform online transactions: • Verify patient eligibility and benefits and generate a Benefit Reference Number (BRN) • Look up a procedure code to obtain coinsurance, maximums, and determine if precertification is required. • Predict the total cost of service and patient liability for specific procedures • Review medical or pharmacy coverage positions • View the prescription drug list • View sample ID cards • Obtain a Reference Guide • Submit preservice precertification appeals	Website: Provider.Evernorth.com
Perform transactions using electronic data interchange (EDI): • Verify patient eligibility and coverage • Inquire about patient coverage and covered services • Check the status of a claim • Request precertification for services • Submit claims electronically • Receive electronic remittance advice	Refer to Cigna.com/EDIvendors for a list of directly connected Cigna vendors.
Perform telephone transactions: • Learn about electronic services • Verify patient eligibility and coverage • Check the status of a claim • Request precertification for services	Telephone: 800.926.2273 Customer Service numbers are also included on the patient's ID card.
Submit a paper claim	Refer to patient's ID card

If you want to:	Use the following:
Submit or inquire about an appeal or dispute	**For Cigna or Evernorth:** Phone: 800.926.2273 Fax: 877.815.4827 Mail: Evernorth Appeals PO Box 188064 Chattanooga, TN 37422 **For patients with "G" ID cards:** Phone: 866.494.2111 Fax: 877.804.1679 Mail: Cigna National Appeals PO Box 23487 Chattanooga, TN 37422-8062
Inquire about provider credentialing	Telephone: 800.926.2273
Obtain other telephone numbers and addresses	Refer to the participant's ID card

Demographic information and directory

We use your demographic information to:

- Publish online provider directories
- Send communications to providers
- Process claims
- Comply with state laws requiring accurate directory listings
- Determine network adequacy

Notify us in writing 90 days before any changes to your practice demographic information. Examples of such changes include changes in service location, billing address, telephone number, Taxpayer Identification Number (TIN), specialties, and new individual NPI or organization NPI. It is also important for you to update your status if you are no longer accepting new patients as this element is included in provider directory and relied upon by consumers.

Pursuant to Section 116 of The Consolidated Appropriations Act, 2021 Group Health Plans must: verify and update provider directory information not less frequently that once every 90 days, establish a procedure for the removal of a provider or facility with respect to which such plan or issues has been unable to verify information during a period specified by the plan or issuers; and the plan or issuer's database must be updated within two business days of such plan or issuer receiving updated information from such a provider or facility.

In order to comply with Section 116 of The Consolidated Appropriations Act, 2021, Evernorth Behavioral Health will outreach to all contracted providers every 90 days to validate directory information. It is the provider's responsibility to reply to that outreach by either confirming that their information is accurate or provide Evernorth Behavioral Health with updated information. In the event that a provider is unresponsive to all outreach attempts over the course of one calendar year, their information may be subject to suppression within Evernorth Behavioral Health's provider directories.

It is essential that you consistently identify yourself in written communications and claim submissions. Using abbreviations, variations of names, physician licensure, or TINs not listed in a Provider Agreement or not provided to Evernorth Behavioral Health, Inc. in advance of the change may result in delayed changes to the provider directory and incorrect claim payments. The latest provider directory is available at Cigna.com.

Submit demographic changes to Evernorth Behavioral Health, Inc. electronically by logging in to Provider.Evernorth.com > Working with Evernorth > Update Provider Information.

You may also submit demographic changes using the following fax and email address:

Fax: 860.687.7257
Email: cforms@evernorth.com

Benefit plan designs and features

Evernorth Behavioral Health provides a menu of services, which include the provision of behavioral care services to Cigna Healthcare participants. Benefit plan types may include health maintenance organization (HMO), Open Access Plan (OAP), preferred provider organization (PPO), or employee assistance program (EAP). In addition, Evernorth Behavioral Health provides behavioral services to other plans nationwide.

Below is a summary of Cigna benefit plan types:

Plan	Highlights
Cigna SureFit®	Cigna SureFit benefit plans build networks around local physician and hospital groups providing customers access to personal, patient-centered care. Highlights: • Primary care provider (PCP) selection is required, where permitted. • **Referrals are not required for behavioral services.** • No out-of-network coverage unless an emergency or urgent care. • You are responsible for obtaining precertification for all in-network services, when required.
Connect Network (Individual & Family Plan [IFP]) A narrow network of participating providers	At enrollment, participants are encouraged to select a PCP from our in-network provider listing. In Illinois, it is required that participants select a PCP. Highlights: • PCP-coordinated care. • Referrals are not required for behavioral services. • You are responsible for obtaining precertification for all in-network services, when required. • In-network coverage only (only emergency care is covered when received from out-of-network providers). • Coinsurance or deductibles should not be collected at the time of service.
HMO Network (In-network coverage only) Point of Service (POS) (In-network and out-of-network coverage)	At enrollment, participants select a PCP from our broad network of participating physicians. Highlights: • PCP-coordinated care. • **Referrals are not required for behavioral services.** • You are responsible for obtaining precertification for all in-network services, when required. • Coinsurance or deductibles should not be collected at the time of service. • Most payment responsibilities and precertification requirements for patients are shown on their ID card.

Plan	Highlights
HMO Open Access Network Open Access (In-network coverage only) Point-of-Service (POS) Open Access (In- and out-of-network coverage)	Plan participants can visit specialists without a referral. Highlights: • PCP optional. The use of a PCP is encouraged, but not required. • You are responsible for obtaining precertification for all in-network services, when required. • In-network and out-of-network coverage (in-network utilization encouraged). • Coinsurance or deductibles should not be collected at the time of service.
LocalPlus® and LocalPlus® IN A narrow network of participating providers	• LocalPlus and LocalPlus IN plans offer local health care communities of in-network doctors, specialists and hospitals to employer groups (not available for IFPs). As of July 1, 2023 , LocalPlus and LocalPlus IN plans are available in 34 markets in 24 states, including AL, AR, AZ, CA, CO, FL, GA, IL, IN, KS, MA, MD, MO, MS, NJ, NV, NY, OR, RI, SC, TN, TX, UT, and WA. The LocalPlus plan gives participants referral-free access to in-network specialists. If participants choose an out-of-network provider, services are covered at a reduced benefit level. The LocalPlus In-Network plan also provides referral-free access to specialty care. However, participants must visit providers in the LocalPlus network to receive benefits (only emergency and urgent care is covered when received from out-of-network providers). Highlights: • PCP optional. The use of a PCP is strongly encouraged, but not required. • No referrals are required. • A local, focused network of participating providers, including doctors, specialists, and hospitals. • You are responsible for obtaining precertification for all in-network services, when required. • For coverage when away from home while traveling for work or pleasure, LocalPlus provides access to LocalPlus networks in any area in the country where one exists. In areas where LocalPlus is not available, customers (e.g., students away from school, workers on temporary assignments) temporarily can access in-network coverage via Away From Home Care products. • Access to Cigna's national network of laboratories, radiology offices, virtual care, and dialysis centers. • Coinsurance and deductibles should not be collected at the time of service.

	Most payment responsibilities and precertification requirements are shown on the participant's ID card.
Plan	**Highlights**
Open Access Plus (OAP) Open Access Plus In-Network (OAPIN)	The Cigna Open Access Plus plan gives participants referral-free access to specialists. If participants choose an out-of-network provider, services are covered at a reduced benefit level. The Cigna Open Access Plus In-Network plan also provides referral-free access to specialty care. However, participants must visit providers in the Open Access Plus network to receive benefits. (Only emergency care is covered when received from out-of-network providers.) Highlights: • PCP optional. The use of a PCP is strongly encouraged, but not required. • No referrals are required. • Broad national network of providers. • You are responsible for obtaining precertification for all in-network services, when required. Coinsurance and deductibles should not be collected at the time of service.
Preferred provider organization (PPO) and exclusive provider organization (EPO) self-directed health care	PPO plan participants have both in-network and out-of-network coverage. You are responsible for filing the claim form and for obtaining precertification for all in-network services, when required. EPO plan participants have in-network coverage only. Emergency and urgent care is covered in-network. You are responsible for obtaining precertification for all in-network services, when required. Highlights: • No PCP selection required. • No referrals are required. • Broad network of providers. • Coinsurance and deductibles should not be collected at the time of service. Most participant payment responsibilities and precertification requirements for patients are shown on their ID card.

Beginning in 2023, Evernorth will introduce custom networks to our benefit plan offerings to help ensure that our customers have access to quality behavioral care that is appropriate and affordable. In alignment with our medical business and industry standards, the networks that support these plans may be refined by geography, specialty, quality metrics, IFP/health care exchange plans, etc.

With the addition of custom networks to our plan offerings, provider participation in a particular network may vary depending on the patients benefit design. As we introduce more of these networks to our plan offerings, it will become increasingly important for providers to verify patient benefit and eligibility prior to rendering services.

Note: Notifications will be sent prior to changing a providers participation status in a custom network.

Products

Products can vary by plan. This section is for participants with Cigna plans only.

Cigna Choice Fund®

Cigna offers two Cigna Choice Fund® options, a Choice Fund Health Reimbursement Account (HRA) and a Health Savings Account (HSA). These plans package a health care fund account with a PPO or OAP plan that has a deductible, coinsurance, and out-of-pocket maximum.

When claims are processed, you may be reimbursed directly from the patient's HRA or HSA account for the participant's coinsurance and deductible (if funds are available). This reduces the need to collect funds from the patient at the point of service.

What you need to know

- Preventive care visits and services are paid at 100 percent for most Choice Fund plans, with no participant cost share applicable.
- These plans typically do not include copayments, but rather coinsurance and deductibles.
- The behavioral copay is the specialist copay.
- Most individuals with a Cigna Choice Fund plan have automatic claim forwarding (ACF). In these cases, the health account is automatically accessed to pay you directly (when funds are available). This helps to alleviate you from having to pursue the participant for any applicable coinsurance or deductible payments.
- The amount that a patient owes is determined by the claim adjudication under the terms of the plan.
- If the patient has ACF, collecting coinsurance and deductibles may cause an overpayment, resulting in a refund owed to the individual. Coinsurance and deductibles should not be collected at the time of service unless:
    - You have accessed the Cigna Cost of Care Estimator® to obtain an estimate of the patient's deductible and coinsurance obligations; and
    - You have provided a copy of the estimate to the patient.

For more information, including information about ACF, please visit Cigna.com/health/provider/medical/ccf.html or call 800.88Cigna (882.4462).

Cigna debit card transactions

If a provider can accept debit card transactions, the participant's debit card should be used only for "medical care" expenses as defined in Internal Revenue Code section 213(d). Behavioral health services qualify as an accepted expense. Your patients may use their debit card to pay for eligible Section 213 medical care expenses through their Flexible Spending Account (FSA) or Health Reimbursement Account (HRA).

When a patient presents a debit card, the card should not be used for covered behavioral services. When a patient uses their debit card for their in-network provider visits, substantiating these claims helps to improve their experience and speed up how quickly you are paid.

If the transactions are not eligible per IRS regulation, the patient should be asked to provide a separate or additional form of payment. Additional information about eligible transactions

can be found at Cigna.com/expenses or http://www.irs.gov/publications/p969/index.html. You can also call Cigna Customer Service at 800.88Cigna (882.4462).

ID cards – quick guide

Quick guide to Cigna ID cards	Provider.Evernorth.com > Resources > Using ID Cards.

"G" ID cards

Some participant ID cards include a "G" in the upper right corner. Service channels, including customer service numbers and claim appeal addresses, may be different for customers with these ID cards. For best results, use the service channels outlined in this Reference Guide or follow the information on the ID cards.

Strategic Alliances

Some of your patients may have a plan offered through a Cigna Strategic Alliance. This means Cigna and another health plan jointly market benefit plans or share in the administration of the plan (e.g., we may perform claim re-pricing and other services). Participants in these plans can access in-network care through the alliance plan's network of participating providers in the alliance plan's select geographic area. Therefore, the Evernorth Behavioral Health, Inc. agreement may or may not apply. Provider's locations where the customer utilizes another health plan will not apply to the agreement.

Please refer to the customer's ID card to determine how to verify eligibility and benefits, obtain precertification, and submit claims.

CareLink℠ (Alliance with Tufts Health Plan)

Effective: August 1, 2005 **Service Area:** Massachusetts (MA) and Rhode Island (RI)

Contract Information:
Participants with a CareLink logo on their ID card have access to the Tufts Health Plan provider network in MA and RI for in-network coverage. Providers in MA and RI who are contracted only with Cigna are considered out-of-network for CareLink participants.

Outside MA and RI, CareLink participants have access to the Cigna national network of participating providers.

Additional Information:
You can contact Tufts Health Plan at 888.884.2404 or by visiting https://tuftshealthplan.com/provider. The CareLink (Tufts Health Plan) Quick Reference Guide is available on the secure Evernorth provider website (Provider.Evernorth.com > Resources > Reference Guides > Medical Reference Guides > CareLink [Tufts Health Plan] Quick Reference Guide).

Priority Health

Effective: January 1, 2021 **Service area:** Michigan's Lower Peninsula

Contract information:
Providers in this service area must be contracted through Priority Health to be considered in network. Outside the state of Michigan, Priority Health participants have access to the Cigna national network of participating providers.

Additional information:
You can contact Priority Health customer service at 800.942.4765, or by visiting priorityhealth.com.

HealthPartners

Effective: January 1, 2007 **Service Area**: Minnesota, North Dakota, Western Wisconsin

Contract information:

Providers in this service area must be contracted through HealthPartners to be considered in network for Cigna participants. Outside the service area, HealthPartners participants have access to the Cigna national network of participating providers, except in South Dakota, Iowa, and Nebraska.

Additional information:

The Quick Reference Guide is available online at healthpartners.com/ucm/groups/public/@hp/@public/documents/documents/entry_142402.pdf. The guide is also available on the secure Evernorth provider website (Provider.Evernorth.com > Resources > Reference Guides > Medical Reference Guides > HealthPartners Quick Reference Guide).

MVP Health Care

Effective: July 1, 2007 **Service Area:** 46 counties in Upstate New York and Bradford County Pennsylvania beginning January 1, 2019

Contract Information:

Providers in this service area must be contracted through MVP to be considered in network. Outside the service area, MVP participants have access to the Cigna national network of participating providers, except in Vermont, one county in Massachusetts, and six counties in lower New York (metropolitan NYC).

Additional Information:

You can contact MVP at 888.687.6277 or by visiting mvphealthcare.com.

The MVP Health Care Quick Reference Guide is available on the secure Evernorth provider website (Provider.Evernorth.com > Resources > Reference Guides > Medical Reference Guides).

Shared administration

Cigna Healthcare participants only

Taft Hartley/Federal Government: Cigna contracts with Taft Hartley trusts and federal employee health benefit plans to share the administration of their self-funded, administrative service only (ASO) plans. For these relationships, Cigna provides access to the PPO, OAP, and LocalPlus networks, performs inpatient medical management (and sometimes outpatient, depending on the client), and re-prices claims according to negotiated rates. For some of these clients, Cigna may also provide stop loss insurance, chronic condition management, and pharmacy benefits. Third-party administrators (TPAs) or the staff of these clients are also involved in the administration of these plans with respect to eligibility and claim payment on their own systems.

- Cigna requires TPAs to provide frequent eligibility information updates to help minimize late identification of non-covered employees.
- Plan designs require an in- and out-of-network benefit difference to encourage patients to use Cigna participating network providers.
- Cigna performs pre-contract checks to help ensure TPAs meet our standards for claim payment accuracy, payment turn-around time, and call statistics (e.g., average speed of answer). Additionally, adherence to these standards is a contractual requirement.
- Cigna audits all TPAs regularly to help ensure compliance with contract standards.
- Cigna's network staff and our Provider Service Representatives are available to support you and facilitate resolution of any claim inquiries or issues.
- Cigna retains the authority to resolve differences regarding provider contract language and intent.
- Participants with Medicare as their primary coverage are not enrolled in these plans.

In these instances, please submit claims directly to Medicare.

For additional information, please log in to the secure Evernorth provider website (Provider.Evernorth.com > Medical Resources > Medical Plans and Products > Shared Administration).

ID cards: ID cards contain the Cigna logo and both paper and electronic claims submission addresses (note: electronic claim submission is the most cost-effective method). The Cigna precertification telephone number along with the TPA telephone number and address for eligibility, benefits, and claim status inquiry are also available on the participant's ID card.

Case management: All utilization review is provided through Cigna and branded as CareAllies. Clients may purchase review of outpatient services (e.g., ambulatory surgery, high-technology radiology). Participants are aware of these requirements.

Eligibility/benefits/claim status and payment: For information related to these topics, please contact the TPA telephone number and address listed on the participant's ID Card.

Claim flow: Please submit claims directly to Cigna using the Cigna electronic payer ID 62308, or to the mailing address listed on the participant's ID card. Cigna prices the claim based on your contracted reimbursement rate and the results of our utilization review program. The priced claim is then forwarded to our Shared Administration clients for payment, based on the participant's eligibility and benefits. The Shared Administration client then remits payment following contractually agreed-upon turnaround requirements. Please

contact the TPA directly to enroll with electronic remittance advice (ERA) and electronic fund transfers (EFTs).

Clinical and contract-related appeals: Please submit appeals of clinical denials to Cigna using the contact information supplied in the denial letter(s). Please submit appeals of application-of-contract rates directly to Cigna at PO Box 188004, Chattanooga, TN 37422, ATTN: Appeals.

Payer solutions segment

Cigna contracts with TPAs, selected insurers, and claim administrators (referred to collectively as “payers”) to share the administration of their self-funded (ASO) and insured plans. For these relationships, Cigna provides access to the PPO, OAP, and LocalPlus networks, may perform medical management, and prices claims according to our negotiated rates. For some clients, Cigna also provides stop loss insurance, chronic condition management, and pharmacy benefits as well as other products. Our contracted payers maintain eligibility, administer benefits, and process claims for these accounts on their own systems.

- Cigna requires payers to provide frequent eligibility information updates to minimize late identification of non-covered employees.
- Plan designs require an in- and out-of-network benefit differential to encourage participants to use providers who participate in the Cigna network.
- Cigna performs a pre-contract review to help ensure, among other things, payers meet our standards for claim payment accuracy, payment turn-around time, call statistics (e.g., average speed of answer). Additionally, adherence to these standards is contractually required.
- Cigna meets regularly with payers to review service metrics and may audit payers to help ensure compliance with contract requirements standards. Cigna also monitors service levels through routine metric reporting.
- The customers enrolled through these payers are “Participants” as defined by your agreement with Cigna. Additionally, Cigna has a direct agreement with the employer groups or insurers responsible for funding claim payments.
- Cigna's contracting staff and Provider Relations representatives are available to support providers with contracting questions. For claim-related inquiries, please contact the TPA listed on the participant’s ID card.

Claim flow: Please submit claims directly using the Cigna electronic payer ID 62308, or to the claims mailing address on the participant’s ID card. Cigna prices the claims based on the Cigna network contracted rates. The priced claim is then forwarded to the payer for payment based on the participant’s eligibility and benefits. The payers then remit payment following contractually agreed upon turnaround requirements.

Eligibility/benefits/claim status and payment: For information related to these topics, please contact the TPA telephone number and address listed on the participant’s ID Card.

Clinical and contract-related appeals: Please submit appeals of clinical denials to Cigna using the contact information supplied in the denial letter(s). Please submit appeals of application-of-contract rates directly to the address on the participant’s ID card. Appeals must be submitted within 180 days of the initial denial. Unless otherwise specified in your contract, contract-related appeals can be faxed to 877.804.1679, or mailed to PO Box 188062, Chattanooga, TN 37422.

Medicare Advantage

In accordance with federal laws, the information under this section complements the Evernorth Behavioral Health Participating Provider Agreement and applicable sections of a Medicare Advantage payer-specific manual.

Medicare managed care

Cigna Medicare Advantage administers behavioral health benefit services, including claims processing, customer service, medical management, and utilization management. Evernorth Behavioral Health administers behavioral health care professional network services, including joining and leaving the network, contracting, credentialing, and fee negotiations.

Cigna Medicare Advantage and Evernorth Behavioral Health are committed to providing our customers with the highest quality and greatest value in health care benefits and services.

For additional information about the Cigna Medicare Advantage Network, including their Provider Manual and Provider Newsletter, please visit their website at MedicareProviders.Cigna.com.

For information related to Cigna Medicare's Behavioral Health Unit, please visit their website at MedicareProviders.Cigna.com/bhunit.

In select states, Evernorth Behavioral Health providers deliver services to Medicare participants enrolled in an HMO or PPO Benefit Agreement with Medicare Advantage organizations. The benefits supplied by Medicare Advantage organizations are a Medicare replacement product, rather than a Medicare supplemental plan. A participant must be enrolled in Medicare and opt to have coverage by a Medicare Advantage organization. Medicare participants are identified by their membership card.

Access to records and facilities

Evernorth Behavioral Health's contracted providers must allow Cigna, U.S. Department of Health and Human Services, the Comptroller General, or their designees to audit, evaluate, or inspect any books, agreements, medical records, participant care documentation, and any other additional relevant information that the Centers for Medicare & Medicaid Services (CMS) may require which pertains to any aspect of services rendered to Medicare participants. All records and documents must be maintained for a period of six years. Contracted providers and downstream entities must also make available their premises, physical facilities and equipment for the purposes described above.

Confidentiality and accuracy of participant records

Evernorth Behavioral Health's contracted providers must safeguard the privacy of any information that identifies a particular participant. Information from, or copies of, records may be released only to authorized individuals. Providers must abide by all federal and state laws regarding confidentiality and disclosure of behavioral health records, medical records, other health information, and participant information. Original medical records must only be released in accordance with federal or state laws, court orders, or subpoenas.
Evernorth Behavioral Health's contracted providers must also maintain participant records and information in an accurate and timely manner.

Transfer of medical records

All Evernorth Behavioral Health contracted providers must have appropriate authorization/release forms and a policy for the transfer of medical records. Requests for

release of any medical information must include a signed release by the participant or legal representative, and the request must be no more than 12 months old or other time period as may be specified by state laws. Medical records are to be transferred within five to 10 working days of receiving a request from a Medicare participant or the participant's legal representative. If the transfer cannot be accomplished within that time period, the participant should be informed by telephone of the reason for the delay, and the date and time of the call should be documented. Medical records are to be packaged and transferred in a manner that protects the privacy of the record in transit.

Expedited requests for the transfer of medical records must be processed in a timely manner that does not interfere or cause delay in the provision of services to the participant.

Emergency requests refer to instances where another health care provider requires past medical/surgical history on a participant to maintain continuity of care. The request should be verified by returning contact with the practitioner. After verification, medical information may be read over the telephone or faxed to the appropriate location. A notation should be made in the participant's record indicating the information released, and to whom it was released. When possible, a release should be sent to the receiving practitioner to be completed, signed by the participant, and returned to the medical record.

Serving a diverse population

No discrimination allowed

Evernorth Behavioral Health contracted providers cannot differentiate or discriminate in the treatment of any Cigna Medicare Advantage participant on the basis of health status, race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, handicap, or source of payment.

Providing services in a culturally competent manner

All services to Cigna's Medicare Advantage participants must be provided and administered in a culturally competent manner; including those services to participants with limited English proficiency or reading skills, those with diverse cultural and ethnic backgrounds, the homeless, and individuals with physical and mental disabilities.

- Please contact the telephone number located on the participant's ID card if information or assistance is needed in administering services in the following areas:
    - Plan and community support services for 'culturally diverse' participants, including participants with diverse cultural and ethnic backgrounds and the homeless.
    - Translator or translation services for non-English speaking participants to meet specific language needs during treatment.
    - Availability of health information brochures for participants in various languages.
    - Hearing impaired assistance through a relay service.
    - Assistance for the visually impaired.

Access must be provided for the physically handicapped. Evernorth Behavioral Health will continue to assess this access during provider site reviews and as part of the credentialing and recredentialing process.

Complex care, follow-up care and self-care

Cigna Medicare Advantage arranges and seeks participant approval to exchange information (including results of health assessments completed in the first 90 days of enrollment) between Medicare Advantage health plans and PCPs.

This information will be used for early identification and coordination of care of participants with complex or serious behavioral health conditions.

Evernorth Behavioral Health's contracted providers must ensure that Cigna Medicare Advantage participants are informed of specific health care needs that require follow up and that they receive, as appropriate, training in self-care and other measures they may take to promote their own health.

Claims and encounter reporting

Reporting of encounter data

Evernorth Behavioral Health's contracted providers who are required to submit encounter data for Cigna Medicare Advantage must certify that the submitted encounter data is accurate, complete, and truthful to the best of their knowledge. The Payer in turn will submit this information to CMS. The encounter data must include all data necessary to characterize the content and purpose of each encounter between a Cigna Medicare Advantage participant and a contracted provider.

Claims processing

Medicare has regulations regarding the timely payment of all claims. In accordance with CMS requirements, the Payer ensures all non-participating practitioners' claims are paid within 30 calendar days following receipt of a clean claim and all other claims are paid within 60 calendar days. To assure compliance with claims payment regulations, the Payer submits monthly, quarterly, and annual claim payment reports are submitted to Medicare Advantage health plans.

Appeals and grievance process

Organization determinations and standard appeals

The Payer and its delegated providers must make an Organization Determination to provide, authorize, deny, or discontinue a Medicare service as expeditiously as the participant's health condition requires (but no later than 14 calendar days for a standard request, seventy-two hours for an expedited request, or within 60 calendar days for a payment of service request).

If the Payer’s decision is unfavorable, (also called Adverse Organization Determination), the denial must be in writing. If unfavorable, the participant may appeal to the contracted health plan for reconsideration. The maximum time frame for Care Management decisions is now calculated in 'calendar days,' as opposed to 'working days.' The Payer may extend the time frame by up to 14 calendar days if the Payer justifies the need for additional information, including how the delay is in the interest of the enrollee, or if the participant requests an extension.

The reconsideration procedure applies to all benefits offered in Medicare Advantages' benefit packages, including mandatory supplemental benefits, and optional additional benefits.

If a participant requests reconsideration, a decision is made by the Medicare Advantage health plan based on a review of the initial determination and any newly available information. If the Medicare Advantage health plan recommends a partial or complete affirmation of the Payer's initial organization determination, the entire case file is forwarded to the Center for Health Dispute Resolution (CHDR), a CMS contractor. If the Medicare Advantage health plan's decision is partially or fully upheld by CHDR, the participant may have their appeal reviewed by an Administrative Law Judge, if the claim/service that is the object of the appeal is at least $100. If the Administrative Law Judge fully or partially upholds the Medicare Advantage health plan's decision, the participant may request a review by the Medicare Appeals Council of the Social Security Office. If the Medicare Appeals Council denies the request for review, or if it makes a decision, which was the final decision of the Secretary, and the amount in controversy is $1,050 or more, a civil action may be filed in a District Court of the United States.

Provider appeals on behalf of participants

Provider may appeal on behalf of Medicare participants. CMS requires that practitioners be an enrollee's 'authorized representative' in order for the practitioner to request an appeal on the enrollee's behalf. An 'authorized representative' is an individual who receives written authorization by an enrollee to act on his or her behalf in obtaining an organization determination, or in dealing with any level of the appeal process.

Non-participating practitioners may appeal on their own behalf and not as an authorized representative. If the non-participating practitioner appeals, he or she must complete and sign the waiver of liability payment form. The health plan coordinator will work with the practitioner to complete this form.

Appeal of hospital inpatient care denial (NODMAR)

According to federal law, the participant's discharge date must be determined solely by medical needs and not by any method of payment. Participants have the right to be fully informed about decisions affecting their coverage and payment for their hospital stay and for any post-hospital services.

Participants have the right to request an immediate review by a Quality Improvement Organization (QIO) prior to being discharged from hospital care, if the participant disagrees with the attending physician's decision to discharge. The Payer will issue a Notice of Discharge and Medicare Appeal Rights (NODMAR) to the participant through the contracted facility staff. The NODMAR notice provides instructions on how to request a QIO review and the applicable time frames.

Grievance process

Evernorth Behavioral Health has established an internal grievance process for receiving and resolving participants' complaints and/or grievances concerning participating practitioners, physicians, or staff. The first step for all grievances is for the participant to speak directly with the practitioner or supervisor in the practitioner's office in which the incident occurred. If the Medicare participant does not feel the matter has been satisfactorily resolved or chooses not to contact the practitioner, he or she may call the Payer Customer Service representative or number on the participant's ID card.

When Evernorth Behavioral Health cannot resolve a grievance to the participant's satisfaction, it must forward the grievance to the health plan's Medicare Grievance Coordinator within five calendar days from the date the complaint was first received by the Payer. The Grievance Coordinator will work with the participant to resolve the grievance within 30 calendar days from the date the complaint was first received by the Payer. If the Medicare participant does not feel the Medicare Grievance Coordinator has satisfactorily resolved the matter, he or she has the right to formal resolution through the health plan's Medicare Grievance Committee. The participant initiates the formal grievance process by making a written request for a hearing before the Medicare Advantage health plan's Grievance Committee. A hearing before the committee will be scheduled within 30 calendar days of the receipt of the written request for a formal grievance. Upon consideration of the facts presented by the participant in writing, the Grievance Committee will render a decision within 14 calendar days of the Grievance Committee meeting. The participant will be notified in writing of the Grievance Committee's decision, which shall be the final administrative review of the matter.

Advance directives

In accordance with the Patient Self-Determination Act, Medicare managed care plans and participating practitioners are required to ensure that: 1) participants are informed of their rights with respect to advance directives, and 2) documentation regarding execution of advance directives is maintained in the medical record.

An advance directive is a written statement completed in advance of serious illness. The statement indicates what kind of medical treatment a participant does or does not want under special serious medical conditions should they become mentally or physically unable to communicate their wishes. The two most common forms of advance directives are Living Will and Durable Power of Attorney.

The role of the physician practitioner

Evernorth Behavioral Health requires all practitioners to make a notation in the participant's medical record as to whether or not the participant has completed an advance directive. When an advance directive exists, a copy should be placed in the medical record. As long as he or she is of sound mind, the participant may complete an advance directive form and may revoke it at any time.

Under the law, a participant has the right to refuse medical treatment and to have their advance directives followed. If a practitioner cannot in good conscience follow those directives, they must contact Evernorth Behavioral Health's Provider Relations department. Evernorth Behavioral Health will then assist the participant in selecting a physician who can comply with these directives.

Neither Evernorth Behavioral Health nor its individual practitioners may condition the provision of care or otherwise discriminate against a participant based on whether the participant has executed an advance directive.

Access to services

All services covered by Medicare must be provided in a manner consistent with professionally recognized standards of health care. Evernorth Behavioral Health participating providers must provide, on a 24/7 basis, necessary covered services to Medicare participants or arrange for a covering provider. A provider must ensure that the

covering provider satisfies Evernorth Behavioral Health's credentialing criteria, and that the covering practitioner will not seek to obtain reimbursement for which the practitioner already receives reimbursement from Evernorth Behavioral Health.

Emergency

CMS has established new definitions for emergency and urgently needed services, codifying the concept that an 'emergency medical condition' exists if a 'prudent layperson' could reasonably expect the absence of immediate medical attention to result in serious jeopardy or harm to the individual. The new definition of 'emergency services' includes emergency services provided both within and outside of the plan.

Urgently needed services

'Urgently needed services' encompass only services provided outside of the plan's service area (or continuation area, if applicable) except in extraordinary circumstances. Specifically, these regulations allow for coverage of non-emergency services where the services are immediately required because of unforeseen illness, injury or condition, and it is not reasonable given the circumstances to obtain the services through the network of participating practitioners.

Post-stabilization

The regulations allow the Payer to assume financial liability for post-stabilization care.

'Post-stabilization' care means medically necessary, non-emergency services needed to ensure that the enrollee remains stabilized from the time that the treating hospital requests authorization from the Payer’s Medicare Behavioral Health until:

- The enrollee is discharged;
- An Evernorth Behavioral Health participating provider arrives and assumes responsibility for the enrollee's care; or
- The treating practitioner and Payer agree to another arrangement.

The decision of the examining practitioner treating the individual participant prevails regarding when the participant may be considered stabilized for discharge or transfer. The Payer is responsible for the cost of post-stabilization care provided by providers outside the plan when the Payer does not respond to a pre-approval request by the practitioner within one hour after the request was initiated, or if the Payer could not be contacted for pre-approval. The Payer liability will extend until the hospital is contacted to arrange for discharge or transfer of the participant.

Plan benefits

Medicare Advantage participants receive the full range of Medicare services plus additional benefits that are not covered by Medicare; for example, prescription drugs and routine care may be included. Please check with the Payer care center for additional benefits applicable to individual participants.

Participants can access mental health and substance use services directly. They do not require a referral from their PCP.

Many Medicare Advantage organizations such as, Cigna, offer extra benefit riders or special additional benefits for employer sponsored retiree groups. Since it is extremely important

that each participant receive all the benefits and supplies they are entitled to, we encourage practitioners to get acquainted with the various Cigna benefit options in your area and check specific coverage details on every participant.

The following are the standard benefits that must be offered to all Medicare Advantage participants.

Outpatient mental health and substance use services:

- Mental health follow-up diagnostic services.
- Mental health therapeutic office services.
- Mental health hospital day treatment.
- Alcohol and substance use day treatment program.

Inpatient mental health services:

- Lifetime maximum of 190 days of care provided in a Medicare-approved psychiatric hospital or licensed psychiatric ward for mental illness and substance use combined.

Participant billing

Providers must hold Medicare Advantage participants harmless for payment of fees that are the legal obligation of the Medicare Advantage organization to fulfill. Such provision will apply, but not be limited to insolvency of the Medicare Advantage organization, contract breach, and practitioner billing. Under no circumstances is a Medicare Advantage participant to be balance billed for care, service, or supplies. If the practitioner uses an automatic billing system, bills must clearly state that they have been filed with the insurer and that the participant is not liable for payment other than applicable copayments.

Should a Medicare Advantage participant elect to have care or service provided that is not a covered benefit or which have been determined prior to providing the service to not be medically necessary or any other reason, the practitioner must have written agreement of financial responsibility from the participant, including the exact dollar amount. This agreement must be signed in advance of service delivery and be added to the permanent medical record of the participant. It is the practitioner's responsibility, not the participant's, to determine coverage parameters in advance of providing the medical/behavioral service.

Practitioner termination/status change notification

Evernorth Behavioral Health and its participating providers must accept all Medicare Advantage participants who select them unless the health plan is notified in advance that the practitioner cannot accept additional participants. Providers must give 60 days’ notice of termination and 30 days’ notice of significant access changes (e.g., vacations).

The provider shall immediately notify Evernorth Behavioral Health of any change in provider's licensure and/or certifications that are required under federal, state, or local laws for the provision of Covered Services to Medicare participants, or change in provider's hospital privileges, whether at an Evernorth Behavioral Health participating facility or non-participating facility.

In the event that Evernorth Behavioral Health has cause to terminate the agreement of a participating provider that renders services to Medicare participants, Evernorth Behavioral Health will issue the provider a written notice. The notice will include, to the extent that it is

relevant to the decision: (1) the reason for termination, (2) the standards and the profiling data used to evaluate the provider, (3) the numbers and mix of providers required in its network, and (4) the terminated provider's right to appeal the action and the process and timing for requesting a hearing.

If either party terminates a participating provider's agreement, Evernorth Behavioral Health will notify all Medicare participants that are seen on a regular basis by that practitioner. The written notification will be made to affected participants at least 30 calendar days in advance of the termination.

Excluded practitioners

In accordance with 42 CFR 422.752, Evernorth Behavioral Health and its downstream providers are barred from employing or contracting with individuals who are excluded from participation in Medicare under section 1128 or 1128A of the Social Security Act, or with an entity that employs or contracts with such individuals for the provision of any of the following:

- Health care
- Utilization review
- Medical social work
- Administrative services

Individuals or entities found to be in violation of this regulation may be subject to sanctions and civil money penalties including, but not limited to, fines ranging from $10,000 to $100,000, suspension of enrollment of Medicare beneficiaries, and suspension of payments.

Insurance

Providers must obtain comprehensive general liability, professional liability, workers' compensation, and other insurance, in amounts determined by Evernorth Behavioral Health, based on the provider's mode of practice/specialty, to insure against any claim(s) for damages resulting from personal injuries or death related to the provision of services pursuant to the Participating Provider Agreement.

If the professional liability insurance is written on a 'claims made' basis, provider agrees that:

(1) if the Participating Provider Agreement is terminated, the provider will continue this insurance with the same or greater policy limits for a period of at least six years following termination; or (2) if this 'claims made' policy is terminated for any reason, provider will procure and maintain 'tail' coverage professional liability insurance at the same or greater policy limits as the primary policy for a period of not less than six years following the termination of the preceding policy.

Provider will submit evidence of this insurance to Evernorth Behavioral Health in a timely manner. Provider will notify Evernorth Behavioral Health at least 30 days prior to the expiration, termination, or material change in the coverages listed on the provider's application. This provision shall survive the termination of the Evernorth Behavioral Health Participating Provider Agreement.

Compensation

1. Providers are to accept reimbursement from the Medicare Advantage Plan in the amount set forth in and in accordance with the Evernorth Behavioral Health

Participating Provider Agreement, its Exhibit(s) and the terms of the Medicare Participant's Plan, as full payment for Covered Services. The rates shall apply to all Covered Services. Cigna Medicare Advantage shall notify practitioner of the copayment, deductible, or coinsurance, if any, which shall be charged to the Medicare Participant pursuant to the Medicare Participant's coverage under their Plan.

2. Providers are to submit an itemized bill for Covered Services personally rendered, on forms acceptable to the Medicare Advantage Plan within 60 days of the Service date. Provider shall supply any additional information reasonably requested by the Medicare Advantage Plan to verify that practitioner rendered Covered Services and the usual charges for such services. The Medicare Advantage Plan may deny payment for claims not submitted within 60 days from the Service date, unless provider can demonstrate to the Medicare Advantage Plan’s satisfaction that there is good cause for such delay. The provider will not be in default if coordination of benefits precludes a timely submission of a bill. The provider will submit the bill as soon as reasonably possible after coordination of benefits activities. Payment may be denied for services that are not Covered Services, not Medically Necessary, or if the Medicare Participant was not eligible for coverage under the Plan.

Physician Incentive Plan (PIP)

PIP regulations require disclosure of financial relationships between Cigna Medicare Advantage or Evernorth Behavioral Health and provider that could put provider at significant risk. CMS seeks to ensure that they are aware of financial incentives for practitioners to withhold referrals for medical care. There is an elaborate process established to calculate 'significant financial risk'. The process requires consideration of numbers of enrollees involved and whether the financial arrangements involve agreements such as capitation, withholds, or bonuses. Physician practitioners are required to secure the Medicare Advantage Plan’s prior approval of any practitioner incentive arrangements relating to Medicare agreement participants.

1. Prior to the execution of the Evernorth Behavioral Health Participating Provider Agreement and throughout the term of the Agreement, provider shall submit to Evernorth Behavioral Health and secure Evernorth Behavioral Health's prior approval of any provider incentive arrangements relating to Medicare Agreement Participants and the Covered Services rendered. Evernorth Behavioral Health has the right to disclose such arrangements if required to do so by applicable laws and regulations. Provider shall maintain at their sole expense any stop-loss coverage required to be maintained by applicable law in connection with any such provider incentive arrangements and shall provide evidence of such coverage upon request.
2. Prior to the execution of the Evernorth Behavioral Health Participating Provider Agreement, practitioners shall secure approval from Evernorth Behavioral Health with regard to the percentage of the total Covered Services under the Agreement, which may be 'referral services' as that term is defined under applicable laws and regulations. Provider shall not change the percentage of referral services without Evernorth Behavioral Health's prior written approval.

Obligations under federal funding

Payments received in connection with services rendered to Medicare Advantage Participants are, in whole or in part, from federal funds. Recipients of such payments are subject to certain laws that are applicable to individuals and entities receiving federal funds, including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, the Americans with Disabilities Act, and all other applicable laws and rules. In addition, in order

to comply with CMS requirements for Medicare Advantage organizations, Evernorth Behavioral Health and Medicare Advantage organizations must follow federal regulations identified in the Balanced Budget Act of 1997 and the Medicare Modernization Act of 2003. All written arrangements between a practitioner and downstream entities must comply with applicable Medicare laws and regulations. All practitioners must agree to comply with the Medicare Advantage organization's policies and procedures.

Employee Assistance Professionals Association (EAPA)

The EAPA definition of an Employee Assistance Program (EAP) is:
". . . a workplace-based program designed to assist in the identification and resolution of productivity problems associated with employees impaired by personal concerns including, but not limited to: alcohol, drug, legal, emotional, stress, and other personal concerns which may adversely affect employee job performance."

Key objectives of EAP programs are to:

- Support employers through assistance for employees to constructively manage personal problems, which may have a negative impact on job performance.
- Work closely with employer's health care benefit programs and local community resources.
- Accurately and quickly match client needs with appropriate resource assistance.

Evernorth Behavioral Health's EAP services are promoted as a resource to assist employers, and employees and their household members in identifying and resolving issues of daily life. The program offers participants a work/life service with lifecycle information, consultation and referral as well as the opportunity for short-term counseling with professionals skilled in the assessment and treatment of a wide range of problems. The results for the sponsoring organization can be significant:

- Higher employee productivity.
- Prevention of potentially costly problems in the workplace.
- The comfort of professional assistance in response to a critical incident.
- The retention of good employees who appreciate their organization’s efforts to maintain a healthier workforce.

A "participant" is: ". . . the eligible employee and his/her household members."

Evernorth Behavioral Health's EAP Models

Assessment and Referral (A&R)

A&R entails one to three face-to-face sessions focusing on participant problem identification and resolution or referral to appropriate resources to complete problem resolution.

Short-Term Counseling (STC)

STC focuses on the resolution of the presenting problem within the EAP. The most common for Evernorth Behavioral Health's short-term therapy model are five to eight session programs.

Participation in our EAP/STC plans has been increasing. This product includes more than three sessions and sometimes up to 12. The goal of this product is to try and achieve problem resolution within the EAP/STC. If, after assessing, you determine that is not an

appropriate goal, you should refer on to the behavioral health benefit. Again, you must contact us when the EAP/STC assessment is complete.

Stand-alone EAP services

Evernorth Behavioral Health is the participant's practitioner for only EAP services. Behavioral health care services are not covered through Evernorth Behavioral Health. Stand-alone EAPs may be either A&R or STC.

Integrated EAP services

Evernorth Behavioral Health is the participant's provider of both EAP and Behavioral Health Care services. Integrated EAP models may also be either A&R or STC.

Participating Evernorth Behavioral Health providers have a face-to-face counseling program for EAP participants. The majority of our EAP customers have a one to three EAP model: Assess and Refer. This model provides up to three sessions to formulate a participant's situation, communicate those findings to the participant, and if ongoing care is necessary, make a referral into the participant's behavioral health benefit. There are two important things to remember:

- Where clinically appropriate, you may refer the participant to yourself for continuing care; and
- You must contact us to close the EAP case once the assessment is complete.

Exclusions

The Evernorth Behavioral Health EAP benefit excludes coverage for:

- Psychiatric evaluations
- Psychological testing
- Court-ordered treatment
- Workers' Compensation/Disability management
- Medication management
- Fitness for duty/Return to work determinations

Non-clinical services not covered by the EAP include:

- Employment law

Special note: Coverage for employment law is excluded due to the dual nature of the EAP client—the individual employee (family participant) and the employer who sponsors the program. Any legal information or advice given by a provider to an individual client concerning employment law can have potentially detrimental consequences for the employer client. To avoid this conflict of interest, employment law services are excluded from the program.

In the course of providing EAP services, providers shall refrain from discussing legal recourse as a potential action in resolving workplace concerns or disputes. Employees with concerns about workplace practices should be referred to their human resources department for further assistance.

Examples of excluded employment law questions or concerns are:

- Workplace safety, accidents, injuries, or illnesses;
- Coworker liability (including workplace assaults or threats);

- Employee benefits issues/disputes or disputes concerning the agents of company-sponsored benefits or services;
- Pension rights, employment termination, retirement questions or disputes;
- Employer-based civil rights violations (including workplace sexual harassment allegations); and
- All other alleged employer liability issues.

Eligibility

Unlike behavioral health care services, in all but a very few cases, eligibility for EAP services is not verified. Employees, their dependents and their household members are eligible for EAP services. Some customers extend EAP services to retired employees. There is no limit to the frequency with which eligible individuals can access EAP services for new problems or concerns.

Types of referrals

Participants may contact the EAP as soon as they feel consultative assistance may be helpful. To prevent possible adverse impact on job performance, employees with personal concerns are encouraged to contact the EAP. Participation in the EAP is confidential within the limits of the law. Participants may access the EAP in one of three ways: 1) self-referral, 2) management referral, or 3) continuation of employment referral.

Self-referral

An EAP self-referral occurs when the participant contacts the EAP directly and voluntarily seeks assistance for a personal concern. The employer is given no information regarding the individual participant's contact.

Management referral

An EAP management referral involves circumstances where the employee has had job performance issues that have generated the referral by a manager or human resources contact.

Participation in the EAP will not jeopardize the employee's job security, promotional opportunities, etc. Conversely, participation in the EAP will not protect the employee from disciplinary action that may result from substandard job performance, conduct infractions, or a violation of company policy. EAP practitioners working with management referral cases are expected to work with an assigned Evernorth Behavioral Health EAP Consultant who maintains communication with the referring manager. EAP practitioners are not expected to contact the referring manager and should direct inquiries to the Evernorth Behavioral Health EAP Consultant.

Provider procedures

- Meet with the employee:
  - Complete a comprehensive assessment.
  - Formulate a plan to address the workplace performance issues and any areas that may be contributing to the problem. Keep in mind that you have two 'clients' with an EAP Management referral: the employee and the employer.
  - Inform the employee of your specific recommendations and let the employee know that those recommendations will be reported back to the employer. No clinical or diagnostic information will be given to the employer.

    - If a referral is needed, provide the employee with the contact information for the referral resource. Obtain permission from the employee to communicate with the referral resource. Follow up with the referral resource to verify initial compliance.

- Contact the Evernorth Behavioral Health EAP Consultant with the initial update:
    - EAP dates of service.
    - Presenting problem.
    - Diagnostic impressions (Chemical Dependence (CD), Mental health (MH), medications, risk of harm).
    - How are the workplace concerns being addressed?
    - Is the employee compliant with EAP process?
    - Date of next EAP appointment
    - Recommendations or referral? Please provide a name and contact number for the referral resource.

    Do not communicate directly with the employer or complete any paperwork for the employee regarding return to work, disability, fitness for duty, etc.

- Update the EAP Consultant regarding the employee's compliance:
    - Dates of subsequent EAP appointments.
    - The employee's progress/compliance with the EAP process.
    - If a referral was made, verification that the employee began attending the recommended treatment.
    - Date that the EAP case was closed and any recommendations for continued treatment.

- The EAP Consultant obtains a signed release via the referring manager and provides the following information:
    - Dates of EAP appointments attended or not attended.
    - Date of next EAP appointment.
    - Any recommendations for services beyond the EAP. The information given to the employer is limited to the level of care, type of referral resource (inpatient, outpatient, etc.), and the name of the treating practitioner or facility.
    - The employee's demonstrated compliance with the initial recommendations.

Continuation of employment referral

An EAP Continuation of Employment Referral is a referral by a manager or human resources representative that has been offered in lieu of termination. Common precipitants to continuation of employment referrals include, but are not limited to, substance use policy violations.

The release of information (ROI) form will allow management to be informed of compliance with EAP attendance and recommendations. EAP practitioners who receive continuation of employment referrals are expected to work with an Evernorth Behavioral Health EAP Consultant who maintains communication with the referring party. It is extremely important that providers respond to the inquiries and requests for updates from the EAP Consultant managing the compliance reporting back to the referring manager or company contact, as these cases involve job jeopardy for the participant. Additionally, the Evernorth Behavioral Health EAP Consultant will work collaboratively with the EAP provider in regard to cases where their provision of Substance Abuse Professional (SAP) services is requested.

Prepaid benefit

As Evernorth Behavioral Health EAP services are available at no cost to eligible participants, there are no out-of-pocket expenses or copayments collected by EAP providers. If a treatment referral is needed beyond EAP services, the employee or household member will receive expense reimbursement in accordance with his or her health plan coverage. Employees should review such coverage with the EAP provider prior to a referral in order to determine what expenses will be covered by his or her medical plan. EAP provider questions about coverage should be directed to Evernorth Behavioral Health Care Management staff.

Barrier-free access

Eligible participants have access to Evernorth Behavioral Health's EAP services 24/7/365 through a toll-free telephone number. Licensed clinical professionals in our Care Center address emergency or crisis situations immediately. During routine calls, EAP participants speak with Evernorth Behavioral Health Personal Advocates who will review their EAP benefit, discuss their personal concerns and identify local EAP providers for referral purposes.

Only in the event of a management/mandatory referral will an Evernorth Behavioral Health staff member give the EAP provider advanced notification of the EAP participant's name, the employer group, presenting problem, type of EAP benefit, and type of referral. If a Cigna Healthcare customer would like to utilize their benefit, they must obtain an EAP code from Cigna, and provide it to you prior to their first counseling session. All EAP claims should be billed using Current Procedural Terminology (CPT®) code 99404.

Self-referring participants may choose to register for EAP services, select a provider, and receive a code for services online at myCigna.com. In this case, both the provider and participant will receive a letter confirming the approved service.

Evernorth Behavioral Health's appointment access standard for routine EAP cases is two business days. If the EAP provider cannot offer an appointment within this time frame (when it is requested), the participant should be directed back to the Evernorth Behavioral Health referral source.

If a participant schedules an appointment and fails to keep it, the provider should contact the participant to discuss their intentions. The provider is expected to report any participant concerns or complaints about satisfaction with EAP services to Evernorth Behavioral Health.

Assessment and evaluation

During the assessment, the EAP provider identifies the nature of the problem and a possible plan of action. Family, significant others, and friends may be included in this process, as appropriate. The EAP assessment (see Appendix E) routinely focuses on the individual's level of functioning in the workplace, presence of any contributing stressors, as well as the need to develop additional coping skills that might enhance job performance and occupational satisfaction. EAP providers use information from the assessment to:

- Help the participant clarify the nature of the presenting problem.
- Identify underlying or collateral issues, including non-clinical contributing factors (e.g., legal, financial, or child/eldercare needs).
- Evaluate the level of problem/symptom severity.
- In collaboration with the participant, create an appropriate action plan.

Evernorth Behavioral Health encourages the EAP provider to work with the EAP participant to resolve their presenting problems within the available EAP visits whenever possible. All EAP participants must receive a Statement of Understanding (see Appendix E) at the beginning of the initial session. Should the participant refuse to sign the Statement of Understanding, please make a note on the form and place it in the participant's file.

If the EAP participant reveals legally sensitive information regarding the workplace (e.g., sexual harassment, discrimination issues) or requests the practitioner to contact the workplace, please notify an Evernorth Behavioral Health EAP Consultant prior to taking any action. Under no circumstances should the EAP provider suggest that the employee consult with or retain an attorney for the purpose of assessing the potential for legal action against the employer.

EAP providers are encouraged to remain aware that, in EAP work, there is a “dual client” relationship. The provider has both the organization/employer and the participant seeking services as the client. In instances where a concern about conflict of interest arises in this dual client relationship, the provider is urged to utilize our EAP Consultants as a resource.

Disposition

To ensure participants receive appropriate services and value from their EAP program, Evernorth Behavioral Health encourages EAP providers to work with the participant to resolve the presenting problems within the context of the EAP. If the participant has only EAP benefits with Evernorth Behavioral Health, the EAP provider will coordinate referrals for ongoing care directly with the participant either through their behavioral health benefits or appropriate community resources.

If Evernorth Behavioral Health manages the EAP participant's behavioral care benefits, referrals must be coordinated with an Evernorth Behavioral Health Care Manager. The EAP provider may request to continue providing care if/when the following criteria are met:

- Evernorth Behavioral Health provides both the EAP and behavioral care benefits for the participant;
- Continuation is clinically the most efficacious course of treatment;
- It is the participant's request; and
- At least two other individual provider options are communicated.

If Evernorth Behavioral Health does not manage the participant's mental health and substance use benefits, or no benefits are available for the participant, the EAP provider is expected to facilitate an appropriate transition to alternate resources. This may include referrals to community-based treatment programs or counseling agencies or interface with other HMOs, etc. The EAP provider is expected to secure an appropriate ROI and contact the treatment provider or community resource to alert them to the referral and confirm that the appropriate services can be provided.

Information, resources, and referrals are also available through the Evernorth Behavioral Health EAP for legal, child and elder care, pet care, HealthyRewards®, and other work-life needs. The EAP provider should direct the participant to call the Evernorth Behavioral Health EAP for these services. In addition, EAP providers are expected to maintain knowledge of community-based support groups and resources that may offer additional

services (e.g., financial concerns, debt management, personal budgeting) and assist in the transition to these resources.

Follow up and case closure

Approximately 45 days after a referral is made, an Evernorth Behavioral Health Personal Advocate contacts the participant, with prior permission, to assess whether their needs were met through the services that were provided. Given this telephonic contact now includes a formal participant satisfaction survey, *it is no longer necessary for the practitioner to distribute the paper survey (EAP Participant Survey, form #00030) at the close of the EAP episode.*

To ascertain the disposition of a case, EAP providers are required to contact the participant 10 to 14 days after the conclusion of the EAP episode of care to ensure that the participant has successfully connected with treatment or community resources for ongoing care or to confirm that no further assistance is needed. The information on case disposition must be reported back to an Evernorth Behavioral Health staff participant to close the EAP episode of care. Required information includes:

- Dates of service
- Date of follow up with the participant
- Diagnosis
- Risk assessment
- Medication status
- Current chemical dependency issues
- Confirmation that the Statement of Understanding was signed
- Recommendation for additional care/resources
- Name(s) of practitioner(s) to whom the participant was referred
- Confirmation that the participant was contacted post-EAP and has either successfully engaged in ongoing treatment, or that no additional resources are necessary

Claim payment process

All EAP claims should be submitted with CPT code 99404. EAP claims submitted without the required CPT code will be denied.

Confidentiality

Evernorth Behavioral Health's EAP success and credibility hinge on the confidence that the EAP respects the individual's right to privacy and will protect the information they disclose within the parameters of the law. The EAP will maintain the confidentiality of participants and fully disclose conditions that limit confidentiality. EAP providers will not share information about involvement in the program without the prior knowledge and written permission of the participant, except as required by law. Every effort is made to maintain strict confidentiality with self-referrals, management referrals, and continuation of employment referrals.

Management consultation and education

The Evernorth Behavioral Health EAP provides a number of consultative and educational tools to help managers recognize and address multiple workplace issues including potential or existing substance use problems. Education, training, and reference guides are available to assist supervisors and human resource managers with problem recognition, intervention, EAP referral, follow up, and reintegration of employees into the workplace.

Evernorth Behavioral Health EAP services provide management consultation by certified EAP professionals, on a per case basis, to support supervisors and Human Resource managers in developing immediate strategies to deal with performance issues, workplace behavior that may be indicative of potential alcohol and/or other drug problems, violence at work and at home, workplace crises, critical incidents and other sensitive situations. Management consultation is available 24/7/365..

EAP providers are expected to collaborate with an Evernorth Behavioral Health EAP Consultant in servicing challenging management referral, continuation of employment referral, and workplace trauma Incidents.

Promotion

Evernorth Behavioral Health believes clear communication about the EAP benefit, at the time it is implemented, as well as frequent reminders about the EAP, enhances the visibility of the program, and encourages utilization of available services. EAP communication materials include brochures, wallet cards, videos, and guides for managers, newsletter articles, as well as quarterly awareness brochures and posters on wellness, prevention, and personal growth. Evernorth Behavioral Health also has an extensive library of wellness seminars that are available to EAP customers and delivered on-site at employer locations by EAP providers. In addition, employee orientation sessions, supervisory training, wellness seminars, and health/benefit fairs provide an effective means to enhance the visibility of Evernorth Behavioral Health's EAP program. Evernorth Behavioral Health also provides timely access to EAP information through *intranet* and *extranet* sites. These resources provide additional avenues to make the availability of EAP prevention, early intervention, consultation and work/life services known to the organization and its participants.

Practitioner roles

As a participating Evernorth Behavioral Health EAP provider, communication is critical to facilitate the effective resolution of participant issues. Our collaborative vision of program services involves the recognition and balancing of both the needs of the employee and employer. An Evernorth Behavioral Health EAP Consultant will facilitate communication, when indicated, with the EAP participant's employer.

Employers who request information from the EAP provider should be directed to the Evernorth Behavioral Health Employee Assistance Consultant. Direct communication between the EAP provider and the participant's employer must be reviewed and approved in advance by Evernorth Behavioral Health.

EAP specialty services

Evernorth Behavioral Health's EAP integrates Provider Specialty Skills in the provision of Critical Incident Assistance, Substance Abuse Professional Services, Employee Education & Wellness Seminars, and Management Training. Evernorth Behavioral Health's Provider Relations Team facilitates the recruitment, orientation, and privileging of EAP providers in these EAP specialty service areas.

Note: In order to have the Critical Incident Assistance Specialty added to your profile, you must sign an attested specialty form confirming that you:

- Have received formal training in Critical Incident Response (CIR)
- Have delivered a minimum of four CIR services in the past two years, and

- Agree to make changes to your schedule to accommodate CIR requests within **two to 12 hours**.

International EAP services

In order to minimize the risks that could interfere with the success of an overseas assignment, Evernorth Behavioral Health offers *pre-deployment* assessments and support for employees and their families. Additionally, *repatriation* assessments and support after a completed overseas assignment are available to help facilitate reculturation upon returning to the United States.

Digital solutions for providers

We want to help you make the most of your time and provide convenient tools to handle the administrative details of health care.

Use our electronic tools to access the information you need – when you need it.

Quick summary of key tools	
• Evernorth provider website (Provider.Evernorth.com)	This site offers secure, easy, and convenient 24/7 access to the following features*: • Patient eligibility and benefits • Patient cost estimator tool • Claim status inquiry • Upload supporting documentation for pended claims • Submit a claim reconsideration or appeal • Remittance reports (when enrolled in EFT) • Precertification status • Precertification appeal • Resources including policies, procedures, forms and online learning *Access to these features are maintained by the website access manager at your practice. Please visit Provider.Evernorth.com > Resources > Website Access Managers for details.
• Electronic data interchange (EDI)	EDI links your computer or practice management system with the plan's systems, as well as with other health plans and government payers, to exchange health care information. You can submit claims, access eligibility/benefits, claim status information, submit precertification requests, or obtain an electronic remittance advice (ERA).
• Electronic funds transfer (EFT)	EFT, also known as direct deposit, offers a secure method for funds to be deposited directly into your bank account for fee-for-service and capitated payments. Reimbursement payments are available the same day the deposit is electronically transferred to your bank account. Access a calendar for payment dates here. EFT is our standard method for payments. Enroll in EFT on the Evernorth provider website (Provider.Evernorth.com) > Working with Cigna > Enroll in electronic funds transfer options. You must be registered and have the 'Enroll and manage electronic funds transfer (EFT)' entitlement.

Quick summary of key tools	
• Online remittance reports	If you are enrolled to receive payments using EFT, you can: • Look up a remittance report using various search options • View each claim within the deposit, including the service line detail, paid amount, and patient responsibility amounts • Search within the remittance report for specific patients or claims Access to remittance reports is available by logging in to the Evernorth provider website (Provider.Evernorth.com > Remittance Reports). You must be registered and have the 'Remittance reports (835) and delivery preferences' entitlement.
• Interactive Voice Response 800.88Cigna (882.4462) Applies to Cigna Healthcare participants only 866.494.2111 Applies to participants with "G" ID cards only	This interactive voice response telephone system provides access to eligibility, benefit and claims status information, precertification information, credentialing status, and more.

The Evernorth provider website

The Evernorth provider website (Provider.Evernorth.com) has been designed with you in mind—to fit your needs and the way you work. It provides secure, 24/7 access to participant and claim information, and includes features like auto-save and flagging that save you time.

On Provider.Evernorth.com you can access:	
Eligibility and benefits	Obtain specific information about your patients covered by plan: • Search up to 10 patients at once • Pull up benefits using a specific procedure code, or view general benefits • View real-time information about coinsurance, deductibles, and plan maximums • Generate a benefit reference number and store the history for two years • View your patient's ID card

Estimate your patient's out-of-pocket costs	• Determine the potential total cost of a medical or behavioral service or treatment • Determine how much plan estimates it will pay for the service or treatment • Provide an estimate of what your patient will owe out-of-pocket
Claim information	• Check claim status and details • Claim payment information • Upload requested documentation for pended claims • Request a claim reconsideration or an appeal • Claims 360 provides an organizational view of your claims. You can broaden the scope of your search by using your Taxpayer Identification Number (TIN) and filters to zero in on the claims you want to view.
Online remittance reports	• Available for providers enrolled in electronic funds transfer (EFT) • Allows you to access your remittance report the same day you receive your EFT • Easily store and search payment information and share it with your office staff
Electronic funds transfer (EFT)	• Enroll in EFT • Check the status of your EFT enrollment • Change EFT settings • Change your report delivery preferences
You can also:	• Find the claim submission address for a patient • View plan policies and procedures • Access online learning

Learn how to get access to Provider.Evernorth.com by navigating to the log in page and clicking on "How to register for access."

To begin using the Evernorth provider website, ask your website access manager for access, **or:**

- Go to Provider.Evernorth.com
- Click **"**Register**"**
- Follow the registration process

Your website access manager will approve your request and grant you the appropriate access for your role. If your TIN does not have a website access manager yet, someone will contact your practice within 10 business days to help set one up. Please visit Provider.Evernorth.com > Resources > Website Access Managers for details about the website access manager role.

Patient eligibility and benefits

View important information about your patient's eligibility including:

- View a copy of your patient's ID card
- Subscriber information
- The initial coverage date, current coverage date, and plan renewal information.
- Employer details, plan funding type, and if there is other insurance.
- Information about a patient's prior coverage, if it has terminated.
- Use the "Am I in-network for this patient?" tool to verify if you are located in the patient's network and understand what level of benefits will apply.
- Look up benefits by procedure code or view general benefits.
- View benefit specifics, including coordination of benefits, coinsurance, deductibles, benefit maximums, and amounts applied to date for coinsurance.
- View detailed information on benefit types, including medical and dental preventive care, vision, maternity, infertility, allergy injections, well-child care, inpatient and outpatient psychiatric services, and more.
- View services, including chiropractic care, durable medical equipment, external prosthetics, home health care, short-term rehabilitation, and magnetic resonance imaging (MRIs). Visit maximums, and the amount met and remaining, are also included, when applicable.
- Save the details of your eligibility and benefit searches for up to two years by generating a benefit reference number.

Claim information

Quickly access the claim status and details you need:

- Claim status: Paid, denied, pended, etc.
- Service line details, including amount not covered, coinsurance, patient responsibility, and service line remark codes
- Claim payment information, including claim paid amount, check number, date issued, payment method, and date of service.

Upload supporting documentation for pended claims:

- Send up to six files at a time, 64 MB maximum per file
- Submit them in any of these formats: BMP, GIF, JPEG, PDF, PNG, or TIF
- Receive a reference number with your submission

Submit a claim reconsideration or appeal:

- An online questionnaire simplifies the process and provides step-by-step guidance
- Ability to attach documentation (up to 10 files at a time, 64 MB maximum per file)
- Enter additional notes
- Receive a reference number with your submission
- View status and submission history

Online remittance reports

If you are enrolled to receive payments from Cigna or Evernorth Behavioral using electronic EFT, you can access remittance reports online that explain your processed claims, such as

direct deposit activity reports (DDARs) or checkless explanations of payment (EOPs). The Remittance Reports search tool allows you to:

- View your remittance reports online the same day you receive your EFT
- Easily reconcile payments using a single remittance tracking number on your EFT report, ERA, or online remittance report
- Look up a remittance report using several options:
  - Deposit Amount: Search for a specific deposit amount or deposits made within a specific date range
  - Patient Information: Search for a specific patient
  - Claim/Reference Number (the Cigna-assigned claim/reference number located on your EOP, claim remittance advice, DDAR, and provider explanation report)
  - Remittance Tracking Number (the Cigna–assigned number to your EFT; the remittance tracking number is included on the EFT file to the bank)
- View each medical claim within the deposit, including the service line detail paid amount, and patient responsibility amounts.
- Search within the remittance report for specific patients or claims.

Cigna Cost of Care Estimator®

The Cigna Cost of Care Estimator is an electronic tool available on the Evernorth provider website (Provider.Evernorth.com), but only applies to Cigna plans. The estimator gives providers the ability to create an estimate of their patient's payment responsibility specific to that provider and the treatment or service, based on a real-time snapshot of the participant's Cigna Healthcare benefits. It helps eliminate financial surprises by estimating the cost of the medical or behavioral service, highlighting the participant's anticipated payment responsibility, and providing you and your patients with an itemized, printable Explanation of Estimate. It is fast to use, easy for your patients to understand, and can be used anytime during your patient's visit: prior to care, at check-in, or at check-out.

By entering the CPT code(s) or identifying information about the procedure along with the plan participant's Cigna Healthcare ID number and date of birth, you will receive a personalized Explanation of Estimate that contains the following information:

- Total cost of the service
- Plan participant's deductible/coinsurance/copayment responsibility
- Plan participant's anticipated payment from their health account (HSA, HRA, FSA) when automatic claim forwarding is enabled
- Plan participant's estimated amount owed out-of-pocket

The estimator is available to participating providers in the Evernorth network. To use it, log in to Provider.Evernorth.com > Patients > Search Patients > Select a Patient > Estimate Costs.

The estimate you receive represents your patient's anticipated out-of-pocket expense if the services billed are covered under their medical plan. It does not guarantee coverage or payment, but allows you to have a financial discussion with your patient and set realistic financial obligations for them.

Electronic data interchange (EDI)

EDI allows patient information to be transferred between you and Cigna or Evernorth plans in a standardized, secure way, and makes it available right on your desktop.

Use your existing EDI vendor, practice management software, or accounts receivable software to connect with our systems to:

- Submit electronic claims to Cigna (837), including COB claims, and receive an electronic claim acknowledgment (277CA)
- Receive payment information in the electronic remittance advice (835), including the amount paid and when the check or EFT was issued
- Submit electronic eligibility and benefit inquiry (270/271) and track claim status (276/277) through your EDI vendor
  - Receive a real-time response in seconds
  - Obtain benefit information
  - Receive remaining health plan deductible and coinsurance amounts
  - Obtain coordination of benefits and shared administration or alliance information
  - Obtain claim status and receive responses using the HIPAA standard health care claim status codes
- Submit electronic health service review/precertification requests (278)

Electronic transaction support

For a list of EDI vendors and transactions they support, visit Cigna.com/EDIvendors. For questions about transactions submitted through your EDI vendor, please contact the vendor directly.

Evernorth payer ID for submitting electronic claims

Payer ID	Claim type
62308*	Medical, behavioral (including employee assistance program), dental, and Cigna Medicare Advantage claims

*Both primary and secondary (COB) claims can be submitted electronically to Evernorth Behavioral Health.

You don't have to submit Medicare Part A and B coordination of benefits agreement (COBA) claims to Evernorth Behavioral Health, as the Medicare EOB or ERA will show that those claims are forwarded to Cigna as the secondary payer.

Toll-Free Telephone Numbers:

- 800.88Cigna (882.4462) – for your patients with Cigna ID cards
- 800.926.2273 – for EAP/Behavioral HMO
- 866.494.2111 – for your patients with "G" ID cards

The above numbers offer access to eligibility, benefit, and claim information. You may use our interactive voice response (IVR) automated telephone system, or speak to a Customer Service Representative.

You can receive eligibility and benefit information for multiple patients during a single telephone call. When using the IVR, you have the option of hearing the requested information or having it faxed to you.

You may also submit requests for precertification, referrals, /or prescription authorizations. Detailed claim information is available, such as claim status, payee, check amounts, and when and where payments were sent.

IVR user tips

- Press "*" to repeat previous information or menu options.
- During menu options, press "9" to go back to the main menu.
- After accessing the self-service information (such as eligibility, benefits, and claim status), press "0" to speak with a Customer Service Representative.
- Press "#" after entering data values (e.g., patient ID number or date of birth).

ePrescribe

ePrescribing is available to providers for your patients covered by Cigna pharmacy benefit plans. ePrescribing provides access to prescription eligibility, drug list, and medication history, and allows prescriptions to be sent electronically to a patient's pharmacy of choice, including Express Scripts Pharmacy (home delivery), and Accredo (specialty pharmacy). ePrescribing can be used during point of care, and prescriptions can be sent before the patient leaves the office.

ePrescribing provides:

- Significant patient safety advantages, including the ability to check for drug allergies or whether a prescription may conflict with another medication
- Access to information that allows for review of medication efficacy and dosage adherence
- Access to the Cigna drug list
- Administrative efficiencies by eliminating the need for written, telephone or fax delivery of a prescription and subsequent telephone calls to clarify handwritten prescriptions or renew a prescription

Online training and resources

Evernorth offers online learning about our electronic capabilities, timely health care topics, and other important information. No special software is required. You can view any of the materials electronically at your convenience, or simply download them to your computer to review later or share with your staff.

Online training materials are available on the Evernorth provider website (Provider.Evernorth.com > Resources > Behavioral Education and Training).

Cultural competency

Diversity within the general population is anticipated to increase in future years. As the population continues to diversify, you may face increasing challenges in providing quality health care to all of your patients. Increased awareness of diversity will help you identify opportunities to collaborate with your patients.

By being culturally competent in health care, providers can understand their patients' diverse values, beliefs, and behaviors, and customize treatment to meet their patients' social, cultural, and linguistic needs.

Evernorth Behavioral Health offers resources that can help create an optimal experience for providers, staff, and patients who may face cultural barriers. These resources are available

on Provider.Evernorth.com. You may access these resources at no cost. Resources include articles, training, videos, a health equity brochure, as well as a powerful public service announcement on the importance of language interpreters in health care.

Visit the Evernorth provider website to learn more (Provider.Evernorth.com > Resources > Behavioral Resources > Doing Business with Cigna > Cultural Competency Training and Resources).

Onboarding

Your participation with Evernorth Behavioral Health helps us fulfill our mission to improve the health, well-being, and sense of security for the people we serve. Our network of providers must treat all Evernorth Behavioral Health participants equally and must agree to participate at all service locations (e.g., participation is not limited to specific TINs).

How to join the Evernorth Behavioral Health network

Individual providers (including new providers affiliated with contracted clinics and facilities):

- Complete the Evernorth Behavioral Provider Information Form.
- Evernorth Behavioral Health will respond by email within 20 business days after reviewing your form.
- The email will be sent to the email address that you list in the "Contracting/Credentialing" field under the Professional Contact Information section.

If you are already contracted with Evernorth Behavioral Health and need to submit demographic changes, please see the directions below that best match your provider type.

- **Individual providers**: Log in to the Evernorth provider website (Provider.Evernorth.com > Working with Cigna > Update Provider Information form). If you are not a registered user for the website, visit Provider.Evernorth.com > Register.
- **Clinics**: To add, change, or delete clinic office locations, complete and submit the Clinic Location Changes For Existing Clinic Contracts Form.
- **Facilities**:
  - To add/remove services, or to add/change service location information, contact your Evernorth Behavioral Health Contractor.
  - To update demographic information other than service locations, contact your Evernorth Behavioral Health Provider Relations Representative or call Provider Services at **800.926.2273**.

Individual practitioners providing behavioral services at Cigna-participating medical practices

If you are providing behavioral services at a participating medical practice and are *not* accepting direct referrals from the community, call 800.88.Cigna (882.4462) to apply to the practice's medical contract.

If you are providing behavioral health services at a participating medical practice and *are* accepting direct referrals from the community, AND/OR you provide behavioral health services outside of the medical practice (e.g. in your own private practice), please apply to join the Evernorth Behavioral Network by submitting the Evernorth Behavioral Health Provider Information Form.

If you practice in Maryland, Ohio, or Washington

The Evernorth Behavioral Health Provider Information Form is not required for practitioners who provide services in the states of Maryland, Ohio, or Washington. Email BehavioralHCPEnrollment@Evernorth.com with your request to participate and include the information below for identification purposes. You will receive a response within 15 business days.

- First and last name
- Middle initial
- CAQH ID# (accepted, but not required for Washington)
- Tax Identification Number (TIN)
- National Provider Identifier (NPI)
- License type (LCSW, LPC, LMFT, MD, LP, etc.)
- Primary mailing address
- Service location(s)
- Telephone number (for contracting/credentialing purposes)

If you practice in Minnesota, North Dakota, or western Wisconsin

In these markets, Evernorth's Behavioral Health network represents an alliance between Cigna and HealthPartners. For contract consideration, complete the HealthPartners Behavioral Health Contract Application available at the HealthPartners Provider portal.

If you practice in Missouri

For status updates about the credentialing process, email BehavioralContracting@evernorth.com, and include the provider's name and TIN.

- For more information about joining our network, visit our Frequently Asked Questions.
- To check on your contract request status, email BehavioralContracting@evernorth.com.
- If you have questions unrelated to your initial contracting, call Provider Services at 800.926.2273.

Clinics

Clinics are groups of behavioral health providers who share the same TIN, location, and administrative staff:

- Complete the Clinic Information Form for Behavioral Health Clinics.
- Evernorth Behavioral Health will respond by email within 20 business days after reviewing your application.
- Our response will be sent to the email address that you list in the "Primary Clinic Contracting Contact."
- For more information about joining our network, visit our Frequently Asked Questions.
- To check on your application status, email BehavioralContracting@Evernorth.com.
- If you have questions unrelated to your initial contracting, call Provider Services at 800.926.2273.

Autism clinics

Autism clinics are groups of autism providers who share the same TIN, location, and administrative staff.

- Complete the Clinic Informational Form for Autism Clinics.
- Evernorth Behavioral Health will respond by email within 20 days after reviewing your application.
- Our response will be sent to the email address that you list in the "Primary Clinic Contracting Contact."
- For more information about joining our network, visit our Frequently Asked Questions.
- To check on your application status, email BehavioralContracting@Evernorth.com
- If you have questions unrelated to your initial contracting, call Provider Services at 800.926.2273.

Facilities

Facilities are hospitals, residential type settings, or programs that provide partial hospitalization or intensive outpatient services for the treatment of mental health or substance use.

- Complete the Facility Information Form.
- Evernorth Behavioral Health will respond by email within 30 days after reviewing your form.
- Our response will be sent to the email address that you list on page one of the Facility Information Form.

Credentialing for providers

Providers are credentialed before becoming an Evernorth Behavioral Health, Inc. participating provider, and are recredentialed periodically thereafter, to help ensure they continue to meet our qualifications for participation. Criteria for participation are determined by business needs and by our credentialing policies and procedures, which are reviewed annually to reflect National Committee for Quality Assurance (NCQA), as well as local and state standards.

Once the initial onboarding process is complete, providers will be prompted to complete the online credentialing form through the Council for Affordable Quality Healthcare (CAQH) at Proview.CAQH.org.

Council for Affordable Quality Healthcare (CAQH) credentialing database system

Evernorth Behavioral Health is part of (CAQH, a nonprofit alliance of managed care plans, physician-hospital organizations, and trade organizations. CAQH recognizes the need to simplify administrative requirements and allow you to focus on caring for patients. Improving processes for obtaining and managing data is a key factor to saving time. Working with health care delivery systems and various technical and software specialists, CAQH sponsors the Universal Provider Datasource® initiative.

This online database system, developed by managed care organizations with help from physicians, professional associations, and accreditation organizations, allows providers to complete one credentialing application by entering confidential information into one, secure database that is shared, with your approval, with participating health plans and other participant organizations. Providers provide the basic information only once, and updates are made online or by fax. There is no charge to submit information to the CAQH credentialing database, and CAQH contacts providers regularly to ensure the information is complete. Some states mandate the use of the CAQH application and Evernorth Behavioral Health strongly encourages its use when submitting your application in all states.

For more information about the Universal Provider Datasource, or to apply online, visit Proview.CAQH.org. For questions about completing the application, call the CAQH Help Desk at 888.599.1771, or email CAQH at Caqh.updhelp@acsgs.com.

Notice of changes of licenses or accreditation

As a participating provider, you are responsible for notifying Evernorth Behavioral Health immediately of any changes to the information presented as part of the credentialing or recredentialing process. Failure to notify Evernorth Behavioral Health of changes or to

satisfy requirements may result in claims issues or your removal from the Evernorth Behavioral Health network.

Termination appeal process

You may appeal our decision to terminate your Evernorth participation agreement based on:
Quality of care reason
Quality of service reason
Failure to meet our credentialing requirements, if you participate in a state and/or network with a requirement that appeal rights be offered

Submit appeals in writing within 30 days of notification of termination from the network. Refer to your Provider Agreement and the dispute resolution section of this reference guide for more information. Appeal rights will only be offered to providers terminated due to quality of care or quality of service, and providers terminated in states that mandate appeal rights be offered.

You must not make any material misrepresentations in the information provided during your contractual relationship with Evernorth Behavioral Health, including medical record information. In addition, you must continue to satisfy all of the criteria.

The credentialing documents must be current in the CAQH Universal Provider Datasource system or be submitted in a credentialing/recredentialing paper packet. If any of the documents are missing, your file cannot be processed and participation in the Evernorth Behavioral Health network may be denied or terminated.

Credentialing process for providers

The credentialing process includes a review of the standard application and independent verification of certain documentation submitted. Information submitted must be accurate, current, and complete.

Evernorth Behavioral Health's requirements for provider participation include, but are not limited to, the following:
A completed signed and dated application (dated within 180 days). Correction liquid must not be used in the signature area of paper applications. Applications with altered signatures will not be processed.
A completed, signed, and dated authorization and release form, if not included in the application form.
A completed, signed and dated Provider Agreement (two originals), copy of a completed Provider Data Sheet, copy of a completed W-9, and copy of a CMS-1500 claim form with Box #33 completed (if not included on Provider Data Sheet).
Documented work history in month/year format.
A current unrestricted license to practice medicine in the state where practicing.
A current unrestricted Drug Enforcement Administration (DEA) certificate (if applicable).

Board certification (if applicable), including but not limited to, specialties by the American Board of Medical Specialties and the American Osteopathic Association.
Professional liability insurance with typical minimum coverage of $1,000,000 per incident and $3,000,000 aggregate for physicians and other providers.
Acceptable history of professional liability claim experience as determined by Evernorth Behavioral Health.
Completed professional liability information (with explanation of each case).
Acceptable history of Medicare/Medicaid sanctions as determined by Evernorth Behavioral Health.
Acceptable responses to all questions on the credentialing application form as determined by Evernorth Behavioral Health.
Acceptable report from the National Practitioner Data Bank as determined by Evernorth Behavioral Health.
An acceptable history relative to all types of disciplinary action by any hospital and health care institution and any licensing, regulatory, or other professional organization.

Provider rights

You have certain rights during the credentialing process, including the right to:
Review information submitted to support credentialing application.* Information from outside sources (e.g., licensing boards) will be made available for review.* Providers may exercise this right by contacting the Provider Service Center at 800.926.2273, or sending an email to BehavioralContracting@Evernorth.com.
Correct erroneous information.* When erroneous information is present, providers are contacted in writing by a representative from the Credentialing Department and notified of the discrepancy. Corrections should be submitted to the Credentialing Department in writing within 15 business days at the location as noted on the request. All responses are recorded with a date of receipt and maintained as part of the provider's credentialing file.
Receive the status of their credentialing or recredentialing application, upon request.* Providers may contact the Provider Service Center at 800.926.2273, or send an email to BehavioralContracting@Evernorth.com.
The decision to accept or deny participation will be communicated in writing within 60 days of the decision.

*References, recommendations and other peer review protected information will not be shared. All state and federal guidelines are also adhered to, where applicable.

All specific provisions requirements for Delegated Credentialing are contained within the Evernorth Standards of Delegation document.

Evernorth will evaluate certain exceptions to its credentialing criteria on a case-by-case basis.

Clinic-based programs

Recredentialing process for professionals

Evernorth Behavioral Health recredentials its participating providers once every three years or more often, if required by state law. If you have not applied through the CAQH Universal Provider Datasource, you will be mailed a recredentialing letter approximately six months before your recredentialing date. The letter will direct you to complete the CAQH Universal Provider Datasource credentialing form.

If you already completed and updated the CAQH application and attestation and authorized Evernorth Behavioral Health to receive current credentialing information, Cigna will automatically have access to your application during the recredentialing process, and will only contact you if needed. If you use a state-mandated form outside of CAQH, you must update any information that has changed, sign the attestation, and submit the application along with current supporting documents.

During the recredentialing process, completed applications are reviewed and certain new information is independently verified.

The criteria reviewed includes, but are not limited to:
A completed signed and dated application (dated within 180 days). Correction liquid must not be used in the signature area of paper applications. Applications with altered signatures will not be processed.
Completed, signed, and dated authorization and release form if not included in the application form,
Current, unrestricted license to practice medicine in the state where practicing,
Current DEA certificate number (if applicable),
Current Controlled Dangerous Substance (CDS) certificate number (if applicable),
Status of current board certification (if applicable),
Record of adequate education and board certification for any new specialty in which you request to be credentialed,
Professional liability insurance with typical minimum coverage of $1,000,000 per incident and $3,000,000 aggregate for physicians and other providers,
Acceptable history of professional liability claim experience as determined by Evernorth Behavioral Health,
Completed professional liability form with explanation of each case for paper applications,
Written explanation relevant to professional liability and practice review questions,
Acceptable history of Medicare/Medicaid sanctions as determined by Evernorth Behavioral Health,

Acceptable results from the National Practitioner Data Bank as determined by Evernorth Behavioral Health.
Acceptable responses to all questions on the credentialing application form as determined by Evernorth Behavioral Health.
Signed, dated, and completed professional liability form,
Copy of current DEA and CDS (if applicable) certificates,
Copy of current professional liability face sheet,

Credentialing requirements for facilities

To help ensure behavioral provider network providers meet Evernorth Behavioral Health quality standards for participation and to comply with accreditation requirements, facilities are credentialed before participating in an Evernorth Behavioral Health network. Participating facilities must maintain an ongoing quality improvement program that monitors and evaluates the quality and appropriateness of patient care, pursues improvement opportunities, and resolves problems. Accrediting organizations, such as the Joint Commission (JC), Association of Academic Health Centers (AAHC); Commission on Accreditation of Rehabilitation Facilities (CARF); American Osteopathic Association (AOA); Community Health Accreditation Program (CHAP), and Council on Accreditation (COA); DNV GL NIAHO®, validate a quality improvement program. When accreditation, state Department of Health, or Medicare certification evidence is not available, Evernorth Behavioral Health may perform a site visit and review of the hospital or ancillary facility quality improvement program.

In accordance with the Evernorth Behavioral Health national credentialing requirements, facilities must apply for participation by completing a standard application form and satisfactorily meeting the established criteria. The Evernorth Behavioral Health credentialing and recredentialing policies and procedures are reviewed at least annually and revised as necessary, including revisions to reflect state and local quality assurance standards.

The information required to complete the credentialing process includes, but is not limited to, the following:
Copy of unrestricted state license or state operating certificate, as applicable.
Copy of current accreditation letter or certificate.
Proof of current professional and general liability insurance coverage that meets Cigna minimum guidelines. **Hospital/Residential Setting**: 1 million per occurrence and 3 million aggregate **Partial Hospitalization and Intensive Outpatient Programs**: 1 million per occurrence and 1 million aggregate
National Provider Identifier (NPI)
Any explanation requested on application, including a list of malpractice settlements and judgments.

If not accredited, a copy of the most recent CMS evaluation.
An onsite assessment, if not accredited or Medicare and Medicaid certified.
A copy of the quality management plan, if not accredited or Medicare and Medicaid certified.
List of available services that can be rendered by facility.
Absence of current sanctions from Medicaid or Medicare.
If an ancillary facility is not subject to state licensure requirements, the Evernorth Behavioral Health credentialing committee will determine if the facility meets remaining credentialing standards for participation in the Evernorth Behavioral Health network.

Recredentialing requirements for facilities

Participating facilities are recredentialed every three years or more frequently, if required by applicable law. Evernorth Behavioral Health credentialing staff will confirm that the facility continues to be in good standing with state and federal regulatory bodies and, if applicable, is reviewed and approved by an accrediting body.

Participating facilities are responsible for notifying Evernorth Behavioral Health immediately of any material changes to the information presented at the time of their prior credentialing or recredentialing cycle. Failure to notify Evernorth Behavioral Health of changes or to satisfy requirements may result in termination from the Evernorth Behavioral Health network. Recredentialing and continued participation in the provider network are dependent upon the facility continuing to meet the Evernorth Behavioral Health credentialing and recredentialing standards.

Ancillary providers

*Please note this section is relevant only to organizations contracted on an Ancillary Provider Agreement.

Evernorth Behavioral Health has implemented the following process for ancillary providers in order to have updated information on a monthly basis about the composition of providers rendering services under the Ancillary Agreement by state as well as growth. The contracted Ancillary entity will submit a monthly provider count by state for each state where they are rendering services under the agreement. The information should be submitted to Ancillaryproviders@evernorth.com by the first of every month.

Credentialing Attestation

Ancillary providers will complete the Evernorth Behavioral Health, Inc. Ancillary Provider Credentialing Attestation Form on an annual basis and submit the completed attestation to Ancillaryproviders@evernorth.com.

Provider specialties and urgent access

Provider specialties

Evernorth Behavioral Health asks provider to identify their specialty areas of focus, as well as the populations they treat, the modalities of treatment utilized, and optional

information about the themselves (e.g., nationality, language spoken, gender identity), so Evernorth Behavioral Health can assist participants in locating a provider to assist with their care.

Evernorth Behavioral Health identified clinical specialties that require specific attestation of competency by practitioners or verification of licensure by Evernorth Behavioral Health, in order to list the specialty as an area of clinical practice. Evernorth Behavioral Health staff will utilize a variety of means to ensure that the specialties listed in a practitioner's record are accurate to promote quality customer care. The verification process will be completed during initial credentialing, when the practitioner requests to add a specialty to their profile, and during the recredentialing process. There are currently three different groups of specialties: Self-reported specialties, attested specialties, and verified specialties.

A **self-reported specialty** is one that the provider can list as an area of practice based upon their own selection. Self-reported specialties include general areas of behavioral health treatment for which practitioners have received training as a licensed behavioral health practitioner.

- Self-reported specialties include depression, anxiety, couples counseling, anger management, grief/loss, LGBTQ+ health, domestic violence, and faith-based counseling.

An **attested specialty** is one that the provider can list as an area of practice based upon education and experience, but does not require additional documentation.

- Attested specialties include sexual disorders/offenders, autism, EAP (CIR, Clinical-Etiology-Anatomy-Pathophysiology (CEAP), assessment and referral, employment education, management referrals, supervisor training,) developmental disorders, dialectical behavior therapy (DBT), dual diagnosis, eating disorders, eye movement desensitization and reprocessing (EMDR), neuropsychological testing, and pain management.

A **verified specialty** is one where the provider can substantiate their ability to provide specialty services by presenting documentation such as, specific licensure or certification.

- Verified specialties include addictionology, alcohol/substance use, behavioral pediatricians, buprenorphine, medication management, Substance Abuse Professional (SAP), and Substance Abuse Expert (SAE).

If a provider does not meet the criteria for any of the attested or verified specialties, these specialties will not be added to the practitioner's profile. If at any point Evernorth Behavioral Health has been made aware that a practitioner no longer meets criteria for an attested or verified specialty, the specialty will be removed from the practitioner's data profile. This will not affect the provider’s network status or payment for services.

However, participants needing these specialty services will only be referred by Evernorth Behavioral Health to those providers who have that specialty listed within their profile.

If you wish to add a verified or attested specialty to your profile, please submit the Verified Specialty or Attested Specialty form(s). To add specialties that are not included

on these forms (e.g. Self-Reported Specialties), please contact Provider Services at 800.926.2273.

Urgent access

Evernorth Behavioral Health is committed to providing excellent service and quality of care to participants. Evernorth Behavioral Health Clinical Operations and Provider Relations staff have worked together to better understand crisis stabilization services. As a result, Evernorth Behavioral Health has defined crisis stabilization services to provide different access levels based on the participant's needs.

Crisis Stabilization Unit

The use of Crisis Stabilization Unit may apply in those cases where one exists outside of an accredited hospital, but where 24-hour supervised and monitored services are available. The facility setting for a crisis stabilization bed is within a unit that provides around-the-clock nursing, or mental health staff supervision and continuous observation and control of behaviors to insure the safety of the individual and others.

- This level of care is for short-term crisis stabilization for those experiencing a mental health emergency.
- The purpose is to prevent further decompensation that would result in an inpatient admission.
- The typical length of stay is one to seven days.

This service provides:

- Evaluation and intervention for individuals with acute symptoms of a mental health or substance use disorder when the clinical presentation does not immediately indicate the need for a higher level of care
- 24-hour supervised and monitored services
- Psychiatric consultation
- Evaluation of family and social support systems that identify both opportunities and challenges, and a plan to address the latter
- Linkage and referrals to long-term services/community services
- An individualized treatment plan
- May provide medication management
- May provide individual and group and family counseling
- A complete medical evaluation and basic medical procedures as indicated

Note: When medical services are not available on site, the program must be able to ensure that the individual will be linked to appropriate treatment and providers within a reasonable time frame.

Crisis Stabilization Appointments

The Crisis Stabilization Network is outpatient providers who are available for emergent referrals, offering active intervention within six hours for participants in need. Our crisis stabilization network is available 24/7/365 , and crisis stabilization providers can be easily identified by clinical operations for referrals.

During a crisis stabilization appointment, a licensed behavioral health care provider facilitates active treatment intervention and is able to assess, stabilize, and proactively identify the most appropriate level of care for a member with an urgent or emergent need.

The goals of the intervention at this level of care:

- Reduction of acute symptoms due to a mental health or substance use disorder
- Reduction of potential for harm to self or others
- Identification and mobilization of available resources, including support networks
- Intervention focused on factors relevant to the crisis

Appropriate interventions include assessment of support networks, identification, and assessment of available services, mobilization of those services, and an estimate of the individual's ability to access services and participate in the treatment plan.

Note: This level of care is not appropriate for an individual who, by clinical presentation or history, requires the intensive structure of acute inpatient treatment for safely and stabilization.

Intermediate care

Intermediate care is a level of intervention that provides precautionary and preventive care to a participant who presents with a level of acuity that, if not addressed within 48 hours, could escalate to a higher level of care. The goal of our intermediate care network is to successfully link complex cases with practitioners who have the clinical expertise to manage specific diagnoses/problems for ongoing treatment. It is expected that the intervention be conducted by a licensed mental health provider, the key elements being to assess, stabilize, and proactively identify the most appropriate level of care for the participant at that time. The intervention should include the following components:

- A comprehensive psychiatric and medical history
- A description of the nature of the participant's impairments and the nature of any safety or risk issues (S/I, H/I)
- Comprehensive evaluation of substance use or chemical dependency issues
- A psychosocial evaluation including a systems analysis of the participant's family and support network; identify any barriers for successful treatment plan
- Documentation of any current treatment providers, description of the services provided and medications, if any (including names, dosages, and frequencies on medications prescribed)

Key objectives for intermediate care services:

- Providers will be able to intensify treatment plans as needed for their participants to prevent unnecessary hospitalization as clinically indicated
- Providers will develop short-term, evidenced-based treatment plans incorporating a systems approach
- Providers will include in their treatment planning, effective collaboration between Evernorth Behavioral Health, psychiatrists, PCPs, and other community resources prior to requesting any higher level of care

If the acuity of the participant's condition does not allow for precertification of coverage, contact Evernorth Behavioral Health as soon as possible. Please be prepared to provide the following information to the Evernorth Behavioral Health clinical staff:

- Participant's name, age, and ID number
- History, diagnosis, indications, and nature of the immediate crisis
- Alternative treatment provided or considered
- Treatment goals, estimated length of stay, and discharge plans

Meet-and-greet appointments

A meet-and-greet appointment is a pre-discharge visit conducted by a participating non-MD provider for the purpose of coordinating and scheduling the ambulatory follow-up appointment, two to seven days after discharge. The practitioner will enter the facility as a visitor; therefore, the practitioner does not need to be credentialed with the facility. Please note that the meet-and-greet service is usually performed during visiting hours, but scheduling may vary by facility.

A meet-and-greet appointment is an Evernorth Behavioral Health-initiated service for which precertification must be obtained from an Evernorth Behavioral Health care manager or care coordinator. Claims should be submitted with CPT code 99499 (unlisted evaluation/management services). The claim will be processed for benefit as long as there is a comment in the inpatient authorization and the provider includes a written description of the service provided, for instance, "pre-discharge consultation" or "meet and greet." Without a written description by the practitioner, the claim payment will be denied due to lack of information. A copayment for this service depends upon the participant's benefit plan.

Behavioral virtual services

Offering services virtually to the participant gives you the potential to broaden the scope of your practice, earn additional income during “off” hours, reach patients in a larger geographical area, expand access to behavioral health care, and reduce your time on the road. Virtual therapy, medication management, and intensive outpatient programs are typically available to participants nationwide and related claims will be administered in accordance with their benefit plan.

Providers should utilize the CPT code that reflects the services rendered and add modifier 95 to indicate that it was a virtual service. This will not change the reimbursement; however, Evernorth Behavior Health needs to monitor how all services are delivered.

Providers must meet all state requirement to provide virtual behavioral services, including any licenses and certifications. Providers must also comply with their state laws about the use of audio or video-based technology and be aware of relevant in-person and virtual practice guidelines. Providers are expected to follow all regulatory and licensure requirements related to their scope of practice, any limitations on the use of specific technologies and prescribing practices, and need to abide by state board and specialty training requirements.

Contracted behavioral providers who meet the telehealth specialty requirements may deliver services virtually with no additional credentialing. To provide virtual sessions through Evernorth Behavioral Health, please attest to meeting the designated specialty requirements on the Attested Specialty Form (see below). Upon receipt and approval by Evernorth Behavioral Health of the completed form, “telehealth” will be added as a specialty to your profile.

Forms

- Specialty Attested Form
- Specialty Attestation for Participation
- Specialty Verified Form

Provider participation

In our role as a health service company, Evernorth Behavioral Health contracts with psychiatrists, nurse practitioners, physician assistants, psychologists, master-level clinicians, clinics, and facilities. In most situations, our customers expect to receive care from Evernorth Behavioral Health participating providers to maximize their in-network benefits, even when their health care professional refers them elsewhere.

As part of your contract with Evernorth Behavioral Health, you agree to refer your patients to other in-network contracted physicians, hospitals, and other providers and facilities. Naturally, there are some exceptions, for example, in an emergency or if services cannot be provided within the network. However, Evernorth Behavioral Health has made significant investments in online tools, smartphone apps, and 24/7 customer service to help individuals make informed decisions about their care and costs so they can “know before they owe.” It is Evernorth Behavioral Health’s expectation that you will partner with customers to help them maximize their benefits by referring additional care to other participating providers.

As an Evernorth Behavioral Health participating provider, you must provide services with the same standard of care, skill, and diligence customarily used by similar health care providers in your community, the requirements of applicable law, and the standards of applicable accreditation organizations. All services that are provided within the scope of your practice or license must be provided on a participating basis, and must behave as contracted, regardless of service location. For the avoidance of doubt, all locations of a participating provider are contracted with Evernorth Behavioral Health.

Services you provide to participants should be done in the same manner, under the same standards, and with the same time availability as offered to other patients. You will not differentiate or discriminate in the treatment of any participant based on race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran’s status, handicap, or source of payment.

Further, as a participating provider, you must meet the Evernorth Behavioral Health credentialing standards for training, licensure, and performance before joining the network. You will also be evaluated periodically to help ensure continued qualification. Performance requirements include providing quality services to participants and cooperating with Evernorth Behavioral Health administrative, quality, and utilization management programs. Evernorth Behavioral Health evaluates performance data for quality improvement activities, preferred status designation in the provider network, and reduced customer cost sharing, as applicable.

Service standards and requirements

Participants in Cigna and Evernorth Behavioral Health plans expect quality health care services. You can assist us in maintaining access to quality service by adhering to the following standards and requirements. Compliance with these standards may be monitored through site visits, medical record reviews, and participant surveys. For more detail, refer to the Quality Management Program section.

Acceptance and transfer of participants

You should not refuse or fail to provide services to any participant unless you are incapable of providing the necessary services or as otherwise provided in the Closing a Panel section that follows. You are expected to provide services to participants in the same manner, in accordance with the same standards, and with the same time availability as provided to other patients.

Communication to participants of professional termination

If your participation with Evernorth Behavioral Health is terminated entirely or with respect to any of our benefit plan types, if applicable, Evernorth Behavioral Health will notify affected participants of the termination to the extent required by applicable law and applicable accrediting requirements. Such notification will occur before the effective date of the termination unless Evernorth Behavioral Health does not receive sufficient advance notice. In this instance, Evernorth Behavioral Health will notify affected participants to the extent required as soon as reasonably possible. Upon request, you are responsible for providing a listing of participants affected by your termination within seven business days of the date of the notice of termination.

In the event you decide to send any written communication to participants about your Evernorth Behavioral Health participation or use our name in such manner, we reserve the right to review and approve the communication prior to release. You may not make any disparaging comments about Evernorth Behavioral Health or its affiliates or misrepresentation in any communications about your participation during your contractual relationship with Evernorth Behavioral Health. Refer to your Provider Agreement for more information.

In the event of suspension, additional referrals to the practitioner are halted, and depending on the reason for suspension, Evernorth Behavioral Health may reassign the practitioner's current participants. In those states where there are laws regulating the appeal process, the state law supersedes this procedure.

Scheduling appointments

Evernorth Behavioral Health has adopted the below access standards based on industry standards. Our appointment access standards now include office wait times. In addition, participants should be seen within the time frames listed below based on the severity of their clinical presentation.

- **Post-discharge from inpatient care** Within seven calendar days
- **Emergent- life threatening**: Within six hours
- **Urgent non-life threatening**: As soon as possible, but not to exceed 48 hours
- **Initial routine**: Within 10 business days
- **Follow-up routine care:** Within 30 calendar days
- **EAP standard:** Within two business days
- **Office wait time**: 15 minutes or less

Providers are asked to make every effort to ensure compliance by seeing participants within these access standard time frames.* Providers who are unable to schedule a participant visit within the access standard time frames should immediately refer the participant to the online provider directory, or contact Evernorth Behavioral Health

through the mental health and substance use telephone number on their ID card for alternative referral.

*State and/or federal requirements will override these standards, when applicable.

Accessibility

There must be a publicized telephone number for participants to call, and telephone calls must be answered promptly by a properly trained person to respond to calls of a routine, urgent, or emergent nature.

Telephone response time

Telephone calls must be answered promptly. When it is necessary to place callers on hold, callers should be asked if they can hold and the caller should only be placed on hold after giving an affirmative response. Callers who do not wish to hold should have their calls handled as appropriate. If the telephone is answered by an answering service/voicemail, the message must give emergency instructions that clearly explains how to get urgent or emergency care, and when appropriate, how to contact another provider who is on-call for triage and screening services or, if needed, to give urgent or emergency care.

General referrals to emergency room settings for all access standards other than non-life threatening and life-threatening emergencies are not considered to be evidence of appropriate crisis coverage. It is also expected that your outward greeting includes your message response time frame (e.g., all calls will be returned within 24 to 48 hours).

Professional services

- All services must be provided, or overseen, by a licensed or certified professional personnel that comply with generally accepted professional and ethical standards as well as community standards
- State and federal law
- Accreditation organization standards

Evernorth Behavioral Health allows providers to bill for professional services, which are rendered by supervisees, as permitted by their state licensing regulations. If you engage in supervisor (or supervisee) billing, the fully credentialed provider should be listed on the claim as the rendering provider. This practice does not replace the need for fully licensed providers to follow Evernorth Behavioral Health credentialing standards.

Cooperation with programs

Evernorth Behavioral Health is committed to promoting access to quality services for participants. To support this commitment, we require your cooperation with Evernorth Behavioral Health programs, including administrative programs such as claim appeals, wellness, and other medical management programs.

Cooperation with Evernorth Behavioral Health in establishing and implementing policies and programs to comply with regulatory, contractual, or certification requirements of Healthcare Effectiveness Data and Information Set (HEDIS®),* the National Committee for Quality Assurance (NCQA), and any other applicable accreditation organization is equally important.

*HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

Referrals

Occasionally, it may be necessary for a practitioner to refer a participant outside of their practice. A provider should search the provider directory or contact an Evernorth Behavioral Health Case Manager for referral to an appropriate Evernorth Behavioral Health-participating practitioner.

Referrals to all non-participating providers and ancillary services, including attending MD services, residential care facilities, and freestanding laboratories

Participants whose benefit plans are administered by Evernorth Behavioral Health generally expect that when they choose to seek care from an Evernorth Behavioral Health network-participating provider, charges for all related care will be processed at the in-network benefit level. For this to occur, the patient must be referred to Evernorth Behavioral Health-participating providers, including other practitioners, laboratories, or facilities. When a patient is referred to a non-participating provider, the patient may incur unexpected financial liability. Patients whose plans include out-of-network benefits are free to choose to use these benefits for services covered under their plan; however, in doing so, these patients will generally incur higher out-of-pocket costs. To ensure that Evernorth Behavioral Health customers are making informed choices when accessing care, the referring provider must fully disclose the financial effect of referrals to participating or nonparticipating providers under their benefit plan, including the referring provider financial interests, if any.

Medication

Non-prescribing providers who believe medication should be considered can search the provider directory or contact an Evernorth Behavioral Health Case Manager for referral to an appropriate Evernorth Behavioral Health practitioner. The provider can offer the participant the name and telephone number of an appropriate prescriber. The participant may then contact the prescriber for an appointment. When medication is prescribed, participants should have prescriptions filled at an authorized pharmacy.

Participant billing

Copayments: A copayment is a fixed dollar amount that a participant pays per service. Copayment amounts are printed on the participant's ID card. Collect the applicable copayment amounts on the ID card at the time of service.

Coinsurance and deductibles: For participants with plans that have deductibles or require participants to pay a percentage of the covered charges (coinsurance) after satisfying any deductible amount, you should submit claims to the Payer or its designee and receive an explanation of payment (EOP) indicating the participant's responsibility before billing patients.

For Cigna plans only, coinsurance and deductibles should not be collected at the time of service unless you have accessed the Cigna Cost of Care Estimator® to obtain an estimate of the deductible and coinsurance obligations of the plan participant, and provided a copy of the estimate to the participant at the time of service.

The Cigna Cost of Care Estimator can inform you and your patients that participate in Cigna medical or behavioral plans of their estimated financial responsibility for services based on their specific Cigna plan. The estimator is available for all plan participants in Preferred Provider Organization (PPO), Exclusive Provider Organization (EPO) , Open Access Plus (OAP), and Open Access Plus In-Network (OAPIN) plans, managed care plans (HMO, Network EPP, HMO Access, Network Open Access, HMO POS – Flex, Network POS – DPP, HMO POS Open Access, Network POS Open Access, Open Access Plus (OAP) Open Access Plus In-Network (OAPIN) and LocalPlus), Choice Fund plans, plans for participants with "G" ID cards, and behavioral health plans.

You can access the Cigna Cost of Care Estimator tool through the secure Evernorth provider website (Log in to Provider.Evernorth.com > Patients > Search for a Patient > Select a Patient > Estimate Costs).

For additional information about the Cigna Cost of Care Estimator, log in to Provider.Evernorth.com > Medical Resources > Doing Business with Cigna > Cigna Cost of Care Estimator. To learn how to use the estimator, access the Cigna Cost of Care Estimator eCourse in Resources > eCourses.

Many Cigna Choice Fund HRA plan participants have automatic claim forwarding (ACF) enabled as chosen by their employer so the deductible and coinsurance amounts they owe are paid directly out of their HRA fund. After claim processing, if funds are available, Cigna automatically sends payment to you on behalf of the Cigna Choice Fund participant, usually along with Cigna's portion of the payment. ACF is currently active on the majority of our Choice Fund HRA plan participants.

Please note: For Choice Fund HSA plan participants, the ACF feature is chosen by the customer. It is now referred to as Auto Pay with our vendor, HSA Bank. The majority of the time it is not a chosen option as it is on HRA plans.

Fee forgiving/waiver of copayment/coinsurance or deductible: Most benefit plans exclude from the participant's coverage those charges for which the participant is not obligated to pay. Therefore, if a plan participant is not obligated to pay a charge, any claim for reimbursement for any part of that charge under such a contract or benefit plan is generally not covered. It is Evernorth Behavioral Health's view that "fee-forgiving" on any particular claim, or any portion thereof, could constitute fraud and may subject a provider to civil and criminal liability.

Participant incentives prohibited: Providers shall not directly or indirectly establish, arrange, encourage, participate in, or offer any "Participant Incentive." Providers include hospitals, ancillary services, health care facilities, individual and group practitioners, and all other entities delivering covered health care services to participants.

"Participant Incentive" means any arrangement by a provider:

1. To reduce or satisfy a participant's cost-sharing obligations (including, but not limited to, copayments, deductibles, or coinsurance, offer a cash price discount, or prompt pay discounts).
2. To pay on behalf of or reimburse a participant for any portion of the participant's costs for coverage (e.g., insurance premiums) under a policy or plan insured or administered by Evernorth or an Evernorth Affiliate.

3. That provides a participant with any form of material, financial incentive (other than the reimbursement terms under this Agreement), to receive Covered Services from the provider or its affiliates.

In the event of non-compliance with this provision:

1. Evernorth Behavioral Health may terminate the provider's participation agreement; as such, non-compliance is a "material breach" of the agreement.
2. The provider shall not be entitled to reimbursement under its participation agreement with respect to Covered Services provided to a participant in connection with a Participant Incentive.
3. Cigna may take such other action appropriate to enforce this provision.

Denied payment and participant non-liability

You cannot bill participants for covered services or for services for which payment was denied due to your failure to comply with your Provider Agreement or Administrative Guidelines or Program Requirements, including Evernorth Behavioral Health utilization management requirements and timely filing requirements.

Self-pay agreements

There may be circumstances in which having a participant sign a Self-Pay Agreement is appropriate. The provider must obtain written approval from the participant, in the form of a Self-Pay Agreement, including full financial disclosure for any services that were denied by the plan, or that were not Covered Services, in advance of those services being rendered. Services not covered by Evernorth Behavioral Health include, but are not limited, to:

- Late appointment cancellations
- Court-ordered treatment that is outside the scope of routine outpatient care and is determined by Evernorth Behavioral Health to be not medically necessary
- Missed EAP appointments
- Services for which the customer elects to not use their benefit plan

Please see Provider.Evernorth.com > Forms Center > Behavioral Health Forms, which contains an approved Evernorth Behavioral Health Self-Pay Agreement. The provider may use a Self-Pay Agreement of their own design; however, all data elements as described in the Self-Pay Agreement must be contained therein. Self-Pay Agreements signed by the participant either at the time of admission to the facility or at the start of outpatient treatment, that reference the possibility of a Self-Pay Arrangement in the future will not be accepted as proof of a Self-Pay Agreement. In these circumstances, the participant must be financially held harmless as per the terms of the Provider Agreement.

The Self-Pay Agreement must include the following:

- That the participant is aware of Evernorth Behavioral Health's appeal process and declines to appeal.
- A statement that the Self-Pay Agreement applies only to the specific level of care or services the participant is requesting. If the participant moves to a different level of care, an authorization must be obtained or another Self-Pay Agreement signed.

The Agreement is in effect only from the date the participant signs it, until or unless it is rescinded; the Agreement may never be retroactive. Although by signing the Agreement the participant, in effect, waives their right of appeal at that time.

Provider concerns related to administrative processes

Evernorth Behavioral Health has a provider concern process separate from the administrative or clinical treatment denial and appeal process discussed immediately above. The purpose of this process is to resolve administrative issues. For administrative concerns, please contact Evernorth Behavioral Health as follows:

- **Appeals of administrative denials:** Call the telephone number listed in the denial letter.
- **Claims:** Call Provider Services at 800.926.2273. For California practitioners, please see Appendix A.
- **Fee schedule-related issues:** Call the appropriate Provider Relations Representative with any provider contract question (see Appendix A).
- **Online patient reviews:** It is the provider's responsibility to present supporting documentation to Evernorth Behavioral Health in order for Evernorth Behavioral Health to assist in the resolution of issue. It is Evernorth Behavioral Health's responsibility to investigate all issues presented and to respond to the provider in a timely manner. To reply to a review or request an appeal to one, a provider must log in to Provider.Evernorth.com > Working with Cigna > Patient Reviews, where they can report a review as being inappropriate or inaccurate. A member of our Digital Editorial Team will determine whether the flag is warranted. If the review is accepted as inappropriate or inaccurate, it will be removed immediately. If it is determined to be appropriate and accurate, the review will remain in the directory, and the provider will be given the opportunity to respond to it directly.
  Please note: There may be instances when a review comment is suppressed, but the overall recommendation remains valid. For example, if profanity is used, the entire comment will be removed but the rest of the review will be published. It generally takes between one to three business days for Cigna to evaluate and make a decision about a provider's response to a negative review.
- Providers may contact the Patient Reviews Team at 888.535.0873, Monday-Friday, 8:00 a.m. – 5:00 p.m. PT, to address their concern. Providers who continue to be dissatisfied may pursue arbitration as outlined in the section entitled Dispute Resolution Procedure in the Participating Provider Agreement.

Resolving participant complaints

If a participant complains to Evernorth Behavioral Health about some aspect of care from a provider, the provider is required to participate in the internal Evernorth Behavioral Health complaint resolution process. An Evernorth Behavioral Health Provider Relations Representative will outreach the provider via telephone or email to address the concern. Once the concern has been discussed, the Provider Relations Representative will either inform the provider that the concern has been closed or that there is further action that needs to be taken to resolve the issue. The action will be outlined in a written communication. If, for any reason, the concern is not addressed in a timely manner or resolved, the Provider Relations Representative may take further action as outlined the Provider Agreement.

If a participant complains to the provider about an administrative issue, the participant should be directed to call the telephone number listed on the participant's ID card. For participants residing in California, please refer to Appendix A.

Confidentiality

Evernorth Behavioral Health maintains strict policies to protect confidential information. As a participating provider, you are responsible for maintaining the confidentiality of participant information in all settings in accordance with federal and state laws. Written policies and procedures should be established that include the designation, maintenance, release, and control of access to confidential records.

If you have questions or comments about plan policies, call 800.926.2273.

Eligibility

Determining eligibility

It is important to determine patient eligibility prior to rendering service. We recommend verifying your patient's eligibility prior to their appointment date. Patients are responsible for presenting their ID card or enrollment form (if they are awaiting receipt of an ID card) as proof of coverage.

Eligibility verification

In addition to viewing your patient's ID card, you should verify eligibility by:

- Accessing our website (Provider.Evernorth.com > Patients > Search Patients)
- Submitting an eligibility and benefit inquiry (270/271) through your EDI vendor

Using our automated IVR system

- Contacting a Customer Service Representative

When verifying eligibility and benefit information on the website or eligibility and benefit inquiry (270/271) through your EDI vendor, you can receive:
Eligibility status (active, inactive, non-covered)
Coverage effective and term dates
Patient insurance and plan types such as PPO, Network, or Choice Fund HRA Open Access Plus
Plan level copayment, coinsurance, deductible, and accumulator amounts
Benefit-specific copayment, coinsurance, and deductible amounts
An indicator of different benefits for in network and out of network
HMO code, network ID, line of business (018, VA085, Flex) for participants covered by managed care plans
PHS, PHS+, Health Matters-Complete and Health Matters-Preferred medical management identification
Coordination of benefits information (Medicare Part A, Medicare Part B, or other)
PCP, if one has been selected
Visit limits, including remaining visits
Benefits that are part of a tiered or client-specific network

Case Management Program

The Clinical Case Management Team works with a customer's treating health care provider to determine whether a procedure, treatment, or service meets medical necessity criteria to be certified. The process gives the provider information about what the customer's coverage is for the procedure, treatment, or service. We work to focus on the whole person so that we may have the greatest positive impact on the clinical outcome ensuring, through utilization management activities, that continued authorization is based on the appropriateness of care provided. Our Case Management process includes close collaboration with our Triage Clinicians, Care Coordinators, and Personal Advocates, who are all an important part of the customer's care.

Our philosophy is to marshal resources and to advocate for participants, with a goal of returning them to the highest possible level of functioning as soon as clinically indicated. Designated Case Management interventions are designed to add value to each case. The Case Manager's ability to manage each case with varying levels of appropriate clinical intensity is one of our greatest strengths.

Precertification protocol

Our precertification program helps you determine if your patient's care will be covered under their benefit plan.

In an effort to support accurate coverage determinations and access to quality care for plan participants, we continually review our precertification process and requirements. Our Coverage Policy Unit is responsible for reviewing and updating our internal clinical guidelines, as well as updating externally developed guidelines. We may make additional changes to the precertification requirements, as needed.

Utilization management – responsibility for precertification

To accomplish these goals, we require that providers obtain precertification for services prior to performing the service for patients whose benefit plans require precertification. For quick reference, providers can review the Billing and Authorization Resource; however, this does not replace checking a participant's eligibility and benefit.

Precertification of coverage determinations is based upon the patient's eligibility, the specific terms of the applicable benefit plan, internal or external clinical coverage guidelines, and the patient's particular circumstances. Failure to obtain precertification may result in nonpayment.

Utilization management – precertification for admissions

We require precertification for all inpatient and residential admissions for all of our utilization management models. Partial and Intensive Outpatient Programs may require precertification depending upon the utilization management model. For your reference, please review the coverage policies, as well as the medical necessity criteria, which can be found at Provider.Evernorth.com > Resources > Coverage Policies.

We review certain level of care to establish medical necessity, confirm that the proposed length of stay is appropriate, and determine if the requested services are covered benefits.

The following information is typically required for precertification:

- Participant name and ID number
- Participant date of birth
- Diagnosis including International Classification of Disease, Tenth Revision, Clinical Modification (ICD-10-CM)
- Requesting or referring provider
- Servicing provider, vendor, or facility
- Pertinent medical history and justification for service
- Date of admission or start date
- Anticipated length of stay for facility stays
- Date of request
- Additional insurance coverage (if applicable)
- Place of service and level of care (inpatient and outpatient)
- Preliminary discharge plan such as next level of care or provider

Emergency admissions

If the acuity of the participant's condition does not allow for precertification of coverage, contact Evernorth Behavioral Health as soon as possible. Please be prepared to provide the following information to the Evernorth Behavioral Health staff:

- Participant's name, age, and participant ID number
- History, diagnosis, indications, and nature of the immediate crisis
- Alternative treatment provided or considered
- Treatment goals, estimated length of stay, and discharge plans

If the clinical indicators for hospitalization are unclear based on prudent layperson guidelines, the MCG Behavioral Health Guidelines, the Level of Care Utilization System (LOCUS) criteria for ages 18+, the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) criteria, or the American Society of Addiction Medicine (ASAM) Criteria®, staff may request additional information or consult a Physician Reviewer, or send the clinical indicators to a Physician Reviewer for review with the facility or provider. If coverage for hospitalization is then authorized, the staff can assist with facilitiating the admission, or if the customer has already been admitted, a Case Manager will conduct regular, ongoing reviews with the facility staff.

Extenuating circumstances

Extenuating circumstances are factors beyond the control of the rendering provider or facility that make it impractical to obtain or validate the existence of a precertification of coverage prior to rendering the service (e.g., natural disaster or incorrect insurance information). When a request for precertification is received retrospectively due to extenuating circumstances, the provider or facility must submit appropriate medical records, supporting information, and an explanation of the extraordinary circumstances for the retrospective medical necessity review that were responsible for the delay or failure to obtain a precertification.

For example, in circumstances where the patient submitted the wrong insurance information, the provider or facility should submit documentation that shows the patient submitted the wrong insurance information (e.g., a copy of the patient's insurance card, note in office records). The denial decision will be upheld if the provider or facility only submits a medical record and not the explanation.

As a reminder, under the terms of your Provider Agreement, you cannot bill plan participants for covered services that are denied due to failure to obtain precertification.

General considerations – precertification

Precertification is neither a guarantee of payment nor a guarantee that billed codes will not be considered incidental or mutually exclusive to other billed services. Coverage is subject to the terms of a participant's benefit plan and eligibility on the date of service. For Quick reference, a provider can review the Billing and Authorization Resource.

We (or our designees) make coverage determinations in accordance with the time frames required under applicable law. You must supply all information requested within the time frames specified for us to make a precertification determination. Failure to provide information within the time frames requested may result in non-payment.

If a precertification request is approved, a precertification authorization number is assigned.

Our Coverage Policy Unit is responsible for the development of internal clinical guidelines, as well as for the proper use of externally developed guidelines (e.g., MCG Behavioral Health Guidelines, LOCUS/CALOCUS-CASII criteria, The ASAM Criteria). Our utilization management staff or delegates use these guidelines to assess the medical necessity of a treatment or procedure, determine coverage for an appropriate inpatient length of stay, or make other clinically based coverage decisions.

Coverage for services is reviewed on a case-by-case basis. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the individual's benefit plan document – a group service agreement, evidence of coverage, certificate of coverage, summary plan description (SPD), or similar document.

However, to facilitate accurate and consistent coverage determinations, we maintain certain collateral source information and product-specific tools that aid our staff in applying the terms of a benefit plan document to a particular benefit request.

Copies of the clinical coverage guidelines and other resources used in making coverage determinations are available at Provider.Evernorth.com.

Retrospective precertification of inpatient services

Evernorth Behavioral Health, or our delegate, may consider retrospective precertification requests for our standard book of business. Some business segments may allow additional time. Requests beyond 15 business days will be managed by a care manager for more detailed assessment and coverage decision.

Provider offices are encouraged to supply as much information as possible when requesting a retrospective precertification request so we can perform a thorough review.

Utilization management (continued stay review)

Under our inpatient case management (continued stay review) program, we (or our designee's clinicians or medical directors) review coverage for a patient's hospital stay and help facilitate discharge planning and post-hospitalization follow-up. As part of this, you are required to provide us (or our designee) access to certain information, including but not limited to:

- Relevant demographics and history
- Precipitants/stressors
- Baseline functioning
- Assessment of symptoms/current presentation
- Treatment plan and barriers
- Interventions and progress, or lack of progress
- Discharge planning documentation

Outpatient services

Typically routine outpatient services do not require precertification; however, it is always recommended to check a participant's specific plan. There are some services that could require precertification.

Retrospective precertification of outpatient services

For outpatient levels of care that may require precertification, such as intensive outpatient (IOP) care, transcranial magnetic stimulation (TMS), and partial hospitalization program (PHP), a delay in request more than 15 business days past the admission date or first uncovered date may result in a retrospective review and could delay the determination for up to 30 days.

For Applied Behavior Analysis (ABA) services, we encourage providers and clinics to request authorizations up to 30 days in advance of or two weeks after the initial date of service.

Autism spectrum disorder and applied behavior analysis

Precertification is typically required for the assessment and treatment of applied behavior analysis (ABA). If you are treating a participant with autism spectrum disorder, please call the number on back of the participant's ID card to confirm eligibility and benefits. Benefit coverage for autism spectrum disorder and ABA varies by benefit plan and state mandates. In most cases, your request will be referred to the Autism Coaching and Support Team for discussion of a customized treatment plan. To learn more about our autism team and how to make a request for ABA services, refer to our Autism Information and Resources page. Please refer to your Participating Provider Agreement, Exhibit A for your fee schedule and a listing of autism spectrum disorder-related services eligible for reimbursement. Please refer to Appendix F for information about Evernorth Behavioral Health's Specialty Networks, including autism assessment and treatment.

Note: Please see section above about the importance of filing timely authorization requests.

Testing

Generally, clinical review for psychological/neuropsychological testing for covered diagnoses will not be required. There may be certain situations where a review will be required such as for a specific customer/account benefit plan. Testing related to custody evaluations, rehabilitation, vocational counseling, or school evaluations are generally not covered. Prior to rendering services, please call the number on back of your patient's ID card to confirm benefits and eligibility.

Buprenorphine treatment

Buprenorphine treatment is a modality for outpatient office-based medication-assisted treatment (MAT) of opioid use disorders. We have Evernorth Case Managers that are able to partner with individuals on MAT to enhance adherence to this treatment. Evernorth Behavioral Health considers outpatient opioid treatment with buprenorphine to be potentially eligible for benefit. Both the induction phase of treatment and ongoing medication management are considered to be routine services and do not typically require prior authorization by Evernorth Behavioral Health.

Evernorth Behavioral Health's compensation

Evernorth Behavioral Health compensates providers in a manner intended to emphasize preventive care, promote quality of care, and assure the most appropriate use of health care services. Evernorth Behavioral Health reinforces this philosophy through utilization management decisions by its Medical Directors, Physician Advisors, and Case Management staff. Evernorth Behavioral Health employees are encouraged to promote appropriate utilization rather than under-utilization of health care services. The same criterion applies for staff eligible to receive additional payments based on their performance. Evernorth Behavioral Health employees and consultants receive no financial incentives or rewards to deny coverage of medically necessary care. Evernorth Behavioral Health offers no incentives for utilization management decision-makers for underutilization of care.

Coverage denials

For clinical cases under review resulting in an adverse determination (coverage denial) following the peer-to-peer review, a review of the decision is available with a physician not previously involved in the case. The appeal review is with an Evernorth Behavioral Health-contracted, board certified psychiatrist or doctoral-level psychologist, and may be done on an expedited basis, if the situation is deemed urgent and the participant is still in that level of care, or on a standard basis, where more information such as the medical record or a summary of treatment may be made available. An appeal must be submitted within 180 calendar days from the claim denial unless determined otherwise by plan or state regulation.

A participant, the participant's delegate, or provider on behalf of a participant, who is dissatisfied with the outcome of the appeals determination, may file an appeal by following the health plan's, or, in some instances, the state's, external appeals process. Many states offer an expedited process if the participant feels the situation is urgent and the participant is still in that level of care. The Case Manager assigned to the case is able to provide information regarding the extent of appeals available.

All appeals are reviewed and determinations made by board certified psychiatrists or

board certified PhD-level psychologists. If an appeal subsequently overturns an earlier decision, Evernorth Behavioral Health will implement the appeal decision or process the authorization or claim for payment of services. Decisions are communicated in writing with all adverse determinations and contain the following information:

- The specific guideline on which the determination is based, including the MCG Behavioral Health Guidelines, LOCUS/CALOCUS-CASII criteria, The ASAM Criteria, or the plan coverage policy;
- The facts and evidence considered; and
- The clinical rationale for the determination

Appeals of coverage denials

A first-level appeal must be submitted within 180 calendar days from the claim denial. A second-level appeal review may be available to the participant, the participant's delegate, or practitioner on behalf of the participant, in those instances when the denial is upheld at first-level appeal. For health plan participants, the standard appeal is filed through the health plan's Appeals Committee. For non-health plan participants, the appeal is filed through the Evernorth Behavioral Health Central Appeals Unit. It is important to note that Appeals Committees are for the purpose of resolving participant issues. Payment disputes where the participant is held harmless are not eligible for review by the Appeals Committee, unless the practitioner, with a participant's written authorization, requests an appeal on behalf of a participant. A second-level appeal must be submitted within 60 days from the receipt of the first-level appeal decision letter. Any appeals time line required by applicable state law shall take precedence over the timelines contained herein.

Administrative denial and appeal

Administrative denials may be issued for a number of reasons, including exhausted benefits for continued stay requests only, services not covered under the participant's benefit plan, lack of precertification or prior authorization for services, /or benefits exhausted for the contract year. Participants, or providers on behalf of participants, are entitled to appeal administrative denials.

The appeal review of an administrative denial occurs at Evernorth Behavioral Health by a Central Appeals Unit Appeals Coordinator. Appeals options can be discussed with Case Management staff and/or calling Provider Services at 800.926.2273 to be connected to the Central Appeals Unit.

Pass-through billing

Please note: Services billed as pass-through billing are not reimbursable as Covered Services. Pass-through billing occurs when an entity bills for a service that is not actually performed by that billing entity. These tests may not be billed to Evernorth Behavioral Health or any Evernorth Behavioral Health affiliate, payer affiliate, payer, or participant.

Coaching and support programs

Evernorth Behavioral Health offers Coaching and Support (C&S) programs to help individuals initiate and engage in behavioral treatment.

The six programs are C&S-Substance Use, C&S-Opioid and Pain Management, C&S-Autism, C&S-Parent and Families, C&S-Eating Disorder, and C&S-Intensive Behavioral Case Management.

Evernorth Behavioral Health Case Managers, specially trained in coaching individuals with mental health and substance use disorders, utilize a motivational interviewing approach focused on decreasing both internal and external barriers that may be preventing the individual from initiating or engaging in treatment or recovery activities. This approach allows each program to meet the individual's unique needs.

In addition, a unique program we offer is Changing Lives by Integrating Mind & Body (CLIMB). This program provides individual and group coaching services to participants who are struggling to cope when living with a chronic physical or emotional condition. The program uses a cognitive behavioral approach based on identifying and improving thinking patterns that cause unhealthy behavior and negative emotions.

Eligibility for The C&S programs or CLIMB will be dependent upon a participant's plan.

Claims and compensation

Timely and accurate reimbursement is important to you and us. We have a number of customer service and claim centers throughout the country responsible for processing claims. For some participants, a third party, in accordance with Evernorth Behavioral Health standards, may provide claim processing. The customer service phone number and claim center mailing address are displayed on your patient's ID card. Check the ID card at each visit for the most current information.

Claim submission

You can help improve claim processing accuracy and timeliness by following Evernorth Behavioral Health guidelines. Be consistent with your demographic information when identifying yourself in claim submissions. If you need to change the way you submit claims, refer to the Demographic information and directory section of this guide. Using abbreviations, putting last name first and first name last or variations of names, or doing business as (DBA) names with combinations of your licensure numbers, NPIs, and TINs not listed in the your agreement can delay or result in incorrect claim payments. Notify Evernorth Behavioral Health in advance of changes to your information.

Evernorth Behavioral Health requires all claims to be submitted for processing including, but not limited to, claims paid in full at the time of service and non-covered services. This information is used for program and reporting purposes.

We strongly encourage you to submit your claims electronically.

Electronic claim submission

Submitting claims electronically can help you save time, money, and improve claim processing accuracy.

Submitting claims electronically can help you to:

- Send primary and secondary]COB claims quickly, reduce paperwork, and eliminate printing and mailing expenses
- Decrease the chance of transcription errors or missing data
- Track claims received electronically, which are automatically archived before processing
- Eliminate the need to submit claims to multiple locations
- Save time on resubmissions – incomplete or invalid claims can be reviewed and corrected online
- Receive confirmation that the plan accepted your claim, or a claim rejection notification

Payer IDs for submitting electronic claims

Payer ID	Claim type
62308*	Medical, behavioral (including employee assistance program), dental, and Cigna Medicare Advantage

*Both primary and secondary (COB) claims can be submitted electronically to plan.

You don't have to submit Medicare Part A and B coordination of benefits agreement (COBA) claims to the plan, as the Medicare explanation of benefit (EOB) or ERA will show that those claims submitted to Medicare are forwarded to the plan as the secondary payer.

Paper claim submission

We strongly encourage you to submit claims electronically to save time and money. However, if you need to file a paper claim, use one of these claim forms:

Use the UB-04 claim form if:	Use the CMS-1500 claim form if:
• You are contracted as a facility on an Institutional Agreement • You are contracted on an Ancillary Agreement and have a per-diem-based fee schedule • You are contracted on a Clinic Services Agreement	• You are contracted on a Provider Services Agreement • You are contracted on an ancillary agreement and have a CPT fee schedule

In instances where you must submit a paper claim, the plan will scan, sort, and store the claim electronically to reduce manual keying errors and improve response time. Follow these guidelines when completing and submitting paper claims:

- If using a super bill or form other than a UB-04 or CMS-1500, the form must have the same information fields listed in the "Definition of a Complete Claim" section below
- Include your NPI on the claim
- Make sure all appropriate claim form fields are completed; use black ink when handwriting information
- Refer to the patient's ID card for the correct claim submission address
- Include the patient's ID number on all claim attachments and correspondence
- The form should be typed or printed clearly; cursive writing is not recommended

If submitting a replacement or corrected claim, please do not stamp "Corrected Claim" on the claim form. Corrected claims should follow the NUBC Guidelines, which are listed below:

- **CMS-1500**: Field 22 should include a '7' or '8' to indicate a replacement or voided claim
- **UB-04**: The Claim Frequency Type Code should be submitted with a '7' or '8' in Form Locator 4, as well, as the tracking number

Definition of a complete claim

A complete CMS-1500 claim includes the following information.
Please note: all text in red is required.

Professional/ CMS-1500		
1. Type of insurance plan		1a. Patient ID number
2. Patient first and last name	3. Patient date of birth	4. Policyholder first and last name

5. Patient street address		6. Patient relationship to policyholder			7. Policyholder street address				
Patient city	Patient state code	8.			Policyholder city	Policyholder state code			
Patient ZIP code	Patient phone number				Policyholder ZIP code	Policyholder phone number			
9. Other insurance name		10. Type of claim a. Employment? b. Auto accident? c. Other accident?			11. Group number				
9a. Other insurance ID					11a. Policyholder date of birth				
9b.					11b.				
9c.					11c.				
9d.		10d.			11d. Is there another insurance plan?				
12. Release of information *Authorizes release of information necessary to process the claim*					13. Assignment of benefits ***INN*** *– Signed or Unsigned: Contract states we must pay the provider* ***OON*** *– Unsigned: Payment made to policyholder/member* ***OON*** *– Signed: Payment made to the provider*				
14.		15.			16.				
17.					18.				
19. Special handling notes					20.				
21. Diagnosis codes					22.				
					23. Authorization number				
24a. Dates of service	24b. Place of service	24c.	24d. CPT or HCPC code and modifier	24e. Diagnosis pointer	24f. Charge	24g. Units	24h.	24i.	24j. Rendering provider NPI
Service line 1									

Service line 2									
Service line 3									
Service line 4									
Service line 5									
Service line 6									

25. Tax ID or SSN	26.	27.	28. Total charge	29.	30.
31. Rendering provider name and license type	32. Service address		33. Billing name and address		
	32a.	32b.	33a. Billing provider NPI	33b.	

Institutional/Facility/UB

1. Service address	2. Billing name and address	3a.		4. Type of bill	
		3b.			
		5. Tax ID	6. Date range on claim	7.	
8a. Patient first and last name	9a. Patient address				
8b.	9b.		9c.	9d.	9e.

10. Patient date of birth	11. Sex	12. Admission information					
31.	32.	33.	34.	35.	36.	37.	
38.				39.	40.	41.	

42. REV code	43. Service description	44. CPT/HCPC code	45. Date of service	46. Units	47. Charge	48.	49.
Service line 1							
Service line 2							
Service line 3							
Service line 4							
Service line 5							
Service line 6							
					Total charge		

50.	51.	52. Relationship to policy holder	53. Assignment of benefits	54.	55.	56. Facility NPI
						57.

58. Policy holder first and last name	59.	60. Patient ID number	61.	62. Group number

63. Authorization number	64.	65.

66. Diagnosis codes	68.

69. Admitting diagnosis code (ER claims only)	70.	71.	72.	73.

74.	74a.	74b.	75.	76. Attending MD name and NPI

74c.	74d.	74e.		77.
80.	81.			78.
				79.

Supplemental claim information

Sometimes it is necessary to include additional information to support a claim or make a benefit determination. Supplemental documentation should be included or sent as soon as possible after requested to avoid delays in claim processing.

Requests for supplemental claim information are sent to the address we have on file for you in our demographic databases, which could potentially be lock boxes for claim payments. Please make sure we have the most current and correct mailing address for you in our database so you receive supplemental claim information, requests, and other correspondence from us in a timely manner.

The table below shows a sample of claim categories that require supplemental information. A complete, up-to-date listing is available at Provider.Evernorth.com > Resources > Clinical Reimbursement Policies and Payment Policies > Claim Policies and Procedures > Clean Claim Requirements. (The requirement to provide supplemental claim information is subject to applicable law and, in the event of a conflict, applicable law will control.)

Claim category	Supplemental attachment
Anesthesia	Time must be specified
Billing Appropriateness	Itemized bill/clinical records or notes
Coordination of Benefits (COB)	Cigna/Evernorth payer ID 62308 is able to receive COB claims electronically. Please contact your vendor for information on how to submit COB claims electronically. For paper claims, provide a copy of the primary carrier's explanation of payment (EOP) when Cigna is secondary.

Claim category	Supplemental attachment
Drugs-Injectable	Healthcare Common Procedure Coding System (HCPCS) codes or National Drug Codes (NDC) When an individual's health plan requires prior authorization, the plan requires the NDC number, NDC units, NDC unit qualifier, and HCPCS code in three claim scenarios: • Not otherwise classified HCPCS codes (e.g., J3490, J3590, and J9999) • HCPCS codes with utilization management controls (e.g., J0725, J1830, and J2941) • Newly launched HCPCS codes without an average sale price

Claim filing deadline

Claims should be filed as soon as possible to promote prompt payment. The plan will only consider claims submitted within 90 days of the date of service, or as otherwise defined in your Provider Agreement and the exceptions noted below.

For services rendered on consecutive days, such as for a hospital confinement, the filing limit will be counted from the last date of service.

The following are exceptions to the 90-day time limit:

- Applicable state law provides for a longer timely filing limit in which case that time limit will apply
- Coordination of benefits (90-day filing limit is applied based on the primary carrier's processing date as stated on an explanation of benefit or payment)
- Medicare (90-day filing limit is applied based on the primary carrier's processing date as stated on an explanation of benefit or payment)
- Medicare secondary payer (three years)
- Medicaid (three years)
- Resubmission of a claim originally filed in a timely manner, returned with new or additional information as requested by Cigna (90-day filing limit is reset to the date of the Cigna request for more information)
- Services provided to participants through arrangements with third-party vendors (filing limit is applied based on third-party requirements, which may be more or less than 90 days)
- Extenuating circumstances (e.g., catastrophic events)

Claim inquiry and follow up

Providers can inquire about claim status using electronic data interchange claim status inquiry (276/277) through your EDI vendor; our website, Provider.Evernorth.com; IVR systems; or by calling the customer service number on the patient's ID card or on the EOP. When contacting Customer Service, have the following information available:

Provider name	NPI
TIN	Patient name

Patient ID	Subscriber name
Date of service	Description of service
Amount of claim	Date claim was submitted

Our website is available to providers for verifying claim status by logging in to the secure Evernorth provider website (Provider.Evernorth.com).

To learn more about connecting electronically visit Cigna.com/EDIvendors.

The claim inquiry and follow-up options listed above allow providers to access details of processed claim information 24/7.

When inquiring on the status of a claim on the website, or through your EDI vendor's claim status inquiry (276/277), you will receive:

- Status of each claim using the standard HIPAA claim status and claims status category codes
- Claim number
- Total charge and paid amounts
- Claim processed date
- Payment date, method (check or EFT) and check number
- Claim status history available for two years

By calling the number on the participant's ID card, you can either access the automated IVR system for claim status 24/7, or speak to a Customer Service Representative during normal business hours.

Claim payment policies and procedures

Claims from participating providers are subject to our claim payment policies and procedures. These policies are the guidelines adopted by us for calculating payment of claims and include our standard claim code auditing methodology, review of charges to service provided, and procedures for claim adjudication. This guide contains information about some of our payment policies. Please review the information online or call the number listed on the participant's ID card for additional questions or information.

Standard claim coding/bundling methodology

If you have questions concerning our standard claim coding, bundling methodology, payment policies, or about how specific types of billing codes will be processed, you can visit the secure Evernorth provider website at (Provider.Evernorth.com > Resources > Policies and Procedures > Claim Editing Policies and Procedures).

Participant liability collection limitations

Copayments

Copayment is a fixed dollar amount that a participant pays per service. Copayment amounts are usually printed on the participant ID card. Collect the applicable copayment amounts on the ID card at the time of service.

Coinsurance and deductibles

For participants with plans that have deductibles or require participants to pay a percentage of the covered charges (coinsurance) after satisfying any deductible amount, submit claims to the plan and receive an EOP indicating the participant's responsibility

before billing patients. Coinsurance and deductibles should not be collected at the time of service.

Cigna plans have access to the Cigna Cost of Care Estimator, if applicable, to obtain an estimate of the deductible and coinsurance obligations of the plan participant, and provide a copy of the estimate to the participant at the time of service.

Many Cigna Choice Fund plan participants have ACF enabled so the deductible and coinsurance amounts they owe are paid directly out of their health care account(s). After claim processing, if funds are available, Cigna automatically sends payment to you on behalf of the Cigna Choice Fund participant, usually along with Cigna's portion of the payment. ACF is currently active on the majority of our Choice Fund plan participants.

Fee forgiving/waiver of copayment/coinsurance or deductible

Most benefit plans insured or administered by a plan exclude from the participant's coverage those charges for which the participant is not obligated to pay. Therefore, if a plan participant is not obligated to pay a charge, any claim for reimbursement for any part of that charge under such a contract or benefit plan is generally not covered. It is Evernorth Behavioral Health's view that "fee-forgiving" on any particular claim, or any portion thereof, could constitute fraud and may subject a provider to civil and criminal liability.

Denied payment and participant non-liability

You cannot bill participants for Covered Services or services for which payment was denied due to your failure to comply with your Provider Agreement or these Program Requirements/Administrative Guidelines, including Evernorth Behavioral Health's utilization management requirements and timely filing requirements.

Coordination of benefits (COB)

Participants may be covered by more than one health benefit plan. In some cases, payment may be the primary responsibility of other payers. Billing multiple health benefit plans to obtain payment is called coordination of benefits (COB). You should assist the plan to maximize recoveries under COB and bill services to the responsible primary plan. After receiving a payment or denial notice from the primary plan, you should submit the COB claim electronically to the plan. However, if you submit COB claims on paper, then a copy of the primary payer explanation of payment is required.

Cigna/Evernorth payer ID 62308 is able to receive COB claims electronically; please contact your vendor for information on how to submit these claims. For more information about electronic claims, go to the Claim Submission section of this guide.

Cigna or Evernorth Behavioral Health as primary payer

When the Cigna or Evernorth Behavioral plan is primary payer, payment is made in accordance with your agreement with Evernorth Behavioral Health without regard to the secondary plan. After receiving payment from Evernorth Behavioral Health, submit the COB claim to the secondary plan.

Cigna or Evernorth Behavioral Health as secondary payer

When the Cigna or Evernorth Behavioral Health plan is a secondary payer, first submit the claim to the primary plan. After receiving a payment or denial notice from the primary

plan, submit the claim to Cigna or Evernorth Behavioral Health, along with a copy of the primary plan EOP. Paper copies are not required if you submit HIPAA-compliant COB content electronically through an EDI claims submission.

Cigna or Evernorth Behavioral Health participates in Medicare Coordination of Benefits Agreement (COBA), also known as Medicare Crossover, for individuals whose coverage is made available through Medicare Parts A and B. This eliminates the need for you to submit Medicare COB claims to the plan. The Medicare EOB or ERA will show that those claims were forwarded to Cigna or Evernorth Behavioral Health as the secondary payer.

Cigna or Evernorth Behavioral Health's payment as secondary payer, when added to the amount payable from other sources under the applicable COB rules, will be no greater than the payment for Covered Services under your Evernorth Behavioral Health Provider Agreement, and is subject to the terms and conditions of the participant's health benefit plan and applicable state and federal law. Use of applicable COB provisions may result in a payment from Cigna or Evernorth Behavioral Health, when added to the amount payable from other sources, which is less than 100 percent of your payment for Covered Services under your Evernorth Behavioral Health Provider Agreement.

When Medicare is the primary payer and the Cigna or Evernorth Behavioral Health administered plan is the secondary payer, applicable Medicare billing rules (including Medicare COB rules) will apply to your reimbursement. The financial responsibility of the Cigna or Evernorth Behavioral Health administered plan as a secondary payer under Medicare COB rules is limited to the participant's financial liability (e.g., the applicable Medicare copayment, coinsurance, or deductible) after application of the Medicare-approved amount. The Medicare payment plus the participant liability (applicable Medicare copayment, coinsurance, or deductible) amounts constitutes payment in full, and you are prohibited from collecting any monies in excess of this amount.

Order of benefit determination

All plans follows the National Association of Insurance Commissioners (NAIC) guidelines about the industry standard of order of benefit determination subject to applicable law and the terms of the benefit plan.

Determining primacy on a participant/spouse

The plan that covers a person as an employee, subscriber, or retiree is always considered the primary payer over a plan that covers the person as a spouse or dependent. If a plan subscriber has two employers and has group health insurance coverage through both, the plan for the subscriber who has worked longer for the company is considered primary.

If a person has coverage under a state or federal continuation plan and is covered under another group health insurance plan, the plan covering the person as an employee, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary.

Determining primacy on a dependent child

Dependent children of parents who are married and living together follow the “birthday rule.” The plan of the parent whose birthday falls earlier in the calendar year is primary to the plan of the parent whose birthday falls later in the year. Only the month and day of birth are relevant; birth year is not taken into consideration. If both parents have the same birthday, the parent with the plan that has been in effect longer is primary.

Dependent children of parents who are divorced, separated, or not living together follow the “custodial rule.” If a court decree states that one of the parents is responsible for the dependent child’s health care coverage, that parent’s plan is primary, followed by the plan of the other parent. If a court decree awards joint custody without specifying which parent is liable for providing health insurance coverage, the birthday rule is followed.

If there is no court decree allocating responsibility for the dependent’s health coverage, the order of benefit determination under the custodial rule is as follows:

1. The plan of the custodial parent
2. The plan of the custodial parent’s spouse, if applicable
3. The plan of the non-custodial parent
4. The plan of the non-custodial parent’s spouse, if applicable

Determining primacy with Medicare

For Medicare beneficiaries, the order of benefit determination is determined by federal law or regulation, which may differ from the rules described above. The group health plan that covers Medicare beneficiaries, age 65 or older, through active employment (theirs or that of their spouse), and where the employer has 20 or more employees is the primary payer. The group health plan that covers Medicare beneficiaries, under age 65, through active employment, and where the employer has 100 or more employees is the primary payer.

The group health plan is primary for Medicare beneficiaries who have end-stage renal disease (ESRD) during the first 30 months of their Medicare eligibility.

Workers’ compensation

Providers must submit a potential workers’ compensation claim to the applicable workers’ compensation carrier for review before submitting the claim to us. If the workers’ compensation carrier denies the claim, a copy of the denial must be included with the claim submission to us. If the workers’ compensation denial is not received with the claim, payment for services will be denied unless state law specifically prohibits a denial on these grounds.

Part of the post-review process may include a plan vendor contacting the patient for information about the case. If it is determined that we have made a medical payment on a valid workers’ compensation case, we will require a full refund. The plan vendor will provide information about that process. In this case, you should then resubmit the claim to the workers’ compensation carrier responsible for payment.

Subrogation and reimbursement requirements

Subrogation may apply if a patient is injured in an accident of any type, and someone else is responsible for the injury. If you treat a patient with a subrogation claim, your

contract, as well as these Administrative Guidelines and Program Requirements, will apply to the same extent that they apply to any other participant. Appropriate authorizations must be obtained to help ensure payment. Additionally, please note that claims should be submitted to us.

Other billing guidelines

Overpayment recovery

When an overpayment has been identified, the plan will obtain a refund in one of two ways:

1. **Offsetting payments from future claims:**
   In states where applicable, when the plan identifies that an overpayment has been made on a participant's claim, the payment will be reversed, leaving a negative balance in the provider's account. Providers are requested to repay overpayments directly to the plan as outlined in the overpayment notice sent once the overpayment is identified. Based on banking arrangements for specific clients, as well as state mandates, some claims may offset prior to the plan receiving the requested refund. When this occurs, any refund received from the provider is returned to the provider with a letter explaining the offset. Until overpayment is resolved, payment on additional claims may be suspended. For inquiries about the overpayment process, please call the number on the participant's insurance card. For ASO accounts and states that allow offset: If the overpayment on the provider's file has not offset within thirty (30) days, an overpayment letter is sent to the provider requesting the refund. If the plan does not receive the refund within 60 days, a second refund request letter is sent advising that if the plan does not receive the refund within the next 30 days, a third notice will be sent. If the refund is not received within the next 30 days, the plan will again attempt to deduct (offset) the negative balance from future payments to be made to the provider. If at any time we receive the refund from the provider and the overpayment has already been offset, the plan will return the check to the provider with a letter advising that the overpayment has been offset.
2. **Requesting a refund from the provider who rendered the services:**
   Not all overpayments can be set up to offset; therefore, you may be advised when an overpayment has been identified and will be expected to promptly refund any overpaid amount to the address enclosed in the refund request. Our standard recovery method is by refund check. Failure to comply with recovery efforts may result in the plan initiating the dispute resolution process set forth in your participating agreement. We reserve the right to reduce future reimbursement amounts to recover previous overpayments subject to all statutory and contractual requirements. If a provider identifies an overpayment, an unsolicited refund can be sent back to the plan via the address on the EOP

Explanation of payment

The plan explanation of payment (EOP) itemizes the services processed or considered for payment. We use standard format for payment explanations, combining the check and claim detail information. The information necessary to reconcile a patient’s account

with the plan payment is provided in a single document. This consolidated format is called the “Check/EOP.”

You must be a registered user of our website to access this information. Register by going to Provider.Evernorth.com, and clicking **“**Register**.”** You will also need to have the ‘Remittance reports’ entitlement.

Explanation of benefits and explanation of payment

An explanation of benefits (EOB) or explanation of payment (EOP) accompanies all claims payments. The EOB and EOP itemize payment information such as copayments, deductibles, patient responsibility amounts, contracted discounts, payment amounts, and date(s) of service. The payment will be attached at the bottom of the EOB/EOP.

Electronic funds transfer

Cigna and Evernorth offer electronic funds transfer (EFT) and electronic remittance advice (ERA). By enrolling in EFT and ERA together, you can access your funds and complete your accounts receivable posting faster.

EFT is Cigna and Evernorth's standard payment method. Electronic funds transfer (EFT) is our preferred payment method for provider reimbursement.

EFT is a secure, direct deposit into your bank account. It is a proven method for securely receiving your claim fee-for-service and capitated payments.

Reimbursement payments are available the same day the direct deposit is electronically transferred to your bank account. Access a calendar for payment dates by visiting Provider.Evernorth.com > Resources > Clinical Reimbursement Policies and Payment Policies > Reimbursement > Electronic Funds Transfer.

What are the benefits of EFT?

- Eliminate paper check mail delivery and handling
- Access funds on the same day of the deposit
- Increase efficiency and improve cash flow
- Easily reconcile payments using a single remittance tracking number
- View a separate remittance report online for each deposit, which shows the:
  - Deposit transaction
  - Details about the claims processed
  - Payments included in that fund transfer
- To view remittance reports for each deposit on the Evernorth provider website (Provider.Evernorth.com):
  - If you are already registered for the website and have access to claims status inquiry, you automatically have access to online remittance reports.
  - Primary Administrators: If you have staff that need access to online remittance reports, log in to Provider.Evernorth.com > Working With Cigna > Assign Access > Modify Existing Users/Add New Users.
  - If you are not yet registered for the website, visit Provider.Evernorth.com and click **“**Register**.”** Once you complete the registration information and it has been validated, you can access your remittance reports online. For step-by-step registration directions, go to Provider.Evernorth.com and click “How to register for access.”

To access your remittance reports, log in to Provider.Evernorth.com > Remittance Reports.

- The remittance report shows the deposit transaction, details the claims processed, and payments included in that fund transfer.
- For step-by-step instructions how access your remittance reports, go to Provider.Evernorth.com > Resources > eCourses > Electronic Funds Transfer and Online Remittance Reports,

Payment bulking options

Choose between two options to receive your payments:

- Taxpayer Identification Number (TIN) and payment address - By electing TIN bulking, all claims will be grouped into a single payment based on TIN and payment address, or
- National Provider Identifier (NPI) - By electing NPI bulking, all claims will be grouped into a single payment for each “Billing Provider” NPI from the submitted claim
  - The ERA or remittance report will be bulked by TIN or NPI, depending on your payment bulking preference with your EDI vendor
  - You can elect a separate bank account for each “Billing Provider” NPI

Enrolling in EFT for Cigna plans

Currently, we are only offering EFT for those participants with a Cigna Healthcare plan; customers with a different plan that utilize the Evernorth Behavioral Health Network are not eligible for EFT at this time.

For those with a Cigna plan:

You can enroll in EFT by logging in to Provider.Evernorth.com > Working with Cigna > Enroll in Electronic Funds Transfer (EFT) Options and following these steps:

1. Complete the electronic enrollment form
2. Cigna sends a “pre-note” transaction to your bank to verify all the banking information is correct:
   - If the pre-note is not returned to Cigna, you begin receiving EFT on your next payment cycle
   - If the pre-note is returned with errors, Cigna contacts you to obtain correct banking information

To check the status of your EFT application, log in to Provider.Evernorth.com > Working with Cigna > Manage EFT Settings

EFT enrollment guidelines

- For savings account deposits, verify that your bank will support EFT.
- The enrollment process typically takes four to six weeks.
- If you use more than one TIN, you must complete a separate enrollment for each TIN.

- To have your payments bulked or grouped based on your billing NPI from the submitted claim, visit Provider.Evernorth.com > Working With Cigna > Manage EFT Settings and update your payment bulking preferences.
- If your TIN, NPI, billing address, or bank account changes, you must submit a change request by logging in to the Evernorth provider website .Provider.Evernorth.com > Working With Cigna > Manage EFT Settings.
- To check the status of your EFT enrollment, visit Provider.Evernorth.com > Working With Cigna > Manage EFT Settings > view Enrollment/Update Status, or email providerdirectdeposit@Cigna.com and include your TIN in the message.

Electronic remittance advice (ERA)

To help reduce your payment cycle, Cigna and Evernorth offer electronic remittance (ERA), or the 835. ERA is the HIPAA-compliant detailed explanation of how a submitted health care claim was processed. The ERA may be automatically loaded into your accounts receivable system, which can help:

- Reduce costs and save time
- Reduce posting errors
- Shorten the payment cycle

Cigna and Evernorth provide the information needed to reconcile your payments on the ERA:

- The patient account number you submitted on the claim
- The charge amount, paid amount, and patient responsibility for the claim
- The charge amount and paid amount for each service line, except for claims that may be paid at a claim level (e.g., diagnosis-related group [DRG] claims)
- The amount and explanation of adjustments between the charged amount and the paid amount
- The allowed amount for each service line
- Adjustments not related to a specific claim (e.g., late payment interest or refund acknowledgments)
- The Billing NPI submitted on your claim(s) is included in the Provider Summary (TS3) field to help you easily reconcile your payment

To enroll for ERA

- Notify your EDI vendor that you would like to enroll for Cigna and Evernorth ERA.
- Provide enrollment information as instructed by your EDI vendor (if you use more than one TIN, complete separate enrollment information for each TIN).
- Your EDI vendor will send the completed enrollment information to Cigna for processing; Cigna will finalize your registration within 10 business days of receiving it.
- You may begin receiving ERAs on your next payment cycle.

For information about our EDI vendors and the transactions they support, visit Cigna.com/EDI vendors.

Posting payments and adjustments

In addition to posting applicable payments, you are required to make contractual adjustments to reconcile a patient's account based upon the contractual or negotiated

rate, and as noted on the EOP. Contractual adjustments are reflected on the EOP, ERA or other plan remittance or payment statement.

Applicable rate

The rates detailed in your Provider Agreement extend to services performed on a participant, including services covered under the participant's in-network benefits.

For facilities, if a service that is covered is not listed in the Agreement, the default rate will apply. The default rate should only be a temporary solution while the Agreement is being amended to apply to that location.

If medical necessity is required and services have been denied, a provider can utilize the Self-Pay Agreement at the time of the denial. As a contracted provider, it is our expectation that the rate for the service be the same as if the care was approved. However, if it is a service that is not covered, the provider may charge their billed charge, but again as a contracted provider, the expectation is that your rate for this service be aligned with the contracted rates.

Rates and changes to coverage

For facilities only

If a participant with coverage is an inpatient when their coverage status changes, the hospital's reimbursement for Covered Services will be prorated based on the total number of days of the entire length of stay that the patient had plan coverage.

Claim quality and cost-effectiveness programs

We manage claims and perform reviews through various quality and cost-focused programs. These programs continue to provide quality results that can help improve both cost-effectiveness and our customers' experience.

Clinical Claim Review Program

The Clinical Claim Review Program evaluates claims for accuracy and appropriateness before a benefit payment determination is made. As part of this program, an experienced team of professionals, including nurses and physicians, reviews billing and coding to confirm accurate reporting, examines submitted documentation, reviews submitted claims against applicable coverage, payment and reimbursement policies, and verifies coverage for services under the terms of the participant's benefit plan.

Resolving payment questions

You can take these steps prior to providing non-emergency treatment or services to a plan participant as well as prior to submitting the claim for reimbursement to help avoid unnecessary claim processing delays or denials and minimize the need to pursue the dispute resolution process.

Prior to providing services

- Log in to the secure Evernorth provider website (Provider.Evernorth.com).
  - Verify benefits for the participant
  - Confirm the CPT or Revenue Code, and that the level of care is covered under the plan
  - Review plan's Coverage Policies
  - Determine if precertification is required for outpatient services and if it is, obtain precertification through the same website
- Call Customer Service at the toll-free number on the patient's ID card.

Prior to filing a claim

- Ensure either your billing staff or vendor includes all critical information needed for the claim to be expeditiously processed. Items to include are:
  - Patient name, date of birth, address, gender, and age
  - Health benefits identification number on your patient's ID card
  - Itemized bill
  - Description of the treatment or service (CPT or HCPCS code)
  - Diagnosis code
  - Specific charge for each service
  - Anesthesia time in hours and minutes
  - Medicare or other insurance EOB, if the plan is the secondary carrier
  - Rendering provider name, address, TIN, and NPI (if applicable)
  - If billing an unlisted procedure code, a description of the service must be included as well as any clinical notes to support the need for the unlisted code. Both items will expedite the processing of the claim.
- Include the modifier on the claim if it is needed to describe the service performed. If billing telehealth services, please use the following guidance:
  - Modifier **95** in Field 24-D to specify telehealth
  - 02 in Place of Service in Field 24-B

When you receive the EOP or ERA, review it carefully to understand plan's reimbursement decisions. If you do not understand the reasons provided on the EOP or ERA, or the decision is different from what was expected, please call the Customer Service number on back of your patient's ID card.

If it is determined that the plan made a claim processing error, Customer Service will send the claim for correction and no additional action is required by you.

If it is determined that there was an omission or incorrect information was submitted on the claim (e.g., missing field or missing modifier), you will be asked to submit a corrected claim to the address on the participant's ID card. Include "Corrected Claim" on the re-submission. The claim will be re-evaluated with this new information.

Dispute resolution

Provider payment appeals

Unless your participation agreement or state law provides for a different process, the processes in this section apply whenever you have a dispute with the plan about a payment, including disputes over the amount that you believe you should have been paid and if you think you were not paid in a timely manner.

Before you start the appeals process described below, please call Provider Services at 800.926.2273 to try to resolve the issue first. Many issues can quickly be resolved by providing requested or additional information.

Before calling Provider Services, please review the claim and your Evernorth Behavioral Health Provider Agreement to confirm there is an issue. If you still have a question about the plan's reimbursement decision, you may call Provider Services. Please have the information submitted with the claim available when you call: participant's name, date of service, treating provider's name, and the TIN.

If Provider Services states the claim has been processed correctly, but you disagree, your next step could be to file an appeal with the Plan (or one of our delegates as noted below). Fee schedule or reimbursement terms for multiple patients do not require individual appeals.

Our appeal process is initiated through a written request. This appeal process aims to resolve contractual disputes about post-service payment denials (or partial denials) and other payment disputes. If the issue is not resolved to the provider's satisfaction, you may request dispute resolution, including arbitration, as the final resolution step.

Disputes between the parties arising with respect to the performance or interpretation of the Evernorth Behavioral Provider Agreement will first be resolved in accordance with the applicable internal dispute resolution (appeals) process outlined in the Administrative Guidelines. If the dispute is not resolved through that process, follow the dispute resolution provisions in your Provider Agreement. The standard dispute resolution process provides that either party may request, in writing, that the parties attempt in good faith to resolve the dispute promptly by negotiation between designated representatives of the parties who have authority to settle the dispute. If the matter is not resolved within 60 days of a party's written request for negotiation, either party may initiate arbitration by providing written notice to the other party.

Unless applicable state law provides otherwise, you may not institute arbitration until the provider has completed the internal appeals process.

Appeals

All appeals are to be initiated in writing within (180 calendar days of the date of the initial payment or denial decision. If the appeal relates to a payment that the Plan adjusted, the appeal is to be initiated within 180 calendar days from the date of the last payment adjustment.

For additional information on how to submit an appeal, review and follow the Claim Adjustment & Appeals Guidelines on the secure Evernorth provider website

(Provider.Evernorth.com > Resources > Reimbursement and Payment Policies > Claim Appeals Policies and Procedures > Appeal Policy and Procedures).

Providers should submit appeal requests using the reconsideration feature on the Evernorth provider website (Provider.Evernorth.com).

Appeal types and filing instructions

Contract, fee schedule, and multiple patients disputes

Fee schedule adjustments and reimbursement disputes may not require individual appeals. They may be **quickly** resolved through submitting an adjustment request via the reconsideration request on Provider.Evernorth.com.

Failure to obtain precertification when required

If the reason on the EOP or ERA was related to failure to obtain precertification, please provide the following in the appeal request (either the Request for Provider Payment Review Form or appeal request letter):

- Clinical documentation and medical records
- Documentation of extenuating circumstances that prevented you from obtaining a precertification

Medical necessity

For medical necessity denials or inpatient facility denials related to level of care, length of stay, or delayed treatment days, include the complete facility record (e.g., physician orders, progress notes, patient's medical history and physical exam results, consultations, results of diagnostic testing, operative reports, and discharge summary).

If your dispute involves an issue about the medical necessity of a service or procedure, in addition to a pricing accuracy concern, a clinician will review the non-pricing part of your appeal. If your dispute relates to a benefit determination issue, in addition to a pricing accuracy issue, the applicable plan's benefits will be reviewed and our response will refer to those benefits.

Most appeals are resolved within 60 calendar days of receipt and notification of our decision will be made to the requesting provider within 75 days unless state law requires a different time frame.

Untimely claim submissions

For any claim denial decisions related to untimely claim submission (failure to submit a claim within 90 days of the date of service), submit justification and supporting documentation for the delay with your appeal request. Acceptable documentation includes the EDI transmission report, or evidence that a claim was submitted due to coordination of benefits with another carrier.

If you are disputing the timeliness of your payment, include documentation showing the date you submitted the claim and any communications with Evernorth Behavioral Health relating to the claim.

For any documentation required under this section, you are responsible for securing the information from any vendors that you might use.

If, after the provider follows with this process, the Plan determines that the initial decision was correct and will be upheld, an appeal denial letter will be sent to you explaining the decision and outlining any additional appeal rights. An appeal determination that overturns the initial decision will be communicated through the EOP with the re-processed claim.

Additional payment appeal options

If you are still not satisfied after completing the internal appeal process, you may request dispute resolution including arbitration. This is a binding, final resolution for the respective claim, unless otherwise specified in the Evernorth Behavioral Provider Agreement or State Addendum.

The process for arbitration may be specified in your Provider Agreement. If it is not specified in your Provider Agreement and is not prohibited by state law, the following process will apply.

If the dispute is not resolved through the appeal processes described above, either party can initiate arbitration by providing written notice to the other. The appeal processes must be followed in their entirety before initiating arbitration. If one of the parties initiates arbitration, the proceeding will be held in the jurisdiction of the provider's domicile. The parties will jointly appoint a mutually acceptable arbitrator. If the parties are unable to agree upon such an arbitrator within 30 days after one of the parties has notified the other of the desire to submit a dispute for arbitration, then the parties will prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service (AHLA ADR Service), along with the appropriate administration fee. Under the Code of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of 10 arbitrators along with a background and experience description, references, and fee schedule for each. The 10 arbitrators will be chosen by the AHLA ADR Service based on their experience in the area of the dispute, geographic location, and other criteria as indicated on the request form. The parties will review the qualifications of the 10 suggested arbitrators and rank them in order of preference from one to nine. Each party has the right to strike one of the names from the list. The person with the lowest total will be appointed to resolve the case.

Each party will assume its own attorney's fees and all of its costs of arbitration; however, the compensation and expenses of the arbitrator along with any administrative fees or costs will be borne equally by the parties. Arbitration is the exclusive remedy for the resolution of disputes under the parties' agreement. The decisions of the arbitrator will be final, conclusive, and binding, and no action at law or in equity may be instituted by the parties other than to enforce the award of the arbitrator. The parties intend this alternative dispute resolution procedure to be a private undertaking and agree that an arbitration conducted under this provision will not be consolidated with an arbitration involving other physicians or third parties, and that the arbitrator will be without power to conduct an arbitration on a class basis. Judgment upon the award rendered by the arbitrator may be entered in any court of competent jurisdiction.

Determinations for hospital and facility appeals

Unless prohibited by state law, if a hospital or facility fails to request an appeal review, or arbitration of the hospital's or facility's payment or termination dispute within the applicable time frames, the plan's last determination about the dispute will be binding. The hospital or facility should not bill the plan participant for payments that are denied on the basis that the hospital or facility failed to submit the request for review or arbitration within the required time frames.

Provider termination appeals

On occasion, Evernorth Behavioral Health deems it necessary to terminate a provider's participation. Appeal rights are offered to providers terminated due to quality of care or quality of service and to providers terminated for failure to meet Evernorth Behavioral Health credentialing requirements in states that mandate appeal rights be offered. To initiate a review of a provider's termination, submit the following information in writing within 30 calendar days of the date of the provider's termination notice.

- A completed provider termination appeal letter indicating the reason for the appeal
- A copy of the original termination notice
- Supporting documentation for reconsideration

National ancillaries: Laboratories

Laboratory services are the most commonly used ancillary by behavioral providers. Evernorth Behavioral Health-contracted providers are expected to refer a patient to a laboratory participating with their plan.

Below are the two most common laboratories utilized for participants with Cigna plans. If your patient has a non-Cigna plan, please call the number on back of your patient's ID card to identify participating laboratories.

Laboratory	Laboratory Corporation of America® Quest Diagnostics, Inc.®	We currently contract with numerous local and national laboratories, including Laboratory Corporation of America and Quest Diagnostics, Inc., as well as other reference, pathology, genetic, and esoteric labs, to provide access to quality laboratory services at in-network, cost-effective rates. By referring patients to a laboratory that participates in our network, providers help ensure their patients maximize the benefits under their Cigna plan, while limiting their out-of-pocket expenses. For a complete list of participating laboratories, visit the provider directory at Cigna.com > Find a Doctor, Dentist, or Facility.	**Laboratory Corporation of America** Phone: 888.LABCORP Website: labcorp.com **Quest Diagnostics, Inc.** Phone: 866.MyQuest Website: questdiagnostics.com

Participant Information

Participants receive an ID card that includes an identification number, designated copayments information, coinsurance and deductibles, and their PCP a, if applicable. The ID card does not guarantee eligibility or coverage.

Review the ID card every time a participant visits your office. See below to learn more about verifying benefits and eligibility.

For Cigna plans:

- Log in to the secure Evernorth provider website (Provider.Evernorth.com > Patients > Search Patients). If you are not registered for the website, go to Provider.Evernorth.com and click “Register.”
- Submit an eligibility and benefit inquiry (270/271) through your EDI vendor
- Call the Customer Service number on the participant’s ID card
- Call Provider Services at 800.926.2273

Evernorth Behavioral Health makes no representations or guarantees about the number of participants referred to a provider. Evernorth Behavioral Health also reserves the right to direct participants to selected participating providers and to influence participants’ choice of participating provider.

Alternate Member Identifier (AMI)

To help protect the privacy of participants and prevent identity theft, plans have phased out the use of Social Security numbers (SSN) as the participant identifier. Use the identifier on the participant’s ID card to submit claims and to inquire about eligibility or claim status. The plan may continue to accept claims and inquiries submitted with either the AMI or the subscriber SSN for participants with an AMI.

Note: Many of the identifiers begin with U0 (zero). In some cases, when entering the identification number the capital letter ‘O’ is being input instead of the number “0” (zero). If your claim submissions for a participant are rejected for “invalid ID,” check that you have entered the correct identifier – U0 (zero), rather than UO (capital letter O).

In addition, you may submit the subscriber ID with or without the subscriber relationship suffix shown on the participant ID card (e.g., U01234567 01).

Verification options

For information on a participant’s benefit plan, including copayments, coinsurance, or deductible amounts:

- Review the participant’s ID card
- Submit an eligibility and benefit (270/271) inquiry through an EDI vendor that securely transmits data to us
- Log in to the secure Evernorth provider website (Provider.Evernorth.com > Patients > Search Patients), or call Provider Services at 800.926.2273

Participant concern or complaint

A participant should contact the number on back of their ID card if they have a concern or complaint about administration, coverage, or exclusions in their benefit plan, or the quality of service or care received. An attempt will be made to resolve the problem during the first telephone call. If a participant is not satisfied with the response, they may follow the processes for submitting a complaint outlined in their benefit plan document.

The process may include contact from an Evernorth Behavioral Health representative to a provider to obtain information that may help in the resolution of the concern or complaint. This also provides an opportunity for the provider to respond to the concern or complaint.

Provider cooperation

A participant may ask for your assistance with an appeal. We encourage you to assist the participant by providing all relevant clinical records or a statement on behalf of the participant.

Evernorth Behavioral Health may contact you during the review and investigation of a participant's concern, complaint, appeal or an audit. Information such as treatment records and/or written statements may be requested. If treatment records are requested, you should include history, assessments and clinical notes. You are required to cooperate and assist with the resolution and appeals process within the time periods requested to help ensure a full and fair review and so Evernorth Behavioral Health is compliant with applicable laws.

Either a participant or an Evernorth Behavioral Health representative may ask for your assistance with an appeal, quality of care, or quality of service complaint. To best address or resolve the participant's concern or appeal, we encourage timely submission of all relevant requested information.

If you believe an accelerated time frame is needed and it meets the expedited criteria, an Expedited Appeal may be requested on behalf of the patient. An Expedited Appeal is available when:

- Participant's treating provider believes that processing the appeal request under the pre-service standard time frames might jeopardize life, health, or ability to regain maximum functionality.
- Due to failure to authorize an admission or continuing inpatient hospital stay for a participant who has received emergency services, but has not been discharged from a facility.
- Participant's treating provider, with knowledge of the participant's behavioral condition, believes that by processing the appeal request under the pre-service standard time frames it would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the appeal.

Contact the plan at the telephone number on the participant's ID card to initiate the process and obtain expedited filing instructions. If faxing your request, include "expedited" in the reference field of the appeal fax cover sheet as well as the appeal itself.

Health Insurance Portability and Accountability Act (HIPAA) of 1996

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 law ensures the portability of insurance coverage to protect patients from "prior condition" limits due to changes in employment or coverage.

The Administrative Simplification provisions of HIPAA include regulations about privacy, standard code sets and transactions, security, and unique health identifiers. They were designed to safeguard a patients' Protected Health Information (PHI), standardize the transmission of certain common transactions between health care entities, and

standardize the medical codes used in those transactions. These standardization rules help reduce health care administrative costs.

We are committed to maintaining the confidentiality of participant PHI. We have established policies and procedures to protect oral, written, and electronic PHI. Our Notice of Privacy Practices describes how we use and disclose PHI and advises participants of their rights under federal and state laws.

Evernorth Behavioral Health acknowledges that certain providers may be subject to the confidentiality requirements of 42 C.F.R. Part 2 as well as certain state laws. Providers may be required to obtain certain consents and authorizations from patients in order to provide information to Evernorth Behavioral Health. Evernorth Behavioral Health relies on provider subject to such laws to obtain all necessary consents and authorizations to submit information to Evernorth Behavioral Health.

Security regulations

The HIPAA standards for the security of electronic health information specifies a series of administrative, technical, and physical security procedures for covered entities to use to ensure the confidentiality, integrity, and availability of electronic PHI.

National Provider Identifier

The National Provider Identifier (NPI) is a unique identification number for use in standard health care transactions. It is a number issued to providers and covered entities that transmit standard HIPAA electronic transactions (e.g., electronic claims and claim status inquiries). Providers and covered entities may apply for NPIs through the National Plan and Provider Enumeration System (NPPES) established by CMS for this purpose.

- Type 1 NPIs are assigned to individual providers, e.g., psychiatrists, nurse practitioners, psychologists, and master-level therapists
- Type 2 NPIs are assigned to organizations, e.g., hospitals, home health agencies, clinics, nursing homes, residential treatment centers, laboratories, ambulance companies, group practices, and pharmacies

The NPI fulfills a requirement of HIPAA, and must be used by health plans, providers, and health care EDI vendors in HIPAA standard electronic transactions. The NPI is intended to:

- Replace other identifiers previously used by providers and assigned by payers (e.g., Unique Physician Identification Number [UPIN], and Medicare or Medicaid numbers)
- Establish a national standard and unique identifier for all providers
- Simplify health care system administration
- Encourage the electronic transmission of health care information

Plans accept the NPI on standard HIPAA transactions as outlined below. This approach should not be confused with any guidance specific to Medicare claims requirements.

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- The “Billing Provider” TIN and NPI are required. Any additional provider identification on the claim, such as the “Rendering Provider” or “Referring Provider” must include the name and NPI when submitted.

- An organization may have more than one organization or type 2 NPI. Use the most appropriate organizational NPI as your primary identifier when submitting the "Billing Provider" on claims. The TIN must be submitted as the secondary provider identifier. This TIN is the number used on the Internal Revenue Service (IRS) form 1099, which is either the Employer Identification Number (EIN) for organizations, or the Social Security Number (SSN) for individuals; both an EIN and SSN number should not be included concurrently. Other identifiers, such as Medicare provider number, are considered "legacy" identifiers and should not be included.
- Submission of the “Billing Provider” TIN on the electronic claim is a HIPAA requirement. The National EDI Transaction Set Implementation Guide specifically states:

  > *“If 'code XX - NPI' is used, then either the Employer's Identification Number or the Social Security Number of the provider must be carried in the REF in this loop. The number sent is the one which is used on the 1099.”*

- Under HIPAA Accredited Standards Committee (ASC) X12 5010 standards, “Pay to Provider” information is limited to an alternate address only. No additional identifiers, neither TIN nor NPI, are permitted. The “Pay to Provider” address is only needed if it is different from that of the “Billing Provider.”
- The plan will reject electronic claims received without an NPI unless the submitter is ineligible to receive an NPI. If you are not eligible to receive an NPI, notify us by updating your demographics.
- As with any change to your billing process, if you or your organization plan to change the way claims are submitted to a plan because of your NPI implementation or enumeration, please notify Evernorth Behavioral Health of this change. One example would be an organization that has enumerated multiple NPI subparts and will start to bill using the "new" subpart providers.

835 electronic remittance advice

- Since October 2013:
  - For claims paid by check or EFT with TIN bulking, we group the claims within the 835 remittance by the “Billing Provider” NPI submitted on the original claim(s). A Provider Summary (TS3) field is added to the 835 and includes the “Billing Provider” NPI to help providers easily reconcile their payments.
  - For claims paid by EFT with NPI bulking, a separate 835 is sent for each NPI with the “Billing Provider” NPI returned as the “Payee” NPI. A Provider Summary (TS3) field is also added to the 835 and will include the “Billing Provider” NPI to help providers easily reconcile their payments.
  - The NPI for the "Rendering Provider" is included in the 835 regardless of bulking preference, if the "Rendering Provider" NPI was submitted on the 837 electronic claim.

Real-time request transactions (270, 276, 278)

- All eligibility and benefit inquiries (270) transactions should be submitted with either a type 1 (individual) or type 2 (organizational) NPI. We will also accept a 270 submitted with a TIN.
- For professional or dental claim status inquiries (276), the “Billing Provider” or “Rendering Provider” NPI from the submitted claim should be used to inquire on claim status.
- For institutional claim status inquiries (276), the “Billing Provider” NPI from the submitted claim should be used to inquire on claim status.

- For all claim types, we will also continue to accept claim status inquiries (276) using the TIN from the submitted claim.
- Health Care Services Review — Request for Review (278) transactions should include the NPI or TIN to identify any providers included in the request.
- Providers should contact their EDI vendor for details about the submission of NPI on these transactions.

Prescription Drug Program

For psychiatrists and prescribers (e.g., nurse practitioners) only

A participant's medical plan will offer a prescription drug benefit program where administered pharmacy benefits generally require that the participant fill prescription medications from the plan's participating pharmacies or from the plan's home delivery pharmacy. Medications are dispensed per prescription order or refilled in quantities normally prescribed up to a 30-day supply or as defined by the plan, the U.S. Food and Drug Administration (FDA), or applicable law. Up to a 90-day supply of maintenance medication may be dispensed through the home delivery pharmacy or obtained from designated retail pharmacies if the participant's benefit plan allows for a 90-day supply at retail cost.

Brand-name medications are often substituted with generic equivalents when available. Participants who choose to fill a brand-name medication rather than its generic equivalent may be subject to higher out-of-pocket costs.

Prescription drug list

For physicians and other providers only

For Cigna plan participants, the prescription drug list is a list of generic and brand-name medications the participant's plan covers. All medications are approved by the U.S. Food and Drug Administration (FDA). You may access the entire drug list by logging in to the Evernorth provider website (Provider.Evernorth.com > Resources > Drug List), or by calling the number on back of the participant's ID card.

Cigna regularly updates the drug list to reflect any changes to covered prescription medications.* Changes are typically made on January 1 and July 1 of each year to ensure customers have access to safe, effective, and lower-cost medications. As a result of these changes, certain medications may change tiers, or certain high-cost medications may no longer be covered. Cigna encourages the use of lower-cost generic or preferred-brand alternatives, when appropriate.

In addition, Cigna may not cover medications that are newly approved by the FDA for the first six months after approval to allow time for a thorough clinical review. This includes medications, medical supplies, or devices that are covered under standard pharmacy benefit plans. If currently available medications/therapies are not appropriate, providers can request coverage through a medical necessity review process during this interim review period.

**The coverage status of a prescription medication may change periodically for various reasons. For example, a prescription medication may be removed from the market, a new prescription medication in the same therapeutic class as a prescription medication may become available, or other market events may occur. Market events, such as an increase in acquisition cost of a prescription medication, may affect the coverage status of a prescription medication. As a result of coverage changes, benefit plans may require customers to pay more or less for the prescription medication, obtain the prescription medication from certain pharmacy(ies), or try another covered prescription medication first.*

Medications requiring prior authorization (medical necessity request process)

Participating prescribers in the Evernorth Behavioral Health network are responsible for following the plan's prescription drug list. You are required to contact the pharmacy service center to request prior authorization if any of the following apply:

- A generic or preferred medication should not be prescribed in your medical judgment for a patient
- The patient has a closed-formulary benefit plan
- The medication is not covered on the plan drug list
- The prescribed medication requires prior approval of coverage

For information about prescribing medications for non-Cigna Healthcare plan customers, call the number on back of the participant's ID. For Cigna Healthcare plan participants, you have the following options:

• Fax :
  ○ Cigna ID cards: 800.390.9745
  ○ "G" ID cards: 866.960.7716

• Your ePrescribing software: Cigna Home Delivery Pharmacy (pharmacy name)

• Electronic health record (EHR) or electronic medical record (EMR):
  ○ CoverMyMeds®
  ○ Surescripts®
• Online submission: CoverMyMeds/epa/Cigna

• Phone:
  ○ Cigna ID cards: 800.88Cigna (882.4462)
  ○ "G" ID cards: 866.265.6578

Information fields must be complete and legible on the submitted request. The review process may take 48 hours. Incomplete forms will be denied or returned for illegible or missing information. Requests marked as urgent will be reviewed the same day they are received.

A copy of the Cigna prescription coverage request form is available at Provider.Evernorth.com > Resources > Pharmacy Resources > Communications > Prior Authorization Forms **or** Provider.Evernorth.com > Resources > Forms Center > Prescription Forms > General Prior Authorization.

Pharmacy clinical support programs

Complex Psychiatric Case Management program

Our Complex Psychiatric Case Management program provides physicians and psychiatrists with integrated support for their patients who are prescribed multiple psychotropic medications. The program leverages pharmacy management and behavioral health management, and is designed to help support their care and their

adherence to utilizing their prescription medications.

Complex Psychiatric Case Management works in conjunction with Evernorth Behavioral Health to optimize medication treatment regimens and decrease potential emergency room visits and mental health and substance use-related hospitalizations. The program uses six months of retrospective pharmacy and medical claims data to help identify individuals with prescription medications filled in multiple therapeutic classes of psychotropic medications and multiple drugs within a specific class. This information is shared with providers to help optimize pharmacy, behavioral health, and medical benefit utilization.

Quality Management Program

Evernorth Behavioral Health's Quality Management Program supports our goal of continuous improvement in the quality of care and services delivered to participants. Evernorth Behavioral Health is accredited by the NCQA as a Managed Behavioral Health Organization (MBHO), and by URAC as a Health Utilization Management organization.

Additionally, the Quality Management Program is designed to fulfill Managed Care Organization (MCO) standards and to support health plan customers in their accreditation through NCQA and URAC.

Evernorth Behavioral Health values the input and involvement of our practitioners in our Quality Management Program, and we communicate program results annually in our national practitioner and provider newsletter. If you would like to receive more information, become more involved, or offer feedback and suggestions concerning Evernorth Behavioral Health's Quality Management Program, please contact us at 800.926.2273.

Creating opportunities for quality improvement

Through Evernorth Behavioral Health's Quality Management Program, data about many aspects of our operations is reviewed and monitored quarterly or annually to assess performance and create improvements in care and service for participants. Data reviewed and monitored include:

- Provider satisfaction surveys
- Participant satisfaction surveys
- Provider treatment record audits
- Complaint and appeal analysis and trending
- Utilization data
- Compliance with Evernorth Behavioral Health's appointment access, practitioner and practitioner geographical availability, and telephone access standards
- HEDIS® metrics
- Follow-up after hospitalization. Typically, all discharged participants should be seen within seven working days of discharge

Coordination of behavioral health and general medical care

It is the policy of Evernorth Behavioral Health that behavioral health services must be closely coordinated with general medical care and between behavioral care providers when care is delivered simultaneously by more than one provider, program, or facility. To enable the sharing of information between providers as treatment proceeds, Evernorth Behavioral Health suggests that providers request a required Release of Information signature from the participant during the treatment process, even if the participant initially declines permission for communication between providers. For the coordination of medical and behavioral care especially, this policy reflects Evernorth Behavioral Health's understanding of the complex interrelationship between emotional and physical factors, and its appreciation for the fact that psychiatric problems often complicate or present as medical illnesses. Conversely, medical problems may present with psychiatric symptoms.

For a sample release form and a draft letter for structured communication with PCPs, visit Provider.Evernorth.com > Forms Center > Behavioral Health Forms, see *Letter*

Templates. You are welcome to use these tools to support your communication with PCPs.

For each consenting participant in simultaneous medical and behavioral treatment, Evernorth Behavioral Health providers are expected to:

- Obtain and document the medical care practitioner's/ PCP's name, address, telephone, and facsimile (if available) numbers.
- Obtain and document a Release of Information, as required by law, to exchange information between you and the medical care provider/P PCP. If the participant refuses to sign a release for communication with the medical care provider/PCP, the reason for refusal should be documented.
- Exchange appropriate clinical information directly with PCP in an effective and timely manner throughout the treatment regimen. With proper consent, facilities may contact the PCP upon admission and discharge. Outpatient providers are expected to exchange appropriate clinical information directly with the PCP in an effective and timely manner throughout treatment, and at a minimum, communication should occur:
    - After the initial assessment, to include diagnosis, medication, initial treatment plan, and diagnostic tests recommended or ordered.
    - When a participant is not compliant with treatment recommendations.
    - When a participant's condition is unstable.
    - When there are clinically significant changes in a participant's condition or level of care, including but not limited to, inpatient, partial hospitalization, intensive outpatient treatment, comorbid medical and behavioral conditions, new, or substantial medication changes.
    - At the completion of behavioral treatment.
- Document verbal and written communication with the PCP.

Evernorth Behavioral Health monitors a provider's compliance coordinating behavioral care with medical care through medical record reviews and Care Management reviews as part of the recredentialing process and the Quality Management Program.

Participant rights and responsibilities

Evernorth Behavioral Health supports informing patients of their rights and responsibilities related to the provision of care and service. As an Evernorth Behavioral Health provider, you should:

- Facilitate the participant's awareness of the Participant Rights and Responsibilities statement at their first appointment. *This can be accomplished by providing a copy to the participant or display of the document. The information in* Appendix C *can be copied for this purpose.*
- Offer to help the participant get more information about any of the items in the statement.
- Notify the participant how to access services, including service outside of normal business hours.
- Discuss the services available to the participant and possible charges for those services.

Please note: Certain states have specific participant notification requirements applicable to mental health or substance use services, or to HIV status. The Participant Rights and

Responsibilities do not necessarily meet all state-specific requirements. State laws vary on participant, access to records, and duty to warn. Therefore, an addendum with required language must be attached to this document to comply with your state specific regulations. Please consult your legal advisor for guidance.

EAP participants should be provided an EAP Statement of Understanding, which is available at Provider.Evernorth.com > Behavioral Resources > Doing Business with Evernorth > Employee Assistance Program (EAP).

Evernorth Behavioral Health is committed to maintaining and protecting the confidentiality of patient's personal and sensitive information. To better understand our handling of personal health information, refer to the statement located in Appendix C.

Customers' rights and responsibilities statement

The following is Evernorth Behavioral Health's statement of our customer's rights and responsibilities:

As a Evernorth Behavioral Health customer, you have certain rights and responsibilities.
You have the right to:

- Receive coverage for the benefits and treatment available under your health benefit plan when you need it and in a way that respects your privacy and dignity.
- Receive information on how to access websites or customer service via toll-free telephone and fax numbers.
- Receive language interpretation and text telephone (TTY) service upon request.
- Receive the understandable information you need about your health benefit plan, including information about services that are covered and not covered and any costs that you will be responsible for paying.
- Obtain understandable information about Evernorth Behavioral Health's programs and services, including the qualifications of staff that support Evernorth Behavioral Health wellness and similar programs and any contractual relationships related to such programs.
- Have access to current information on participating doctors, health care professionals, hospitals and places you can receive care and information about a particular health care professional's education, training and practice.
- Select a primary care doctor for yourself and each covered member of your family, and change your PCP for any reason. However, many benefit plans do not require that you select a PCP.
- Have your personal identifiable data and medical information kept confidential by Evernorth Behavioral Health and your health care professional, know who has access to your information, and know the procedures used to ensure security, privacy and confidentiality. Evernorth Behavioral honors the confidentiality of its customers' information and adheres to all federal and state regulations about confidentiality and the release of personal health information.
- Participate with your health care professional in health decisions and have y them give you information about your condition and your treatment options, regardless of coverage or cost. You have the right to receive this information in terms and language you understand.
- Learn about any care you receive. You should be asked for your consent for all care, unless there is an emergency and your life and health are in serious danger.

- Refuse medical or behavioral care. If you refuse care, your health care professional should tell you what might happen. We urge you to discuss your concerns about care with your doctor or other health care professional. Your health care professional will give you advice, but you will have the final decision.
- Be advised of who is available to assist you with any special Evernorth Behavioral Health programs or services you may receive and who can assist you with any requests to change or unenroll from programs or services offered by or through Evernorth Behavioral Health.
- Be heard. Our complaint-handling process is designed to: Hear and act on your complaint or concern about Evernorth Behavioral or the quality of care you receive from health care professionals and the various places you receive care in our network; provide a courteous, prompt response; and guide you through our grievance process if you do not agree with our decision. Evernorth Behavioral Health strives to resolve your complaint on initial contact and in a manner that is consistent with your applicable benefit plan. Language interpretation and TTY services are available for complaint and appeal processes.
- Know and make recommendations about our policies that affect your rights and responsibilities. If you have recommendations or concerns, please call Customer Service at the toll-free number on your ID card.
- Request and receive information regarding how to appeal a utilization management decision.
- Receive utilization management determinations from quality professionals who do not receive financial incentives based on utilization management decisions.

Statement on confidentiality of alcohol and drug use records

Evernorth Behavioral Health staff and network practitioners will not identify a participant as involved in alcohol or substance use treatment to others outside the treatment program, unless:

- The participant consents in writing; OR
- The disclosure is allowed by court order; OR
- The disclosure is made to medical personnel in a medical emergency, or to qualified personnel for research, audit, or program evaluation; OR
- The disclosure is made to a PCP to coordinate care when required by a health plan and the participant consents verbally or in writing; OR
- The participant commits or threatens to commit a crime at the treatment program or against any person who works for the program; OR
- There is suspected child abuse or neglect or a danger to yourself or others when reporting is permitted or required under state laws to appropriate state or local authorities.

You have the responsibility to:

- Review and understand the information you receive about your health benefit plan. Please call Customer Service when you have questions or concerns.
- Understand how to obtain services and supplies that are covered under your plan, including any emergency services needed outside of normal business hours or when you are away from your usual place of residence or work, by using the indicated number on your ID card or by accessing online resources.
- Show your ID card before you receive care.
- Schedule a new patient appointment with any participating health care professional; build a comfortable relationship with your health care professional; ask questions

about things you don’t understand; and follow your health care professional’s advice. You should understand that your condition may not improve and may even get worse if you don’t follow your health care professional’s advice.
- Understand your health condition and work with your health care professional to develop treatment goals that you both agree upon and to follow the treatment plan and instructions.
- Provide honest, complete information to the health care professionals caring for you.
- Know what medicine you take, why, and how to take it.
- Pay all copayments, deductibles, and coinsurance for which you are responsible, at the time service is rendered or when they are due.
- Keep scheduled appointments and notify the health care professional’s office ahead of time if you are going to be late or miss an appointment.
- Pay all charges for missed appointments and for services that are not covered by your plan.
- Voice your opinions, concerns or complaints to Customer Service or your health care professional.
- Notify your plan administrator and treating health care professional as soon as possible about any changes in family size, address, telephone number, or status with your health benefit plan, or if you decide to unenroll from our programs and services.

Improving participant safety

The Institute of Medicine emphasized the safety of health care in the public spotlight by publication of their report, *"To Err is Human: Building a Safer Health System."* As a result, safety catapulted to a national health care issue. Every health care professional should be evaluating:

- What is my role in preventing potential errors or safety risks?
- What barriers exist to improving participant safety?
- What strategies can be implemented in my practice to reduce errors or improve safety?

While there are many steps needed to reduce error in America's complex health care system, health care professionals may consider the following:

- With approved consent, communicate and coordinate care with other behavioral health, primary care, or other health care professionals who are involved in the participant's care.
- Gather information on all prescription and over-the-counter medications and dietary supplements that the participant is taking.
- Inquire about any known allergies or adverse medication reactions.
- Educate the participant on how and when to take medication, and how to manage possible side effects.
- Evaluate how computerized records and other technology may contribute to improved safety.

Through the Quality Management Program, Evernorth Behavioral Health evaluates data on various measures to identify opportunities for improving safety for our participants.

Health promotion/preventive health services

Evernorth Behavioral Health encourages participating providers to educate participants about their diagnosis along with treatment information and suitable health promotion strategies. This may also include providing literature, suggesting books, or informing the participant of other educational resources and self-help groups. As appropriate, the provider should recommend the use of preventive strategies that may include relapse prevention, stress management, wellness programs, and lifestyle changes. In addition, be sure to document your efforts in your medical record.

Evernorth Behavioral Health offers consumer-oriented educational materials on Attention-Deficit/Hyperactivity Disorder (ADHD) and a variety of other topics.

The intent of our Attention-Deficit/Hyperactivity Disorder (ADHD) materials is to educate and empower caregivers, to reduce the impact of problems commonly associated with the disorder, and to encourage early detection of ADHD in siblings.

Educational information and tools are mailed to parents and guardians, when requested, to improve their understanding of, and their ability to manage their child's condition, and to encourage coordination and consistency of response across medical, behavioral, educational, family, and other social settings.

Initial and annual screening for depression, stress, and anxiety is now routine within Cigna's Medical Disease Management Programs, encouraging the identification and treatment of behavioral health disorders that may occur as a coexisting condition with a medical disease. Those who screen positive are provided intensive care management and ongoing standardized protocols for assessment and intervention are applied until the behavioral health condition remits. Where consent is provided, additional materials and support are made available to their medical provider or a referral for treatment with a qualified behavioral health professional can be arranged.

See the Resources and forms section for the latest information on these services, or contact us at 800.926.2273.

Educational opportunities for providers

You are encouraged to participate in educational programs focusing on clinical practice issues pertinent to service delivery systems.

Medical necessity criteria

MCG Behavioral Health Guidelines

On November 27, 2020, Cigna terminated use of its Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders and transitioned to the MCG Behavioral Health Guidelines. For regulatory and reference purposes, applicable versions of Cigna's former Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders above will be used throughout the duration of cases that were submitted to Cigna prior to November 27, 2020. These cases include:

- Prior authorization requests
- Continued care requests/concurrent reviews
- Appeals where the Cigna document is used in initial determinations

Evernorth Behavioral Health uses the MCG Behavioral Health Guidelines for guidance in conducting mental health level of care medical necessity reviews for health plan business unless contractual requirements, or federal or state law require use of other clinical criteria. The MCG guidelines have wide acceptance as an evidence-based standard for mental health care, are developed and maintained in compliance with state and federal regulations, including mental health parity laws, and are informed by consideration of guidance issued by at least 10 professional organizations.

LOCUS/CALOCUS-CASII criteria

Evernorth Behavioral Health adopted the Level of Care Utilization System (LOCUS) criteria for ages 18+, and the Child and Adolescent Level of Care/Service Intensity Utilization System (CALOCUS-CASII) criteria for ages 6 to 17, in compliance with California Senate Bill 855.

LOCUS/CALOCUS-CASII criteria are accepted as evidence-based standards for mental health care. These criteria are used to conduct mental health level of care medical necessity reviews for all commercial health plans in California unless federal or state law require the use of other specifically identified clinical criteria. These guidelines complement our suite of existing evidence-based criteria to support your clinical judgment and decision-making processes.

Additional resources

In addition to the MCG Behavioral Health Guidelines and LOCUS/CALOCUS-CASII criteria used in California, the following resources are currently being used to make medical necessity determinations:

- The ASAM Criteria®
  Evernorth uses this criteria, developed by the American Society of Addiction Medicine, for guidance in conducting medical necessity reviews of substance use disorder levels of care for all health plan business, unless contractual requirements, or federal or state law require use of other clinical criteria.
- Cigna Medical Coverage Policies (e.g., for autism spectrum disorders/pervasive developmental disorders and transcranial magnetic stimulation [TMS])
- Evernorth Authorization and Billing Resource
- State and federal regulations and licensing standards*

For more information about all of the resources listed above, visit the Coverage Policies page on this website and see *Supporting Behavioral Websites*. Please note that a login is required to access all of the resources available.

- Archived criteria Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders (Revised April 2020)
- Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders (Revised January 2020)
- Standards and Guidelines/Medical Necessity Criteria for Treatment of Mental Health Disorders (Revised January 2019)

* Evernorth complies with state-specific laws, as written.

Clinical practice guidelines

Evernorth Behavioral Health has adopted clinical practice guidelines from professional societies and other recognized sources, such as the American Psychiatric Association, the American Academy of Pediatrics, or the National Institute of Alcohol Abuse and Alcoholism. Our Care Management staff use these in their work with practitioners to guide decisions about the appropriate type of treatment for common behavioral disorders. The conclusions expressed within these guidelines are based on scientific, evidence-based research. A full list of guidelines currently approved for use and instructions on where the full-text source documents can be obtained at Provider.Evernorth.com > Behavioral Resources > Clinical Practice Tools > Clinical Practice Guidelines.

Through the Quality Management Program, Evernorth Behavioral Health monitors whether treatment is consistent with selected guidelines that Evernorth Behavioral Health Guidelines have adopted. Feedback, suggestions, and input regarding Clinical Practice Guidelines are always welcome and can be provided to Evernorth Behavioral Health by contacting your Provider Relations Representative, or by calling 800.926.2273.

Clinical screening tools and treatment support toolkits

Evernorth Behavioral Health has assembled a number of validated screening and assessment tools and, where necessary, obtained permissions from copyright holders for distribution to our network for use. These tools can be found at Provider.Evernorth.com > Behavioral Resources > Clinical Practice Tools > Clinical Screening Tools.

Additionally, patient and provider toolkits, containing educational and treatment support tools, are available for download and use at Provider.Evernorth.com > Behavioral Resources > Education Center > Primary Physician Tool.

Integration with chronic condition/disease management

Chronic condition programs (Your Health First℠) are supported by Evernorth Behavioral Health via an integrated approach to help program participants manage chronic health conditions. Your Health First addresses the health of the whole person rather than focusing on a single disease that triggers program participation.

Supported by evidence-based medical guidelines and influential behavioral techniques, the integrated multidisciplinary approach helps participants fully manage their personal health, including adherence to medications, understanding and managing risk factors, and maintaining up-to-date screenings.

For more information about our chronic condition programs, including provider rights and responsibilities, see the Chronic Condition Management section of the Medical Resources found on Provider.Evernorth.com, or contact us at 855.246.1873.

Treatment record-keeping

Evernorth Behavioral Health believes well-documented treatment records, whether electronic or paper, facilitate communication, coordination, and continuity of care; and promote the efficiency and effectiveness of treatment. The health provider is responsible for maintaining an adequate clinical record for each participant and furnishing Evernorth Behavioral Health with clinical data as necessary for utilization review or quality

management. Evernorth Behavioral Health's recordkeeping standards require the participant name and ID number on each page in the record. Treatment record entries should be legible, signed with the clinician's name and credentials, in ink, dated, and maintained in a consistent chronological order within each file. Records should be easily and readily retrievable in a secure environment that protects participant confidentiality.

Treatment Record Review (TRR) standards are based on state mandates, when applicable, and CMS requirements about treatment of Medicare participants.

The provider's treatment records should include documentation of all contacts about the participant. Documentation in the record should include, but is not limited, to:

- Key demographic data
- The presenting problem (reason for visit)
- A full psychological and medical history
- A mental status evaluation, including assessment of suicidal and homicidal ideation
- ICD-10 diagnosis
- Treatment plan with measurable goals
- All diagnostic and treatment services ordered or provided, directly or through referral.
- With participant consent, evidence of coordination of care with the PCPs and other involved clinicians, in addition to other recordkeeping requirements outlined in the Behavioral Treatment Record Review Tool.
- CMS requirements on whether:
    - Were advanced directives executed?
    - Does the PCP have a copy of the advanced directives?

To support your efforts in documentation, behavioral providers are encouraged to document in the treatment record:

- Your attempts to coordinate care with the participant's PCP
- Discussions in which you encourage participant's without a PCP to choose a PCP

To assess compliance with its medical record standards, the medical recordkeeping practices of selected high-volume providers are audited by Evernorth Behavioral Health. As high-volume provider near recredentialing, participants seen by them in the prior 12 months are identified. A letter is sent to selected providers, professionals, soliciting blinded copies of 3 clinical records. Audit results are used to give providers feedback (particularly when results are below the 80 percent performance goal), and to drive organizational quality improvement. Evernorth Behavioral Health has also found that effective treatment record documentation supports treatment outcomes through improved treatment planning, the monitoring of participant progress towards goals, and improved communication in the case management process.

Quality clinical recordkeeping may also reduce risk management difficulties for providers by providing a record of the treatment progress along with documentation of informed consent, participant's understanding of their rights and responsibilities, and participant's understanding of the treatment plan. Please see the sample 'Informed Consent Form,' which you are welcome to use.

In states where there are laws regulating the recordkeeping process, these laws shall prevail if greater than Evernorth Behavioral Health's minimum standards; if not, Evernorth Behavioral Health standards shall apply.

Clinical and quality improvement studies

Clinical and quality improvement studies help evaluate quality and appropriateness of care provided to patients. Topics for evaluation and special studies are chosen based on relevant demographics and epidemiological characteristics of participants. Clinical studies review issues such as, preventive care/HEDIS measures against preventive care guidelines, and compliance with treatment standards for depression. Scientifically-based criteria are used for specific conditions, as developed by nationally recognized organizations and adopted by Evernorth Behavioral Health. Population-based assessment is conducted whenever appropriate, supplemented by focused medical record review or patient surveys. Data are collected, reviewed, and analyzed for trends and opportunities for improvement.

National quality initiatives

National Quality Forum

The National Quality Forum (NQF) was established to facilitate a national collaboration to improve health and health care quality through measurement. It strives to achieve this mission by convening key public- and private-sector leaders to establish national priorities and goals to achieve health care that is safe, effective, patient-centered, timely, efficient, and equitable. NQF-endorsed measures are considered the gold standard for health care quality measurement in the United States. Expert committees that are comprised of various stakeholders, including patients, providers, and payers, evaluate measures for NQF endorsement. The Federal Government and many private sector entities use NQF-endorsed measures above all others due to the rigor and consensus process behind them. We encourage all providers to become familiar with the endorsed measures to promote public accountability and quality improvement. Many of the measures are used in our evaluation process for hospitals and providers. More information is available at qualityforum.org.

Centers of Excellence

When participants are in need of behavioral care, we encourage providers to refer them to facilities with the Evernorth Behavioral Centers of Excellence designation, which have met important standards for providing quality, cost-effective care. Designated facilities have met certain measures for patient outcomes and cost-efficiency based on the Evernorth Behavioral Health methodology outlined below.

The patient outcomes score is a quality measure of a facility’s relative effectiveness in treating a mental health, substance use, or eating disorder. This score is based on the quality measures listed below:

- Readmission rates
- Seven-day ambulatory follow up
- Discharge to a participating provider

The cost-efficiency score is a measure of a facility's average cost to treat a particular mental health, substance use, or eating disorder, and is based on a facility's Evernorth Behavioral Health fee schedule and average length-of-stay data. It does not include provider fees or outpatient services. The score reflects the rates that a facility charges, as well as the average time spent in the facility for the specific treatment. A variety of factors, including geographic cost differences, may affect the overall score.

A facility can receive a score of up to three stars (*) for both patient outcomes and cost efficiency for each evaluated mental health, substance use, or eating disorder. Those that attain at least five stars (three stars for patient outcomes and two stars for cost efficiency, or three stars for cost efficiency and two stars for patient outcomes) receive the Evernorth Center of Excellence designation for mental health, substance use, or eating disorders.

Resources and forms

- Contact Information
- Claims Information
- Participant Rights and Responsibilities
- Collection, Use And Disclosure Of Protected Health Information
- Health Care Provider Forms
- Employee Assistance Program (EAP) Forms
- Specialty Networks and Forms
- Primary Care Physician (PCP) Communication Information
- Standards for Delegation of Credentialing Activities

Legal Statement

All Evernorth products and services are provided exclusively by or through operating subsidiaries and affiliates of Evernorth, including **Evernorth Care Solutions, Inc., and Evernorth Behavioral Health, Inc.**

ALABAMA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Alabama regarding provider contracts with providers rendering health care services in the State of Alabama. To the extent that such Alabama laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Alabama laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

Payor may only retroactively deny, adjust or seek recoupment for reimbursement made to Provider (a) during the twelve (12) month period after the date Payor paid such claim; or (b) the expiration of the same period of time that Provider is required to submit claims pursuant to Provider's contract, whichever date occurs first. Except that Payor may retroactively deny, adjust or recoup reimbursement for Covered Services subject to coordination of benefits with another carrier, the Alabama Medicaid Agency, or to Medicare claims, except the Medicare+Choice plan, during the eighteen (18) month period after the date Payor paid such claim.

(a.) The above provision does not apply if Payor retroactively denies, adjusts or recoups reimbursement to Provider because: (1) the information submitted to Payor was fraudulent; or (2) the claim submitted to Payor was a duplicate claim.

(b.) Payor must give Provider notice specifying the reason for retroactively denying, adjusting or recouping reimbursement. Notice may be in paper or electronic format, but Provider must agree to accept notice by electronic media.

(c.) If Provider disputes the retroactive denial, adjustment, or recoupment on all or a portion of a claim, Provider must notify Payor within thirty (30) days after receipt of notice.

(d.) If the retroactive denial, adjustment or recoupment deals with a medical necessity determination, level of service determination, coding error, or billing irregularity, retroactive denial, adjustment or recoupment must be reconciled to specific claim.

II

The following is provided in accordance with Act No. 2015-320 (Code of Alabama § 27-1-17.1).

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

ALASKA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of Alaska regarding provider contracts with providers rendering health care services in the State of Alaska. To the extent that such Alaska laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Alaska laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) Emergency Services. The term "Emergency Services" means health care services that are provided by a hospital or other emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention would reasonably be expected by a prudent person who possesses an average knowledge of health and medicine to result in the placing of the Participant's health in serious jeopardy, or a serious impairment to bodily functions, or, a serious dysfunction of a bodily organ or part.

(2) Clean Claim. The term "Clean Claim" means a claim that does not have a defect, impropriety or circumstance requiring special treatment that precludes timely payment on the claim.

(3) Termination. To the extent that the Agreement contains a provision allowing discretionary termination of the Agreement, such provision shall apply equitably to both Provider and Evernorth.

(4) Dispute Resolution. In the event of a dispute between Evernorth and Provider, a fair, prompt and mutual dispute resolution process shall be used. Provider and Evernorth will hold an initial meeting at which Provider and Evernorth are present or are represented by individuals with authority regarding the matters in dispute. The meeting shall be held within ten (10) working days after Evernorth receives written notice of the dispute or gives written notice to Provider, unless Provider and Evernorth agree in writing to a different schedule. If, within thirty (30) days following the initial meeting, Evernorth and Provider have not resolved the dispute, the dispute shall be submitted to mediation directed by a mediator who is mutually agreeable to Evernorth and Provider and who is not regularly under contract to or employed by either Evernorth or Provider. Each party shall bear its proportionate share of the cost of mediation, including the mediator fees. If, after a period of sixty (60) days following commencement of mediation, Evernorth and Provider are unable to resolve the dispute, either party may seek other relief allowed by law. Evernorth and Provider agree to negotiate in good faith at the initial

meeting and in mediation. Prior to the initiation of the mutual dispute resolution process set forth herein, at the Provider's discretion, and to the extent permitted by Alaska Stat. § 21.07.010, Evernorth and Provider may attempt to resolve payment disputes in accordance with the payment dispute resolution procedures set forth in the Medical Management Program.

(5) Communication with Participants. In accordance with Alaska Stat. § 21.07.010(a)(5), Evernorth shall not penalize Provider or terminate the Agreement because Provider acts as an advocate of a Participant in seeking appropriate, medically necessary health care services. Evernorth shall not interfere with Provider's ability to openly communicate with a Participant about all appropriate diagnostic testing and treatment options.

(6) Financial Inducements or Incentives. In accordance with Alaska Stat. § 21.07.010(b)(1), this Agreement shall not be interpreted to contain direct financial incentives to Provider for withholding Covered Services that are medically necessary. Nothing herein, however, shall be construed to prohibit incentives to Provider for efficient management of the utilization and cost of Covered Services.

(7) Product Participation and Compensation. Nothing in this Agreement shall be interpreted to require Provider to contract for all products currently offered or that may be offered in the future by Evernorth. Nothing in this Agreement shall be interpreted to require Provider to accept from Evernorth or Payor the same rate of compensation for Covered Services rendered as that which Provider has contracted for with another managed care entity.

(8) Indemnification. In accordance with Alaska Stat. § 21.07.010(c), nothing in this Agreement shall require Provider to indemnify or hold harmless Evernorth for the acts or conduct of Evernorth.

(9) Effect of Termination and Liabilities After Termination. If a Participant is pregnant or being actively treated by Provider on the date of termination of this Agreement, the Participant may continue to receive Covered Services from Provider as described herein and this Agreement shall remain in force with respect to the continuing treatment. The Participant shall be treated for the purposes of benefit determination or claim payment as if Provider were still under agreement with Evernorth. However, treatment is required to continue only while the Participant's coverage remains in effect and until the end of the medically necessary treatment for the condition, disease, illness or injury, if the Participant has a terminal (life expectancy of less than one (1) year) condition, disease, illness or injury or for the period that is the longest of the following: the end of the current plan year; up to ninety (90) days after the termination date, if the event triggering the right to continuing treatment is part of an ongoing course of treatment; or, through completion of postpartum care, if the Participant is pregnant on the date of termination.

(10) Claims and Overpayment Recovery. To the extent required by applicable law, Evernorth and Provider shall comply with the provisions of Alaska Stat. § 21.36.495, as may be amended from time to time. The recovery of overpayments, if any, shall be conducted in accordance with Alaska Stat. § 21.36.125, as may be amended from time to time, and Bulletin B 07-06 as applicable.

(11) Covered Services. Upon request, Evernorth shall make available to Provider information that identifies Covered Services.

ARIZONA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Arizona regarding provider contracts with providers rendering health care services in the State of Arizona. To the extent that such Arizona laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context indicates otherwise. For the avoidance of doubt, to the extent such Arizona laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

1. The Compensation section of the Agreement is amended to add the following subsections:

    a. In the case of a non-Medicare HMO plan offered by Evernorth or an insured Plan offered by an Evernorth affiliate, and except in cases of fraud, Evernorth will adjust or request adjustment of the payment of a claim within one (1) year after the date Evernorth has paid the claim, unless the parties agree to a mutually applicable longer period of time.

    b. The following applies in the event that Provider believes Provider has been underpaid for a Covered Service. In the case of a non-Medicare HMO plan offered by Evernorth or an insured Plan offered by an Evernorth affiliate, and except in cases of fraud, Provider must submit a written request for an appeal or adjustment with Evernorth or its designee within one (1) year from the date of Evernorth's payment or explanation of payment, unless the parties agree to a mutually applicable longer period of time. In the case of a self- insured Plan administered by an Evernorth affiliate, Provider must submit a written request for an appeal or adjustment with Evernorth or its designee within one hundred eighty (180) days from the date of Payor's payment or explanation of payment. All requests for appeal or adjustment must be submitted in accordance with Evernorth's provider payment appeal process set forth in the Medical Management Program. Requests for appeals or adjustments submitted after the date specified may be denied for payment, and Provider will not be permitted to bill Evernorth, Payor or the Participant for those services for which payment was denied.

2. In the event of Evernorth's insolvency, Provider shall continue to provide Covered Services

to Participants covered under an HMO Plan at the same rates and subject to the same terms and conditions established in the Agreement, until the earliest of the following:

a. A determination by the court that Evernorth is either unable to pay, or unable to provide adequate assurance that it will be able to pay, Provider's claims for Covered Services that were rendered to Participants after Evernorth is declared insolvent.

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

c. A determination by the court that Evernorth has satisfied its obligations to all Participants under its HMO Plans.

3. Credentialing: Evernorth is part of the Council for Affordable Quality Healthcare (CAQH) for credentialing and recredentialing network physicians. Evernorth strongly encourages the use of the CAQH Universal Provider DataSource when submitting Provider's application. CAQH does comply with Arizona state application requirements.

4. Appointments and Scheduling Guidelines:

   a. Specialist Access Standards:

      - Urgent or emergent care – call 911
      - Urgent or emergent care that does not require 911 – immediate or same day appointment
      - Non-Urgent or emergent care – within one (1) week (seven (7) days)
      - Elective care (routine) – within thirty (30) days
      - High index of suspicion of malignancy – Less than seven (7) days

ARKANSAS REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Arkansas regarding provider contracts with providers rendering health care services in the State of Arkansas. To the extent that such Arkansas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Arkansas laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

(1) Pursuant to the requirements of A.C.A. § 23-63-1801 et seq.:

(a) Except in cases of fraud committed by Provider, Payor may only exercise recoupment for reimbursement from Provider during the eighteen (18) month period after the date that Payor paid the claim submitted by Provider.

(a.1) Provider may submit a corrected claim for up to six (6) months after recoupment for services that were actually provided but billed in error without intent to defraud.

(b) If Payor exercises recoupment from Provider under this section, Payor shall give Provider a written or electronic statement specifying the basis for the retroactive denial and the statement shall contain, at a minimum, the information required by subsection (e) below.

(c) If Payor determines that payment was made for services not covered under Participant's Plan, Payor shall give written notice to Provider of its intent to exercise recoupment and may:
  (1) Request a refund from Provider; or
  (2) Make a recoupment of the payment from Provider in accordance with subsection (e).

(d) Notwithstanding subsection (a) above, if Payor or an agent contracted to provide eligibility verification verifies that an individual is a Participant and if Provider provides health care services to the individual in reliance on such verification, Payor may not thereafter retroactively deny a claim on the basis that the individual is not a Participant unless such retroactive denial occurs within one hundred twenty (120) days of the date that Payor paid the claim; otherwise Payor is barred from making such recoupment unless there was fraud by Provider.

(e) If Payor chooses to recoup from Provider amounts previously paid under a retroactively denied claim pursuant to subsections (a) or (c), Payor shall provide Provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The person's name to whom the recoupment applies;

(3) Patient identification number;

(4) Date or dates of service;

(5) The health care service or services on which the recoupment is based;

(6) The pending claims being recouped or that future claims will be recouped; and

(7) Specific reason for the recoupment.

(2) Upon termination of the Agreement, Provider may, at the option of Participant, continue to provide Covered Services for a current episode of an acute condition for which a Participant was under Provider's care at the time of such termination so long as Participant retains eligibility under a Plan, until the earlier of completion of such services, or the expiration of ninety (90) days. During the period of continued care, Provider shall be deemed to be a Participating Provider for purposes of reimbursement, utilization management and quality of care. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements of the terminated Agreement until ninety (90) days following termination. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(3) The Agreement may permit network rental arrangements which allow Evernorth to sell, lease, assign, convey, or otherwise grant access to Provider's health care services, discounted rates, or fees established in the Agreement.

(4) To the extent required by A.C.A. § 23-99-1305, as may be amended from time to time:

(a) "Material Amendment" shall mean, as set forth in A.C.A. § 23-99-1302 as may be amended from time to time: a change in the Agreement that results in a decrease in fees, payments, or reimbursement to Provider; a change in the payment methodology for determining fees, payments or reimbursement to Provider; a new or revised coding guideline; a new or revised payment rule; or, a change of procedures that may reasonably be expected to significantly increase Provider's administrative expenses.

(b) Evernorth shall provide in writing any Material Amendment to the Agreement at least ninety (90) days before the effective date of the Material Amendment.

(5) Notwithstanding any provision in the Agreement to the contrary, the Agreement shall open for renegotiation and revision at least one (1) time every three (3) years; neither party is required to terminate the Agreement in order to open the Agreement for renegotiation of the terms.

II

(1) To the extent required by A.C.A. § 23-99-1306, nothing in the Agreement or in any exhibit, schedule, or addendum to the Agreement, shall be construed to directly or indirectly prohibit Provider from entering into a healthcare contract with another contracting entity or another healthcare provider. Subject to the severability provision of the Agreement, if any provision may be so construed, such provision shall be null and void and the Agreement shall be construed so as not to contain such provision.

CALIFORNIA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc., Evernorth Behavioral HealthCare of California, Inc, Evernorth Group Life Insurance Company (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with
legislative and regulatory requirements of the State of California regarding provider contracts with providers rendering health care services in the State of California. To the extent that such California laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such California laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

1. Language Assistance Program (LAP) Requirements. The following provision is required by (i) CA Health and Safety Code Section 1367.04 and Title 28 California Code of Regulations Section 1300.67.04 with respect to services rendered by Provider to Participants covered by Evernorth Behavioral HealthCare of California, Inc. and (ii) CA Insurance Code Section 10133.8 and Title 10 California Code of Regulations Section 2538.3 with respect to services rendered by Provider to Participants insured by Evernorth Health and Life Insurance Company ("CHLIC").

   (a) Evernorth shall establish and maintain an ongoing language assistance program to ensure Limited English Proficient ("LEP") Participants have appropriate access to language assistance while accessing health care services as required by the LAP laws referenced above. Provider shall cooperate and comply, as applicable, with Evernorth's Language Assistance Program; however, Evernorth shall maintain ongoing administrative and financial responsibility for implementing and operating on an ongoing basis the Language Assistance Program for Participants. The term "Limited English Proficient" shall have the same meaning as set forth in the LAP laws cited above.

2. Provider Directory Requirements:
   On July 1, 2016, California Senate Bill 137 became effective for managed care and insured benefit plans. Its purpose is to improve the accuracy of provider directories, as well as support future requirements that will become effective next year for content standardization and new search criteria.

   The new law requires that for the directories for these plans, all health plan insurers:
   - Develop and implement procedures to periodically contact contracted providers to validate the accuracy of their information displayed, and keep this information current. Provider verification may be required several times per year, depending on contracting arrangements.
   - Display certain fields of information, including the National Provider Identifier (NPI) number, California license number(s), an office email address, non-English languages you may speak, and if you have a qualified medical interpreter on staff.
   - Display all contracted providers.

The following provision is required by (i) CA Health and Safety Code Section 1367.27 with respect to services rendered by Provider to Participants covered by Evernorth HealthCare of California, Inc. and (ii) CA Insurance Code Section 10133.15 with respect to services rendered by Provider to Participants insured by CHLIC.
(A) Provider shall inform Evernorth within five (5) business days when either of the following occurs:
(1) Provider is not accepting new Participants;
(2) If Provider had previously not accepted new Participants, Provider is currently accepting new Participants.
(B) If Provider is not accepting new Participants and is contacted by an Evernorth Participant or potential customer; provider shall direct the individual to:
(1) Evernorth Customer Service for assistance in finding another provider.

(2) the California Department of Managed Care or the Department of Insurance if Provider's accepting new patients status in the provider directory is inaccurate, or does not reflect the information most recently provided to Evernorth. Provider will refer the Participant or potential customer to the department with jurisdiction over the Participant's or potential customer's plan to report any inaccuracy with the provider directory or directories.

Pursuant to the obligations established by (i) CA Health and Safety Code Section 1367.27 with respect to services rendered by Provider to Participants covered by Evernorth HealthCare of California, Inc. and (ii) CA Insurance Code Section 10133.15 with respect to services rendered by Provider to Participants insured by CHLIC, the following shall apply:
(A) Providers will have thirty (30) business days to respond to all notices sent to them by Evernorth or a group or entity on behalf of Evernorth, and either confirm their directory information is current and accurate, or otherwise, update their directory information. Provider verification may be required several times per year, depending on contracting arrangements.
(B) If Provider is not a hospital:

- Providers that do not respond to directory verification notices, or providers who respond with partial or inaccurate information that cannot be verified by Evernorth will receive a notice that if a response is not received within ten (10) business days, they will be suppressed from showing in on-line and printed directories at their next update.
- Providers shall be suppressed from the on-line and printed directories at the next required update after the ten (10) day notice period. Providers shall not be suppressed if they respond before the end of the ten (10) day notice period.
- Providers will be restored in the on-line and printed directories once a full and accurate response is received and verified in accordance with Evernorth policies and requirements for updating directory errors and information.
- To the extent permitted by applicable laws, Evernorth may terminate this Agreement for a pattern or repeated failure of Provider to alert Evernorth to a change in the information required by applicable laws to be in the directory or directories.

3. Pursuant to the obligations established by (i) CA Health and Safety Code Section 1374.14 with respect to covered services rendered by Provider to Participants covered by Evernorth HealthCare of California, Inc. and (ii) CA Insurance Code Section 10123.855 with respect to Covered Services rendered by Provider to Participants insured by CHLIC, the following shall apply:
(a) If Provider is not a hospital:
    - Evernorth shall reimburse Provider for the diagnosis, consultation, or treatment of a Participant appropriately delivered through covered telehealth services on the same

basis as and to the same extent that Evernorth is responsible for reimbursement for the same Covered Service through in-person diagnosis, consultation or treatment.

4. Pursuant to the obligations established by AB 457 Protection of Patient Choice in Telehealth Provider Act if a health care service plan offers a service via telehealth to an enrollee through a third-party corporate telehealth provider, third-party corporate telehealth provider shall:
   (a) Share enrollees record of services with their primary care provider, unless the enrollee objects
   (b) Ensure enrollees record are entered into a patient record system shared with the enrollee's primary care provider or are otherwise provided to the enrollee's primary care provider, unless the enrollee objects, in a manner consistent with state and federal law.
   (c) Provide to the carrier a roster of providers, upon request.
   (d) Comply with requests from Carrier to submit proof of enrollee consent form consistent with Section 2290.5 of the Business and Professions Code for auditing purposes.

Third-party corporate telehealth provider means a corporation directly contracted with a health care service plan that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

II

1. California Department of Insurance Requirements for Contracts between Network Providers and Insurers. The following provisions are required by Title 10 California Code of Regulations Section 2240.4 and shall apply to health care services rendered by the Provider with respect to Participants insured by CHLIC:
   (a) Provider shall not make any additional charges to Participants for rendering Covered Services except as provided for in the contract between CHLIC and the Participant (or the employer group under which the Participant is entitled to health coverage).

   (b) The parties acknowledge that Provider's primary consideration shall be the quality of the health care services rendered to the Participants.

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

   (d) The Agreement including this Addendum and any exhibits or documents referenced therein contains all the terms and conditions agreed upon by the parties pertaining to the rendering of Covered Services by the Provider to Participants.

III

1. Evernorth Healthcare of California, Inc. is a prepaid comprehensive health care service plan, licensed in the State of California under the Knox-Keene Health Care Services Plan Act of 1975, as amended, to provide or arrange for the provision of health care services to Participants of various prepaid health programs or plans operated by Evernorth Healthcare of California, Inc. that are subject to the requirements of Chapter 2.2 of Division 2 of the Code and Chapter 1 of Title 28 of the California Code of Regulations; any provision required to be in the contract by either of the above shall bind

the Plan whether or not provided in the contract.

2. Changes to Agreement applicable to Evernorth HealthCare of California, Inc. The following provisions apply with respect to services rendered by Provider to Participants covered by Evernorth HealthCare of California, Inc. and shall amend the corresponding terms in the base Agreement. The underscored language reflects the changes made to the corresponding term in the base Agreement as required by the California Department of Managed Health Care.

Emergency Medical Condition - Means a medical condition manifesting itself by acute symptoms of sufficient severity (including active labor and severe pain) such that a Participant could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

Emergency Services - Means those Covered Services that are (i) required by a Participant for the evaluation or stabilization of an Emergency Medical Condition, and (ii) furnished by a health care provider qualified to furnish Emergency Services. Where applicable, Emergency Services also means an additional screening, examination, and evaluation by an appropriate provider to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

Records.
Provider shall maintain medical records and documents relating to Participants as may be required by applicable law. but at any rate for at least two (2) years. Medical records of Participants and any other records containing individually identifiable information relating to Participants will be regarded as confidential, and Provider and Evernorth shall comply with applicable federal and state law regarding such records. Provider will obtain Participants' consent to or authorization for the disclosure of private and medical record information for any disclosures required under this Agreement if required by law. Upon request, Provider will provide Evernorth with a copy of Participants' medical records and other records maintained by Provider relating to Participants for purposes of conducting quality assurance and peer review, case management and utilization reviews, credentialing, payment adjudication and processing, resolving Participant grievances and appeals and other activities reasonably necessary for the proper administration of the Plans.
These records shall be provided to Evernorth at no charge and within the timeframes requested by Evernorth and will also be made available during normal business hours for inspection by Evernorth, Evernorth's designee, accreditation organizations, or to any governmental agency that requires access to these records. This provision survives the termination of this Agreement.

Compensation.
Payments for Covered Services will be the lesser of the billed charge or the applicable fee under Exhibit A, subject to the Medical Management Program and minus any applicable Copayments, Coinsurance and Deductibles. The rates in this Agreement will be payment in full by Payor for all services furnished to Participants under this Agreement. Provider shall submit claims for Covered Services at the location identified by Evernorth and in the manner

and format specified in this Agreement and the Medical Management Program. Claims for Covered Services must be submitted within ninety (90) days of the date of service or, if Payor is the secondary payor, within ninety (90) days of the date of the explanation of payment from the primary payor. Claims received after this ninety (90) day period may be denied, unless Provider submits evidence of good cause for the delay. Provider shall not bill Evernorth, the Payor or the Participant for those denied services. Amounts due and owing under this Agreement with respect to complete claims for Covered Services will be payable within forty-five (45) working days of receipt. If such claims are not processed within such timeframe, then late payment penalties will be paid to the extent required under applicable state prompt payment of claims laws. No other late payment penalties shall apply.

Amendment.

Except as provided hereafter, amendments of material terms of this Agreement shall be agreed to in advance in writing by Evernorth and Provider. Evernorth shall provide at least forty-five (45) business days' notice to Provider of its intent to change a material term of this Agreement unless the parties mutually agree to waive the notice. In the event that state or federal law or regulation or any accreditation requirements of an accreditation organization, should change, alter or modify the present services, levels of payments to Evernorth, standards of eligibility of Participants, or any operations of Evernorth, such that the terms, benefits and conditions of this Agreement must be changed accordingly, then upon notice from Evernorth, this Agreement shall be deemed to be automatically amended to conform to the requirements (including notice requirements if less than forty-five (45) business days) of such state or federal law or regulation, and Provider shall continue to perform Covered Services under this Agreement as modified.

The parties acknowledge that Evernorth may find it necessary to amend the Medical Management Program from time to time that will impact Provider. Evernorth shall notify Provider in writing of material revisions to the Medical Management Program, and such material revisions shall be deemed approved by Provider if Provider does not notify Evernorth of Provider's disapproval within forty-five (45) business days of receipt of notice of such material revisions. Provider's approval of such amendments shall not be unreasonably withheld, conditioned or delayed. If Provider disapproves of the change within the specified timeframe and the parties cannot reach agreement to the change in the Medical Management Program, Provider shall have the right to terminate the Agreement prior to the implementation of the change.

3. Provider shall report to Evernorth all surcharge and copayments paid by Participant directly to Provider in accordance with California Health and Safety Code § 1385. Surcharges are prohibited for Covered Services. If Evernorth learns that Provider is charging Participants a surcharge or a fee for sums owed by Evernorth for Covered Services, Evernorth shall take appropriate action against Provider.

4. Within each service area of the Plan, basic health care services shall be provided in a manner which provides continuity of care including the availability of primary care physicians who will be responsible for coordinating the provision of health care services to Participants.

IV

1. Office Hours and Accessibility: Primary care physicians and specialists must be available to provide services or arrange for services to be provided to Participants twenty-four (24) hours per day every day of the year. There must be a publicized telephone number for Participants to call and telephone calls must be answered promptly. Participants must be informed of the length of time they may expect to wait for a return call from a provider. Staff who answers calls must be trained in the appropriate response to medical calls of a routine, urgent or emergent nature, specifically in the types of questions to ask a caller. However, under no circumstances shall unlicensed staff attempt to assess, evaluate, advise or make any decisions regarding the condition of a Participant or determine when a Participant needs to be seen by a licensed medical professional. A provider's telephone answering machine and/or an answering service must clearly explains how Participants can get urgent or emergency care, and when it's appropriate, how they can contact another provider who's agreed to be on-call for triage and screening services or, if needed, give urgent or emergency care.

2. Access: Participants must have access to appropriate medical care within a reasonable length of time, appropriate to the individual Participant's health care needs.

3. Appointments and Scheduling Guidelines: The following guidelines represent both the Plan's and the state of California's requirements for appointment accessibility.

    a. Provider should ensure Participants have access to timely appointments and scheduling.
    b. Emergent or high risk cases should have access to immediate appointments, appropriate emergency room authorization or direction to dial 911.
    c. Urgent cases not requiring prior-authorization should have access to appointments within forty-eight (48) hours of the appointment request.
    d. If services must be prior authorized, appointments should be offered concurrent with the prior authorization request and the appointment should be provided within ninety-six (96) hours of the appointment request.
    e. Non-urgent, symptomatic or routine appointments with a mental health provider (non-psychiatrist) should be scheduled within 10 business days of the appointment request for initial appointments and within 10 business days of the prior appointment for follow-up appointments.
    f. Non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition should be scheduled within fifteen (15) days of the appointment request.
    g. Average waiting time in the office should not exceed thirty (30) minutes.
    h. When it is necessary for a provider or a Participant to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the Participant's health care needs, and ensures continuity of care consistent with good professional practice.
    i. California Department of Insurance requires that basic health care services (excluding emergency health care services) are available until at least 10:00 p.m. at least one (1) day per week or for at least four (4) hours each Saturday, except for Saturdays falling on holidays (§ 2240.1. Adequacy and Accessibility of Provider Services, Insurance Code 106(b)).

A prompt investigation will be required should Evernorth's monitoring efforts identify potential deficiencies. Such communication will be made in writing. A corrective action plan (CAP) will be required if deficiencies are confirmed. The CAP request will be made in writing and will include a description of the identified deficiency, the rational for the CAP request and the name and telephone number of the person authorized to respond to questions or concerns.

4. Customer Billing: Provider should not collect or attempt to collect or maintain any legal action against a Participant for any sums owed by Evernorth as per applicable law. Provider's agreement with Evernorth shall include the following language as required by California Health and Safety Code § 1379: contracted providers in California "shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Evernorth's or its designee's Utilization Management Program or other Medical Management Program, or failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles.

5. Medical Management Program; Precertification Protocol

    a. Utilization Management – Precertification of Inpatient Admissions
        i. Evernorth requires precertification for all planned inpatient non-obstetrical admissions for all of Evernorth's medical management models.
        ii. Evernorth reviews certain procedures to establish medical necessity, confirm that the proposed length of stay is appropriate, and determine if the requested services are covered benefits.
        iii. The following information is available on the Evernorth for Health Care Professionals website, Provider.Evernorth.com.
        iv. Note: Precertification requirements may vary based upon the delegated relationships between Evernorth and medical groups or hospitals. For some managed care programs, medical services may require prior authorization from both a delegated entity and Evernorth (e.g. inpatient stays for managed care patients affiliated with delegated entities). Other services may require prior authorization from only the delegated entity, or from Evernorth alone. Please contact Evernorth for clarification on specific precertification requirements for HMO, Network and POS plans.
    b. Post-Service Pre-Pay Medical Necessity List – review to determine which services will be reviewed for coverage retrospectively. Evernorth also recommends Provider review Evernorth's coverage criteria by accessing Evernorth's Coverage Policies on Provider.Evernorth.com > Resources > Reimbursement and Payment Policies. Services that are noted as not being medically necessary or experimental, investigational or unproven, may not be covered under either PHS or PHS+ plans.

6. Out-of-Network Referrals: Provider must refer patients to, or arrange for the provision of Covered Services by, Participating Providers except in the case of emergency or as otherwise required by law, or in the event that Participating Providers in the geographic area are unable to provide Medically Necessary services. Where Provider does refer patients to a non-Participating Provider, Provider must use Evernorth's Out-of-Network Referral Disclosure form, requesting a written agreement from the patient that states the patient knows the service may not be covered, and that if the patient has out-of-network benefits, that the patient may have higher out-of-pocket costs. Additionally, Provider must indicate to the patient whether or not Provider has a financial interest in the non-Participating Provider or facility. A copy of the form must be given to the patient and the original must be placed in the patient's medical file.

7. Non-Covered Services: When Provider determines that a service is not a covered benefit prior to the delivery of the service, Provider may request a written agreement from the patient that states the patient knows the service is not covered and agrees to pay directly for the specific service. If Provider

does not secure a written agreement for specified services from a patient receiving non-covered services, Provider may not charge the patient directly for the service.

8. Payment received is less than expected: In the event that Evernorth or a delegated payer, such as a medical group, pays Provider less than expected on a claim for Covered Services, the patient is not liable for any amount Provider believes is owed to Provider from Evernorth or the delegated payer. If Provider thinks a claim for Covered Services was not paid correctly, please submit an appeal through Evernorth's claim appeal process (Provider.Evernorth.com > Resources > Reimbursement and Payment Policies > Claim Appeals Policies and Procedures). Explain in the appeal why Provider thinks Provider's claim was not paid correctly and include additional detail as appropriate.
    a. Provider's Evernorth Agreement: The Agreement with Evernorth includes the following language as required by California Health and Safety Code § 1379: contracted providers in California "shall not bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payer for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Evernorth's or its designee's utilization management program or the Medical Management Program, or failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles."

       In an effort to support access to quality care for Plan Participants, Evernorth continually reviews its precertification process and requirements. Updates include additions and removals based on the Evernorth review process, as well as new Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes that require precertification. Evernorth may make additional changes to the precertification requirements, as needed.

9. Maternal Mental Health Program:

   California Assembly Bill (AB) 2193 requires:
   1) Health plans to develop a maternal mental health program, and
   2) Obstetricians (including OBGYNs, nurse midwives, and family practice physicians who deliver babies) to screen pregnant women for maternal mental health disorders including but not limited to postpartum depression in accordance to sound clinical practice guidelines and using validated screening tools.

   Evernorth offers a high-risk pregnancy case management program that provides customers with support in managing treatment and accessing behavioral health care. To learn how patients with Evernorth coverage can enroll in this program, Provider may call Evernorth or direct them to call Evernorth at 1.800.615.2906. Patients with Evernorth coverage may also seek treatment for these disorders directly and learn about qualified in-network behavioral health providers by visiting myEvernorth.com or calling the telephone number on the back of their ID card.

10. Autism Behavioral Health Treatment Requests:
    Patients enrolled in any Evernorth plan type that have behavioral health benefits through Evernorth should submit requests for autism behavioral treatment through the Evernorth Behavioral Health autism prior-authorization team. A mental health coordinator will verify benefits and review the request against the requirements noted in California SB 964 (2011). Review requests may be submitted by the Participant, the treating physician or the delegated medical group by contacting Evernorth at

1.800.Evernorth24 (1.800.244.6224). Select the prior authorization prompt, then the Evernorth Behavioral Health prompt.

For Participants that belong to a delegated capitated medical group, Evernorth maintains financial risk for behavioral health services, including ABA therapy.

For more information on Assembly Bill 1000 and referral requirements, please visit the California Legislative Information homepage at http://leginfo.legislature.ca.gov/faces/home.xhtml# > Bill Information > Bill Number AB 1000

11. Claims and Compensation:
    a. California Specific Prior Authorization Guarantee:
    Providers who wish to pursue payment for services which Evernorth provided written authorization and verification of eligibility for a Participant who subsequently is determined not to be eligible, do not bill the member and instead the following steps should be taken:
    - Use best efforts to collect the charges directly from the responsible party including: another insurance company, the government, a self-insured employer, or the participant.
    - If the responsible party is a Participant and the Provider receives no payment for at least three (3) billing cycles, request reimbursement by submitting a written dispute/appeal as per the Dispute Resolution process outlined in this Addendum. Evernorth will provide compensation for the Covered Services rendered at the rate set forth in the contract, less applicable Copayments, Coinsurance and Deductibles.
    - The dispute should include the Evernorth authorization and either the notes from your Accounts Receivable (AR) system indicating that the ineligible Participant was billed three (3) cycles, and if applicable that the other insurance was billed and payment wasn't received, or a copy of the last bill sent to the Participant and if applicable a (EOP) received from the other insurance carrier.

    File the appeal for reimbursement either three hundred sixty-five (365) days from the Evernorth issued denial (standard California dispute submission timeframe) or one hundred twenty (120) days from the last billing cycle, whichever is more, for the request to be considered.

12. Uniform Prior Authorization Drug Form Requirements:

    California Senate Bill 866 requires the use of a uniform prior authorization drug form by all insurers and plans effective April 1, 2014. Provider can complete the standardized form on the Evernorth for Health Care Professionals website at Provider.Evernorth.com > Resources > Forms Center > State Specific Forms > California General Medication Prior Authorization Form.

    To prevent inadvertent delays related to Evernorth's request for additional information, please provide as much detail as possible about the request. Provider can review Evernorth's pharmacy coverage policies (Provider.Evernorth.com > Resources > Coverage Policies > Pharmacy A-Z Index) and attach any relevant chart notes and lab results that will facilitate the review.

    If Provider has questions about California Senate Bill 866 and the use of prior authorization drug forms, call Evernorth's pharmacy service center at the number on Provider's patient's ID card, and press the prompt for provider and pharmacy services.
    For more information on Senate Bill 866 and referral requirements, please visit the California Legislative Information home page at: http://leginfo.legislature.ca.gov/faces/home.xhtml# > Bill Information > Bill Number SB 866

13. Prohibition Against Participant Billing:
    Contracted providers should not bill the Evernorth Plan Participant for payments that are denied on the basis that the provider failed to submit the request for review or arbitration within the required time frames, nor shall contracted provider bill participants for amounts greater than their contracted rates (other than applicable Copayments/Coinsurance).

14. Participant Information:
    a. Interpretation Services for Limited English Speaking Patients
        i. Participants who reside in the state of California have the right to an interpreter when receiving treatment and services. Providers must follow applicable state and federal regulations to deliver language services through trained and qualified interpreters. Evernorth offers contracted providers access to free telephonic interpretation through a qualified language service vendor 24 hours a day/7 days a week. To engage an interpreter once the participant is ready to receive services, please call 1.800.806.2059. Provider will need the participant's Evernorth ID number, date of birth and your Tax ID number to confirm eligibility and access interpretation services. It is not necessary to arrange for these services in advance.
        ii. If a participant prefers to use a family member or friend to provide interpretation services, after s/he has been told that a trained interpreter is available free of charge, the participant's refusal to use the trained interpreter shall be documented in the participant's medical record, when in a provider setting, or the participant's administrative file (call tracking record) in the Customer Services setting.
    b. Participant Grievance Process
        i. If participants have complaints or appeals about administration, coverage or exclusions in their benefit plan, or service or care received, they can contact Evernorth Customer Service for plan participants using the number on their ID card. Participants may also complete and submit our standard grievance form to file their complaint or appeal. Evernorth's California Medical Grievance Form and California Grievance Brochure (outlining submission instructions) are available on our website at Evernorth.com > I Want To > Find a Form, or at the following link: http://www.Evernorth.com/customer-forms. To view and print this information, scroll down to the California Specific Forms section of the webpage.
        ii. In accordance with state law, copies of the California Grievance Form must be made available to Evernorth participants at all affiliated provider offices. Hard copies of these forms are available on our website in Evernorth's threshold languages (English, Spanish and Traditional Chinese) to accommodate our limited English proficient (LEP) customers. Copies should be distributed annually to all affiliated providers offices with instructions to supply the form to any patient with Evernorth coverage who communicates dissatisfaction with the services or care received, a utilization management decision or a claim denial.
        iii. It is Evernorth's policy to provide all participants who are filing a grievance and who are in need of language assistance, with such assistance upon request. This assistance is not limited to those who speak certain non-English languages. Evernorth participants may request assistance by calling Evernorth Customer Service using the telephone number on the back of their ID cards.
        iv. Once a complaint or appeal is received by Evernorth, Evernorth's investigation process may include outreach by an Evernorth representative to the administrative or claim office or to a specific provider in order to obtain information that will aid in the resolution of the concern or complaint; and to provide an opportunity for the provider to respond to the concern or complaint.

v. Evernorth provides information, on our website, to participants on how to contact their health plan, file a complaint, obtain assistance from the DMHC and seek an Independent Medical Review (IMR). IMR forms are available in non-English languages, including English, Spanish and Traditional Chinese, on the DMHC website at dmhc.ca.gov > File a Complaint > Submit an Independent Medical Review > Complaint Form. Hard copies may be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

COLORADO REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between EVERNORTH Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Colorado regarding provider contracts with providers rendering health care services in the State of Colorado. To the extent that such Colorado laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Colorado laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1)(A) The definition for Emergency Services, if any, shall comply with Colorado laws and regulations to the extent applicable.

(1)(B) "Participating Provider" shall mean, to the extent necessary to comply with applicable laws and regulations, a hospital, physician or group of physicians, or any other health care practitioner or entity, either within or outside of Colorado, that has a direct or indirect contractual arrangement with Evernorth to provide Covered Services with regard to the Plan covering the Participant.

(2) Provider shall receive payments for Covered Services as set forth in the Agreement. Colorado law prohibits the use of financial disincentives or the withholding of full compensation because of the number or type of referrals made by Provider to Participating Providers in accordance with applicable utilization management requirements concerning the provision of Covered Services to Participants.

(3) Pursuant to the requirements of Section 10-16-704 (4.5), Colorado Revised Statutes, to the extent applicable:

With respect to services reimbursed on a fee-for-service basis, if Provider believes Provider has been underpaid for a Covered Service, Provider must submit a written request for an appeal or adjustment with Evernorth or its designee within twelve (12) months after the date of the original payment or explanation of benefits.

With respect to services reimbursed on a fee-for-service basis, Payor may only retroactively adjust reimbursement made to Provider during the twelve (12) month period after the date of the original explanation of benefits.

Adjustments to claims related to coordination of benefits with federally funded health benefit plans, including Medicare and Medicaid, shall be made within thirty-six (36) months after the date of service.

(4) Neither Provider nor Evernorth is prohibited from protesting or expressing disagreement with a medical decision, medical policy or medical practice of Provider or Evernorth.

(5) If the Participant's primary care physician, in consultation with the Participant and their participating specialist determines that the Participant needs ongoing care from such specialist, the Participant may receive a referral for Medically Necessary treatment to such participating specialist ("Standing Referral"). A time period for the Standing Referral of up to one (1) year (or longer if authorized by Evernorth) shall be determined by the primary care physician, in consultation with the participating specialist. The Participant's primary care physician shall record the reason, diagnosis or treatment plan necessitating the Standing Referral. The participating specialist shall refer the Participant back to the primary care physician for primary care. The participating specialist shall be compensated for Covered Services rendered to any Participant in accordance with their agreement with Evernorth.

(6) Evernorth may not take an adverse action, as defined by applicable state laws or regulations, against Provider because: a) Provider expresses disagreement with Evernorth's decision to deny or limit benefits to a Participant or assists the Participant to seek reconsideration of Evernorth's decision; or b) 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 Evernorth or not, policy provisions of a plan or Provider's personal recommendation regarding selection of a health plan based on Provider's personal knowledge of the health needs of such patients.

(6)(A) Evernorth may not take an adverse action, as defined by applicable state laws or regulations, against Provider because Provider, acting on good faith: communicates with a public official or other person concerning public policy issues related to health care items or services; files a complaint, makes a report, or comments to an appropriate governmental body regarding actions, policies, or practices of Evernorth that Provider believes might negatively affect the quality of, or access to, patient care; provides testimony, evidence, opinion, or any other public activity in any forum concerning a violation or possible violation of any provision of C.R.S.A. § 10-16-121; reports what Provider believes to be a violation of law to an appropriate authority, or; participates in any investigation into a violation or possible violation of any provision of C.R.S.A. § 10-16-121.

(6)(B) Evernorth may not take an adverse action, as defined by applicable state laws or regulations, against Provider or provide financial incentives or subject Provider to financial disincentives based solely on a patient satisfaction survey or other method of obtaining patient feedback relating to the patient's satisfaction with pain treatment.

(7) In the event the Agreement is terminated due to expiration or nonrenewal, or the Benefit Plan is terminated or changed, resulting in a loss of benefits with respect to Provider, the provisions of Section 10-16-705(4), as amended by 2022 CO SB 1284 (Laws of 2022 ch. 446), of the Colorado Statutes shall apply.

(8) If Provider is not a hospital, Agreements for less than two (2) years in duration may be terminated without cause by Evernorth or Provider with ninety (90) days advance written notice to the other party. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider or Evernorth, such longer notification period will apply.

(9) If Provider is a hospital, Evernorth and Provider shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider or Evernorth, such longer notification period will apply.

(10) If Provider is not a hospital, the following provisions shall apply:

(a) Agreements for two (2) or more years in duration may be terminated without cause in accordance with the terms set forth in the Agreement.

(b) Evernorth can terminate Provider's participation immediately (or upon such longer notice required by applicable law, if any) if such Provider no longer maintains the licenses required to perform their duties under the Agreement, Provider is disciplined by any licensing, regulatory, accreditation organization, or any other professional organization with jurisdiction over Provider, or if Provider no longer satisfies Evernorth's credentialing requirements.

(c) Evernorth or Provider can terminate the Agreement if the other becomes insolvent.

(d) Any termination notice must be in writing and sent by United States mail, postage prepaid, to Evernorth to the address provided pursuant to the Notice section of the Agreement. Evernorth may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's email address. Either party can change the address for notices by giving written notice of the change to the other party in the manner just described.

(e) Payment terms shall not survive the termination of the Agreement except as required by law or as agreed upon by Provider.

(f) Evernorth shall provide Provider with at least ninety (90) days written notice of the effective date of a Material Change to the Agreement. Such notice will be conspicuously entitled "NOTICE OF MATERIAL CHANGE TO CONTRACT."

"Material Change" means a change to an Agreement that: a) decreases the Provider's payment or compensation; b) changes the administrative procedures in a way that may reasonably be expected to significantly increase the Provider's administrative expense; c) replaces the maximum allowable cost list used with a new and different maximum allowable cost list by a person or entity for reimbursement of generic prescription drugs; or d) adds a new category of coverage.

A Material Change does not include: a) a decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the Agreement; b) a decrease in payment or compensation resulting from a change in an Agreement for pharmacy services such as a change in a fee schedule based on average wholesale price or maximum allowable cost; c) a decrease in payment or compensation that was anticipated under the terms of the Agreement, if the amount and date of applicability of the decrease is clearly identified in the Agreement; d) an administrative change that may significantly increase the Provider's administrative expense, the specific applicability of which is clearly identified in the contract; e) changes to an existing prior authorization, precertification, notification or referral program that do not substantially increase the Provider's administrative expense; or changes to an edit program or to specific edits.

If Provider objects in writing to the material change within fifteen (15) days and there is no resolution of the objection, Evernorth or Provider may terminate the Agreement upon written notice to the other party but no later than sixty (60) days prior to the effective date of the Material Change.

If Provider does not object to the Material Change within fifteen (15) days, the change shall be effective as specified in the notice.

If the Material Change is the addition of a new category of coverage and Provider objects within fifteen (15) days, the Material Change shall not be effective and Evernorth may not terminate Provider for this reason.

Notwithstanding anything in this section, Evernorth may modify the Agreement by operation of state or federal law or regulation and Evernorth may make such notification to Provider by any reasonable means.

(11) Provider shall, consistent with state and federal statutes and regulations, share medical record information with providers treating or who have treated the same health maintenance organization plan Participant which facilitates the continuity of health care services.

(12) Intermediary Contracts. If Provider is an Intermediary as defined by C.R.S.A. § 10-16-102(25.5) and 3 Colo. Code of Regs. § 4.2-15(IV)(B), or any other applicable law, Provider as an Intermediary agrees to the following:

(a) If contracted to perform utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, disease management programs, or any other program subject to Section 10-16-705(6.5) C.R.S., Intermediary shall comply with the same standards, guidelines, medical policies, and benefit terms as Evernorth.

(b) If contracted to perform utilization management, utilization review, provider credentialing, administration of health insurance benefits, setting or negotiation of reimbursement rates, payment to providers, network development, disease management programs, or any other program subject to Section 10-16-705(10.5)(a) C.R.S., Intermediary shall indicate the name of Intermediary and the company for which it is conducting the work when making any payment to a health care provider on behalf of Evernorth.

(c) Intermediary will comply, and shall require Subcontracted Providers to comply, with all of the applicable requirements of Section 10-16-705, C.R.S.

(d) Evernorth is responsible for ensuring that Subcontracted Providers have the capacity and legal authority to furnish Covered Services.

(e) Evernorth has the right to approve or disapprove participation status of Subcontracted Providers in its own or a contracted network for the purpose of delivering Covered Services to its Participants.

(f) Intermediary shall provide Evernorth with copies of Subcontracted Providers' contracts in accordance with applicable law and Evernorth shall maintain copies of all such contracts.

(g) As applicable, Intermediary shall transmit utilization documentation and claims paid documentation to Evernorth. Evernorth shall monitor the timeliness and appropriateness of payments made to providers and health care services rendered to Participants.

(h) As applicable, Intermediary shall maintain books, records, financial information,

and documentation of services provided to Participants at the Intermediary's place of business in the State of Colorado.

(i) Intermediary agrees to allow the Commissioner of the Division of Insurance for the State of Colorado access to the Intermediary's books, records, financial information and any documentation of services provided to Participants as necessary to determine compliance with the law.

(j) Evernorth shall have the right, in the event of Intermediary's insolvency, to require the assignment to Evernorth of the provisions of a Subcontracted Provider's contract addressing the provider's obligations to furnish Covered Services.

(13) Summary Disclosure Form: Evernorth provides a Summary Disclosure Form during the contracting process and upon request thereafter. Evernorth will make available copies of fee schedules and supply Material Change Notices when applicable. As a reminder, this disclosed information is considered confidential as defined by the Agreement.

(14) Eligibility Verification Mechanisms: In accordance with Colorado law, a participating physician, hospital, ancillary or other health care professional (collectively referred to as "health care professionals") may determine, at the time services are provided, whether or not a person is covered by Evernorth. Within two (2) business days prior to rendering services, participating health care professionals may:

Call Evernorth directly at 800.926.2273 to request an eligibility verification number from Provider Service. A unique 10-digit Service Request number will be provided. Or, Participating Providers can obtain an electronically dated eligibility screen print from the Evernorth provider website (Provider.Evernorth.com). Evernorth will accept the screen print as proof of eligibility verification.

(15) Participant ID Cards: Colorado uses Participant ID cards with a unique format and content as prescribed by Colorado state law. For more information on Colorado specific participant ID cards call Customer Service (see How to Contact Us section of the guide).

(16) Covered Services: Covered Services or treatment rendered at a network facility, including covered ancillary services, or treatment rendered by an out-of-network provider performing the services or treatment at a network facility, must be covered at no greater cost to the Covered Person than if the services or treatment were obtained from an in-network provider.

(17) Carrier Dispute Resolution Process: If Provider is a Participating Provider and Provider has an administrative, payment or other dispute that does not involve a utilization

review analysis or routine inquiry, then Provider or Provider's representative may present a second level appeal to a Health Care Professional Carrier Dispute Resolution Committee in person or via teleconference or videoconference. The Committee will make a decision based on evidence or documentation and information presented during the meeting. If Provider would like to present Provider's second level appeal to a Health Care Professional Carrier Dispute Resolution Committee, Provider should send the request and additional supporting information, within sixty (60) calendar days to Evernorth, Attn: Health Care Professional Carrier Dispute, P.O. Box 188011, Chattanooga, TN 37422. Provider will receive a confirmation letter within thirty (30) calendar days of Evernorth's receipt of Provider's request for a Health Care Professional Carrier Dispute Resolution Committee meeting.

(18) Uniform Credentialing Form: The Colorado legislature has mandated that all health care entities and all health care plans engaged in the collection of information to be used in the process of credentialing and recredentialing of providers use this form.

Evernorth credentials all providers with whom we have both an independent relationship and are directly contracted. We will use the mandated Colorado Health Care Professional Credentials Uniform Application and will accept electronic and paper copy applications. Evernorth HealthCare of Colorado, Inc. participates in the Coalition for Affordable Quality Healthcare (CAQH) credentialing initiative. Providers are not restricted to submitting applications through CAQH. CAQH participating providers must update CAQH's dataset to accommodate new questions on the Colorado application.

A health care professional means any:

physician	dentist	dental hygienist	chiropractor
podiatrist	psychologist	certified nurse midwife	optometrist
acupuncturist	licensed clinical social worker	ophthalmologist	osteopath
registered professional nurse			

Or any other provider who is registered, certified or licensed by the state of Colorado, who practices or intends to practice, in Colorado, and who is subject to credentialing.

(19) Credentialing timing: Evernorth will send provider written or electronic receipt within seven (7) days of receiving an application. Upon receipt of the application, Evernorth will promptly determine whether the application is complete. If the application is incomplete, Evernorth will notify the applicant in writing or by electronic means within ten (10) calendar days after the date Evernorth received the application. This notice will

describe the items that are required to complete the application.

If Evernorth receives a completed application but fails to provide the provider a receipt in written or electronic form within seven (7) calendar days after receiving the application, Evernorth must consider the provider a participating provider, effective no later than fifty-three (53) calendar days following the receipt of the application.

Evernorth must conclude the process of credentialing a provider within 60 calendar days after it receives the provider's completed application. Evernorth must provide each provider written or electronic notice of the outcome of the provider's credentialing within 10 calendar days after the conclusion of the credentialing process. After concluding the credentialing process for any provider and making a determination regarding the provider's application, Evernorth must provide to the provider, at the provider's request and as allowed by law, all non-proprietary information pertaining to the application and to the final decision regarding the credentialing application.

The Commissioner has the authority to enforce these requirements and impose penalties for violations.

(20) Preventive Care: Evernorth follows the recommendations of the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices, and complies with federal and state requirements when determining preventive care benefits.

(21) Evernorth Care Designation Appeals Process for Colorado Health Care Professionals:

(a) Procedures to Obtain Additional Information:

To review additional quality and cost-efficiency information, obtain a full description of the methodology and data that our decisions were based on or declined, the Provider should submit the request by email at PhysicianEvaluationInformationRequest@Evernorth.com or by faxing the request to 866.448.5506.

A Network Clinical Manager will contact the Provider to provide additional details about the process and the results. If the request is regarding the methodology and data that the designation decisions were based on or declined, Evernorth will provide the Provider or Provider Group with this information within forty-five (45) days of our receipt of the request. Where the law or Evernorth's contractual obligations with a third party prevents disclosure of the data required to be disclosed, Evernorth will provide sufficient information to allow the Provider or Provider Group to determine how the withheld data affected the designation. After disclosure of the description of the methodology described above, the Provider or Provider Group may request further information related to the designation decisions. Such further information, if it exists and has not been previously disclosed, will be provided by Evernorth within thirty (30) days of the request.

The "Evernorth Care Designation and Quality and Cost-Efficiency Profiles Methodology" is available on the Evernorth provider -website at Provider.Evernorth.com.

(b) Request an Appeal of the Designation Decision:

To request an appeal of Evernorth Care designation and quality and cost-efficiency displays in Colorado (including the opportunity for a face-to-face meeting), have corrected data relevant to the designation decision considered, have the applicability of the methodology used in the designation decision considered, or to submit additional information, the Provider should contact the email or fax number noted above. A Network Clinical Manager will contact the Provider or Provider Group to provide additional details about the process and the results.

The National Selection Review Committee, who review all appeal requests, is a national committee that reviews appeal and reconsideration requests with Evernorth participants in locations other than Colorado. The committee participants are listed below:

- Voting Committee Participants
  - National Medical Director for Network Clinical Performance and Improvement (Chair)
  - Physician representatives from the four regions, their alternates, and ad hoc physicians
    Non-voting Committee Participants
  - Assistant Vice President, Provider Measurement and Performance
  - National Network Business Project Senior Analyst – Network Management
  - Health Data Senior Specialist, Clinical Insights Provider Metrics
  - Marketing Product Senior Specialist
  - Network Clinical Managers

- Non-voting and Ad hoc Committee Participants
  - Network Product Integration Lead when a reconsideration is pertinent to their market
  - Market Medical Executive when a reconsideration is pertinent to their market

Upon request, the physician will be provided with the name, title, qualifications, and relationship to Evernorth of the persons participating on the National Selection Review Committee who are responsible for making a determination on the Provider's appeal. If requested, a face-to-face meeting will be arranged at a location reasonably convenient to the Provider; other participants can join the meeting using teleconference.

The Provider has the right to be assisted by a representative. The provider should provide the name and credentials of the representative to the Network Clinical Manager at least two (2) weeks in advance of the scheduled Selection Review Committee meeting. If the Provider requests an explanation of the designation decision, which is the subject of the appeal to be considered as part of the appeal, it will be included.

The Provider or Provider Group will receive a written decision regarding the physician's appeal that states the reasons for upholding, modifying, or rejecting the Provider's appeal. The appeal process will be completed within forty-five (45) days from the date the data and methodology are disclosed unless otherwise agreed to by the parties to the appeal. No change or modification of a designation that is the subject of an appeal shall be implemented or used until the appeal is final. Evernorth will update any changes to designations previously disclosed publicly within thirty (30) days after the appeal is final.

CONNECTICUT REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Connecticut regarding provider contracts with providers rendering health care services in the State of Connecticut. To the extent that such Connecticut laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Connecticut laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for Emergency Services, if any, shall comply with Connecticut laws and regulations to the extent applicable.

(1.1) "Material Change" or "Material Adverse Change" shall mean a change that could reasonably be expected to have a material adverse impact on the aggregate level of payment by Evernorth or Payor to Provider for Covered Services under this Agreement, or on Provider's administration of their services.

(1.2) "Timely Notice" shall mean the timeframes established by the parties for advance written notice of a Material Change as set forth in this Addendum.

(2) Provider, in utilizing laboratories or testing facilities for Participants, shall utilize laboratories or testing facilities that are Participating Providers or notify the Participant if Provider intend to utilize a laboratory or testing facility that is not a Participating Provider.

(3) Evernorth and Provider shall provide at least ninety (90) days' written notice to each other before Evernorth removes Provider from the network or Provider leaves the network. Provider shall, within thirty (30) days of receiving or issuing a written notice under this section, provide to Evernorth a list of its patients who are Participants who have been treated by Provider within the last twelve (12) months.

(3.1) If Provider is a hospital, the parties shall continue to abide by the terms of the Agreement, including reimbursement terms, for a period of sixty (60) days from the date of nonrenewal or termination of the Agreement by either party, except where the parties agree in writing to the termination of the Agreement and provide Participant notices applicable under state laws and regulations.

(3.2) Evernorth shall administer Participant requests for continuity of care in accordance with applicable state laws and regulations, including but not limited to C.G.S.A. § 38a-472f(g)(2)(B).

(4) (A) Provider hereby agree that in no event, including, but not limited to, nonpayment by Payor, Evernorth or an intermediary, Evernorth's insolvency or the insolvency of an intermediary, or breach of the Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Participant or person acting on the Participant's behalf, other than Payor, Evernorth or an intermediary, for services provided pursuant to the Agreement. The Agreement and this provision shall not prohibit collection of Coinsurance, Deductibles, Copayments or cost-sharing amounts, or costs for non-covered services delivered on a fee-for-service basis, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Participants in accordance with the terms of the Participant's Plan.

(A)(1) The Agreement does not prohibit Provider and a Participant from agreeing to continue services solely at the expense of Participant as long as Provider has clearly informed Participant that such services are not covered or are no longer covered. Except as provided herein, the Agreement does not prohibit Provider from pursuing any available legal remedy.

(B) Provider agree, in the event of Evernorth's insolvency, to continue to provide Covered Services to Participants for the duration of the period for which premiums on behalf of the Participant were paid to Evernorth, or until the Participant's discharge from inpatient facilities, whichever time is greater.

(B)(1) In the event of Evernorth's or an intermediary's insolvency or other cessation of operations, Provider shall deliver Covered Services to Participants without requesting payment from a Participant other than a Coinsurance, Copayment, Deductible or other out-of-pocket expense for such services until the earlier of the termination of the Participant'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 applicable state law, or are totally disabled, or (ii) the date the Agreement would have terminated if Evernorth or an 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.

(C) Notwithstanding any other provision in the Agreement, nothing in the Agreement shall be construed to modify the rights and benefits contained in the Participant's Plan.

(D) Provider may not bill a Participant for Covered Services, except for cost-sharing amounts, where Evernorth denies payment because Provider have failed to comply with the terms or conditions of the Agreement.

(E) Provider further agrees (i) that the provisions of paragraphs (A), (B), (C) and (D) of this section shall survive termination of the Agreement regardless of the cause giving rise to

termination and shall be construed to be for the benefit of the Participant, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Participant, or persons acting on Participant's behalf.

(F) If Provider contracts with other providers or facilities who agree to provide Covered Services to Participants with the expectation of receiving payment directly or indirectly from Payor, such providers or facilities shall agree to abide by the provisions of paragraphs (A), (B), (C), (D) and (E) of this section.

(5) Pursuant to Connecticut law, it is an unfair trade practice for Provider to request payment from a Participant, other than Coinsurance, Copayment, Deductible or other out-of-pocket expense for Covered Services or Emergency Services, or facility fees or surprise bills as defined by applicable state laws, or to report to a credit reporting agency a Participant's failure to pay a bill for such services when Evernorth has primary responsibility for payment of such services, fees or bills.

(6) If Provider is not a hospital, Evernorth may make Material Changes to Provider's fee schedule once annually upon at least ninety (90) days advance written notice. Upon receipt, Provider may accept the changes, or terminate the Agreement by giving at least sixty (60) days advance written notice. Evernorth may make Material Changes to Provider's fee schedule at any time as permitted under applicable law subject to at least thirty (30) days advance written notice of the changes.

(6.1) Evernorth shall give Provider at least ninety days' advance written notice of any change to the provisions of the Agreement or other documents incorporated by reference in the Agreement, and any change to the Administrative Guidelines, provider manuals and policies incorporated by reference in the Agreement, that will result in a Material Change to the Agreement or the procedures that Provider must follow pursuant to the Agreement.

(6.2) Evernorth shall afford Provider the right to appeal any proposed change to the provisions, other documents, Administrative Guidelines, provider manuals or policies incorporated by reference in the Agreement.

(7) If Provider is not a hospital, Evernorth shall not cancel, deny or demand the return of full or partial payment for an authorized Covered Service due to administrative or eligibility errors more than eighteen (18) months after the receipt of a clean claim except as permitted under applicable law. Evernorth shall provide at least thirty (30) days advance written notice of any cancellation, denial or demand.

(8) If included in the Agreement, a "Most Favored Nation" provision prohibited by C.G.S.A. § 38a-479b(c) is hereby deleted in its entirety.

(9) In addition to the terms of the Agreement establishing requirements for records, 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. 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.

(10) Subrogation/Worker's Compensation: Subrogation applies if the patient with Evernorth coverage is injured in an accident of any type and someone else is responsible for the injury. Examples may include motor vehicle accidents, dog bites, slips and falls, or the results of an act by a third party. State law may prohibit recovery of subrogation claims in certain circumstances.

(11) Precertification Protocol: Precertification of coverage is not required for Emergency Services. However, Emergency Services resulting in a hospital admission should be reported on the day of admission to the patient's primary care physician where applicable and to Evernorth if Evernorth has weekend and after-hours coverage or within twenty-four (24) hours or the next business day for remaining locations.

(12) Referrals: Child Early Intervention services do not require a referral for a specialist to provide services to assess or provided as part of an individualized family services plan (IFSP).

(13) Retroactive Adjustments and Denials:

(A) Advance Notice to Deny, Cancel, Recover Payment:

a. The organization shall give at least thirty (30) days' advance notice to a health care professional by mail, electronic mail or facsimile of the organization's cancellation, denial or demand for the return of full or partial payment.
b. When the exception is for return of full or partial payment from a health care professional, the notice shall disclose (i) the amount that is demanded to be returned, (ii) the claim that is the subject of such demand, and (iii) the basis on which such return is being demanded.

(B) Health Care Professional Dispute Rights, Responsibilities & Time Lines

a. No later than thirty (30) days after the receipt of the notice, a health care professional may appeal such cancellation, denial or demand in accordance with the procedures provided by such organization. Any demand for the return of full or partial payment shall be stayed during the pendency of such appeal.
b. If there is no appeal or an appeal is denied, the health care professional may resubmit an adjusted claim to the organization not later than thirty (30) days after the receipt of the notice or the denial of the appeal, whichever is applicable.
c. If a return of payment was demanded, the disputed claim shall not be resubmitted.
d. A health care professional shall have one (1) year after the date of the written notice to identify any other appropriate insurance coverage applicable on the date of service and to file a claim with the organization, regardless of the organization's timely filing requirements.

(C) Exceptions to 18-Month Time Period

a. The law allows organizations to cancel, deny payment recovery requirement more than eighteen (18) months after receipt of a clean claim in these exception situations:
    i. The organization has documented basis to believe that such claim was submitted fraudulently by such health care professional;
    ii. The health care professional did not bill appropriately for such claim based on the documentation or evidence of what medical service was

actually provided;

iii. The organization has paid the health care professional for such claim more than once;

iv. The organization paid a claim that should have been or was paid by a federal or state program; or

v. The health care professional received payment for such claim from a different insurer, payor or administrator through coordination of benefits or subrogation, or due to coverage under an automobile insurance or workers' compensation policy (in which case, the health care professional shall have one (1) year after the date of the cancellation, denial or return of full or partial payment to resubmit an adjusted secondary payor claim with the organization on a secondary payor basis, regardless of such organization's timely filing requirements).

(14) Other Important Information: The applicable contracted rate includes all Medically Necessary services that hospitals customarily provide to outpatients and specifically excludes those services, which, in accordance with community standards, are considered office-based procedures, or services.

(15) Emergency Room, Ambulatory Surgery and Observation Admissions: If a patient with Evernorth coverage is admitted as an inpatient from hospital's emergency, outpatient, rapid treatment or observation or ambulatory surgery facility, all such facility charges are included in and are part of the compensation for inpatient services. If a patient with Evernorth coverage is admitted to a hospital's ambulatory surgical facility from the hospital's emergency area, all such emergency charges are included in and are part of the applicable outpatient surgery rate. If a patient with Evernorth coverage is admitted to the observation unit from the hospital's emergency area, all such emergency charges are included in and are part of the applicable observation rate. If a patient with Evernorth coverage is admitted to the observation area from the ambulatory or outpatient surgery facility or the cardiac catheterization/angioplasty laboratory, all such observation unit charges are included in and part of the applicable ambulatory or outpatient surgery rate or cardiac catheterization or angioplasty rate. Under no circumstances shall the cost of Medically Necessary rapid treatment or observation care exceed the cost of an inpatient medical per diem. If the primary reason for admission from the ambulatory surgery facility is associated with the hospital's scheduling or administrative procedures, the ambulatory surgery rate will apply.

(16) Provider Responsibility: The provider is responsible for notifying a covered customer of their financial obligations for non-covered services, if possible, prior to the delivery of the non-covered health services.

DISTRICT OF COLUMBIA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the District of Columbia regarding provider contracts with providers rendering health care services in the District of Columbia. To the extent that such District of Columbia laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such District of Columbia laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

A. (1) Payor may only retroactively deny reimbursement to Provider:

(a) For services subject to coordination of benefits with another health insurer during the eighteen (18) month period after the date that the Payor paid the Provider; or

(b) Except as provided in paragraph A. (1) (a) of this subsection, during the six (6) month period after the date that the Payor paid the Provider.

(b)(i) A Payor that retroactively denies reimbursement to a Provider under subsection A. (1) (a) shall provide the Provider with a written statement specifying the basis for the retroactive denial. If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

(2) This subsection shall not apply if a Payor retroactively denies reimbursement to a Provider because:

(a) The information submitted to the Payor was fraudulent;

(b) The information submitted to the Payor was improperly coded and the Payor has provided to the Provider sufficient information regarding the coding guidelines used by the Payor at least thirty (30) days prior to the date the services subject to the retroactive denial were rendered; or

(c) The claim submitted to the Payor was a duplicate claim.

(3) Information submitted to the Payor may be considered to be improperly coded under paragraph A. (1) (a) of this subsection if the information submitted to the Payor by the Provider:

(a) Uses codes that do not conform with the coding guidelines used by the Payor applicable as of the date that services were rendered; or

(b) Does not otherwise conform with the contractual obligations of the Provider to the Payor applicable as of the date that services were rendered.

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

(d) A Payor that retroactively denies reimbursement to a Provider under this section shall provide the Provider with a written statement specifying the basis for the retroactive denial.

(e) This section shall not apply to an adjustment to reimbursement made as part of an annual contracted reconciliation of a risk-sharing arrangement.

(4) In the event the Agreement is terminated by either party, Evernorth shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.

(5) Except in cases where termination of the Agreement was due to failure to meet quality standards of care or fraud, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination as follows. When Medically Necessary, Participants with serious illness undergoing a course of treatment or who are in the second trimester of a pregnancy shall be permitted to continue to receive Medically Necessary Covered Services, with respect to the course of treatment or for such pregnancy, for ninety (90) days from the date of the notice of termination. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Plan. Provider has no obligation under the Agreement to continue to provide services to individuals who cease to be Participants.

(6) To the extent required by D.C. Code § 31-3132, Evernorth shall allow Provider a minimum of one hundred eighty (180) days from the date a Covered Service is rendered or the date of inpatient discharge to submit a claim for reimbursement of services.

DELAWARE REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Delaware regarding provider contracts with providers rendering health care services in the State of Delaware. To the extent that such state laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Delaware laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

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

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

Response to Petition for Arbitration: Within twenty (20) days of receipt of the Petition, Evernorth must deliver to the Department an original and three (3) copies of a Response

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

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

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

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

Arbitrator's Written Decision: The Arbitrator shall render a decision and mail a copy of

the decision to the parties within forty-five (45) days of the filing of the Petition. The Arbitrator's decision is binding upon the parties, except as provided in 18 Del. C. Section 333(f).

II

1. Payments. Provider shall submit a claim for reimbursement for a Covered Service within one hundred eighty (180) days of the date the Covered Service was rendered.

FLORIDA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Florida regarding provider contracts with providers rendering health care services in the State of Florida. To the extent that such Florida laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Florida laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(A) (1) The "Dispute Resolution Procedure" provision of the Agreement is amended to add the following optional dispute resolution process for the resolution of disputes relating to the payment of provider claims:

After the exhaustion of the Agreement's internal process to resolve disputes relating to the payment of provider claims, but before the initiation of arbitration to resolve such disputes, either party may initiate the Agency for Health Care Administration dispute resolution process, to the extent that such process applies to the dispute, by providing written notice to the other party. If the Agency for Health Care Administration dispute resolution process does not apply to the dispute, and therefore such dispute resolution process does not occur, either party may initiate arbitration by providing written notice to the other party.

(2) Notwithstanding the time period for correcting underpayments as provided in the Agreement or the Medical Management Program, all claims for underpayment from a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 of the Florida Statutes must be submitted to Evernorth or its designee within twelve (12) months after Payor's payment of the claim.

(3) The Compensation provision of the Agreement is amended to add the following:

(a) All claims for overpayment submitted to a provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 of the Florida Statutes must be submitted within twelve (12) months after the Payor's payment of the claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.

(b) Notwithstanding the twelve (12) month period provided in subsection (a) above,

all claims for overpayment submitted to a provider not included in subsection (a) above must be submitted within thirty (30) months after the Payor's payment of the claim, except that claims for overpayment may be sought beyond that time from providers convicted of fraud.

(B) With respect to Covered Services rendered to Participants covered under an HMO Plan:

(1) The definition for **Emergency Services**, if any, shall comply with Florida laws and regulations to the extent applicable.

(2) To the extent applicable and/or not otherwise preempted by federal law, the parties shall comply with Section 641.3155 of the Florida Statutes. To the extent required by Section 641.3155 of the Florida Statutes, Provider shall submit all claims for payment by mail or by electronic transfer within six (6) months after the date of discharge for inpatient services or the date of service for outpatient services.

(3) Evernorth or Provider may not terminate the Agreement unless the terminating party provides the other party with a written reason for such termination, which may include termination for business reasons of the terminating party. Termination of the Agreement by Provider, for any reason, shall be upon sixty (60) days' prior written notice to Evernorth and the State of Florida Office of Insurance Regulation. Nonpayment for goods or services rendered by Provider is not a valid reason for avoiding such sixty (60) day advance notice of termination. Evernorth will provide sixty (60) days' advance written notice to Group and the State of Florida Office of Insurance Regulation before terminating the Agreement, except in the case in which Participants' health is subject to imminent danger or Provider's ability to practice medicine is effectively impaired by an action of the Board of Medicine or other governmental agency. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider or Evernorth, such longer notification period will apply.

(4) In accordance with Section 641.234 of the Florida Insurance Laws, the Agreement may be terminated by an order of the State of Florida Office of Insurance Regulation, if it determines that the compensation paid by Evernorth under the Agreement is unreasonably high.

(5) If the Agreement is terminated for any reason other than for cause, Evernorth and Provider shall allow Participants for whom treatment was active to continue coverage and care when Medically Necessary, through completion of treatment of a condition for which the Participant was receiving care at the time of termination so long as Participant retains eligibility under a Plan, until the Participant selects another treating provider, or during the next open enrollment period offered by the organization, whichever is longer, but not longer than six (6) months after termination of the Agreement. Each party to the terminated contract shall allow a Participant who has initiated a course of prenatal care, regardless of the trimester in which care was initiated, to continue care and coverage until completion of postpartum care. This does not prevent Provider from

refusing to continue to provide care to a subscriber who is abusive, noncompliant, or in arrears in payments for services provided. For care continued under this provision, Evernorth and Provider shall continue to be bound by the terms of the Agreement. Changes made within thirty (30) days before termination of a contract are effective only if agreed to by both parties.

(6) Provider shall prominently post a consumer assistance notice to Participants in Provider's reception area. The notice must include the address and toll-free number of the Agency for Health Care Administration, the Subscriber Assistance Program, and the State of Florida Office of Insurance Regulation. The notice shall also state that the toll-free number for the applicable Member Service Center shall be provided upon request.

(C) With respect to Covered Services rendered to Participants covered under a non-HMO Plan which is insured by Evernorth or an Evernorth affiliate:

To the extent applicable and/or not otherwise preempted by federal law, the parties shall comply with Section 627.6131 of the Florida Statutes.

(D) Risk Management Program

(1) Participating providers must report all adverse incidents involving Evernorth HMO participants to the Evernorth HealthCare of Florida Risk Management Department. This responsibility is in accordance with F.S. 641.55(1) (d) and the Agency for Health Care Administration's Interpretive Guidelines for Internal Risk Management Programs. Florida law requires HMOs to develop and implement an incident reporting system based upon the affirmative duty of all providers to report injuries and adverse incidents to the health plan Risk Manager.

(2) Evernorth defines an adverse incident as "any outcome or event that is inconsistent with the routine care of a patient." Examples of adverse incidents include medication errors, treatment errors, unexpected death, and delays in treatment or diagnosis.

(3) Provider should report an adverse incident immediately by calling the Risk Management Hot Line at 813.637.1248 to leave a detailed message about the adverse incident. Provider may also submit a summary of the incident to the Risk Management department by fax to 860.687.4317, or send an email to FloridaRiskManagement@cigna.com. Provider should to include Provider's full name, provider identification number and a telephone number where Evernorth can reach Provider for further information. Strict confidentiality is maintained at all times.

(4) For questions or concerns about the program or Provider's responsibilities, Evernorth encourages Provider to contact Evernorth's Risk Management department at 860.902.4943.

GEORGIA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of Georgia regarding provider contracts with providers rendering health care services in the State of Georgia. To the extent that such Georgia laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Georgia laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) It is the intent of the parties to this Agreement to ensure quality services that meet all uniform treatment standards required by Georgia law and any provision herein which may be inconsistent with that intent shall be void.

(2) The definition for **Emergency Services**, if any, shall comply with Georgia laws and regulations to the extent applicable.

(3) The following definitions are added to the Agreement:

Physician - Means an individual who is qualified to practice medicine under the applicable state law or partnership or professional association of such persons and is a licensed Doctor of Medicine or Doctor of Osteopathy.

Primary Care Physician - Means a Physician engaged in general practice, family practice, internal medicine or pediatrics who, through an agreement with Evernorth, provides basic health services to and arranges specialized services for those Participants who select him or her as their Primary Care Physician.

(4) Pursuant to Georgia Code Section 33-20A-62 to the extent applicable and/or not otherwise preempted by federal law:

(i) Evernorth, or any agent thereof, shall not conduct a post-payment audit or impose a retroactive denial of payment of any claim by Provider relating to the provision of health care services to Participants unless:

1. Evernorth, or any agent thereof has provided to Provider written notice of the intent to conduct such an audit or impose such a retroactive denial of

payment of such claim, or any part thereof, and has provided in such notice the specific claim and the specific reason for the audit or retroactive denial of payment;

2. Not more than twelve (12) months have elapsed since the last date of service or discharge covered by the claim prior to the delivery to Provider of such written notice; and
3. Any such audit or retroactive denial of payment was completed and notice provided to Provider of any payment or refund due within the following time periods, whichever is applicable: (a) if the claim was submitted within ninety (90) days of the last date of service or discharge covered by the claim, within eighteen (18) months of the last date of service or discharge covered by such claim; or (b) if the claim was submitted more than ninety (90) days after the last date of service or discharge covered by the claim, the earlier of eighteen (18) months after Provider's initial submission of such claim or twenty-four (24) months after the date of service.

(ii) Evernorth, or any agent thereof, shall not be required to respond to Provider's request for additional payment or to adjust any previously paid claim or any part thereof following a final payment unless:

1. Provider makes a request in writing to Evernorth, or any agent thereof, specifically identifying the previously paid claim, or any part thereof, and provides the specific reason for additional payment; and
2. The written request for additional payment or adjustment was submitted within the following time periods, whichever is applicable: (a) if the claim was submitted within ninety (90) days of the last date of service or discharge covered by the claim, the earlier of twelve (12) months after the date both Provider and Evernorth, or any agent thereof, agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by Provider or twenty-four (24) months after the date of service or discharge; or (b) if the claim was submitted more than ninety (90) days after the last date of service or discharge covered by the claim, the earlier of six (6) months after the date both Provider and Evernorth, or any agent thereof, agree that all payments relative to the claim have been made and all appeals of such determinations have been made or waived by Provider or twenty-four (24) months after the date of service or discharge.

(iii) A Participant who is not billed by Provider, or agent thereof, within forty-five (45) days of the date that Provider, or agent, knew that further payment was due as a result of a post-payment audit, retroactive denial, or rejected request to adjust a previously paid claim shall be relieved of any and all legal obligations to respond to a request for additional payment.

(iv) Notwithstanding any other provision to the contrary, when precertification has

been obtained for a service, Evernorth, or any agent thereof, shall be prohibited from contesting, requesting payment, or reopening such claim, or any portion thereof, except to the extent Evernorth is not liable for the payment under Georgia Code Section 33- 20A-7.1.

(5) Physician providers only: In the event of termination of the Agreement by either party, the provisions of Georgia Code Section 33-20A-61 concerning continued services and rights and obligations upon termination of the Agreement.

(6) If included in the Agreement, a "Most Favored Nation" provision or any other provision prohibited by Georgia laws and regulations is hereby deleted in its entirety.

HAWAII REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Hawaii regarding provider contracts with providers rendering health care services in the State of Hawaii. To the extent that such Hawaii laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Hawaii laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

1. Definitions. Unless otherwise defined in the Agreement, the following terms shall have the meaning set forth below. The definition for Emergency Services, if any, shall comply with state laws and regulations to the extent applicable.

1.1 Material Change or Material Adverse Change shall mean a change that could reasonably be expected to have a material adverse impact on the aggregate level of payment by Evernorth or Payor to Provider for Covered Services under this Agreement, or on Provider's administration of their services.

1.2 Timely Notice shall mean the timeframe or timeframes established by the parties for prior written notice of an amendment to the Agreement as set forth in the Amendment provision, or any other provisions of the Agreement governing changes or amendments to the Agreement.

2. In addition to the negotiated terms of the Agreement establishing limits on billing Participants, the following shall apply in accordance with applicable laws and regulations:

A. Provider agrees that in no event, including but not limited to nonpayment by Evernorth or its intermediary, insolvency of Evernorth, or breach of this Agreement, shall

Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Participant or a person other than Evernorth or its intermediary acting on behalf of Participant for Covered Services

provided pursuant to this Agreement. This provision does not prohibit Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the evidence of coverage, or fees for non-covered services delivered on a fee-for-service basis to Participants. Nor does this provision prohibit Provider and Participant from agreeing to continue services solely at the expense of the Participant, as long as Provider has clearly informed Participant that Evernorth may not cover or continue to cover a specific service or services. Except as provided in the Agreement, this provision does not prohibit Provider from pursuing any available legal remedy.

A.1 Provider shall obtain an executed agreement of financial responsibility prior to the time services are rendered for non-covered services or services that do not meet the criteria in section 432E-1.4, Hawaii Revised Statutes, before billing or collecting from a Participant or person acting on behalf of a Participant.

B. In the event of Evernorth's or its intermediary's insolvency or other cessation of operations, Provider's obligation to deliver Covered Services to Participants without balance billing will continue until the earlier of: the termination of the Participant's coverage under the Plan, including any extension of coverage provided under the contract terms or applicable state or federal law for Participants who are in an active course of treatment or totally disabled; or, the date the Agreement, including any required extension for Participants in an active course of treatment, would have been terminated if Evernorth or its intermediary had remained in operation.

C. Subsections A, A.1 and B shall be construed in favor of the Participant, shall survive the termination of the contract regardless of the reason for termination, including Evernorth's insolvency, and shall supersede any oral or written contrary agreement between Provider and Participant or the representative of a Participant if the contrary agreement is inconsistent with the hold harmless and continuation of covered services provisions required by subsections A, A.1 and B or applicable laws and regulations.

3. In no event shall Provider collect or attempt to collect from a Participant any money owed to Provider by Evernorth.

4. Nothing in the Agreement shall be construed to offer an inducement to Provider to provide less than Medically Necessary services to Participants. Nothing in the Agreement shall be construed to prohibit Provider from discussing treatment options with Participants irrespective of Evernorth's position on the treatment options, or from advocating on behalf of Participants within the utilization review or grievance or appeals processes used by Evernorth or its delegate or in accordance with any rights or remedies available under applicable state or federal law.

5. Nothing in the Agreement shall be construed to penalize Provider because Provider, in

good faith, reports to state or federal authorities any act or practice by Evernorth that jeopardizes patient health or welfare.

6. Evernorth and Provider shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply. When Provider either gives or receives notice of termination, Provider shall supply a list of those Participants that are patients of the Provider.

7. Except as set forth in the negotiated and agreed upon terms of the Agreement, the rights and responsibilities under the Agreement shall not be assigned or delegated by either party without prior written consent of the other party.

8. In addition to the negotiated terms of the Agreement establishing requirements for records, 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 Participants, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records and Participant's right to see, obtain copies of, or amend the Participant's medical and health records.

9. The provisions in the Agreement shall be construed to avoid conflict with the provisions contained in the Plan, or in applicable laws and regulations.

10 To the extent required by section 432E-10, Hawaii Revised Statutes, Provider agrees to comply with requests for any information necessary for Evernorth to comply with the plan performance measurement and data reporting, including information relevant to effectiveness, appropriateness, access and availability of care, Participant satisfaction, utilization, and any other information as required to comply with applicable laws and regulations.

II

This section shall apply only if Provider is an intermediary as defined by applicable state laws and regulations including but not limited to section 431:26-101, Hawaii Revised Statutes, as may be amended from time to time.

1. Provider shall ensure that all contracts entered into with participating providers comply with all the requirements of applicable laws and regulations including but not limited to section 431:26-104, Hawaii Revised Statutes.

2. Nothing in the Agreement shall be construed to delegate or assign to Provider Evernorth's statutory responsibility to monitor the offering of Covered Services to Participants.

3. In accordance with applicable laws and regulations, Evernorth shall have the right to approve or disapprove the participation status of a subcontracted provider in Evernorth's or Provider's contracted network for the purpose of delivering Covered Services to Evernorth's Participants.

4. In accordance with applicable laws and regulations, Evernorth shall have the right, in the event of Provider's insolvency, to require the assignment to Evernorth of the provisions of Provider's contract addressing the Provider's obligation to furnish Covered Services.

5. In addition to the negotiated terms of the Agreement, Evernorth shall have access to all Provider's subcontracts, and shall have the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from Evernorth.

6. In addition to the negotiated requirements of the Agreement, Provider shall maintain the books, records, financial information and documentation of services provided to Participants at its principal place of business in the state and shall preserve them for the time period required by applicable law in a manner that facilitates regulatory review.

7. Provider shall allow the insurance commissioner access to Provider's books, records, financial information and any documentation of services provided to Participants, as necessary to determine compliance with applicable laws and regulations.

8. If applicable under the terms of the Agreement, Provider shall transmit utilization documentation and claims paid documentation to Evernorth as set forth in the Agreement. Evernorth shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Participants.

ADDENDUM TO PROVIDER AGREEMENT
FOR THE STATE OF IDAHO

The provisions set forth in this Addendum are being added to the Agreement with the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Idaho regarding provider contracts with providers rendering health care services in the State of Idaho. To the extent that such Idaho laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans.

(1) Emergency Services. The term "Emergency" means the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity including, but not limited to, severe pain, such that the absence of immediate medical attention could reasonably be expected by a prudent person who possesses an average knowledge of health and medicine, to result in placing a person's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ.

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

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

(4) Indemnification. Nothing in this Agreement shall be construed to require Provider to indemnify or hold Evernorth harmless unless Evernorth also agrees to indemnify and hold harmless Provider under comparable circumstances.

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

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

(7) Collection from Participants and Participant Non-Liability. In accordance with Idaho Administrative Code § 18.01.26.004, Provider shall not bill or charge any Participant for the difference between the amount specified in the fee schedule for a Covered Service and the amount normally charged by Provider for the particular service. This provision shall not preclude Provider from collecting the specified coinsurance, copayment, or applicable deductible under the Participant's health benefit plan.

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

(9) Compensation and Claims Submission. To the extent required by Applicable Law, Evernorth or payor and Provider shall comply with the provisions of Chapter 56 of Title 41 of the Idaho Code regarding the administration and payment of claims, including but not limited to Idaho Code § 41-5602.

(10) Binding Effect and Assignment. To the extent required by Applicable Law, including but not limited to Idaho Code § 41-1847, if Evernorth assigns the Agreement as permitted herein, Evernorth shall send prompt written or electronic notice to Provider in accordance with the notice provisions of the Agreement. Such notice shall include the name and principal business address of each assignee.

ILLINOIS REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between EVERNORTH Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Illinois regarding provider contracts with providers rendering health care services in the State of Illinois. To the extent that such Illinois laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Illinois laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(A) "Emergency Services" shall mean, unless otherwise defined by applicable Illinois laws and regulations, transportation services, including but not limited to ambulance services, and covered inpatient and outpatient hospital services furnished by a provider qualified to furnish those services that are needed to evaluate or stabilize an emergency medical condition. "Emergency medical condition" shall mean, unless otherwise defined by applicable Illinois laws and regulations, a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual or, with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

(B) With respect to Covered Services rendered to Participants covered under an HMO Plan:

(1) Provider shall, upon request of Participant, provide Participant the following: (a) information related to the provider's educational background, experience, training, specialty, and board certification, if applicable; (b) the names of licensed facilities on the provider panel where the provider presently has privileges for the treatment, illness or procedure that is the subject of the request; and (c) information regarding the provider's participation in continuing education programs and compliance with any licensure, certification, or registration requirements, if applicable.

(2) a. Evernorth must give Provider at least sixty (60) days' notice of nonrenewal or termination of the Agreement. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to

termination of the Agreement by Evernorth, the longer notification period will apply.

b. Provider must give Evernorth at least sixty (60) days' notice for termination of the Agreement for cause and at least ninety (90) days' notice by Provider for termination of the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, the longer notification period will apply.

(3) Evernorth shall not retaliate against Provider if Provider advocates for appropriate health care services for Participants. To advocate for medically appropriate health care services means to appeal a decision to deny payment for health care services pursuant to the reasonable grievance or appeal procedure.

(4) All nurse and other ancillary and paramedic personnel shall maintain all necessary professional credentials, including but not limited to appropriate licenses, certifications, accreditations and other similar approvals required by applicable local, state and federal laws and regulations.

(5) a. Upon termination of the Agreement by Provider, or upon termination of the Agreement by Evernorth, if Evernorth terminates the Agreement for reason(s) other than termination in situations involving imminent harm to a patient or a final disciplinary action by a state licensing board, Provider shall, at the Participant's option, continue to provide Covered Services to the Participant for up to ninety (90) days following the date of the written notice of Provider's termination, or if the Participant is in the third trimester of pregnancy, throughout the term of the Participant's pregnancy, including post-partum care directly related to the pregnancy. During the transitional period under this section, Provider shall agree: (1) to continue to accept reimbursement at the rates applicable prior to the start of the transitional period; (b) to adhere to the Plan's quality assurance requirements and provide the necessary medical information related to such care; and (c) to otherwise adhere to the Plan's policies and procedures, including but not limited to procedures regarding referrals and obtaining preauthorizations for treatment.

b. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Plan.

c. Provider has no obligation under the Agreement to continue to provide Covered Services to individuals who cease to be Participants.

(6) Provider shall give Evernorth at least fifteen (15) days advance written notice of cancellation, modification or termination of general or professional liability insurance.

(7) The "Charges to Participants" provision is amended to add the following Participant hold harmless requirements:

a. the provision shall also apply to Provider's assignees or subcontractors;

b. the Participant, persons acting on Participant's behalf (other than Payor) and the employer or group contract holder shall be third party beneficiaries of the provision; and

c. the provision supersedes any oral or written agreement now existing or hereafter entered into between Provider and Participant, persons acting on Participant's behalf (other than Payor) and the employer or group contract holder.

(8) Evernorth or Payor shall not request recoupment or withhold an offset from future payments eighteen (18) months or more after the original payment was made, except in cases in which: a court, government administrative agency, other tribunal, or independent third-party arbitrator makes or has made a formal finding or fraud or material representation; Evernorth or Payor is acting as a plan administrator for the Comprehensive Health Insurance Plan under the Comprehensive Health Insurance Plan Act; or, Provider has already been paid in full by another payor, third party, or worker's compensation insurer.

(9) To the extent that Provider is subject to the requirements of IAC 50, Section 2051.290, as may be amended from time to time:
   a. Provider shall maintain and make medical records available as required by IAC 50, Section 2015.290 c) 1);
   b. the rights and responsibilities under the Agreement cannot be sold, leased, assigned, assumed or otherwise delegated by either party except as provided by IAC 50, Section 2015.290 h);
   c. Provider shall not differentiate or discriminate in the treatment of any Participant because of race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, age, health status, veteran's status, handicap or source of payment, or participation in the preferred provider program, ethnicity, sexual preference, disability or as otherwise required by IAC 50, Section 2015.290 j);
   d. Evernorth will give Provider access to benefit information concerning the type, scope and duration of benefits to which a Participant is entitled as required by IAC 50, Section 2015.290 o) and the terms of the Agreement.

INDIANA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Indiana regarding provider contracts with providers rendering health care services in the State of Indiana. To the extent that such Indiana laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Indiana laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(A) (1) If included in the Agreement, a "Most Favored Nation" provision or any other provision prohibited by Indiana Code Section 27-8-11-9 (Insurers) or Section 27-13-15-4 (Health Maintenance Organizations) is hereby deleted in its entirety.

(2) The definition for **Emergency Services**, if any, shall comply with Indiana laws and regulations to the extent applicable.

(3) (a) A Payor may not, more than two (2) years after the date on which an overpayment on a claim was made to Provider by the Payor:

(1) request that Provider repay the overpayment; or
(2) adjust a subsequent claim filed by the Provider as a method of obtaining reimbursement of the overpayment from the Provider.

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

(c) This section does not apply in cases of fraud by Provider, the Participant, or the Payor with respect to the claim on which the overpayment or underpayment was made.

(4) With respect to those providers defined in Indiana Code Section 27-1-37.1-4, Evernorth shall give written notice to Provider of any amendment to the Agreement not less than forty-five (45) days before the proposed effective date of the amendment. Provider may terminate the Agreement without penalty by informing Evernorth that Provider does not accept the amendment. Written notice of termination must be given to Evernorth not later than fifteen (15) days after

Provider receives notice of the amendment. Termination of the Agreement is effective ninety (90) days after the date Evernorth receives written notice that Provider does not accept the amendment or, on an earlier date if the parties mutually agree. This section does not apply to amendments that are required to comply with a state or federal law.

(5) The Agreement may permit network rental arrangements which allow Evernorth to lease, rent, or otherwise grant access to a Participating Provider's health care services to a third party, and the third party accessing the health care contract is:

(a) a payer or third-party administrator or another entity that administers claims on behalf of the payer;

(b) a preferred provider organization or preferred provider network, including a physician-hospital organization; or

(c) an entity engaged in the electronic claims transport between Evernorth and the payer.

(B) With respect to Covered Services rendered to Participants covered under an HMO Plan:

(1) If Provider terminates the Agreement, Provider shall give Evernorth not less than sixty (60) days' prior written notice of the termination. If Provider renders thirty (30) percent or more of the services required by Evernorth's commercial HMO Participants, Provider shall give Evernorth not less than one hundred twenty (120) days' prior written notice of termination. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

(2) (a) Upon termination of the Agreement by Provider, or upon termination of the Agreement by Evernorth, if Evernorth terminates the Agreement for reasons other than due to a quality of care issue, Provider shall, upon the request of the Participant, continue to provide Covered Services to the Participant until the earlier of the following: (1) sixty (60) days following termination of the Agreement; (2) if the Participant is in the third trimester of pregnancy, throughout the term of the Participant's pregnancy; or (3) if Provider is a hospital, the day the Participant is released from inpatient status at the hospital. During the continuation period under this section, Provider: (1) shall continue to accept the terms and conditions of the Agreement, together with the applicable Coinsurance, Copayments or Deductibles, as payment in full; and (2) is prohibited from billing a Participant for any amounts in excess of the Participant's applicable Coinsurance, Copayments or Deductibles.

(b) Provider has no obligation under the Agreement to provide continued services to individuals who cease to be Participants.

IOWA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of Iowa regarding provider contracts with providers rendering health care services in the State of Iowa. To the extent that such Iowa laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Iowa laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for Emergency Services, if any, shall comply with Iowa laws and regulations to the extent applicable.

(2) A. Upon termination of the Agreement by Provider, or upon termination of the Agreement by Evernorth, if Evernorth does not terminate the Agreement for cause, Provider shall continue to provide Covered Services to Participants undergoing a specified course of treatment for a terminal illness or a related condition for a period of up to ninety (90) days from the date of Provider's termination, or if the Participant is in the second or third trimester of pregnancy, throughout the term of the Participant's pregnancy including postpartum care related to the childbirth and delivery. During the continuation period under this section: (1) the parties shall be bound by the terms and conditions of the Agreement; (2) Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement; and (3) Provider is prohibited from billing Participants for any amounts in excess of the Participant's applicable Coinsurance, Copayments or Deductibles.

B. Provider has no obligation under the Agreement to continue to provide Covered Services to individuals who cease to be Participants.

KANSAS REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of Kansas regarding provider contracts with providers rendering health care services in the State of Kansas. To the extent that such Kansas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Kansas laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(A) In the event that Payor erroneously pays a claim providing payment to which Provider is not entitled, Payor shall not initiate a request for reimbursement or refund of the erroneous payment, or in any other way seek to recoup the erroneous payment, unless such action is initiated within eighteen (18) months after the end of the month in which the erroneous payment was made. In cases of fraud, such action may be initiated within the applicable statute of limitations pursuant to K.S.A. 60-513, and amendments thereto.

(B) With respect to Covered Services rendered to Participants covered under an HMO Plan:

Upon termination of the Agreement, Provider shall continue to provide Covered Services to Participants for a period of up to ninety (90) days in those cases where the continuation of such care is Medically Necessary and in accordance with the dictates of medical prudence and where the Participant has special circumstances such as a disability, a life threatening illness or is in the third trimester of pregnancy. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement until ninety (90) days following termination and thereafter compensation for continued services authorized by Evernorth shall be as mutually agreed. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(C) Dispute Resolution Process: Kansas requires a single level appeals process for providers submitting on behalf of patients with Evernorth coverage. See the dispute resolution provisions in the Agreement and the Medical Management Program.

KENTUCKY REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Kentucky regarding provider contracts with providers rendering health care services in the State of Kentucky. To the extent that such Kentucky laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Kentucky laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for Emergency Services, if any, shall comply with Kentucky laws and regulations to the extent applicable.

(2) If Provider enters into any subcontract agreement with another provider to provide their licensed health care services to Participants, where the subcontracted provider will bill Evernorth or Participant directly for the subcontracted services, the subcontract agreement must meet all the requirements of KRS 304.17A-527 and shall be filed with the Commissioner of Insurance.

(3) (a) Evernorth shall, upon request of Provider, provide or make available, when contracting or renewing an existing contract with Provider, the payment or fee schedules or other information sufficient to enable Provider to determine the manner and amount of payments under the contract for Provider's services prior to the final execution or renewal of the contract and shall provide any change in such schedules at least ninety (90) days prior to the effective date of amendment.

(b) Any change to payment or fee schedules applicable to Provider shall be made available to Provider at least ninety (90) days prior to the effective date of the amendment. This subsection (b) shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

(4) Pursuant to KRS 304.17A-235 this section (4) is applicable to agreements with Participating Providers as defined below:

(a) Definitions:

"Material Change" means a change to an Agreement, the occurrence and timing of which is not clearly identified in the Agreement, that decreases the health care provider's payment or compensation or changes the administrative procedures in a way that may reasonably be expected to significantly increase the provider's administrative expense, and includes any changes to provider network requirements, or inclusion in any new or modified insurance products.

"Participating Provider" means a Provider that has entered into an agreement with Evernorth to provide health care services.

(b) Evernorth shall provide Participating Provider with at least ninety (90) days written notice of a Material Change to the Agreement. The notice shall provide the proposed effective date of the change and include a description of the Material Change, and such notices and disclosures as required by applicable laws and regulations, including but not limited to KRS 304.17A-235, as may be amended from time to time, in the manner and format as prescribed by applicable laws and regulations.

For changes to an existing prior authorization, precertification, notification, or referral program, or changes to an edit program or specific edits, Evernorth shall provide notice of the change to the Participating Provider at least fifteen (15) days prior to the change.

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

(6) (a) Pursuant to KRS 304.17A-643, if the Agreement between Evernorth and Provider is terminated for reasons other than a quality of care issue or fraud, Provider may request, with the concurrence of the Participant or authorized person, to continue treatment for Participants in special circumstances. "Special circumstances" includes a circumstance in which a Participant has a disability, a congenital condition, a life-threatening illness, or is past the 24th week of pregnancy where the disruption of the Participant's continuity of care could cause medical harm. With respect to those Participants who retain eligibility under a Plan and who are in an active course of treatment for special circumstances, Provider shall continue to provide Covered Services in accordance with the terms of this Agreement: (a) for a period up to nine (9) months in the case of a Participant who at the time of the termination has been diagnosed with a terminal illness; (b) if a Participant is beyond the 24th week of pregnancy, for a period that extends through the delivery of the child, immediate

post-partum care, and examination within the first six (6) weeks following delivery; or (c) for a period up to ninety (90) days after the effective date of termination for all other Participants in an active course of treatment for special circumstances. Provider shall be compensated for such Covered Services in accordance with the compensation arrangements under the Agreement.

(b) Pursuant to KRS 304.17A-527 (1)(b), if the Agreement between Evernorth and Provider is terminated for any reason, other than a quality of care issue or fraud, Provider shall continue to provide services and Payor shall continue to reimburse Provider in accordance with the compensation arrangements under the Agreement until Participant is discharged from an inpatient facility, or the active course of treatment is completed, whichever is greater, and in the case of a pregnant woman, services shall continue to be provided through the end of the post-partum period if the pregnant woman is in her fourth (4^{th}) or later month of pregnancy at the time the Agreement is terminated.

(c) This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between you and a Participant or persons acting on the Participant's behalf.

(7) Limitations on Billing Participants. Pursuant to KRS 304.17A-527 (1)(a), Provider shall not under any circumstances, including nonpayment of moneys due Provider by Payor, insolvency of Payor, or breach of the Agreement bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or any person acting on their behalf for Covered Services or for any amounts denied or not paid under this Agreement. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles. This provision survives termination of this Agreement, regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Participants and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

(8) How This Agreement Can Be Terminated.

(a) If Provider is not a hospital: Provider can terminate this Agreement at any time by providing at least sixty (60) days advance written notice. Either Provider or Evernorth can terminate this Agreement immediately if the other becomes insolvent. Evernorth can also terminate the Agreement immediately (or upon such longer notice required by applicable law, if any) if Provider no longer maintains the licenses required to perform his/her/its duties under this Agreement, the Provider is disciplined by any licensing, regulatory, accreditation organization, or any other

professional organization with jurisdiction over the Provider, or if the Provider no longer satisfies Evernorth's credentialing requirements.

(b) If Provider is a hospital: Provider may initiate the termination of this Agreement by providing six (6) months written notice to the other party prior to any anniversary of the Effective Date (the "Notice Period") provided however, that no such termination shall be effective prior to the expiration of the initial term. During the Notice Period, Evernorth may cease marketing efforts for Provider and discontinue referral of Participants to Provider.

(c) Any termination of this Agreement as a result of a professional review action will comply with the standards of 42 U. S. C. § 11112.

(9) The section of the Agreement entitled Compensation is amended to add the following sentence to conform to applicable state laws:

Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, to the extent required by KRS 304.17C-085 as may be amended from time to time, the rates in the Agreement will be payment in full for all Covered Services furnished to Participants under the Agreement.

(10) The section of the Agreement entitled Compensation is amended to add the following sentence to conform to applicable state laws:

Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, to the extent required by KRS 304.17C-085 as may be amended from time to time, the rates in this Agreement apply to all Covered Services provided to Participants in the Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits and whether the Payor or Participant is financially responsible for payment.

LOUISIANA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Louisiana regarding provider contracts with providers rendering health care services in the State of Louisiana. To the extent that such Louisiana laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall apply. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Louisiana laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

A. Upon termination of the Agreement:

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

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

3. Provider shall be compensated for such Covered Services in accordance with the compensation arrangements under the Agreement. The contractual requirements for Provider to comply with Evernorth's utilization management and quality management policies and procedures shall remain in effect for the applicable period specified in subsections 1. and 2. above.

B. The above provisions do not apply if:

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

2. The Participant chooses to change Provider.

3. The Participant moves out of the geographic service area of the Provider.

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

C. Evernorth Prepayment Programs: To the extent permitted by applicable state law, prepayment programs described herein will be conducted in accordance with applicable state laws (including Regulation 49) and the terms of the Agreement.

MAINE REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Maine regarding provider contracts with providers rendering health care services in the State of Maine. To the extent that such Maine laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Maine laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

A. (1) The definition for **Emergency Services**, if any, shall comply with Maine laws and regulations to the extent applicable.

(2) Payor may not impose on Provider any retrospective denial of a previously paid claim or any part of that previously paid claim unless:

a. Payor has provided the reason for the retrospective denial in writing to Provider; and

b. The time that has elapsed since the date of payment of the previously paid claim does not exceed twelve (12) months. The retrospective denial of a previously paid claim may be permitted beyond twelve (12) months from the date of payment only for the following reasons:

(1) The claim was submitted fraudulently;

(2) The claim payment was incorrect because Provider or Participant was already paid for the health care services identified in the claim;

(3) The health care services identified in the claim were not delivered by Provider;

(4) The claim payment was for services covered by Title XVIII, Title XIX or Title XXI of the Social Security Act;

(5) The claim payment is the subject of adjustment with another insurer, administrator or payor; or

(6) The claim payment is the subject of legal action.

For purposes of this provision, "retrospective denial of a previously paid claim" means any attempt by Payor to retroactively collect payments already made to Provider with respect to a claim by requiring repayment of such payments, reducing other payments currently owed to Provider, withholding or setting off against future payments or reducing or affecting the future claim payments to Provider in any other manner.
Provider has six (6) months from the date of notification under this provision to determine whether Participant has other appropriate insurance that was in effect on the date of service. Notwithstanding the terms of the Agreement, Evernorth shall allow for the submission of a claim that was previously denied by another insurer because of Participant's transfer or termination of coverage.

(3) a. Any modification, addition, or deletion to the provision of the Agreement relating to limitations on billing participants shall become effective upon the review and approval of the Maine Bureau of Insurance.

b. Evernorth shall notify Provider of a proposed amendment to the Agreement at least sixty (60) days prior to the amendment's proposed effective date. If an amendment that has substantial impact on the rights and obligations of Provider is made to a manual, policy or procedure document referenced in the Agreement, such as material changes to fee schedules or material changes to procedural coding rules specified in the manual, policy or procedure document, Evernorth shall give sixty (60) days notice to Provider. After the sixty (60) day notice period has expired, the amendment to a manual, policy or procedure document becomes effective and binding on both Evernorth and Provider subject to any applicable termination provisions in the Agreement, except that Evernorth and Provider may mutually agree to waive the sixty (60) day notice requirement. This subsection may not be construed to limit the ability of Evernorth and Provider to mutually agree to the proposed change at any time after Provider has received notice of the proposed amendment.

(4) a. Evernorth may not terminate or nonrenew the Agreement, unless Evernorth provides Provider with a written explanation prior to the termination or nonrenewal of the reasons for the proposed termination or nonrenewal and provides an opportunity for a review or hearing. Termination or nonrenewal may not be effective earlier than sixty (60) days from Provider's receipt of the notice of termination or nonrenewal. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Evernorth, such longer notification period will apply.

b. Notice and Hearing. If Evernorth should choose to terminate the Agreement, Evernorth will notify Provider of this decision in writing. The notice will include the reason(s) for the termination including reference to the evidence or documentation

leading to the decision and a notice of Provider's right to request a hearing or review, at Provider's discretion. If Provider should desire a hearing with regard to the termination of the Agreement, Provider must notify Evernorth in writing within thirty (30) days of Provider's receipt of the notice of termination. A hearing will be held within thirty (30) days after receipt of the request by Evernorth. The hearing shall be conducted by a panel of at least three (3) people appointed by Evernorth, at least one-third of which shall be clinical peers of Provider. The panel shall render a decision in a timely manner and shall notify Provider of the decision in writing which will include one of the following resolutions: (a) unconditional reinstatement; (b) provisional reinstatement subject to certain conditions as set forth by Evernorth; or (c) termination. Termination will be effective no earlier than sixty (60) days after Provider's receipt of the panel's decision or until the termination date of the Agreement, whichever is earlier. If Provider is unsatisfied with the panel's decision, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement and Medical Management Program.

c. The requirements set forth in this provision do not apply in cases involving imminent harm to patient care, a final determination of fraud by a governmental agency or a final disciplinary action by a state licensing board or other governmental agency that impairs Provider's ability to practice.

(5) a. Upon termination of the Agreement, except in cases involving imminent harm to patient care, a final determination of fraud by a governmental agency, or a final disciplinary action by a state licensing board or other governmental agency that impairs Provider's ability to practice, Provider shall continue to provide Covered Services, for those Participants who retain eligibility under a Plan and are in active treatment under Provider's care at the time of such termination, for a transitional period of sixty (60) days from the date of notice to the Participant of Provider's termination, or if the Participant is in the second or third trimester of pregnancy at the time of the termination of the Agreement, and Provider is treating the Participant during the pregnancy, the transitional period shall extend through the provision of postpartum care directly related to the pregnancy.

b. During the transitional period under this provision, Provider shall: (a) continue to accept reimbursement at the rates applicable prior to the start of the transitional period as payment in full and shall not impose cost-sharing with respect to the Participant in an amount that would exceed the cost-sharing that would have been imposed had the Agreement not been terminated; (b) adhere to Evernorth's quality assurance requirements and provide the necessary medical information related to such care; and (c) otherwise adhere to Evernorth's policies and procedures, including but not limited to procedures regarding referrals and prior authorizations and providing services pursuant to any treatment plan approved by Evernorth.

c. Provider has no obligation under the Agreement to provide services to individuals

who cease to be Participants.

(6) In addition to the Participant billing obligations set forth in the Agreement, in accordance with 24-A MRSA § 4303(8-A), a Participant is not liable to Provider for any sums owed by Payor, and Provider may not collect or attempt to collect any amount from Participant beyond the amount permitted by the Agreement or the managed care plan, notwithstanding Payor's failure to pay, insolvency, or any other breach of the Agreement.

(7) If included in the Agreement, a "Most Favored Nation" provision prohibited by 24-A MRSA § 4303(15) is hereby deleted in its entirety.

(8) Benefit Design/Coverage Decisions: Evernorth, Evernorth's designee or the Payor will be solely responsible for the Plan design and for interpreting the terms of and making final coverage determinations under a Plan so long as such interpretation is consistent with 24A MRSA 4303(11).

(9) Healthplan Quality Committee for Maine: As a health care professional in Maine, Provider has the opportunity to provide input on Evernorth policies, serve on Evernorth's Healthplan quality committee and volunteer to participate in focus groups and surveys. Should Provider wish to provide feedback to the Quality Management Department about Evernorth's published health care professional satisfaction and preventive health reports or receive more information about the Evernorth Quality Management Program, the annual program evaluation or other chronic case or preventive health measures, please call 800.591.9407.

(10)

MARYLAND REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Maryland regarding provider contracts with providers rendering health care services in the State of Maryland. To the extent that such Maryland laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Maryland laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for **Emergency Services**, if any, shall comply with Maryland laws and regulations to the extent applicable.

(2) The following definition of **Experimental Medical Care** is added to the Agreement:

"Experimental Medical Care" means medical, surgical or other health care procedures and treatments which are experimental or investigational, as determined by Evernorth's Medical Director in accordance with consensus derived from peer review medical and scientific literature and the practice of the national medical community, including (i) any procedures or treatments which are not recognized as conforming to accepted medical practice; (ii) any procedures or treatments in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness has not been established; and (iii) any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are rendered. Covered Services do not include Experimental Medical Care.

However, to the extent applicable under Section 15-827 of the Insurance Article, Covered Services include the patient cost to a Participant in a clinical trial, as a result of:

(a) treatment provided for a life-threatening condition; or
(b) prevention, early detection, and treatment studies on cancer.

Coverage shall be required if:

(1) The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or the treatment is being

provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition.

(2) The treatment is being provided in a clinical trial approved by:
   (i) one of the National Institutes of Health;
   (ii) a National Institutes of Health cooperative group or a National Institutes of Health center;
   (iii) the FDA in the form of an investigational new drug application;
   (iv) the federal Department of Veterans Affairs; or
   (v) an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutions of Health.

(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.

(4) There is no clearly superior noninvestigational treatment alternative.

(5) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Covered Services include the patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

An entity seeking coverage for treatment in a clinical trial approved by an institutional review board under subsection (2)(v) above shall post electronically and keep up-to-date a list of the clinical trials meeting the requirements of this section. The list shall include for each clinical trial: (a) the phase for which the trial is approved; (b) the entity approving the trial; (c) whether the trial is for treatment of cancer or another life-threatening disease and, if not cancer, the particular disease; and the estimated number of patients in the trial.

(3) Provider has the right to elect not to serve on a provider panel for workers' compensation services.

(4) If Provider is a hospital, where precertification is not required for a hospital admission, Provider must notify Evernorth or its designee within twenty-four (24) hours after the admission as prescribed in the Medical Management Program, unless in the case of an emergency inpatient admission, the Participant's medical condition prevents Provider from determining Participant's insurance status and any applicable emergency admission notification requirements.

(5) To the extent required by § 15-1005 of the Maryland Insurance laws, Provider shall

submit claims on the appropriate claim form for all Covered Services within one hundred and eighty (180) days of the date those services are rendered. Claims received after this one hundred and eighty (180) day period may be denied for payment.

Pursuant to Maryland law, to the extent applicable, within thirty (30) days after Payor's receipt of a claim Payor shall pay any undisputed fee-for-service amounts owing under the Agreement in accordance with this provision. If Payor contests the claim, denies all or part of the claim, or needs additional information to adjudicate the claim, Payor shall send a notice of receipt and status of the claim that states: (i) that Payor refuses to reimburse all or part of the claim and the reason for the refusal; (ii) that the legitimacy of the claim or the appropriate amount of reimbursement is in dispute and additional information is necessary to determine if all or part of the claim will be reimbursed and what specific additional information is necessary; or (iii) that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim. "Clean claim" means a claim for reimbursement as defined in regulations adopted by the Commissioner under Section 15-1003 of the Annotated Code of Maryland, as may be changed from time to time.

If additional information is requested by Payor, Payor shall pay or deny the claim, or portion of the claim, within thirty (30) days after receipt of the required additional information. If Payor fails to comply with the requirements of this provision, Payor shall pay interest on the amount of the claim that remains unpaid thirty (30) days after the claim is received by Payor. The applicable monthly interest rate shall be: 1.5% for claims paid from the 31st through the 60th day; 2% for claims paid from the 61st through the 120th day; and 2.5% after the 120th day. Any interest owing under the Agreement shall be paid without the necessity of filing an additional claim for such interest.

(6) Pursuant to Maryland law, to the extent applicable, Payor may only retroactively deny reimbursement made to Provider during the six (6) month period after the date Payor paid such claim. Notwithstanding the foregoing, Payor may retroactively deny reimbursement for services that are subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare program during the eighteen (18) month period after the date Payor paid such claim. The term "reimbursement" includes any applicable capitation payments made to Provider.

The requirements of this provision do not apply if Payor retroactively denies reimbursement to Provider because: (1) the information submitted to the Payor was fraudulent; (2) the information submitted to Payor was improperly coded and Payor provided sufficient information regarding the coding guidelines used by Payor at least thirty (30) days prior to the date the services subject to the retroactive denial were rendered; or (3) the claim submitted to Payor was a duplicate claim.

(7) Termination of the Agreement, by either party, shall be upon at least ninety (90) days' prior written notice by the terminating party, unless said termination is for reasons

related to fraud, patient abuse, incompetency, or loss of licensure status. To the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement, that notification period will apply.

(8) In the event that Provider terminates the Agreement, Provider shall continue to furnish health care services to Participants for whom Provider was responsible for the delivery of health care services prior to the notice of termination for at least ninety (90) days after the date of the notice of termination.

(9) Evernorth may not prohibit Provider from discussing with or communicating to Participant information that is necessary for the delivery of health care services, including:

(a) communications that relate to treatment alternatives:
(b) communications that are necessary or appropriate to maintain the provider-patient relationship while the patient is under Provider's care;
(c) communications that relate to Participant's right to appeal a coverage determination with which Provider or Participant does not agree; and opinions and the basis of an opinion about public policy issues.

(10) Disclosure of Carriers. Pursuant to Section 15-112.2 of the Insurance Article, a list of carriers shall be available to Provider at Provider.Evernorth.com.

(11) Services After Hours. Pursuant to Section 15-136 of the Insurance Article, Evernorth or Payor shall, as specified in the Agreement or an Exhibit to the Agreement, pay a bonus to a primary care provider when rendering services, pursuant to contracts or policies that provide hospital, medical or surgical benefits to individuals or groups on an expense-incurred basis, in the office between the hours of 6 p.m. and 8 a.m. or on weekends or national holidays.

(12) Nurse Practitioners in Maryland: Evernorth contracts with nurse practitioners in Evernorth's network in Maryland who meet credentialing requirements and who are practicing primary care medicine. Complete an application with CAQH or call Evernorth at 800.88Evernorth (882.4462) to begin the application process.

(13) Electronic Health Records: In 2009, Maryland became the first state to require that certain state-regulated payers, including Evernorth, provide incentives to select providers to promote the adoption of electronic health records (EHRs) with the passage of House Bill 706 Electronic Health Records – Regulation and Reimbursement. For more information, visit:
http://mhcc.maryland.gov/mhcc/pages/hit/hit_ehr/hit_ehr_state_incentive.aspx

(14) Patient Centered Medical Home Program: Evernorth is participating in the Maryland Multi-Payer Patient Centered Medical Home Pilot (MMPP). For more information, visit http://mhcc.maryland.gov/pcmh/.

MASSACHUSETTS REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Massachusetts regarding provider contracts with providers rendering health care services in the State of Massachusetts. To the extent that such Massachusetts laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Massachusetts laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) "Emergency Medical Condition" is a medical condition, whether physical or mental, manifesting itself by symptoms of sufficient severity, including severe pain, that the absence of prompt medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine, to result in placing the health of an insured or another person in serious jeopardy, serious impairment to body function, or serious dysfunction of any body organ or part, or, with respect to a pregnant woman, as further defined in § 1867(e)(1)(B) of the Social Security Act, 42 U.S.C. § 1395dd(e)(1)(B).

(2) "Medical Necessity" or "Medically Necessary" is defined as, health care services that are consistent with generally accepted principles of professional medical practice as determined by whether:
    (a) the service is the most appropriate available supply or level of service for the insured in question considering potential benefits and harms to the individual;
    (b) is known to be effective, based on scientific evidence, professional standards and expert opinion, in improving health outcomes; or
    (c) for services and interventions not in widespread use, is based on scientific evidence.

(3) If Evernorth contracts with another entity to perform some or all of the functions governed by the requirements of M.G.L. c. 176O, Evernorth shall be responsible for ensuring compliance by said entity with the applicable provisions of Massachusetts law. Any failure by said entity to meet such requirements shall be the responsibility of Evernorth to remedy and shall subject Evernorth to any and all enforcement actions, including financial penalties authorized under M.G.L. c. 176O.

(4) Notwithstanding anything to the contrary set forth in the Agreement, the following shall be applicable to the Compensation section of the Agreement:

(a) Within forty-five (45) days after Payor's receipt of Provider's completed claim, Payor shall: (i) pay for any fee-for-service amounts owing under this Agreement for such health care services provided; (ii) notify Provider in writing of the reason or reasons for nonpayment or (iii) notify Provider in writing of what additional information or documentation is necessary to complete the claim for reimbursement.

(b) If Payor fails to comply with the requirements of (a) above, Payor shall pay 1½ % interest per month, not to exceed 18% per year, accruing beginning forty-five (45) days after the Payor's receipt of request for reimbursement. Interest payments shall not apply if the claim for the Covered Service was submitted fraudulently or negligently or Provider was already paid for the Covered Service.

(5) Provider shall comply with Evernorth's requirements for utilization review, quality management and improvement, credentialing and the delivery of preventive health services.

(6) Provider shall provide ninety (90) days advance written notification to Evernorth should Provider plan to implement a policy to charge a fee to Participants as a condition to be part of Provider's panel for care.

(7) Evernorth shall not refuse to contract with or compensate Provider for Covered Services solely because Provider has in good faith communicated with or advocated on behalf of one or more prospective, current or former patients regarding the provisions, terms or requirements of a Plan as they relate to the needs of Provider's patients, or communicated to one or more prospective, current or former patients with respect to the method by which Provider is compensated for Covered Services. Nothing in this provision shall be construed to preclude Evernorth from requiring Provider to hold confidential specific compensation terms.

(8) In the event of termination of the Agreement by either party, the written notice of termination must include the reason(s) for such termination. The parties do not have the right to terminate the Agreement without providing a reason for such termination, as neither party has the right to terminate the Agreement without cause.

(9) Pursuant to the requirements of M.G.L. c. 176O, Section 15 to the extent applicable to the Agreement:

(a) Evernorth shall notify a Participant at least thirty (30) days before the disenrollment of such Participant's primary care physician and shall permit such Participant to continue to be covered for health services, consistent with the terms of the Plan, by such primary care physician for at least thirty (30) days after said primary care physician is disenrolled, other than disenrollment for quality-related reasons or for fraud. Such notice shall also include a description of the procedure for choosing an alternate primary care physician.

(b) Evernorth shall allow any female Participant who is in her second or third trimester of pregnancy and whose provider in connection with her pregnancy is involuntarily

disenrolled, other than disenrollment for quality-related reasons, or for fraud, to continue treatment with said provider, consistent with the terms of the Plan, for the period up to and including the Participant's first postpartum visit.

(c) Evernorth shall allow any Participant who is terminally ill and whose provider in connection with said illness is involuntarily disenrolled, other than disenrollment for quality-related reasons, or for fraud, to continue treatment with said provider, consistent with the terms of the Plan, until the Participant's death.

(d) During the period of continued treatment by a provider under subsections (a), (b) and (c), of this provision, Provider must agree: (1) to accept reimbursement from Payor at the rates applicable prior to the notice of disenrollment as payment in full and not to impose cost sharing with respect to the Participant in an amount that would exceed the cost sharing that could have been imposed if Provider had not been disenrolled; (2) to adhere to the quality assurance standards of Evernorth and to provide Evernorth with necessary medical information related to the care provided; and (3) to adhere to Evernorth's policies and procedures, including procedures regarding referrals, obtaining prior authorization and providing services pursuant to a treatment plan, if any, approved by Evernorth. Nothing in this provision shall be construed to require the coverage of benefits that would not have been covered if Provider remained a Participating Provider.

(10) Evernorth shall notify Provider in writing of modifications in provider compensation, modifications in Covered Services, or modifications in Evernorth's procedures, documents or requirements, including those associated with utilization review, quality management and improvement, credentialing and preventive health services, that have a substantial impact on the rights or responsibilities of Provider, and the effective date of the modifications. The notice shall be provided sixty (60) days before the effective date of such modification.

(11) Provider is not required to indemnify Evernorth 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 Evernorth based on Evernorth's management decisions, utilization review provisions or other policies, guidelines or actions.

(12) In the event of Payor's insolvency, Provider shall look solely to Payor for compensation for Covered Services, except for Copayments, Deductibles or Coinsurance. Under no circumstances shall Provider directly or indirectly make any charges or claims, other than for Copayments, Deductibles or Coinsurance, against any Participants or their representatives. This provision shall survive the termination of the Agreement for services rendered prior to the termination, regardless of the cause of the termination.

(13) Pursuant to the requirements of M.G.L. c. 176O § 9A and 211 CMR 152.00 to the extent applicable to the Agreement:

(a) Provider shall have the right to opt-out of any new select network, limited,

regional or tiered network health benefit plan introduced by Evernorth at least sixty (60) days before the plan is submitted for regulatory approval.

(b) Nothing in the Agreement shall be construed to: guarantee Provider a right to participate in any Evernorth select network or tiered network plan; require or permit either party to alter or terminate the Agreement, in whole or in part, to affect parity with an agreement with other carriers or health care providers based on Evernorth's decision to introduce or modify a select network plan or tiered network plan; require Evernorth to place all members of Provider in the same tier of a tiered network plan; or require Evernorth to include all members of Provider in a select network plan on an all-or-nothing basis. Any supplemental payment required or permitted under the Agreement shall not be enforceable unless each payment has been publicly disclosed as a condition of state accreditation. To the extent the Agreement contains any provision prohibited by this section, the duties and obligations of the provision shall apply only to health benefit plans not subject to M.G.L. c. 176O § 9A and 211 CMR 152.00.

(c) Evernorth shall notify Provider in writing at least sixty (60) days before the effective date of any modification to the process used to classify participating providers by benefit tier, the timelines used to make and implement reclassification decisions by benefit tier, the information collected from participating providers, and the criteria used to make classifications.

(d) Provider shall have the right to receive notification of classification to a benefit tier, an explanation of the past experience and other criteria used to make classification decisions, and to appeal classification decisions and receive an appeal decision prior to the new classification being made available.

(e) Evernorth shall notify participating providers about health benefit plans that use networks subject to 211 CMR 152.00 as set forth in the Medical Management Program.

(14) With respect to the 48 hour notification requirement 211 CMR 52.14 (d):

(a) insureds have the opportunity to obtain health care services for an Emergency Medical Condition, including the option of calling the local pre-hospital emergency medical service system by dialing the emergency telephone access number 911, or its local equivalent, whenever the insured is confronted with an Emergency Medical Condition which in the judgment of a prudent layperson would require pre-hospital emergency services;

(b) no insured shall in any way be discouraged from using the local pre-hospital emergency medical service system, the 911 telephone number, or the local equivalent;

(c) no insured will be denied coverage for medical and transportation expenses incurred as a result of such Emergency Medical Condition; and

(d) if the carrier requires an insured to contact either the carrier or its designee or the primary care provider of the insured within forty-eight (48) hours of receiving Emergency Services, that notification already given to the carrier, designee or primary care provider by the attending emergency provider shall satisfy that requirement.

(15) With respect to Medical Management:

(a) Evernorth shall make an initial determination regarding a proposed admission, procedure or service that requires such a determination within two (2) business days of obtaining all necessary information. For the purposes of this section, "necessary information" shall include the result of any face-to-face clinical evaluation or second opinion that may be required. In the case of a determination to approve an admission, procedure or service, Evernorth shall notify the health care professional by telephone within twenty-four (24) hours, and shall provide written or electronic confirmation of the telephone notification to the Participant and the health care professional with two (2) business days thereafter. In the case of an adverse determination, Evernorth shall notify the health care professional by telephone within twenty-four (24) hours, and shall provide written or electronic confirmation of the telephone notification to the Participant and the health care professional within one (1) business day thereafter.

(b) Evernorth shall make a continued stay review determination within one (1) business day of obtaining all necessary information. In the case of a determination to approve an extended stay or additional services, Evernorth shall notify the health care professional by telephone within one (1) business day, and shall provide written or electronic confirmation to the Participant and the health care professional within one (1) business day thereafter. A written or electronic notification shall include the number of extended days or the next review date, the new total number of days or services approved, and the date of admission or initiation of services. In the case of an adverse determination, Evernorth shall notify the health care professional by telephone within twenty-four (24) hours, and shall provide written or electronic notification to the Participant and the health care professional within one (1) business day thereafter. The service shall be continued without liability to the Participant until the Participant has been notified of the determination.

(c) The written notification of an adverse determination shall include a substantive clinical justification therefore that is consistent with generally accepted principles of professional medical practice, and shall, at a minimum: (a) identify the specific information upon which the adverse determination was based; (b) discuss the patient's presenting symptoms or condition, diagnosis and treatment interventions and the specific reasons such medical evidence fails to meet the relevant medical review criteria; (c) specify any alternative treatment option offered by Evernorth, if any; (d) reference and

include applicable clinical practice guidelines and review criteria; and (e) include a clear, concise and complete description of Evernorth's formal internal grievance process and procedures for obtaining external review pursuant to 105 CMR 128.400.

(d) Evernorth shall give the health care professional treating a Participant an opportunity to seek reconsideration of an adverse determination from a clinical peer reviewer in any case involving an initial determination or a concurrent review determination. The reconsideration process shall occur within one (1) business day of the receipt of the request and shall be conducted between the health care professional rendering the service and clinical peer reviewer or a clinical peer designated by the clinical peer reviewer, if said reviewer cannot be available within one (1) business day. If the adverse determination is not reversed by the reconsideration process, the Participant, or the health care professional on behalf of the Participant, may pursue the grievance process established pursuant to 105 CMR 128.000. . The reconsideration process allowed pursuant to 211 CMR 52.08(6) shall not be a prerequisite to the internal grievance process or an expedited appeal required by 105 CMR 128.000.

(16) With respect to Quality Management:

(a) Evernorth shall conduct an annual survey of customers to assess satisfaction with access to specialist services, ancillary services, hospitalization services, durable medical equipment and other covered services. The survey shall compare the actual satisfaction of customers with projected measures of their satisfaction. If incentive plans are utilized, Evernorth shall establish mechanisms for monitoring the satisfaction, quality of care and utilization compared with projected utilization of health care services by customers.

(17) With respect to Expedited Psychiatric Inpatient Admission (EPIA):

(a) Evernorth shall arrange payments for all medically necessary care for patients within the inpatient psychiatric facilities, including such care as may be required to enable the facility to accept a patient with specialty needs (such as 1:1 staff member/patient ratio, payment to convert a double occupancy room into a single, etc.). Such payment may be dictated by a specific or default rate within the Inpatient Psychiatric Facility's contract or may be negotiated on a case-by-case basis, per request.
(b) Request for specialty services should be made during the authorization process.

(18) Covered Practitioners in Massachusetts: A carrier that requires the designation of a primary care physician shall provide Participants with an opportunity to select a participating nurse practitioner as a primary care physician or to change their primary care physician to a participating nurse practitioner at any time during their coverage period. Evernorth accepts applications from licensed Nurse

Practitioners who wish to be contracted as a primary care practitioner and appear in Evernorth's directory. Additionally, MA law requires carriers recognize Physician Assistants (PAs) as participating providers and if a carrier requires the designation of a primary care practitioner, it shall provide customers with an opportunity to select a participating Physician Assistant as a primary care practitioner. A participating Physician Assistant practicing within the scope of their license, including all regulations requiring collaboration with or supervision by a physician under section 9E of chapter 112, shall be considered qualified within the carrier's definition of primary care provider to an insured. To request an application or for more information, contact Evernorth at 800.88Evernorth. (882.4462).

(19) Pain Management: In compliance with Massachusetts statute ALM GL ch. 175, § 47KK and Bulletin 2019-06, Evernorth has identified possible alternative pain management services and medications that may be covered for Provider's Evernorth patients. Listed below are some of Evernorth's non-medication services and medications that may be alternative treatments to opioids for treating pain. These are typically covered under Evernorth's plans, but Provider will need to check coverage for each individual patient as coverage will vary based on the customer's plan.

(a) Non-Medication Treatment Alternatives for Pain:

- Acupuncture
- Chiropractic
- Physical therapy
- Occupational therapy
- Physician medicine/rehab
- Cognitive behavioral therapy
- Nutrition counseling
- Osteopathic manipulation medicine
- Interventional pain management nerve block
- Spine surgery
- TENS unit

(b) Non-Opioid Medication Alternatives for Pain:

- NSAIDs
- Topical analgesics
- COX-2 inhibitors
- Skeletal muscle relaxants
- Antidepressants
- Anticonvulsants
- Corticosteroids

Provider can find more information about these and other possible alternatives to treating pain at Evernorth's "help with pain" website (https://www.Evernorth.com/helpwithpain/) or by reviewing Evernorth's coverage policies (https://www.Evernorth.com/health-care-providers/coverage-and-claims/policies/).

MICHIGAN REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Michigan regarding provider contracts with providers rendering health care services in the State of Michigan. To the extent that such Michigan laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Michigan laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) Claims for Covered Services must be submitted within one (1) year of the date of service or the date of discharge from the facility.

(2) With respect to a Provider who is a physician:

If the Agreement is terminated, Provider may, at the option of Participant, continue to provide Covered Services for an ongoing course of treatment for which a Participant was under Provider's care at the time of such termination so long as Participant retains eligibility under a Plan, until (a) for a Participant in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery; (b) for a period up to six (6) months in the case of a Participant who at the time of the termination has been diagnosed with a terminal illness; or (c) for a period up to ninety (90) days after the effective date of termination for all other Participants in an active course of treatment.

During the period of continued care, Provider shall continue (a) to accept as payment in full reimbursement at the rates applicable prior to the termination;
(b) to adhere to Evernorth's standards for maintaining quality health care and to provide to Evernorth necessary medical information related to the care; and (c) to adhere to Evernorth's policies and procedures, including, but not limited to, those concerning utilization review, referrals, preauthorizations and treatment plans. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

MINNESOTA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Minnesota regarding provider contracts with providers rendering health care services in the State of Minnesota. To the extent that such Minnesota laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Minnesota laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

1. The definition for Emergency Services, if any, shall comply with Minnesota laws and regulations to the extent applicable.

2. In addition to the negotiated terms of the Agreement governing amendments to the Agreement, the following shall apply in accordance with applicable laws and regulations:

   A. Evernorth shall disclose to Provider at least forty-five (45) days prior to the effective date of any proposed amendment or change to the terms of the Agreement. Changes or amendments required by law or governmental regulatory authority will be disclosed when the requirement is made known to Evernorth.

   B. Evernorth shall disclose to Provider any amendment or change in the Agreement that alters the fee schedule or materially alters the written contractual policies and procedures governing the relationship between the parties not less than forty-five (45) days before the effective date of the proposed change; Provider may, in accordance with the terms of the Agreement, terminate the Agreement before the amendment or change is deemed to be in effect.

3. Evernorth may terminate this Agreement without cause upon one hundred twenty (120) days' notice to Provider.

4. In the event this Agreement contains a Most Favored Nation provision, the Most Favored Nation provision is null and void to the extent that it is prohibited under applicable Minnesota laws and regulations.

II

1. If Provider is a hospital, ambulatory surgical center, or freestanding emergency room, in addition to the negotiated terms of the Agreement establishing obligation on amendments to the Agreement, the following shall apply in accordance with applicable laws and regulations:

A. Evernorth shall disclose to Provider any proposed amendment or change to the terms of the Agreement.

B. Evernorth shall disclose to Provider any amendment or change in the Agreement that alters the financial reimbursement or alters the written contractual policies and procedures governing the relationship between the parties before the amendment or change is deemed to be in effect.

MISSISSIPPI REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Mississippi regarding provider contracts with providers rendering health care services in the State of Mississippi. To the extent that such Mississippi laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Mississippi laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

1. In addition to the negotiated terms of the Agreement establishing limits on billing Participants, the following shall apply in accordance with applicable laws and regulations:

A. Provider agrees that in no event, including but not limited to nonpayment by Evernorth, insolvency of Evernorth, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Participant or a person (other than Evernorth) acting on behalf of Participant for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in the evidence of coverage, or fees for uncovered services delivered on a fee-for-service basis to Participants. Nor does this provision prohibit Provider and Participant from agreeing to continue services solely at the expense of the Participant, as long as Provider has clearly informed Participant that Evernorth may not cover or continue to cover a specific service or services. Except as provided in the Agreement, this provision does not prohibit Provider from pursuing any available legal remedy.

B. In the event of Evernorth's or Provider's insolvency or other cessation of operations, Covered Services to Participants will continue through the period for which a premium has been paid to Evernorth on behalf of the Participant or until discharge from an inpatient facility, whichever time is greater. Covered Services to Participants 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.

C. Subsections A and B shall be construed in favor of the Participant, shall survive

the termination of the contract regardless of the reason for termination, including Evernorth's insolvency, and shall supersede any oral or written contrary agreement between Provider and Participant or the representative of a Participant if the contrary agreement is inconsistent with the hold harmless and continuation of Covered Services provisions required by subsections A and B or applicable laws and regulations.

D. Provider shall ensure that all contracts entered into with Participating Providers contain a provision substantially similar to subsection A above, or substantially similar to the text required by applicable laws and regulations.

2. In no event shall Provider collect or attempt to collect from a Participant any money owed to Provider by Evernorth.

3. Nothing in the Agreement shall be construed to offer an inducement under a managed care Plan to Provider to provide less than Medically Necessary services to Participants. Nothing in the Agreement shall be construed to prohibit Provider from discussing treatment options with Participants irrespective of Evernorth's position on the treatment options, or from advocating on behalf of Participants within the utilization review or grievance processes used by Evernorth.

4. Nothing in the Agreement shall be construed to penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by Evernorth that jeopardizes patient health or welfare.

5. To the extent required by applicable law, including but not limited to Miss. Code Ann. §83-41-219, as may be amended from time to time, Evernorth or Payor shall have the same time limit following payment of a claim to perform any review or audit for reconsidering the validity of the claim and requesting reimbursement for payment of an invalid claim or overpayment of a claim as Provider has to submit a claim for payment under this Agreement. To the extent the Agreement does not limit the time in which Provider is required to submit a claim for payment, Payor shall not request reimbursement of offset another claim payment for reimbursement of an invalid claim or overpayment of a claim more than twelve (12) months after the payment of an invalid claim or overpaid claim. Nothing in this section shall apply to claims submitted in the context of misrepresentation, omission, concealment, or fraud, or to claims submitted by Provider for reimbursement under the Mississippi Medicaid Program.

6. Evernorth and Provider shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply. Within five (5) working days of the date that Provider either gives or receives notice of termination, Provider shall supply a list of those Participants that are patients of the Provider.

7. To the extent permitted by applicable law, Evernorth shall retain the right to

immediately terminate the Agreement upon a valid order issued by the Mississippi Department of Insurance or other lawful authority.

8. In accordance with applicable laws and regulations, Evernorth shall have the right to approve or disapprove the participation status of a participating provider in Provider's contracted network for the purpose of delivering Covered Services to Evernorth's Participants.

9. Evernorth's rights and responsibilities under the Agreement shall not be assigned or delegated by Provider without prior written consent. Nothing in the Agreement shall be construed to delegate or assign to Provider Evernorth's statutory responsibility to monitor the offering of Covered Services to Participants.

10. In accordance with applicable laws and regulations, Evernorth shall have the right, in the event of Provider's insolvency, to require the assignment to Evernorth of the provisions of Provider's contract addressing the Provider's obligation to furnish Covered Services.

11. In addition to the negotiated terms of the Agreement, Evernorth shall have access to all Provider's subcontracts, and shall have the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from Evernorth.

12. In addition to the negotiated requirements of the Agreement, Provider shall maintain the books, records, financial information and documentation of services provided to Participants at its principal place of business in the state and shall preserve them in a manner that facilitates regulatory review.

13. Provider shall allow the commissioner of insurance access to Provider's books, records, financial information and any documentation of services provided to Participants, as necessary to determine compliance with applicable laws and regulations.

14. In addition to the negotiated requirements of the Agreement establishing requirements for records, 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 Participants, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

15. If applicable under the terms of the Agreement, Provider shall transmit utilization documentation and claims paid documentation to Evernorth as set forth in the Agreement. Evernorth shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Participants.

16. Definitions or other provisions in the Agreement shall be construed to avoid conflict with the definitions or provisions contained in the managed care plan, or in applicable laws and regulations.

MISSOURI REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Missouri regarding provider contracts with providers rendering health care services in the State of Missouri. To the extent that such Missouri laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Missouri laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

A. (1) The definitions for Emergency Medical Condition and Emergency Services are amended to read in their entirety as follows:

Emergency Medical Condition - Means the sudden and, at the time, unexpected onset of a health condition (emergency medical condition) that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required, which may include, but shall not be limited to:

1. placing the person's health in significant jeopardy;
2. serious impairment to a bodily function;
3. serious dysfunction of any bodily organ or part;
4. inadequately controlled pain; or
5. with respect to a pregnant woman who is having contractions;
   a. that there is inadequate time to effect a safe transfer to another hospital before delivery; or
   b. that transfer to another hospital may pose a threat to the health or safety of the woman or unborn child.

Emergency Services - Means health care items and services furnished or required to screen and stabilize an emergency medical condition, which may include, but shall not be limited to, health care services that are provided in a licensed hospital's emergency facility by an appropriate provider.

(2) Provider shall be bound by and comply with the provisions of all applicable State of Missouri Regulations and Statutes (including but not limited to the credentialing and recredentialing requirements of 20 CSR 400-7.180), all applicable federal laws and regulations, and Evernorth Medical Management Program. Provider shall comply with

the requirements of and shall participate in quality management and utilization management.

(3) The Agreement shall be governed by applicable State of Missouri Regulations and Statutes and any applicable federal law.

(4) To the extent required by RSMo § 376.384, Provider shall file a claim for reimbursement for a health care service provided in this state for a period of up to six (6) months from the date of service, unless the Agreement specifies a different standard.

B. With respect to Covered Services rendered to Participants covered under an HMO Plan:

(1) Evernorth shall give Provider thirty (30) days to review the Agreement.

(2) Pursuant to RSMo 354.603.1(3), Evernorth shall monitor, on an on-going basis, the ability, clinical capacity, and legal authority of Provider to furnish all Covered Services to Participants.

(3) Throughout the term of the Agreement, Provider shall maintain general and professional liability coverage in a form and amount acceptable to Evernorth ($_1 million_per occurrence and $ 3 million_in the aggregate).

(4) Payor shall not request a refund or offset against a claim more than twelve (12) months after a Payor has paid a claim except in cases of fraud or misrepresentation by Provider.

(5) Evernorth will not terminate the Agreement solely because Provider has:

a. advocated on behalf of a Participant;
b. filed a complaint against Evernorth;
c. appealed a decision made by Evernorth;
d. provided information or filed a report with the Missouri Department of Commerce & Insurance; or
e. requested a hearing or review.

(6) Evernorth and Provider shall provide at least sixty (60) days written notice to each other before terminating the Agreement with notice. The written notice shall include an explanation of why the Agreement is being terminated. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with regard to termination of the Agreement by Provider or Evernorth, such longer notification period will apply.

(7) If Provider is not a hospital, the following shall apply: Notwithstanding anything to the contrary set forth in the Agreement, the grounds for immediate termination of the Agreement or for the immediate termination of Provider are cases involving imminent harm to patients, a determination of fraud, or a final disciplinary action by a state

licensing board or other governmental agency.

(8) If Provider is not a hospital or ancillary provider, the following shall apply:

a. Health Care Professionals:

Notice and Hearing: If Evernorth should choose to terminate Provider, Evernorth shall provide Provider a written explanation of the reason(s) for the proposed termination and give Provider an opportunity for a review or hearing as hereinafter set forth. Provider must notify Evernorth in writing of the request for a hearing within thirty (30) days of receipt of the notice of termination. A hearing will be held within thirty (30) days after receipt of the Provider's request by Evernorth. The hearing shall be conducted by a panel of three (3) or more people appointed by Evernorth, at least one-third of whom shall be clinical peers of Provider. The panel shall render a decision within fifteen (15) days after the hearing and shall notify Provider of the decision in writing which will include one of the following resolutions: (1) unconditional reinstatement; (2) provisional reinstatement subject to certain conditions as set forth by Evernorth; or (3) termination.

Termination will be effective no earlier than thirty (30) days after Provider's receipt of the panel's decision. In no event shall the termination be effective earlier than sixty (60) days from Provider's receipt of the notice of termination.

Imminent harm, fraud and final disciplinary actions: The above requirements regarding notice and hearing do not apply in cases involving imminent harm to patients, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency.

Non-renewal: Any nonrenewal of the Agreement shall not constitute a termination for the purposes of this provision.

(9) Notice to Participants: Upon termination of the Agreement, Evernorth shall give written notice within thirty (30) working days of such termination to all Participants who are seen on a regular basis by Provider. When termination involves a primary care physician, all Participants who are patients of such provider shall be notified. Within fifteen (15) working days of the date of termination Provider shall supply Evernorth with a list of Participants that must be notified of the termination.

(10) 1. Upon termination of the Agreement, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination where the continuation of care is Medically Necessary and in accordance with the dictates of medical prudence, including circumstances such as disability, pregnancy or life- threatening illness, so long as Participant retains eligibility under a Plan, until the earlier of completion of such services, or the expiration of ninety (90) days. Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation

arrangements under the Agreement. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during such period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Plan.

2. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

(11) In the event of Evernorth's insolvency or other cessation of operations, Covered Services to Participants shall continue through the period for which a premium has been paid to Evernorth on behalf of the Participant or until the Participant's discharge from an inpatient facility, whichever time is greater. This provision survives termination of this Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Participants and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Participant or persons acting on the Participant's behalf.

(12) If a party initiates arbitration to resolve a dispute, the arbitrator will be instructed that, to the extent that an external review organization or the Missouri Department of Commerce & Insurance has rendered a final determination as permitted by RSMo 376.1350 through RSMo 376.1399 regarding coverage of a particular service rendered to a particular Participant, the arbitrator will not have authority to revise that final determination.

(13) The Charges to Participants provision survives termination of this Agreement regardless of the cause giving rise to such termination, including Payor's insolvency.

(14) The provision of the Agreement relating to the limitation on billing Participants shall also apply in the event of nonpayment by the intermediary or the intermediary's insolvency or breach of the Agreement.

(15) Any modification, addition, or deletion to the provision of the Agreement relating to the limitation on billing Participants shall become effective on a date no earlier than thirty (30) days after the applicable state regulatory agency has received written notice of such proposed changes, or the date permitted by applicable law, whichever is later.

(16) a. Evernorth shall not prohibit or restrict Provider from disclosing to Participant any information that Provider deems appropriate regarding the nature of treatment, risks, or alternatives thereto, the availability of other therapy, consultation or test, the decision of any plan to authorize or deny services, or the process that the plan or any person contracting with the plan uses or proposes to use, to authorize or deny health care services. Evernorth shall not prohibit any other communication expressly protected under all applicable State of Missouri Regulations and Statutes and all applicable federal laws and regulations.

b. Provider's duties to comply with Evernorth's Participant Grievance procedure shall

be subject to RSMo 376.1350 through RSMo 376.1399, including in particular Provider's option to appeal Evernorth decisions and those provisions related to determinations to the Missouri Department of Commerce & Insurance or external review organizations. Evernorth shall not penalize Provider because Provider, in good faith, reports to state or federal authorities any act or practice by Evernorth that Provider reasonably determines may jeopardize patient health or welfare.

(17) Claim Payment: Where Missouri statute applies, claims are processed in accordance with Missouri's prompt pay laws.

(18) Credentialing Requirements: For practitioners defined in MO RSMo 376.1575, Missouri requires the following be included in the credentialing process:

a. Within two (2) working days after receipt of a faxed or completed application, Evernorth shall send a notice of receipt to the practitioner.
b. Access to a provider web portal that allows the practitioner to receive notice of the status of an electronically submitted application must be made available - http://www.Evernorth.com/healthcare-professionals/join-our-network.
c. Within sixty (60) business days of the date of receipt of the completed application, Evernorth must make a decision as to whether to approve or deny the practitioner's credentialing application.

(19) Telehealth/Telemedicine: Missouri has minimum requirements for provision of covered services through telehealth or telemedicine.

Individual and Family Plans
Cigna Health and Life Insurance Company

CONNECT NETWORK

CONNECT NETWORK

St. Louis, Missouri

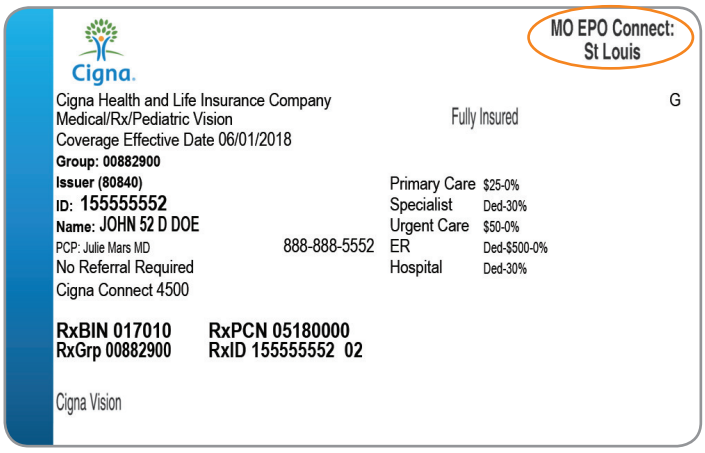
Cigna's Individual & Family Plans offer a range of coverage options and access to quality care at cost-effective prices. Our Connect plan, offered in select markets, is aligned with the Connect Network. These plans provide individuals and families access to providers in their local area.

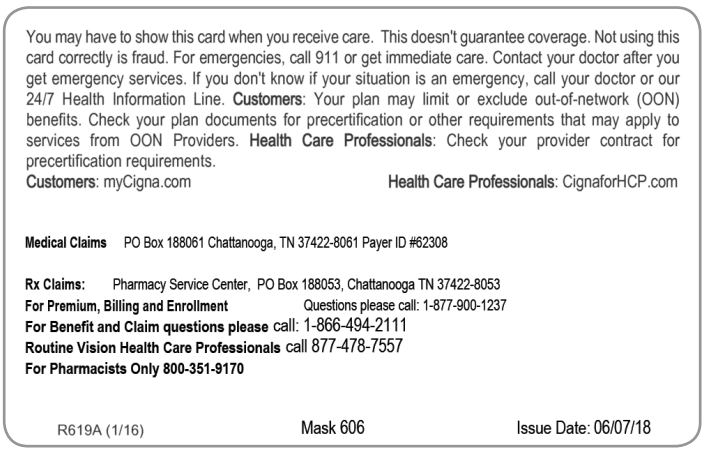
Important plan information for St. Louis, Missouri

Plan aligned with the network	Cigna Connect
Plan type	In-network only
Emergencies	In-network and out-of-network coverage for emergency care*
Primary care provider (PCP) selection	PCP selection encouraged
Specialists' referrals	Referral encouraged
Out-of-network coverage	Visits to providers outside of the Connect Network are not covered by the plan
National ancillary providers	All Cigna-contracted national ancillary providers participate
Participating provider search	**Cigna.com/ifp-providers**

* Emergency medical condition as defined in the plan.

Look in the top right corner of the ID card to identify the network aligned with the patient's plan





ID cards for illustrative purposes only.

This plan encourages customers to select a PCP, which will be printed on their ID card. However, customers are allowed to select a different PCP, and therefore may use a network-participating PCP other than the one shown on the card and receive the same level of coverage.

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Cigna®

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Referrals and precertification

To support coordination of care, PCPs are encouraged to request referrals to specialists for their patients with the Connect plan. Precertification may be required for some services.

If you need to submit a referral or obtain precertification for a patient, please use one of the following options.

- **Health care request and response (ANSI 278):** Contact your electronic data interchange (EDI) or practice management system vendor.
- **Phone:** 866.494.2111. Choose the prompt for specialist referral or precertification.
- **Fax:** 866.873.8279.
  - You can obtain a referral form on the Cigna for Health Care Professionals website (**CignaforHCP.com** > Resources > Form Center > Medical Forms).
- **Mail:** Cigna
  Attn: Precertification and Referral Department
  2nd Floor, 1640 Dallas Parkway
  Plano, Texas 75093

Specialists can confirm referrals by using one of the following options.

- The PCP's written referral presented by the patient.
- Calling Cigna Customer Service at **866.494.2111** and choose the prompt for specialist referral.

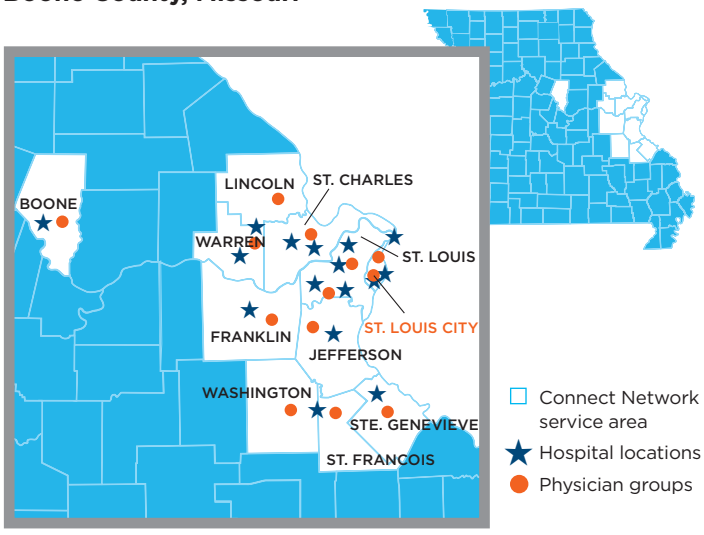
When making referrals, access the online directory at **Cigna.com/ifp-providers** to find participating physicians, hospitals and other providers.

To avoid delays in processing your referral or precertification, please confirm your EDI vendor is using "SC" for specialty care review in the Request Category Code field (UM01 segment) for referrals, and "AR" for admission review or "HS" for health services review in the Request Category Code field (UM01 segment) for precertification.

Connect Network service area

St. Louis Metropolitan counties: Franklin, Jefferson, Lincoln, St. Charles, St. Louis City, St. Louis, St. Francois, Ste. Genevieve, Warren, Washington

Boone County, Missouri



The Connect Network includes access to many hospital systems and physician groups, including:

Hospital systems

- BJC Health System
  - Barnes-Jewish Hospital
  - Barnes-Jewish St. Peters Hospital
  - Barnes-Jewish West County Hospital
  - Boone Hospital
  - Christian Hospital NE NW
  - Missouri Baptist Medical Center
  - Missouri Baptist Sullivan Hospital
  - Northwest HealthCare
  - Parkland Health Center (Farmington, Bonne Terre)
  - Progress West Hospital
  - St. Louis Children's Hospital
- Mercy Hospital South (formerly St. Anthony's Medical Center
- Ste. Genevieve County Memorial Hospital
- Washington County Memorial Hospital

St. Louis, Missouri physician groups

- BJC Medical Group
- Esse Health Physician Group
- Mercy Clinic South Physicians (formerly St. Anthony's Physician Organization)
- Washington University School of Medicine Physicians

This listing is not all inclusive. For a complete listing of physicians or facilities, please refer to the provider directory.

Boone County, Missouri physician groups

- BJC Medical Group and Affiliates
  - Boone Physician Services, LLC
  - CHAS Physician Services, LLC
  - Physicians Group, LLC
- Columbia Orthopaedic Group, LLP
- Family Health Center
- Missouri Cancer Associates, LLP
- Missouri Medical Affiliates (MMA) – A multispecialty Independent Practice Association (IPA) that includes, but is not limited to, the following groups.
  - Central Missouri Dermatology Associates
  - Columbia Allergy & Asthma Specialists
  - Gastrointestinal Associates
  - Missouri Ear Nose & Throat
  - Nephrology & Hypertension Associates
  - Retina Associates of Missouri
  - Tiger Pediatrics
  - Women's Health Associates
  - Women's Wellness Center

Health Insurance Marketplace

The on-Marketplace premium payment grace period

Customers who have purchased coverage on-Marketplace, and are receiving federal premium assistance, may be entitled to an extended grace period to pay their premiums. Providers should develop a policy on how to address patients who are in the premium payment grace period.

Days 1–30	▸ Claims for customers with unpaid premiums will be paid by Cigna. ▸ Cigna will not attempt to recoup funds should premiums go unpaid.
Days 31–90	▸ Claims incurred during the extended grace period (days 31–90) for premium subsidized customers will be pended until full premium payment is made.
Days 91+	▸ Claims for premium subsidized customers with unpaid premiums will be denied. ▸ Customer is subject to a waiting period before reenrolling with Cigna.

Eligibility

Providers should always verify a patient's eligibility at the time of service to determine whether a patient is covered based upon the eligibility information available to Cigna at that time. Eligibility can be verified at **CignaforHCP.com** or through a practice management vendor or clearinghouse submission of an eligibility and benefit inquiry and response (ANSI 270/271) transaction.

Your patient may be within the extended grace period, and not be eligible for benefits, if:

- You see "Eligibility pending for verification of premium payment" on the Coverage Details screen.
- A code "5" (active – pending investigation) is returned.

For more information on the Health Insurance Marketplace or other aspects of the Patient Protection and Affordable Care Act, visit **InformedOnReform.com**. There you will find information and tools, designed with you and your patients in mind, that explain the law and how it applies.

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INFORMATION FOR PROVIDERS

Cigna **SureFit** – Saint Louis and surrounding counties

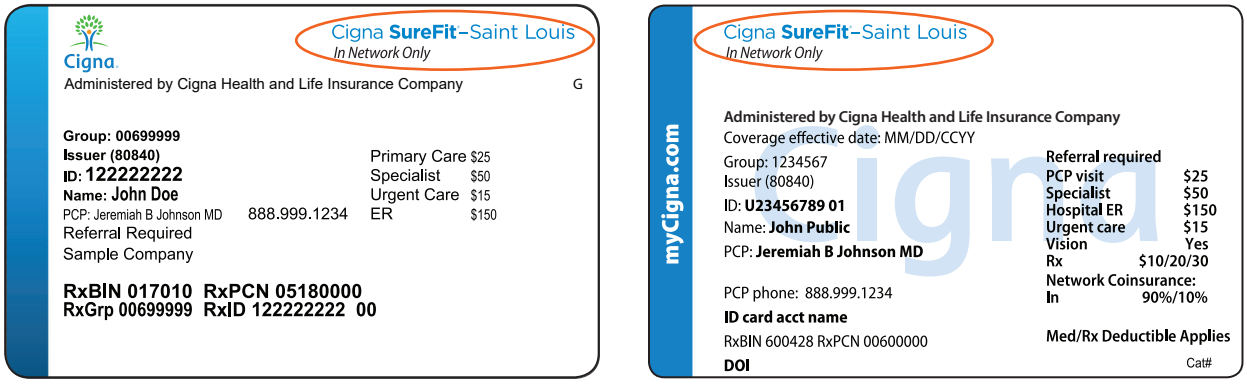
Cigna SureFit® is a new plan offering that builds networks around local physician and hospital groups and provides our customers with access to personal, patient-centered care.

Important plan information for St. Louis and surrounding counties

Emergencies*	In-network and out-of-network coverage for emergency care
PCP selection	PCP selection is required
Specialist referrals	**Referrals required**
Out-of-network coverage	No out-of-network coverage
National ancillary providers	All Cigna-contracted national ancillary providers participate
Participating provider search	Access the online directory at **Cigna.com/hcpdirectory/** and select Cigna SureFit Saint Louis

*For emergency medical conditions as defined in the plan documents.

Look at the top of the ID card to identify the network aligned to the patient's plan



Images for illustrative purposes only. Please refer to the patient's Cigna ID card for specific plan information.

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Cigna®

913727 THN-2018-104-MO 02/18

Referrals and precertification

To support coordination of care, **PCPs must request referrals to specialists** for their patients with a Cigna SureFit plan. Precertification may be required for some services.

If you need to submit a referral or obtain precertification for a patient, please use one of the following options.

- **Health care request and response (ANSI 278):** Contact your electronic data interchange (EDI) or practice management system vendor.
- **Phone:** 1.866.494.2111, choose the prompt for specialist referral or precertification.
- **Fax:** 1.866.873.8279

  You can obtain a referral form on the Cigna for Health Care Professionals website (**CignaforHCP.com** > Resources > Form Center > Medical Forms).
- **Mail:** Cigna, Attn: Precertification and Referral Department, 2nd Floor, 1640 Dallas Parkway, Plano, Texas 75093

Specialists should have an open dialogue with the referring PCP to understand the customer's needs and why a referral was submitted.

Specialists can confirm referrals by using one of the following options.

- The PCP's written referral presented by the patient
- Calling Cigna Customer Service at **1.866.494.2111**. Choose the prompt for specialist referral

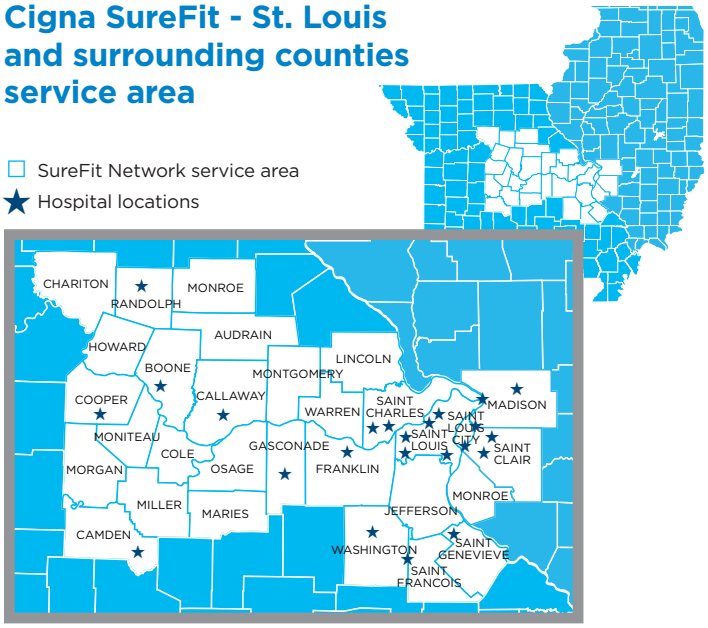
Providers can confirm precertification by using one of the following options.

- Health care request and response (ANSI 278)
- Calling Cigna Customer Service at **1.866.494.2111**

Eligibility

Providers should always verify a patient's eligibility at the time of service to determine whether a patient is covered based upon the eligibility information available to Cigna at that time. Eligibility can be verified at **CignaforHCP.com** or through a practice management vendor or clearinghouse submission of an eligibility and benefit inquiry and response (ANSI 270/271) transaction.

Cigna SureFit - St. Louis and surrounding counties service area



Collaborating with BJC HealthCare and Washington University Physicians, Cigna SureFit St. Louis includes access to many hospital and physician groups including:

Hospital systems

BJC Health System

- Alton Memorial Hospital, Alton IL
- Barnes-Jewish Hospital
- Barnes-Jewish St. Peters Hospital
- Barnes-Jewish West County Hospital
- Boone Hospital
- Christian Hospital NE NW
- Memorial Hospital, Belleville IL
- Memorial Hospital East, Shiloh IL
- Missouri Baptist Medical Center
- Missouri Baptist Sullivan Hospital
- Northwest HealthCare Center
- Parkland Health Center (Farmington, Bonne Terre)
- Progress West Hospital
- St. Louis Children's Hospital

Key physician groups

- BJC Medical Group and Affiliates
- Washington University School of Medicine Physicians

This listing is not all inclusive. For a complete listing of physicians or facilities, please refer to the provider directory on Cigna.com or call Cigna Customer Service at 1.866.494.2111.

Questions? We're here to help.
Visit **CignaforHCP.com** or call **1.866.494.2111**.

To avoid delays in processing your referral or precertification, please confirm your EDI vendor is using "SC" for specialty care review in the Request Category Code field (UM01 segment) for referrals, and "AR" for admission review or "HS" for health services review in the Request Category Code field (UM01 segment) for precertification.

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MONTANA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Montana regarding provider contracts with providers rendering health care services in the State of Montana. To the extent that such Montana laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Montana laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

In the event of Evernorth's insolvency or other cessation of operations, Covered Services to Participants shall continue through the period for which a premium has been paid to Evernorth on behalf of the Participant, but not to exceed thirty (30) days, or until the Participant's discharge from an acute care inpatient facility, whichever time is greater. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Plan. Provider further agrees that this provision shall survive the termination of the Agreement regardless of the cause giving rise to such termination and shall be construed to be for the benefit of Participants, and that this provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Participant or persons acting on the Participant's behalf.

NEBRASKA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Nebraska regarding provider contracts with providers rendering health care services in the State of Nebraska. To the extent that such Nebraska laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Nebraska laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

1. The definition for Emergency Services, if any, shall comply with Nebraska laws and regulations to the extent applicable.

2. Definitions or other provisions in the Agreement shall be construed to avoid conflict with the definitions or provisions contained in the Participant's Plan, or in applicable laws and regulations.

3. In addition to the negotiated terms of the Agreement establishing limits on billing Participants, the following shall apply to services rendered under Plans subject to applicable laws and regulations:

A. Provider agrees that in no event, including but not limited to, nonpayment by Evernorth or an intermediary, insolvency of Evernorth or an intermediary, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a Participant or a person, other than Evernorth or an intermediary, acting on behalf of Participant for Covered Services provided pursuant to this Agreement. This provision does not prohibit Provider from collecting Coinsurance, Deductibles or Copayments, as specifically provided in Participant's Plan or the evidence of coverage, or fees for non-covered services delivered on a fee-for-service basis to Participants. Nor does this provision prohibit Provider and Participant from agreeing to continue services solely at the expense of the Participant, as long as Provider has clearly informed Participant that Evernorth may not cover or continue to cover a specific service or services. Except as provided in the Agreement, this provision does not prohibit Provider from pursuing any available legal remedy.

B. In the event of Evernorth's or an intermediary's insolvency or other cessation of operations, Covered Services to Participants will continue through the period for

which a premium has been paid to Evernorth on behalf of the Participant or until discharge from an inpatient facility, whichever time is greater. Covered Services to Participants 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.

C. Subsections A and B shall be construed in favor of the Participant, shall survive the termination of this Agreement regardless of the reason for termination, including Evernorth's insolvency, and shall supersede any oral or written contrary agreement between Provider and Participant or the representative of a Participant if the contrary agreement is inconsistent with subsections A and B or applicable laws and regulations.

4. In no event shall Provider collect or attempt to collect from a Participant any money owed to Provider by Evernorth.

5. Evernorth and Provider shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

6. The rights and responsibilities under this Agreement shall not be assigned or delegated by Provider without Evernorth's prior written consent.

7. Provider shall furnish Covered Services to Participants without regard to the Participant's enrollment in the Plan as a private purchaser or as a participant in a publicly financed program of health care services. This requirement shall not apply to circumstances when Provider cannot render health care services due to limitations arising from lack of training, experience, skill or licensing restrictions.

8. In addition to the negotiated terms of the Agreement establishing requirements for records, 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 Participants, and to comply with the applicable state and federal laws related to the confidentiality of medical or health records.

9. If Provider is an intermediary as defined by applicable laws and regulations, the following provisions shall apply:

A. Nothing in the Agreement shall be construed to delegate or assign Evernorth's statutory responsibility to monitor the offering of Covered Services to Participants to Provider.

B. Evernorth shall have the right to approve or disapprove of the participation status of a subcontracted provider in its own or a contracted network for the purpose of delivering Covered Services to Participants.

C. Provider shall maintain copies of all Provider health care subcontracts at its principal place of business or Provider shall allow access to all Provider health care

subcontracts; Evernorth shall have the right to make copies to facilitate regulatory review upon twenty (20) days' prior written notice.

D. Evernorth shall have the right, in the event of Provider's insolvency, to require the assignment to Evernorth of the provisions of Provider's contracts addressing Provider's obligation to furnish Covered Services.

E. If applicable, Provider shall transmit utilization documentation and claims paid documentation to Evernorth. Evernorth shall monitor the timeliness and appropriateness of payments made to Provider and health care services received by Participants.

F. If applicable, Provider shall maintain the books, records, financial information, and documentation of health care services provided to Participants at its principal place of business in the state and preserve them for five (5) years in a manner that facilitates regulatory review.

G. Provider shall allow regulator access as required by applicable laws and regulations to the Provider's books, records, financial information, and any documentation of health care services provided to Participants, as necessary to determine compliance with the Managed Care Plan Network Adequacy Act.

NEVADA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Nevada regarding provider contracts with providers rendering health care services in the State of Nevada. To the extent that such Nevada laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Nevada laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. This Addendum shall supersede any previous state mandate amendments to the Agreement. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

1. Definitions. Unless otherwise defined in the Agreement, the following terms shall have the meaning set forth below.

(1.1) "Material Change" or "Material Adverse Change" shall mean a change that could reasonably be expected to have a material adverse impact on the aggregate level of payment by Evernorth or Payor to Provider for Covered Services under this Agreement, or on Provider's administration of their services.

(1.2) "Timely Notice" shall mean the timeframe or timeframes established by the parties for prior written notice of an amendment to the agreement as set forth in the Amendment section, or any other provisions of the Agreement governing changes or amendments to the Agreement.

2. In addition to the obligations set forth in the Amendment provision of the Agreement, and to the extent permitted or required by applicable Nevada law:

> Evernorth may amend this Agreement by providing forty-five (45) days' prior written notice to Provider of the modification or amendment of the schedule of payments, including any changes to the fee schedules applicable to Provider's practice. Failure of Provider to object in writing to any such proposed amendment within forty-five (45) days following receipt of notice shall constitute Provider's acceptance thereof. Timely written notification of rejection of such proposed amendment to Evernorth means that this Agreement shall remain in force without the proposed amendment.

Except as provided above, Amendments to this Agreement shall be agreed to in writing by Evernorth and Provider.

3. The Agreement subsection of the Effect of Termination of the Agreement or Plan listed in Exhibit C section of the Agreement is hereby deleted and replaced with the following:

Except in cases where Provider's participation under this Agreement is terminated due to medical incompetence or professional misconduct, Provider shall, if the Provider and Participant agree, continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination until the later of:

a) the one hundred twentieth (120th) day after the date the contract is terminated; or

b) if the medical condition is pregnancy, the forty-fifth (45th) day after:

1) the date of delivery; or

2) if the pregnancy does not end in delivery, the date of the end of the pregnancy.

During the continuation period under this section: (1) the parties shall be bound by the terms and conditions of this Agreement; (2) Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under this Agreement; and (3) Provider are prohibited from billing Participants for any amounts in excess of the Participant's applicable Coinsurance, Copayments or Deductibles. Provider have no obligation under this Agreement to continue to provide services to individuals who cease to be Participants.

3.1 In the event of Evernorth's insolvency or the insolvency of any applicable intermediary, or in the event of any other cessation of Evernorth's operations or the operations of any applicable intermediary, Provider must continue to deliver health care services covered by the network plan, as defined by applicable state law, to a Participant without billing Participant for any amount other than Coinsurance, Deductibles or Copayments, as specifically provided in the evidence of coverage, until the earlier of: the date of the cancellation of Participant's coverage under the network plan pursuant to applicable state law, including, without limitation, any extension of coverage provided pursuant to the terms of the contract between Participant and Evernorth, and applicable state continued medical treatment (continuity of care) laws, or any applicable federal law for Participants who are in an active course of treatment or totally disabled; or the date on which the contract between the Evernorth and Provider 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 the terms of the

contract between the Participant and Evernorth, and applicable state laws, or any applicable federal law for Participants who are in an active course of treatment or totally disabled.

4. If Provider is not a hospital, the Term and Termination provision of the Agreement is amended as follows:

   Either party can terminate this Agreement at any time by providing at least ninety (90) days advance written notice.

4.1. The Term and Termination provision of the Agreement is amended by adding the following:

   Evernorth shall not terminate this Agreement, refuse to contract with, or refuse to compensate Provider because Provider in good faith advocates in private or in public on behalf of a Participant, assists a Participant in seeking reconsideration of a decision to deny coverage for a health care service, or reports a violation of law to an appropriate authority.

5. Disclosure of Fee Schedules. If Provider is not a hospital:

   Evernorth shall provide the schedule of payments, including any changes to the fee schedules applicable to Provider's practice, if requested at the time the Agreement is executed and at any other time within seven (7) days upon receipt of Provider's request.

6. The following provisions shall, to the extent required by applicable law, replace and supersede the Section of the Agreement entitled Charges to Participants:

Charges to Participants. Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than the applicable Payor for Covered Services or for any amounts denied or not paid under this Agreement due to Provider's failure to comply with the requirements of Evernorth's or its designee's utilization management program or Medical Management Program, or failure to file a timely claim or appeal. This provision does not prohibit collection of any applicable Copayments, Coinsurance and Deductibles, as specifically provided in the evidence of coverage. This provision survives termination of this Agreement, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Modifications to this section will become effective no earlier than the date permitted by applicable law.

This provision does not prohibit collection of fees for uncovered services delivered on a

fee-for-service basis to Participants. This provision does not prohibit Provider and a Participant from agreeing to continue health care services solely at the expense of the Participant, as long as Provider has clearly informed the Participant that Evernorth 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 Provider from pursuing any available legal remedy.

7. Provisions included in this Agreement to comply with the requirements set forth in Sections 3.1 and 6 shall be construed in favor of the covered person, shall survive the termination of the contract regardless of the reason for the termination, including, without limitation, the insolvency of the health carrier or any applicable intermediary, and shall supersede any oral or written contrary agreement between a participating provider of health care and a covered person or the representative of a covered person if the contrary agreement is inconsistent with provisions included in the contract to comply with the requirements set forth in applicable state law.

8. Evernorth will provide written notice to Provider as soon as practicable in the event that a court determines Evernorth or any applicable intermediary to be insolvent, or of any other cessation of operations of Evernorth or any applicable intermediary.

9. In addition to the requirements of the Agreement governing Participant health records, 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 Participants, and to comply with the applicable state and federal laws related to the confidentiality of medical and health records and Participant's right to see, obtain copies of or amend their medical and health records.

10. Neither Evernorth nor Provider may assign or delegate the rights and responsibilities of either party under the contract without the prior written consent of the other party.

11. In addition to the requirements of the Agreement governing standards of care, Provider is responsible for furnishing Covered Services to all Participants without regard to the participation of the Participant in a network plan (as defined by applicable law) as a private purchaser of the network plan or as a participant in a publicly financed program of health care services.

12. In addition to the requirements of the Agreement governing services upon termination, for services rendered by a non-hospital Provider subsequent to Provider's termination of the Agreement to a Participant who had obtained prior authorization for such services prior to the termination of the Agreement, or if a Participant is confined in the hospital at a time when a hospital Provider terminates, coverage for Covered Services provided by a non-hospital Provider to any such Participant and any coverage for the period of confinement for a hospital Provider will be at the rate negotiated before Provider terminated the Agreement and at no additional cost to the Participant, in

accordance with the terms of the Participant's Plan.

13. Evernorth shall, in a timely manner, upon request from Provider or upon any change to the status or inclusion of Provider, inform Provider of the status as a provider of health care in a network plan and the status and inclusion of Provider on any list maintained by Evernorth.

14. The Agreement permits Evernorth to contract with another party to provide access to Evernorth's rights and responsibilities under this Agreement. Upon request, Evernorth will provide information necessary to determine whether a particular party has been authorized to access Provider's health care services and contractual discounts under this Agreement. Any party authorized to access the health care services and contractual discounts under this Agreement must comply with all applicable terms, limitations, and conditions of the Agreement.

15. Credentialing: Evernorth is part of the Council for Affordable Quality Healthcare (CAQH) for credentialing and recredentialing network physicians. Evernorth strongly encourages the use of the CAQH Universal Provider DataSource when submitting Provider's application. CAQH does comply with Nevada state application requirements. If Provider does not have access to the internet, however, Provider will need to submit Provider's credentialing information using the Nevada state application.

NEW HAMPSHIRE REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of New Hampshire regarding provider contracts with providers rendering health care services in the State of New Hampshire. To the extent that such state laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such New Hampshire laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

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(1) Provider agrees that in no event, including but not limited to nonpayment by Payor, Payor's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons other than Payor for Covered Services.

(2) Evernorth shall not terminate or refuse to renew the Agreement, discriminate against or penalize Provider for participating in Participant's internal grievance procedure or external review.

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

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

provide services to individuals who cease to be Participants.

(5) Nothing in the Agreement shall be construed to require or obligate a provider who is employed by a hospital or any affiliate to refer patients to providers also employed or under contract with the hospital or any affiliate.

NEW JERSEY REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of New Jersey regarding provider contracts with providers rendering health care services in the State of New Jersey. To the extent that such New Jersey laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such New Jersey laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

A. Compliance with New Jersey Statutory and Regulatory Requirements

(1) The following terms shall have the following defined meanings, in accordance with applicable New Jersey laws and regulations. In addition to the forgoing defined terms, all other terms used in this Agreement shall be deemed defined in compliance with New Jersey laws and regulations to the extent applicable.

a. Adverse benefit determination means a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from application of any utilization review, denial of a request for an in-plan exception, as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic, dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.

b. Continuous quality improvement or CQI means an on-going and systematic effort to measure, evaluate, and improve either a carrier's process of providing quality health care services to covered persons with respect to managed care plans, or the carrier's process of performing utilization management functions with respect to health benefits plans in which utilization management has been incorporated.

c. Clean Claim. A Clean Claim is a claim that is submitted with all the information, including the substantiating documentation, requested by eviCore or Payor, and (1) The claim is for a service or supply covered by the applicable

health benefits plan; (2) The claim is submitted with all the information requested by the carrier on the claim form or in other instructions distributed to the provider or covered person in accordance with N.J.S.A. 17B:30-51 and N.J.A.C. 11:22-1.4; (3) The person to whom the service or supply was provided was covered by the applicable health benefits plan on the date of service; The PROVIDER providing the service or supply is an eligible provider on the date of service (that is, a health care provider whose services or supplies are covered under the health benefits plan; Neither eviCore nor applicable Payor reasonably believes that the claim has been submitted fraudulently; and, for claims where services are provided to a person enrolled in a Medicare Advantage plan, the claim conforms to the clean claim requirements for claims processed under a Medicare Advantage Program.

d. Credentialing/Recredentialing. Credentialing/Recredentialing is the set of policies, processes, procedures and clinical standards established, determined and utilized by eviCore or Payor to evaluate and determine whether PROVIDER has satisfied all credentialing and recredentialing requirements adopted by eviCore or Payor and to approve PROVIDER's participation in the network.

e. Independent Health Care Appeals Program means the external appeals process for a covered person or provider on behalf of the covered person with the covered person's consent, to appeal a decision of a carrier to deny, reduce or terminate services or payment of benefits resulting from a decision by a carrier with respect to the covered person which services are otherwise covered under the health benefits plan

f. Independent utilization review organization or IURO means an independent organization with which the Department contracts to provide independent reviews through the Independent Health Care Appeals Program of carrier determinations regarding medical necessity or appropriateness of services which are contested by the covered person or a provider on behalf of the covered person.

g. Medically Necessary Services. "Medically Necessary" or "Medical Necessity" means or describes a health care service that a health care provider, exercising his or her prudent clinical judgment, would provide to a person covered by a health benefits plan for the purpose of evaluating, diagnosing, or treating an illness, injury, disease, or its symptoms and that is: in accordance with the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for the covered person's illness, injury, or disease; not primarily for the convenience of the covered person or the health care provider; and not more costly than an alternative service or sequence of services at least as likely to

produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered person's illness, injury, or disease. Medical necessity disputes do not include claims payment disputes.

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

i. Urgent care claim means any claim for medical care or treatment with respect to which application of the time periods for making non-urgent determinations, in the judgment of a prudent layperson who possesses an average knowledge of health and medicine, could seriously jeopardize the life or health of the covered person or the ability of the covered person to regain maximum function, or which, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the covered person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

j. Utilization management means a system for reviewing the appropriate and efficient allocation of health care services under a health benefits plan according to specified guidelines in order to recommend or determine whether, or to what extent, a health care service given or proposed to be given to a covered person should or will be reimbursed, covered, paid for, or otherwise provided under the health benefits plan. The system may include: preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory care procedures and retrospective review.

(2) a. Providers who are physicians shall maintain appropriate hospital admission privileges at the designated hospital Participating Provider(s) throughout the terms of this Agreement. Providers that are hospitals shall follow clear procedures for granting admitting and attending privileges to physicians and shall notify Evernorth and Payors when such procedures are no longer appropriate.

b. Evernorth shall review and resolve issues raised by Provider relating to the

provision of Covered Services to Participants.

c. Detailed information on Evernorth's policies on the following topics is found in Evernorth's Medical Management Program, Administrative Guidelines and Provider Manual:

Credentialing/Recredentialing
Access Standards
Provider Data Changes
Quality Management
Utilization Management
Member Rights and Responsibilities

d. If Provider is a provider group, Evernorth must be a third party beneficiary to Provider's contracts with its providers and such contracts must provide that Evernorth has privity of contract with the providers such that Evernorth has standing to enforce the providers' contracts with Provider in the absence of enforcement by Provider. If applicable, Provider shall follow clear procedures for granting admitting and attending privileges to physicians and shall notify Evernorth when such procedures are no longer appropriate.

e. Unless otherwise specifically addressed in the Agreement, Provider shall be available for the treatment of patients not less than 35 hours per week.

f. Unless otherwise specifically addressed in the Agreement, Provider shall maintain availability for routine Member appointments upon two (2) weeks' notice, and if Provider is a clinic, facility or organization which is responsible of providing Urgent Care, Provider shall maintain availability for Member appointments for urgent matters within twenty-four (24) hours of contact.

(3) a. In the event Provider does not submit a claim within the number of days specified in the Agreement, Payor, in accordance with N.J.A.C. 11:22-1.6, shall reserve the right to deny payment or dispute the claim and Provider shall be prohibited from seeking payment in whole or in part directly from Participant. Where Provider is submitting a claim under an assignment of benefits from a Participant, Provider shall, in accordance with N.J.S.A. § 45:1-10.1, file the claim within one hundred eighty (180) days of the last course of treatment.

b. Any fee-for-service amounts owing under the Agreement shall be paid within thirty (30) calendar days following receipt of a claim or no later than the time established for the payment of claims in the Medicare program pursuant to 42 U.S.C. s.1395u(c) (2) (B), whichever is earlier, if the claim is submitted by electronic means, and no later than forty (40) calendar days following receipt if the claim is submitted by other than electronic means, if:

(i) Provider is eligible at the date of service;
(ii) the person who received the health care service was covered on the date of service;
(iii) the claim is for a service or supply covered under the Plan;
(iv) the claim is submitted with all the information requested by the Payor on the claim form or in other instructions that were distributed in advance to Provider or Participant in accordance with the provisions of section 4 of P.L. 2005, c.352 (C.17B:30-51); and
(v) Payor has no reason to believe that the claim has been submitted fraudulently.

c. If all or a portion of the claim is not paid within the time frame provided in the paragraph above because:

(i) the claim submission is incomplete because the required substantiating documentation has not been submitted to Payor;
(ii) the diagnosis coding, procedure coding, or any other required information to be submitted with the claim is incorrect;
(iii) Payor disputes the amount claimed; or
(iv) there is strong evidence of fraud and Payor has initiated an investigation into the suspected fraud,

Payor shall notify Provider, by electronic means and the Participant in writing within thirty (30) days of receiving an electronic claim, or notify the Participant and Provider in writing within forty (40) days of receiving a claim submitted by other than electronic means that:

(i) the claim is incomplete with a statement as to what substantiating documentation is required for adjudication of the claim;
(ii) the claim contains incorrect information with a statement as to what information must be corrected for adjudication of the claim;
(iii) the Payor disputes the amount claimed in whole or in part with a statement as to the basis of that dispute; or
(iv) the Payor finds there is strong evidence of fraud and has initiated an investigation into the suspected fraud in accordance with its fraud prevention plan established pursuant to section 1 of P.L.1993, c.362 (C.17:33A-15), or referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor in the Department of Law and Public Safety established pursuant to section 32 of P.L.1998, c.21 (C.17:33A-16).

d. If all or a portion of an electronically submitted claim cannot be adjudicated because the diagnosis coding, procedure coding or any other data required to be

submitted with the claim was missing, Payor shall electronically notify Provider or Provider's agent within seven (7) days of that determination and request any information required to complete adjudication of the claim.

e. Any portion of a claim that meets the criteria established in the first paragraph of this subsection b. shall be paid in accordance with the time limit established in the first paragraph of this subsection b.

f. Payor shall acknowledge receipt of a claim submitted by electronic means from Provider, no later than two (2) working days following receipt of the transmission of the claim.

g. If payment is withheld on all or a portion of a claim pursuant to the reasons stated above, the claim payment shall be overdue if not remitted to Provider or their agent on or before thirty (30) calendar days or the time limit established by the Medicare program, whichever is earlier, for claims submitted by electronic means and forty (40) calendar days for claims submitted by other than electronic means, following receipt by the Payor of the required documentation or information or modification of an initial submission.

h. If payment is withheld on all or a portion of a claim pursuant to the reasons stated above and Provider is not notified within the time frames provided, the claim shall be deemed to be overdue.

i. An overdue payment shall bear simple interest at the rate of 12% per annum. The interest shall be paid to Provider at the time the overdue payment is made.

j. With the exception of claims that were submitted fraudulently or submitted by health care providers that have a pattern of inappropriate billing or claims that were subject to coordination of benefits, Payor shall not seek reimbursement for overpayment of a claim previously paid pursuant to this section later than eighteen (18) months after the date the first payment on the claim was made. Payor shall not seek more than one reimbursement for overpayment of a particular claim. At the time the reimbursement request is submitted to Provider, Payor shall provide written documentation that identifies the error made by Payor in processing or payment of the claim that justifies the reimbursement request.

k. No Payor shall base a reimbursement request for a particular claim on extrapolation of other claims, except under the following circumstances:

(a) in judicial or quasi-judicial proceedings, including arbitration;
(b) in administrative proceedings;
(c) in which relevant records required to be maintained by Provider have been improperly altered or reconstructed, or a material number of

relevant records are otherwise unavailable; or

(d) in which there is clear evidence of fraud by Provider and Payor has investigated the claim in accordance with its fraud prevention plan, and referred the claim, together with supporting documentation, to the Office of the Insurance Fraud Prosecutor.

l. Payor shall not collect or attempt to collect reimbursement for the overpayment of a claim on or before the 45th calendar day following the submission of the reimbursement request to Provider and until Provider's right to appeal, as set forth in the Dispute Resolution provision in item (11) below, is exhausted.

m. Evernorth will not retroactively deny reimbursement for a Covered Service provided to a Participant on grounds which contradict the written or oral authorization of Evernorth, or its agents, to Provider, reasonably relied upon by Provider prior to providing the service to the Participant, except in cases where there was material misrepresentation or fraud. Payor will be liable only for those specific services which are provided to a Participant and which were authorized and no additional services rendered without specific authorization.

n. Provider shall not seek reimbursement from Payor or Participant for underpayment of a claim submitted pursuant to this section later than eighteen (18) months from the date the first payment on the claim was made, except if the claim is the subject of an appeal submitted pursuant to section 1. of the Dispute Resolution section of the Agreement set forth in item (11) below, or the claim is subject to continual claims submission. Provider shall not seek more than one reimbursement for underpayment of a particular claim.

o. Provider may bill an individual directly for any services provided following the date the individual ceases to be a Member, unless such individual was a Member at the time of inpatient admission. Evernorth has no obligation under the Agreement to pay for services rendered to individuals who no longer are Members

p. Claims will be paid in accordance with the requirements of N.J.S.A. 26:2J-8.1, N.J.S.A. 17B:26-9.1, N.J.S.A. 17B:27-44.2 and N.J.A.C. 11:4-28.7, as may be amended from time to time.

q. Evernorth shall give written notice to Provider of any amount Provider inappropriately collected from Participant and Provider shall have thirty (30) days from the date of receipt of the written notice to appeal such determination.

r. If Provider fails to reimburse Participant for any amount Provider inappropriately collected from Participant, Evernorth may elect to withhold compensation amounts from future compensation payments otherwise due to Provider. Evernorth shall provide Provider with written notice and full disclosure

of the funds withheld prior to such deduction.

s. To resolve disputes relating to the payment of provider claims see the Dispute Resolution section of the Agreement set forth in item (11) below.

t. If Provider is a hospital, Provider may bill an individual directly for any services provided following the date the individual ceases to be a Participant, unless such individual was a Participant at the time of admission. Payor has no obligation under the Agreement to pay for services rendered to individuals who no longer are Participants.

(4) Provider and Evernorth shall cooperate to facilitate timely and appropriate information and record exchanges necessary for quality management, utilization management, peer review or other programs required for Evernorth's operation or in connection with the provision of health care services to Participants.

(5) In no event shall Evernorth retaliate against Participants or Provider because of complaints or appeals on behalf of a Participant.

(6) Provider shall maintain general and professional liability coverage in an amount sufficient for Provider’s anticipated risk but no less than
$1,000,000 per occurrence and $3,000,000 in the aggregate per year.

(7) Notwithstanding anything to the contrary set forth in the Agreement:

a. Provider shall not be penalized or the Agreement terminated by Evernorth because Provider acts as an advocate for the Participant in seeking appropriate, medically necessary health care services. If Provider is a hospital, Provider may communicate openly with a patient about all appropriate diagnostic testing and treatment options.

b. Provider shall not be penalized or the Agreement terminated by Evernorth because Provider appeals a coverage determination or files a complaint against Evernorth.

(8) Any provision of the Agreement which conflicts with state or Federal law(s) or regulation(s) is hereby amended to conform to the requirements of such law(s) or regulation(s).

(8.1) In addition to the obligations set forth in the Agreement governing amendments to the Agreement:

a. Any adverse change or amendment during the term of the Agreement shall be made in accordance with the terms of the Agreement only upon ninety (90) days’

notice prior to the effective date of the change or amendment or as otherwise specified by N.J.A.C. 11:24C-4.3(d) as may be amended from time to time. If Provider declines to accept the amendment, Provider may terminate by providing notice in advance of the effective date.

b. If applicable, no adverse change may be made to the terms of the Agreement upon its automatic renewal. Any such change shall be made to the Agreement as set forth above either before or after renewal. Notwithstanding any timeframe set forth in the Agreement governing amendments to the Agreement, no adverse change may be made to the Agreement without sufficient advance notice to permit Provider to terminate the Agreement in advance of the effective date of the change.

c. Adverse change or amendment shall mean any action taken by Evernorth that could reasonably be expected to have a material adverse impact on either the aggregate level of payment to a health care provider or the administrative expenses incurred by the provider in complying with the change, or as otherwise defined by N.J.A.C. 11:24C-4.2 as may be amended from time to time. Such changes attributable to a third party, including a health care provider, over which Evernorth has no control, and such changes as identified in applicable state laws or regulations, are not adverse changes.

(9) If Provider is not a hospital or ancillary provider, the following shall apply:

a. Notice and Hearing.

Evernorth may not terminate Provider's participation under the Agreement with less than ninety (90) days prior written notice except where otherwise permitted by state laws or regulations. Evernorth's written notice of this decision shall include notice of a right to a hearing**.** If requested by Provider Evernorth shall, within fifteen (15) days of the receipt of the request, provide the reasons for the termination in writing. Within ten (10) business days following the date of receipt of notice of termination Provider shall have the right to make a written request for a hearing. Such hearing would be held within thirty (30) days of the date of the request**.**

The hearing shall be conducted by a panel appointed by Evernorth, which panel shall be comprised of a minimum of three (3) persons, at least one of whom is a clinical peer in the same discipline and the same or similar specialty as Provider.

Unless the review panel provides notice of the need for an extension for the rendering of its decision to Provider and Evernorth prior to the date the panel's decision would otherwise be due, the panel shall render a decision

on the matter in writing within thirty (30) days of the close of the hearing. The review panel shall make a decision that: (1) Provider's participation shall be terminated; or (2) Provider shall be reinstated or provisionally reinstated, subject to conditions set forth by the panel. The panel's determination shall be in writing and shall be made in a timely manner. Participation in this process shall not be deemed to be an abrogation of Provider's legal rights. If Provider is unsatisfied with the determination, Provider may appeal the decision further pursuant to the Dispute Resolution provision set forth in item (11) below.

b. Expiration of Agreement, Breach of Agreement, Imminent Harm, and Fraud.

The requirements regarding notice and hearing set forth above shall not apply in the following cases: when the Agreement expires and is not renewed; when the termination is due to breach of the Agreement; when in the opinion of the Medical Director, there is an imminent danger to an individual Participant or the public health, safety or welfare; or when there is a determination of fraud.

If Evernorth finds that Provider represents an imminent danger to an individual Participant or to the public health, safety or welfare, Evernorth shall promptly notify the appropriate professional State licensing board.

c. If Provider's participation under the Agreement is terminated, Provider shall continue to provide Covered Services with regard to those Members who retain eligibility under a Benefit Plan for up to 4 months in cases where it is Medically Necessary for the Member to continue treatment with Provider, except as follows: (1) for a period not to exceed 6 months in the case of post-operative follow-up care; (2) for a period not to exceed 12 months in the case of oncological treatment and psychiatric treatment; and (3) through the duration of a pregnancy and up to 6 weeks after delivery in the case of obstetrical care. The terms, conditions and compensation arrangements of the Agreement shall apply during the applicable continuation period.

(10) A. If Provider is not a hospital or ancillary provider, the following shall apply:

a. Retainer Arrangements. Retainer Arrangements shall mean any arrangement, program or agreement that limits a physician's panel of patients to those who agree to pay a fee to a physician or practice for a set of services to be delivered for a specific period of time. Retainer Arrangements between Provider and Participants shall only apply with respect to services above and beyond Covered Services; such services shall

be clearly described by Provider to Participant prior to rendering services. No Participant agreeing to such a retainer arrangement shall be charged any amounts in excess of cost-sharing amounts for Covered Services under the health benefit plan. Should Provider transition to a retainer arrangement practice, Provider shall give notice to Evernorth and Participants under Provider's care at least ninety (90) days prior to adopting such practice. Participants already receiving Covered Services shall be afforded such rights under state laws and regulations as are applicable to a patient whose provider has dropped out of the network, including rights to continuity of care, without making any retainer payments. The terms, conditions and compensation arrangements of the Agreement shall apply during the continuation period.

B. If Provider is a hospital, the following shall apply:

a. In the event the Agreement is not renewed or is terminated by either party, Provider and Evernorth shall continue to abide by the terms and conditions of the Agreement for a period of four (4) months from a severance date mutually agreed upon by both parties as required by N.J.S.A. 26:2J-11.1.

b. With respect to a termination of the Agreement initiated by Evernorth, Evernorth shall not begin transferring Participants to other Evernorth Participating Providers during the Cure Period to the extent such transfer would conflict with the requirements of N.J.S.A. 26:2J-11.1.

C. If Provider is an ancillary provider, the following shall apply:

a. Provider and Evernorth shall abide by the terms of the Agreement, including reimbursement terms, for four (4) months following the date of the termination. Provider has no obligation to provide, and Evernorth has no obligation to reimburse at the contracted rate, services which are not Medically Necessary to be provided on and after the 31st day following the date of termination.

(11) The Agreement permits Payor to enter into agreements with third parties (PPOs, ODSs, and any such other entities to which Payor may lease its networks) that allow third parties to obtain Payor's contracting entity rights and responsibilities under the Agreement as if the third party is the contracting entity. To the extent that the terms of the Agreement allow a third party access the Agreement, the rights of the third party to access discounted rates shall cease upon termination of the Agreement.

(12) To the extent that some portion of Provider's compensation in accordance with Exhibit A to this Agreement, is tied to the occurrence of a pre-determined event, or the

nonoccurrence of a pre-determined event, such event shall be clearly specified in Exhibit A, and Provider shall have a right to receive a periodic accounting (not less frequently than annually) of the funds held for, and paid to, Provider by Evernorth.

(13) The provision in the Agreement entitled "Dispute Resolution" is replaced in its entirety by the following:

1. (a) To resolve disputes relating to the payment of provider claims under Health Benefit Plans as defined in N.J.S.A. 17B:30-50 but not including appeals to resolve disputes pertaining to medical necessity which are eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L. 1997, c. 192 (C.26:2S-11):

In the event that Provider has a dispute with respect to a claim, the dispute shall be submitted for review and resolution to the Evernorth designee identified by Evernorth in Evernorth's explanation of payment, or by calling 1.800.Evernorth24. Provider must submit a written request for a review of a claim dispute within ninety (90) calendar days of the date of the initial explanation of payment on an appeal form prescribed by the Commissioner of Banking and Insurance which shall describe the type of substantiating documentation that must be submitted with the form. The appeal form is available at: http://www.state.nj.us/dobi/chap352/352genapplication.doc The internal review shall be conducted at no cost to Provider and Provider shall be notified of the determination on or before the 30th calendar day following receipt of the appeal form.

The written decision shall include:

(i) The names, titles and qualifying credentials of the persons participating in the internal review;
(ii) A statement of Provider's grievance;
(iii) The decision of the reviewers along with a detailed explanation of the contractual and/or medical basis for such decision;
(iv) A description of the evidence or documentation which supports the decision; and
(v) If the decision is adverse, notice of the right to have the decision submitted to arbitration as provided below.

If the appeal is resolved in favor of Provider, Payor must pay the amount owed, plus interest at 12% per year, on or before the 30th calendar day following Provider's notification of the determination on the appeal. If Provider is not notified of the determination of the appeal within thirty (30)

days, Provider may refer the dispute to arbitration as provided in this section 1.

(b) Any dispute regarding the determination of an internal appeal conducted pursuant to subsection (a) above may be referred to arbitration as provided in this section 1. The Commissioner of Banking and Insurance has contracted with a nationally recognized, independent organization, MAXIMUS, Inc., that specializes in arbitration to conduct the arbitration proceedings. Information is available at: http://www.state.nj.us/dobi/chap352/352implementnotice.html Any party may initiate an arbitration proceeding on or before the 90th calendar day following the receipt of the determination which is the basis of the appeal, on a form prescribed by the Commissioner of Banking and Insurance. No dispute shall be accepted for arbitration unless the payment amount in dispute is $1,000 or more, except that Provider may aggregate disputed claim amounts for the purposes of meeting such threshold requirement. No dispute pertaining to medical necessity which is eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L. 1997, c. 192 (C.26:2S-11) shall be the subject of arbitration pursuant to this section 1.

(c) The arbitrator shall conduct the arbitration proceedings pursuant to the rules of the arbitration entity, including rules of discovery subject to confidentiality requirements established by State or federal law.

(d) An arbitrator's determination shall be:

(i) signed by the arbitrator;
(ii) issued in writing, in a form prescribed by the Commissioner of Banking and Insurance, including a statement of the issues in dispute and the findings and conclusions on which the determination is based; and
(iii) issued on or before the 30th calendar day following the receipt of the required documentation.

The arbitration shall be nonappealable and binding on all the parties to the dispute.

(e) If the arbitrator determines that Payor has withheld or denied payment in violation of the provisions of this section, the arbitrator shall order Payor to make payment of the claim, together with accrued interest, on or before the 10th business day following the issuance of the determination. If the arbitrator determines that Payor has withheld or denied payment on the basis of information submitted by Provider and Payor

requested, but did not receive, this information from Provider when the claim was initially processed by Payor or reviewed under internal appeal pursuant to subsection (a) above, Payor shall not be required to pay any accrued interest.

(f) If the arbitrator determines that Provider has engaged in a pattern and practice of improper billing and a refund is due to Payor, the arbitrator may award a refund, including interest accrued at the rate of 12% per year. Interest shall begin to accrue on the day the appeal was received for resolution through the internal appeals process established pursuant to subsection (a) above.

(g) The arbitrator shall file a copy of each determination with and in the form prescribed by the Commissioner of Banking and Insurance.

(h) To be eligible for PICPA arbitration, a claim must meet all of the criteria below:

(i) The claim was submitted under a health insurance policy or HMO contract issued in New Jersey. Claims submitted under self-funded employer plans are not eligible for resolution through the PICPA;
(ii) The claim arises from health care services rendered on or after July 11, 2006;
(iii) The health care professional has appealed the denied claim to access the carrier's internal claims appeal process by submitting the Health Care Professional Application to Appeal a Claims Determination available online at http://www.state.nj.us/dobi/formlist.htm#352.
(iv) The carrier's internal claims appeal process was completed, or the carrier failed to comply with the processing and review timeframes with respect to the claim and the health care professional has documentation supporting that contention;
(v) When aggregating claims (for the purpose of reaching the minimum $1,000 dispute threshold), a health care professional aggregates claims by carrier and covered person or by carrier and CPT code; and
(vi) The health care professional timely submits the application for arbitration and the appropriate fees.
(vii) The application for PICPA arbitration must be submitted within ninety (90) days following the date that the claims appeal is (or should have been) completed by the payer. The AO shall render a decision on such accepted requests within thirty (30) days following the date of receipt of the required documentation and fees.

(viii) (Note: The following exception applies to disputes for which claims appeal was completed, or should have been completed, by the carrier on or before July 31, 2007: Then the application for arbitration of any such claim and claim appeal determination must be submitted no later than November 30, 2007, and the AO shall render a decision within sixty (60) days following receipt of the required documentation and fees.)

(i) Both parties to an arbitration are required to pay a review fee and an arbitration fee. The party seeking to initiate arbitration must submit its fees with its arbitration application. If the application initially meets the criteria for acceptance, the AO will notify the responding party of the action and of the fee requirement. If, based on information from the responding party, the AO ultimately determines that the case does not meet the criteria for arbitration; the AO will return the arbitration fees to both parties, but will retain the review fees. The fees are as follows:

(i) For arbitration of a single claim in which the amount in dispute is at least $1,000, the AO requires each party to pay a $50 review fee and a $130 arbitration fee by submitting two separate checks or money orders (one (1) for the review fee, and one (1) for the arbitration fee) annotated by the application's case number.

(ii) For arbitration of aggregated claims in which the disputed amount for each individual claim is less than $1,000, an additional $50 review fee and $130 arbitration fee will be assessed for every $1,000 worth of disputed claim amounts. For example, five (5) aggregated claims in which the disputed amount for each individual claim is $900, for a total of $4,500, would be assessed on the basis of four (4) review and four (4) arbitration fees.

(iii) For arbitration of aggregated claims in which the disputed amount for each individual claim exceeds $1,000, fees will be assessed based on the number of individual claims rather than their dollar amount. For example, five (5) aggregated claims in which the disputed amount for each individual claim is $5,000 would be assessed on the basis of five (5) review and five (5) arbitration fees.

(j) The AO reviews the case based solely on the documented record. The AO will take phone calls to discuss the arbitration process and administrative issues only. Independent and impartial health claims professionals with at least five (5) years of health claims processing experience will perform reviews. If the AO requires any information in addition to that already submitted by either party, the AO will make a request in writing, and the information must be supplied in writing within ten (10) days.

2. To resolve disputes with respect to a termination and for claim disputes with respect to ASO Participants, but not including appeals to resolve disputes pertaining to medical necessity which are eligible to be submitted to the Independent Health Care Appeals Program established pursuant to section 11 of P.L. 1997, c. 192 (C.26:2S-11):

   In the event that Provider has a dispute with respect to a claim or a termination, the dispute shall be submitted for review and resolution to the Evernorth designee identified by Evernorth in Evernorth's explanation of payment or termination letter, as applicable (the "First Level Review"). Provider must submit a request for a First Level Review of a payment dispute within one hundred eighty (180) days of the date of the initial explanation of payment and a request for a First Level Review of a termination dispute within thirty (30) days of the date of the termination letter. If Provider is not satisfied with the resolution at the First Level Review, Provider may submit the matter for a second level review to the Evernorth designee identified in the First Level Review decision letter (the "Second Level Review"). Provider must submit a request for a Second Level Review within sixty (60) days of the date of the letter communicating the First Level Review decision. The Second Level Review decision will be binding on Evernorth and Provider if the resolution is accepted by Provider.

   If the Second Level Review is adverse Provider may have the decision submitted to arbitration pursuant to the arbitration process set forth in the Agreement and the Medical Management Program. Provider must submit a request for arbitration within twelve (12) months of the date of the letter communicating the Second Level Review decision.

3. Disputes regarding a claim or a termination that are not resolved through the process described in section 2. above and any other dispute between the parties regarding the performance or interpretation of the provider agreement may be resolved by arbitration between the parties pursuant to the arbitration process set forth in the Agreement and the Medical Management Program. Either party may initiate arbitration by providing written notice to the other party. If Provider initiates arbitration, Provider must submit a request for arbitration to:

   Evernorth HealthCare National Appeals Unit
   P.O. Box 37963
   Charlotte, NC 28237

4. In addition to the above, for disputes concerning the application of Evernorth's coding and payment rules and methodologies to patient specific

factual situations, Provider should consult Evernorth's website for details regarding a billing dispute resolution process that may be applicable in lieu of arbitration.

(14) The Agreement may permit Evernorth to enter into agreements with third parties (PPOs, ODSs, and any such other entities to which Evernorth may lease its networks) that allow third parties to obtain Evernorth's contracting entity rights and responsibilities under the Agreement as if the third party is the contracting entity. To the extent that the terms of the Agreement allow a third party access the Agreement, the rights of the third party to access discounted rates shall cease upon termination of the Agreement.

B. Utilization Management and Appeals

(1) Utilization Management. Provided that Evernorth has accepted a delegation of responsibility to handle Utilization Management, Provider shall participate in Evernorth's utilization management program, as further described below, through which Evernorth shall be responsible for conducting utilization management activities, including prospective, concurrent and retrospective review on behalf of applicable Payors. Evernorth utilization management program shall be under the direction of appropriately licensed (in New Jersey) medical professionals. Provider has the right to rely upon Evernorth written or oral prior authorization of a service. Services pre-authorized by Evernorth will not be retroactively denied as not medically necessary except in cases of fraud, or in cases where there was a material misrepresentation of the facts to Evernorth the applicable Payor, or to an authorized third-party representative of the applicable Payor.

(a) Reasons for Denial. Through Evernorth's Utilization Management program, payment for or authorization for services may be denied by Evernorth on the following bases: (1) Lack of sufficient documentation to determine medical necessity; (2) The relevant services do not meet medical necessity requirements; or (3) The relevant services are not within the scope of care to be provided by Provider. Other bases not related to the medical necessity (and hence outside the scope of the Utilization Management program) may exist for the denial of payment of claims or authorization for treatment. Such denials of authorization or payment are handled through Evernorth's claims administration function. Upon written request to Evernorth, Provider may review and provide comment on the applicable utilization management protocols.

(b) Utilization Management Review Procedures. Evernorth's utilization management program, in which Provider is required to participate, consists of three (3) types of review. In each type of review, Evernorth will arrange for an expert reviewer, who is a duly licensed medical provider, to conduct such reviews, and will provide Provider with contact information of the expert reviewer such that Provider may review determinations with the applicable expert reviewer.

1. *Prospective review*. Prospective Review is the process by which Evernorth reviews and approves, modifies, delays, or denies prior authorization of care requests. In the case of routine prior authorization of care requests, Evernorth shall render a determination within 15 calendar days of receipt of all information reasonably necessary to render a decision. In the case of emergent expedited prior authorization requests (Requests where Provider indicates that the standard timeframes could seriously jeopardize the Member's life or health or ability to attain, maintain or regain maximum function), Evernorth shall render a determination in an appropriate timeframe as dictated by the medical exigencies of the case, but in no case longer than 72 hours following receipt of the request.

2. *Concurrent Review*. Concurrent review is review of an ongoing treatment regimen already in place. When Evernorth conducts concurrent review, care provided by Provider shall not be discontinued until the Provider has been notified of Evernorth's decision, and a care plan has been agreed upon by Provider that is appropriate for the medical needs of the Member. Evernorth will render a determination on concurrent reviews within five (5) or fewer business days or receipt of request, consistent with urgency of Member's medical condition.

3. *Post-Service / Retrospective Review*. Evernorth may conduct a retrospective review of the medical necessity of services provided by Provider. In cases where the review is retrospective, the decision shall be communicated to the Provider that performed services within 30 days of the receipt of the claim.

(2) Utilization Management Appeals. Provider has the right to receive notice of each utilization management determination made by Evernorth with regard to a Member for which Provider is providing services. Provider, with the express written consent of Member, may seek an appeal of a utilization management determination made by Evernorth on behalf of a Member by submitting an appeal according to the instructions stated on the notice of adverse benefit determination. Utilization management appeals may be handled either by Evernorth or by Payor. If Evernorth is responsible for handling utilization management appeals (which shall be the default), the below procedure shall govern the appeal process. An applicable Payor's specific procedures may vary as set forth in the applicable Client Summary.

(a). Informal Internal Appeals: Provider shall have an opportunity to speak, regarding an adverse benefit determination, with Evernorth's medical director, or the medical director's designee who rendered the adverse benefit determination. If Provider disagrees with the medical director's or designee's denial and Provider (or a Member) pursues an appeal, Evernorth will conduct a full investigation of each internal appeal, taking into consideration all documents, clinical records, and other

information submitted, without regard to whether such information was considered in the initial review of the case. In all cases, professional reviewers adhere to established clinical criteria.

1. Once Evernorth has received the clinical information required to make a decision, a licensed provider who is not subordinate to the clinical peer reviewer who conducted the original review will determine whether medical necessity is established based on the records presented and relevant clinical criteria; if so, the provider will overturn the initial denial and Evernorth will communicate the decision in accordance with applicable timeframes required by New Jersey law.

2. If the provider reviewing the appeal is unable to establish medical necessity based on the facts of the case, (s)he will uphold the original adverse determination.

3. Following Evernorth's initial review and determination of the appeal to uphold the initial adverse determination, if the applicable Member is an individual health benefit plan Member, Evernorth shall provide notice to the Member and treating Provider that Evernorth has reached a final adverse benefit determination including notice of the member and/or provider's rights to pursue an external appeal to an independent utilization review organization pursuant to the procedures set forth below. Such determination shall be rendered as soon as possible in accordance with the medical exigencies of the case, but in no event shall such time exceed seventy-two hours in the case of an appeal from an adverse benefit determination regarding urgent or emergency care, an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility; or ten calendar days in the case of all other appeals.

4. If the applicable Member is a group health benefits plan member, Evernorth shall provide notice to the Member and his or her treating provider that the member's informal internal utilization management (stage 1) appeal has been denied, and that the member or his or her treating provider may pursue a formal internal utilization management (stage 2) appeal).

(b). Formal Internal Appeals. The Stage 2 internal formal appeal process is a process where Provider (with consent of the Member) can request that the adverse determination via the Stage 1 appeal process be reviewed by a panel of licensed physicians. Following receipt of a request from a Member or Member's designee for a Stage 2 appeal, Evernorth will acknowledge the request in writing within 10 business days of receipt, and will render a determination within 20 business days

of receipt of the appeal. If medical exigencies require an expedited appeal, Evernorth will render a determination on the Stage 2 appeal within seventy-two (72) hours of receipt of the appeal. If Evernorth's determination is to deny the Stage 2 appeal, Provider will be provided notice of such determination, together with notice of its right to pursue an external appeal to an independent utilization review organization, as outlined below.

(c) External Appeals to an Independent Utilization Review Organization (IURO) / FAIR Hearing. Provider, with express written consent of the Member, may appeal a final internal adverse benefit determination to an external review. This may include an IURO and/or a Medicaid FAIR Hearing, as applicable.

1. In circumstances where Provider has provided services to a NJ FamilyCare or Medicaid beneficiary member, Provider may, with the consent and participation of the member, request a Medicaid FAIR Hearing with the New Jersey Department of Human Services. A FAIR Hearing may be requested in addition to, or in place of, and external appeal to an IURO.

2. To initiate an External Appeal to an IURO, Provider may submit the applicable form provided by the New Jersey Department of Banking and Insurance (DOBI) (available at https://www.state.nj.us/dobi/chap352/352ihcapform.docx) to DOBI within four months after receipt of EVERNORTH's final internal adverse benefit determination.

3. The IURO's determination shall be binding on Evernorth, the applicable Payor, Member and Provider, except to the extent that other remedies are available to either party under State or Federal law.

4. Evernorth and the applicable Payor will comply with the decision of an IURO in 10 days or less according to the exigencies of the case.

(C) With respect to Covered Services rendered to Participants covered under an HMO or Managed Care Plan:

1. Provider shall hold Participant harmless for the cost of Covered Services, whether or not Provider believes its compensation for such Covered Service from Payor is made in accordance with the reimbursement provisions of the Agreement, or is otherwise inadequate.

2. If Provider is a hospital or ancillary provider, in the event of Evernorth's insolvency, Covered Services to Participants who are confined in an inpatient facility on the date of the declaration of insolvency shall continue until the Participant's discharge

from the facility or the expiration of the Participant's benefits, whichever occurs first.

(D) The following provisions will apply, in accordance with N.J.A.C. 11:24B, to any Agreement between Provider and an Evernorth entity that is an with an Organized Delivery System:

(1) Except as permitted by applicable laws and regulations, the Agreement and amendments thereto are subject to prior approval by the New Jersey Department of Banking and Insurance, and may not be effectuated without such approval.

(2) § 6.12 of the Agreement is amended to add the following:

The Agreement is governed by New Jersey law with respect to business transacted in New Jersey.

(3) Nothing in the Agreement shall be construed, contrary to N.J.A.C. 11:24B- 4.2(c)4, to limit Evernorth's obligation to provide remuneration, in accordance with the terms of the provider agreements, to providers under contract with an ODS for covered services rendered by those providers to covered persons in the event of the default of bankruptcy of the ODS.

(4) Nothing in the Agreement shall be construed, contrary to N.J.A.C. 11:24B- 5.2(c)6 to deny payment to a provider with respect to Medically Necessary services if the services were not pre-certified or pre-authorized; payment may be reduced for such services, as permitted by applicable state laws and regulations, in accordance with the terms of the Agreement and the Medical Management Program.

(5) Records relevant to Evernorth or Payor operations, other than medical records, are the property of Evernorth or Payor unless otherwise specified in the Agreement.

(6) Provider may not delegate any of the functions it is performing on behalf of Evernorth or Payor except as specified in the Agreement and the applicable Exhibit to the Agreement, and subject to advance notice as specified in the Agreement or applicable Exhibit; unless otherwise specified in the Agreement or the applicable Exhibit to the Agreement, Evernorth or Payor shall have the right to reject any delegation.

(7) Provider shall not require a Member to make a payment for any amount for a deductible, coinsurance payment, or a copayment for a Covered Service that is a prescription drug benefit in an amount that exceeds the amount the Member would pay for the prescription drug if the Member purchased the prescription drug without using a health benefits plan.

(8) Provider may disclose, and neither Evernorth nor any Payor shall not penalize or otherwise dis-incentivize Provider, disclosure to a Member of lower cost prescription drug options, including those that are available to the Member if the Member purchases the prescription drug without using health insurance coverage

(9) Notwithstanding any provision of this Agreement contrary, Provider shall inform each patient, at the time of taking an order from a patient for home delivery or at the time of dispensing a prescription drug to the patient at the practice site: (a) of the lowest cost option for the prescription drug; and (b) whether there is an alternative drug that is less expensive and interchangeable with the prescription drug, and if needed, that the consumer can discuss with the prescribing health care provider whether the alternative drug would be appropriate for the consumer.

(10) § 2.8 of the Agreement is amended to add the following:

Evernorth shall have continued access to Provider books and records following the termination of the Agreement for such time as needed for the purposes of collecting such data as Evernorth is required to report to the Department of Banking and Insurance for any part of the calendar year for which the Agreement is in effect. Evernorth-owned records shall, in the event of the termination of the Agreement, be transferred in a timely and orderly fashion as agreed upon by the parties at the time of the notice of termination.

(11) If Provider is a hospital or ancillary facility:

Subrogation/Worker's Compensation Subrogation and third party recovery provisions are prohibited.
Posting payments Explanation of benefits (EOB) and explanation of payments (EOP) have been revised to include plan language and specific reasons for denials; not just the denial code. In addition, the EOB has been revised as follows: if you are covered by more than one health benefit plan, you should file all of your claims with each plan and provide each plan with information regarding the other plans under which you are covered.
Service Standards Urgent care should have access to appointments within twenty-four (24) hours of the patient's phone call.

Order of Benefit Determination When the primary plan is not subject or compliant with New Jersey regulations, the secondary plan must attempt to (i) secure all information needed to correctly determine its liability or (ii) assume the primary position if the non-complying plan is unwilling to act as primary or does not supply the needed information. Please note New Jersey has specific procedures for secondary plans/managed care coordination.
Retiree Rule The retiree rule for the state of New Jersey should be used when determining coverage for laid off or retired employees. Maintenance of Benefits (MOB), Non-duplication of Benefits (Non Dup) and Super 65 options are not permitted.
Emergency Services Emergency Services include any medical screening examination or other evaluation required by state or federal law to be provided in an emergency department of a hospital, which is necessary to determine whether an Emergency Medical Condition exists and Medically Necessary Emergency Services required for the treatment and stabilization of an Emergency Medical Condition.

(12) Referrals to Non-Participating Providers including Ambulatory Surgical Centers and Free Standing Laboratories: Patients with Evernorth coverage generally expect that when they choose to seek care from a provider who participates with Evernorth, the entire episode of care will be reimbursed using in network benefits. For this to occur, the patient needs to be referred to Evernorth participating providers including other practitioners, laboratories and facilities. When a patient is referred to non-participating provider, the patient may incur unexpected financial liability. Patients with Evernorth coverage who have out-of-network benefits are free to choose to use these benefits for covered medical services. In doing so, the patients will generally incur higher out of pocket costs. To ensure that patients are making informed choices regarding whether to seek care from participating or non-participating providers, they must have full disclosure regarding the financial effect of such referrals under their benefit plans, including the referring physician's financial interests, if any.

(13) American College of Medical Quality; Professional Policies -POLICY 32-Physician Self-Referral: The referral of patients to an additional individual provider or institution for any services in which the referring physician has a financial interest may constitute "self-referral." Physicians who make referrals to professional practitioners or health care entities or facilities in which they have financial interest must provide full disclosure of that interest to patients, allowing them to make informed decisions. In addition, patients should be given a list of effective alternative resources, if any, that are reasonably available, informed that they have the option to use one of the alternative resources, and assured that the physician will not treat them differently if they choose an alternative provider or entity. Physicians should make referrals to providers based only on

the needs of the patient and the medical standard of care in order to provide quality health care to their patients. http://www.acmq.org/policies/policies32and33.pdf

(14) New Jersey law regarding self-referrals and Ambulatory Surgery:

a. Self-Referrals Generally Prohibited: New Jersey law generally prohibits health care practitioners from referring a patient (or directing an employee to refer a patient) to a health care service in which the practitioner, or the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a significant beneficial interest.

b. Permitted Self-Referral Exceptions On and After March 1, 2010:

The law is amended effective March 1, 2010 to make exceptions and permit self-referrals for the following:

(1) Medical treatment or a procedure that is provided at the practitioner's medical office and for which a bill is issued directly in the name of the practitioner or the practitioner's medical office;
(2) Renal Dialysis; and
(3) Ambulatory surgery or procedures requiring anesthesia performed at a surgical practice registered with the State Department of Health and Senior Services or at an ambulatory care facility licensed by the Department of Health and Senior Services to perform surgical and related services.

c. Conditions of Exception for Ambulatory Surgical Services:

The self-referral exception for ambulatory surgical services and facilities is only permitted if all the following conditions are met:

(1) the practitioner who provided the referral personally performs the procedure;
(2) the practitioner's remuneration as an owner of or investor in the practice or facility is directly proportional to his ownership interest and not to the volume of patients the practitioner refers to the practice or facility;
(3) all clinically-related decisions at a facility owned in part by non-practitioners are made by practitioners and are in the best interests of the patient; and
(4) disclosure of the referring practitioner's significant beneficial interest in the practice or facility is made to the patient in writing, at or prior to the time that the referral is made, consistent with the prescribed disclosure provisions in the law.

d. Disclosure of Practitioner’s Interest:

If a practitioner is permitted to refer a patient to a health care service pursuant to these exceptions, the practitioner shall provide the patient with a written disclosure form prepared according to the provisions in the law, and post a copy of this disclosure form in a conspicuous public place in the practitioner's office.

The disclosure shall inform the patient whether any services or facility fees associated with the referral will be considered to be, and reimbursed at, an "out-of-network" level by the patient's insurance carrier or other third party payer.

(15) Demographic Information and Directories: Evernorth ensures that the information in the directory is based on the most recently submitted information from provider or CAQH. Evernorth confirms the participation of any provider who has not submitted a claim for a twelve (12) month period or otherwise communicated with us in a manner evidencing the intention to continue to participate in the network, and for whom no change in provider status has been reported by CAQH. If follow up contacts cannot confirm the provider has continued intention to participate, the provider will be removed from the network.

(16) Evernorth Required Form for Out-of-Network Referrals in New Jersey: To ensure that patients with Evernorth coverage have the necessary information to make an informed decision, the “Out-of-Network Referral Disclosure Form” must be completed and the choices must be explained to the patient. The use of this form is required in addition to any other state mandated requirements. A copy of the completed form should be given to the patient and the original placed in the patient’s medical file. Use of this form is a condition of participation for Evernorth’s Participating Providers. Evernorth may audit the use of this form by Evernorth’s Participating Providers.

(17) If Provider is a hospital, with respect to indemnification of the parties, nothing in the Agreement shall waive, modify, delegate or shift the liability of either party under N.J.S.A. 2A:53A-33a.

NEW MEXICO REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of New Mexico regarding provider contracts with providers rendering health care services in the State of New Mexico. To the extent that such New Mexico laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of the Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such New Mexico laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) In addition to the requirements set forth in the Agreement, Provider agrees that in no event, including but not limited to non-payment by Evernorth or Payor, insolvency of Evernorth or Payor, or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against, a Participant or covered person, or person acting on behalf of the covered person, for health care services provided pursuant to the Agreement. This does not prohibit Provider from collecting Coinsurance, Deductibles, or Copayments as specifically provided in the Plan, or fees for uncovered health care services delivered on a fee-for-service basis to persons referenced above, nor from any recourse against Evernorth or Payor or their successors. The requirements of this provision shall survive the termination of the Agreement regardless of the reason for the termination, including the insolvency of Evernorth or Payor.

(2) In addition to the obligations and requirements set forth in the Agreement, Provider will comply with the Administrative Guidelines including, but not limited to, policies and programs contained therein with respect to payment systems, utilization review, quality assessment and improvement programs, credentialing, confidentiality requirements, and any applicable federal or state programs.

Provider may, pursuant to 13.10.16 NMAC, and in accordance with the Administrative Guidelines, raise concerns regarding the operation of the plan, including concerns regarding quality of and access to health care services, the choice of health care providers, and the adequacy of the plan's provider network.

(3) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, Provider will notify Evernorth not more than ten (10) days after the Provider's receipt of notice of any reduction or cancellation of professional liability and malpractice insurance.

(4) Provider shall, in accordance with applicable state laws and regulations, observe, protect,

and promote the rights of Participants or covered persons as patients.

(5) In addition to the obligations and requirements set forth in the Agreement, if any, and in accordance with applicable state laws and regulations, Evernorth shall provide interpreters for limited English proficient individuals and interpretive services for patients who qualify under the Americans with Disabilities Act; such interpretive services will be made available to Provider's office at no cost to Provider.

(6) Terms used in the Agreement that are defined by state statutes and division regulations will be used in the Agreement in a manner consistent with any state definitions.

(7) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, should Payor fail to pay Provider for Covered Services within forty-five (45) days after receipt of a clean claim, as defined by applicable laws and regulations, Payor shall be liable for the amount due and unpaid with interest on that amount at the rate established by applicable law.

(8) "Clean Claim" means a manually or electronically submitted claim that contains all the required data elements necessary for accurate adjudication without the need for additional information from outside of Evernorth or Payor's system and contains no deficiency or impropriety, including lack of substantiating documentation currently required by Evernorth or Payor, or particular circumstances requiring special treatment that prevents timely payment from being made by Evernorth or Payor.

(9) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, Payor shall make any retroactive adjustments for overpayment within eighteen (18) months absent Provider miscoding, claim submission error, suspected fraud and abuse, or retroactive adjustments required by federal or state agencies.

(10) In addition to the obligations and requirements set forth in the Agreement, and in accordance with applicable state laws and regulations, if the Agreement is terminated without cause, Provider shall continue to provide Covered Services for a Participant to continue an ongoing course of treatment for a transitional period as set forth in the Administrative Guidelines; the transition period for a Participant who is in the third trimester of pregnancy at the time of termination shall include the provision of postpartum care directly related to the delivery. Authorization for continuing care shall be subject to Provider's agreement to accept reimbursement at the rates applicable prior to the commencement of continued care as payment in full, adherence to Evernorth's policies and procedures and quality assurance program, and agreement to provide Medically Necessary information related to continued care.

NEW YORK REGULATORY
ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of New York regarding provider contracts with providers rendering health care services in the State of New York. To the extent that such New York laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such New York laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) To the extent permitted by Insurance Law § 3217-b, either party may seek resolution of a dispute arising pursuant to the payment terms of the Agreement through a proceeding under article seventy-five of the civil practice law and rules.

(2) To the extent required by Insurance Law § 3224-a, the parties agree to the following. Provider shall initially submit a claim within one hundred twenty (120) days after the date of service unless a longer time period is permitted under the Agreement and applicable law. Evernorth or Payor shall permit Provider to request reconsideration of a claim that is denied exclusively because it was submitted untimely if Provider can demonstrate that non-compliance was a result of an unusual occurrence and that Provider has a pattern or practice of submitting claims in compliance with timely submission requirements. Evernorth or Payor may reduce the reimbursement due for an untimely claim by an amount not to exceed twenty five percent (25%) of the amount that would have been paid had the claim been submitted in a timely manner. Evernorth or Payor may deny the claim in full for a claim submitted three hundred sixty-five (365) days after the date of service.

(3) To enable compliance with legislative and regulatory requirements of the State of New York regarding insurer provider network disclosures to insureds set forth by Insurance Law § 3217-a(a)(17) as may be amended from time to time, a physician will, in addition to the provider directory requirements found in the Medical Management Program, provide to Evernorth board certifications, languages spoken and any affiliations with participating hospitals, in writing or as specified in the Medical Management Program. Physician will also notify Evernorth in writing or as specified in the Medical Management Program in advance of any change in any affiliations with participating hospitals.

(4) For enrollees covered under and fully insured health plan and in accordance with 42 U.S.C. Section 300gg-139(b), as may be amended from time to time, If a health care provider submits a bill to an enrollee based on cost-sharing for treatment or services provided by the health care provider that is in excess of the normal cost-sharing applied for such treatment or services provided in-network, as prohibited under section 300gg–115(b) of this title, section 1185i(b) of title 29, or section 9820(b)

of title 26, as applicable, and the enrollee pays such bill, the provider shall reimburse the enrollee for the full amount paid by the enrollee in excess of the in-network cost-sharing amount for the treatment or services involved, plus interest, at an interest rate determined by the Secretary of Health and Human Services.

(5) Provider Payment Appeals: The utilization review appeal procedures available to covered individuals may be available for certain post service medical necessity denials.

(6) Provider Information and Directories: Demographic information sent to Evernorth should also be consistent with the providers' information posted in the New York Department of Education database and the New York Department of Health "Health Provider Network" (HPN) database.

(7) Patient Rights and Responsibilities – Enrollee Right to Obtain Medical Information: When it is advisable not to give diagnosis, treatment and prognosis, information to a covered individual (for example, to a minor or incapacitated dependent) the information is to be made available to an appropriate person acting on the individual's behalf.

(8) Patient Rights and Responsibilities – Non-Covered Services: Prior to initiating a non-covered service, providers are required to advise the enrollee that the service is not covered by Evernorth and to state the cost of the service.

(9) Patient Liability Collection Guidelines: For uncovered services, Provider must advise the patient, prior to initiating of service, that the services are uncovered and the cost of the service.

(10) Dispute Resolution: If a provider's license, certification or registration is revoked or suspended, by the State, the provider will be terminated from the HMO network.

(11) Referral Process:
(A) Exceptions to Referral Process:

a. A new patient whose provider is not a customer of the Healthplan's network and who:
    i. Is receiving an on-going course of treatment for a life-threatening disease or condition, or a degenerative or disabling disease or condition, or
    ii. Has entered the second trimester of pregnancy as of the effective date of enrollment may be eligible to receive continuity of care from that non-participating provider for a transitional period of up to sixty (60) days, or the post-partum period directly related to the delivery of the child . Such continuity of care must be approved in advance by Evernorth and the non-participating provider must agree to accept Evernorth's reimbursement rate and to abide by Evernorth policies, procedures, and quality assurance requirements.

(12) Emergency Services: An "Emergency Medical Condition" is defined as a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in: (a) placing the health of the person afflicted with such condition in serious jeopardy, or in the case of a behavioral condition, placing the health of such person or others in serious jeopardy; or (b) serious impairment to such person's bodily functions; or (c) serious dysfunction of any bodily organ or part of such person; or (d) serious disfigurement of such person.

(13) Specialized Care over a Prolonged Period of Time: Extended referral to a specialty provider may be requested for a condition that requires ongoing care from a specialist. The primary care physician ("PCP") should contact Evernorth to discuss the medical necessity of the extended referral and to arrange for the authorization. For a life-threatening condition or disease, a degenerative and disabling condition or disease, or a condition that requires specialized medical care over a prolonged period of time, a specialty provider may be designated as the patient's coordinating care provider or the patient may be referred to a specialty care center for treatment. The PCP should contact Evernorth to determine the medical necessity of the situation and to arrange for authorization.

(14) Medical Record Reviews – Medical Record Documentation:
(A) Additional medical record guidelines:
   a. Separate medical record for each enrollee;
   b. Record verifies that PCP coordinates and manages care
(B) Medical record retention requirements:
   a. Six (6) years after date of services to enrollees or cessation of HMO operation.
   b. For minors, six (6) years from date of majority.

(15) Quality Assurance:
(A) Confidentiality of HIV-related information:
   a. Each provider must develop policies and procedures to assure confidentiality of HIV information. The policies and procedures must include:
      i. Initial and annual in-service education of staff, contractors;
      ii. Identification of staff allowed access and limits of access;
      iii. Procedure to limit access to trained staff (including contractors);
      iv. Protocol for secure storage (including electronic storage);
      v. Procedures for handling requests for HIV-related information;
      vi. Protocols to protect persons with or suspected of having HIV infection from discrimination.

(16) Peer Review Committee: Inappropriate conduct reviewed includes fraud. In addition, actions will be taken as appropriate in a case of imminent harm to patient health.

(17) Credentialing: Healthplan will notify provider applicants within ninety (90) days of receipt of completed applications, informing the applicants whether they are credentialed or whether additional information is needed or Healthplan needs no further information. More information is available upon request from Provider Service Department at 800.926.2273

(18) Recredentialing Process: Evernorth will provide Provider with information, profiling data and analysis used to evaluate performance during any evaluation process, and upon request. Evernorth is available to discuss the unique nature of Provider's professional patient population, which may have bearing on Provider's profile, and to work cooperatively with Provider to improve performance.

(19) Provider Performance Evaluations:
(A) Healthplan's policies and procedures to review provider performance include:
   a. The information maintained to evaluate the performance/practice of providers;
   b. The criteria against which the performance of providers will be evaluated;
   c. The process used to perform the evaluation;

d. The procedure to providers with any information and profiling data used to evaluate the professional's performance;
e. the procedure to make available on a periodic basis and upon request of the provider the information, profiling data and analysis used to evaluate the professional's performance;
f. The opportunity to discuss the unique nature of the professional's patient population, which may have bearing on the professional's profile, and to work cooperatively with Healthplan to improve performance.

(20) Provider Termination Appeals:

(A) If Evernorth proposes to terminate a contract, Evernorth will provide a written explanation of the reasons for the proposed contract termination and an opportunity for a review or hearing as described below. The termination notice will explain the reasons for the proposed action, include a notice that Provider has the right to requests a hearing on review at Provider's discretion before a panel appointed by Evernorth, and include the time limit for a hearing date within thirty (30) days after the date of receipt of a request for a hearing. The hearing panel will be comprised of three (3) persons appointed by Evernorth. At least one (1) person on the panel in the same discipline or same specialty as the person under review. The panel can consist of more than three (3) customers, provided the number of clinical peers constitutes one-third or more of the total membership. The hearing panel shall render a decision a decision in a timely manner. Decisions will include one of the following and will be provided in writing to the healthcare professional: reinstatement; provisional reinstatement with conditions set forth by the MCO, or termination. Decisions of termination shall be effective not less than thirty (30) days after receipt by the healthcare professional of the hearing panel's decision. In no event shall determination be effective earlier than sixty (60) days from receipt of the notice of termination. A provider terminated due to the following is not eligible for a hearing or review: a case involving imminent harm to patient care, a determination of fraud, or a final disciplinary action by a state licensing board or other governmental agency that impairs the health of the healthcare professional's ability to practice.

(B) Evernorth does not propose contract terminations solely for the following actions by a provider:
a. advocated on behalf of an enrollee
b. filed a complaint against a managed care organization
c. appealed a decision of the managed care organization
d. provided information or filed a report to PHL4406-c regarding prohibitions of plans
e. requested a hearing for review

(C) Per Evernorth, along with the Hospital shall continue abiding by all provisions of the terminated contract for a "cooling off" period of two calendar months, beginning on the termination date. During this time Evernorth must pay and the Hospital must accept the previous contracted rate. Either party may request a waiver of the cooling off period by submitting a written request to the Director of the Bureau of Certification and Surveillance no more than 5 business days after Evernorth submits the notice of termination to the Department.

(21) Provider Responsibilities:

(A) Continuity of Care with Current Providers: New enrollees whose provider is not a participating provider may request directly or through such professional to continue an ongoing course of treatment.
a. If the covered individual has a life-threatening disease or condition or a degenerative and disabling disease or condition, coverage for the ongoing

treatment may be continued for up to sixty (60) days.

b. If the covered individual has entered the second trimester of pregnancy at the effective date of enrollment date, coverage for the ongoing care may be continued through the period of post-partum care related to the delivery.

(B) Transitional Care Following Contract Termination: If a patient with Evernorth or GWH-Evernorth coverage has been receiving care from a provider whose participation in the Evernorth network ends and a continued course of covered treatment is Medically Necessary, he/she may be eligible to receive "transitional care" from the non-participating provider for up to ninety (90) days. Patients may also be eligible to receive transitional care if in the second trimester of pregnancy. In this case, transitional care may continue through delivery and post-partum care. Such transitional care must be approved in advance by Evernorth and the provider, and the provider must agree to accept our reimbursement rate and to abide by Evernorth's policies, procedures, and quality assurance requirements. There may be circumstances where continued care by a provider no longer participating in Evernorth's network will not be available, such as when the provider loses his or her license to practice or retires.

(C) Precertification Protocol: Precertification of coverage is not required for Emergency Services. However, Emergency Services resulting in a hospital admission should be reported on the day of admission to a patient's PCP where applicable and to Evernorth if Evernorth has weekend and after-hours coverage or within twenty-four (24) hours or the next business day for remaining locations.

(D) Referrals: Child Early Intervention services do not require a referral for a specialist to provide services to assess or provided as part of an individualized family services plan (IFSP).

(22) **Confidentiality and Disclosure Protocols for Victims of Domestic Violence Residing in New York**: New York Insurance Law §2612 prohibits discrimination against an individual that is or has been a victim of domestic violence. This law also directs insurers that receive a valid order of protection to keep confidential and not disclose the address and telephone number of the victim of domestic violence or the address and telephone number of any child residing with the victim.

(A) **Request for Confidentiality**: Evernorth must receive a valid order of protection along with a completed Request of Use and Disclosure of Protected Health Information form** in order to request that Evernorth keep confidential and not disclose:

a. the address and telephone number of the victim of domestic violence or any child residing with the victim; and

b. the name and address, and telephone number of a person providing covered services to the victim, to:

i. a policyholder; or

ii. another insured covered under the policy against whom the victim has a valid order of protection.

To initiate a request, the patient must complete the form and submit to Evernorth at the address on the form or the patient can call the number on the back of their identification card. They may also contact Evernorth at 800.Evernorth24 (244.6224).

(B) **Request to Receive Claim Related Information by Alternative Means or at Alternative Locations**: An insured may also make a reasonable request to receive communications of claim related information by alternative means or at alternative locations. To make such a reasonable request an Evernorth insured or requestor must complete a Request for Confidential Communications form**.

To initiate a request, the patient must complete the form and submit to Evernorth at the address on the form or the patient can call the number on the back of their identification card. They may also contact Evernorth at 800.Evernorth24 (244.6224).

(C) **Request to Revoke a Reasonable Request**: A requestor may request a revocation of a reasonable request by completing a Change/Revoke Request form**.

To initiate a request, the patient must complete the form and submit to Evernorth at the address on the form or the patient can call the number on the back of their identification card. They may also contact Evernorth at 800.Evernorth24 (244.6224).

(D) **To access any of the above-mentioned forms, the patient can log on to myEvernorth.com > Forms > Customer Information Privacy.

(E) **New York State Domestic and Sexual Violence Hotline**: To report an incident, contact the New York State Domestic and Sexual Violence Hotline at 800.942.6906. The Spanish language telephone number is 800.942.6908. In New York City only, dial 800.621.HOPE (4673) or dial 311. The Office for the Prevention of Domestic Violence website, http://www.opdv.ny.gov/index.html, provides additional information and resources.

NORTH CAROLINA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of North Carolina regarding provider contracts with providers rendering health care services in the State of North Carolina. To the extent that such North Carolina laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context indicates otherwise. For the avoidance of doubt, to the extent such North Carolina laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The following definitions are applicable to insured Plans issued in the State of North Carolina:

(a) The definition for Emergency Services and Emergency Medical Condition shall comply with North Carolina laws and regulations to the extent applicable.

(b) "Medically Necessary" means those Covered Services or supplies that are:

a. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and, except as allowed under G.S. 58-3-255, not for experimental, investigational, or cosmetic purposes.

b. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.

c. Within generally accepted standards of medical care in the community.

d. Not solely for the convenience of the Participant, the Participant's family, or the provider.

For Medically Necessary services, Evernorth is not precluded from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

(c) If Provider is a hospital, "Utilization Review" shall mean, as set forth in applicable state laws and regulations, as may be amended from time to time, a

set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures, providers or facilities, which may include, as specified in applicable state laws and regulations, ambulatory review, case management, certification, concurrent review, discharge planning, prospective review, retrospective review, and second opinion.

(2)a. Provider shall be duly licensed by the appropriate state licensing board in North Carolina and shall be bound by and comply with the provisions of applicable local, state and federal laws and regulations. Provider shall maintain all necessary professional credentials sufficient to meet Evernorth's credential verification, including but not limited to appropriate licenses, certifications, accreditations and other similar approvals required by applicable local, state, and federal laws and regulations. If applicable, Provider shall comply with Evernorth's Standards for Delegation of Credentialing, as amended from time to time. Evernorth's credentialing requirements may be found in the Medical Management Program. Provider shall notify Evernorth promptly of any subsequent changes in the status of any information relating to the provider's professional credentials. Provider shall comply with Evernorth's utilization management programs, credential verification programs, quality management programs, and, if applicable, provider sanction programs with the stipulation that none of these shall override the professional or ethical responsibility of Provider or interfere with Provider's ability to provide information or assistance to Provider's patients.

a.(1) If applicable pursuant to a delegation set forth in the Agreement, Provider shall comply with all applicable requirements of 11 NCAC 20.0400. Provider shall submit an updated list of its providers no less frequently than quarterly, or as otherwise specified by 11 NCAC 20.0410.

b. Provider shall provide necessary Covered Services to Participants on a twenty-four (24) hour per day, seven (7) day per week basis, or arrange to provide backup services to cover Participants.

c. Evernorth shall establish a system of Participant identification and eligibility, based on current information held by the plan, prior to Provider rendering services to Participants, communicate the Medical Management Program to Participating Providers and identify Participating Providers to Payors and Participants. With regard to Participant identification, Participants shall be required to present an Evernorth identification card at the time of service. Such identification card does not guarantee eligibility. Prior to rendering services Provider should verify Participant eligibility by calling the phone number indicated on the identification card. Mutually agreeable provisions may be made for cases where incorrect or retroactive information was submitted by employer groups.

d. Evernorth shall include the name of Provider in the provider directory distributed to its members.

e. Evernorth shall provide data and information to Provider, such as:

(1) Performance feedback reports or information to Provider, if compensation is related to efficiency criteria.
(2) Information on benefit exclusions; administrative and utilization management requirements; credential verification programs; quality assessment programs; and, if applicable, provider sanction policies. Notification of changes in these requirements shall also be provided by Evernorth allowing Provider time to comply with such changes.

f. Provider shall:

(1) Maintain confidentiality of Participant medical records and personal information as required by G.S. 58, Article 39 and other health records as required by law.
(2) Maintain medical records and other health records according to industry and Evernorth's standards.
(3) Make copies of such records available to Evernorth and the North Carolina Department of Insurance in conjunction with its regulation of Evernorth. Provider shall provide such records to the Department of Insurance at no charge.

f.(1) Evernorth shall maintain all records, books, documents, and other business records subject to 11 N.C.A.C § 19 for at least five years from the date of a disposition or report issued or adopted pursuant to 11 N.C.A.C § 19.

g. If Provider is a hospital, Evernorth shall not deny payment for Emergency Services required for the treatment of an Emergency Medical Condition or other case where a delay in providing Emergency Services would be detrimental to a Participant's health as reasonably determined by Provider's emergency room staff.

(3) The provision in the Agreement that applies regarding coordination of benefits does not relate to subrogation.

(4) a. For pre-paid benefit plans, Provider shall not bill any network plan Participant for Covered Services, except for any applicable Copayments, Deductibles or Coinsurance. This provision shall not prohibit Provider and Participant from agreeing to continue non-covered services, at the Participant's own expense, as long as Provider has notified the Participant in advance that Evernorth may not cover or continue to cover specific services and the Participant chooses to receive the service.

b. Provider shall be responsible for collecting any applicable Participant Copayments, Deductibles or Coinsurance, and fees for non-covered services

shall be specified.

c. For any Covered Services, which are reimbursed on a fee-for-service basis, Provider shall bill for Covered Services according to the following:

Claims for all Covered Services shall be submitted on the appropriate claim form within one hundred eighty (180) days after the date of service or one hundred eighty (180) days after the Participant's discharge from the facility. Unless otherwise agreed to by Evernorth and Provider, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the Participant, later than one (1) year from the time submittal of the claim is otherwise required.

d. 1. Payor may recover claim overpayments made to Provider by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made pursuant to the requirements of North Carolina law. Not less than thirty (30) calendar days before Payor seeks overpayment recovery or offsets future payments, Payor shall give written notice to Provider including adequate specific information to identify the specific claim and the specific reason for the recovery. The recovery of overpayments or offsetting of future payments shall be made within the two (2) years after the date of the original claim payment unless Payor has reasonable belief of fraud or other intentional misconduct by Provider, or Provider's agents, or the claim involves a payment for the same service from a government payor.

2. If Provider is a hospital, Provider may recover underpayments in the manner and format specified in the Agreement or the Administrative Guidelines; the recovery of underpayments shall be made within the two years after the date of the original claim adjudication, unless the claim involved Hospital receiving payment for the same service from a government payor.

e. Chargemaster. Evernorth shall provide such notice as required by applicable law, including but not limited to NCGS § 58-3-227, when making adjustments permitted by any chargemaster provisions of the Agreement, or when conducting an audit permitted by any chargemaster provisions of the Agreement.

f. Sale of Business/Change in Management. Evernorth shall provide such notice as required by applicable law, including but not limited to NCGS § 58-3-227 and 58-3-225, in response to a notice or failure to provide a notice required under the Agreement, when exercising rights under the Agreement to retroactively adjust reimbursements or initiate an overpayment recovery process.

(5) Provider shall cooperate with Participant and Evernorth in the implementation of Evernorth's Participant appeal procedure and shall assist Participant and Evernorth in taking appropriate corrective action.

(6) Throughout the term of the Agreement, Provider shall maintain at Provider's expense general and professional liability coverage in a form and amount acceptable to Evernorth ($ 1 million per occurrence and $ 3 million in the aggregate). Provider shall give Evernorth written notice of any subsequent changes in the status of such insurance, or of any claims against Provider's liability coverage.

(7) Nothing in the Agreement shall limit: (1) Evernorth's authority or responsibility to ensure Provider's participation and compliance with Evernorth's quality management, utilization management, member grievance or other provisions of the Medical Management Program; (2) the North Carolina Department of Insurance's authority to monitor the effectiveness of Evernorth's Medical Management Program; (3) Evernorth's authority to sanction or terminate Provider for giving inadequate or poor quality care or failing to comply with Evernorth's Medical Management Program; or (4) Evernorth's obligation to comply with applicable law.

(8) Upon termination of the Agreement or upon Evernorth's or intermediary's insolvency or cessation of operations, Provider shall continue to provide Covered Services to Participants for the duration of the period for which premium payment has been made. For Participants who are confined in an inpatient facility, Provider shall continue to provide Covered Services until the Participant is ready for discharge. Provider shall be compensated for Covered Services provided to Participants in accordance with the compensation arrangements under the Agreement. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles, or Coinsurance billed in accordance with the terms of the applicable Plan, or for non-covered services delivered on a fee-for-service basis to Participants. Provider shall also comply with all Evernorth's procedures in the transfer of Participants to other providers, including without limitation the transition of administrative duties and records.

This provision shall survive the termination of the Agreement, regardless of the cause giving rise to termination and shall be construed to be for the benefit of Participants. This provision supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and the Participant or persons acting on the Participant's behalf insofar as such contrary agreement relates to liability for payment for services provided under the terms and conditions of the Agreement.

(9) The entire Agreement includes this Addendum, any amendments to the Agreement and any exhibits to the Agreement.

(10) Provider's duties and obligations under the Agreement shall not be assigned, delegated or transferred without the prior written consent of Evernorth. Evernorth, upon prior written notice to Provider, shall be entitled, but not obligated, to assign, delegate or

transfer all or any part of its rights, benefits, duties, or obligations hereunder to any of its current or future subsidiaries or affiliates, or to any entity which succeeds its business through a sale, merger, or other similar transaction.

(11) If Provider is a provider group:

a. Provider acknowledges and agrees that the form of Provider's standard agreement with its providers and any amendment thereto shall comply with and include all applicable provisions of 11 NCAC 20.0202.

b. Evernorth shall retain legal responsibility to monitor and oversee the offering of services to Participants and financial responsibility to Participants.

c. Provider may not subcontract for its services without Evernorth's written permission.

d. Evernorth may approve or disapprove individual providers for inclusion in or removal from its network.

e. Provider shall make available for review by the Department of Insurance all provider contracts and subcontracts held by Provider.

f. If Provider pays its providers on a risk basis, or is responsible for claims payment to its providers:

(i) Evernorth shall receive documentation of utilization and claims payment and maintain accounting systems and records.

(ii) Evernorth shall arrange for financial protection of itself and Participants through such approaches as Participant hold harmless language, retention of signatory control of the funds to be distributed, or financial reporting requirements.

(iii) To the extent provided by law, the Department of Insurance shall have access to the books, records, and financial information to examine activities performed by Provider on behalf of Evernorth. Such books and records shall be maintained in the State of North Carolina.

g. Provider shall comply with all applicable statutory and regulatory requirements that apply to the functions delegated by Evernorth and assumed by Provider.

(12) Notice Contact. Any notice required under the Agreement must be in writing and sent by United States mail, postage prepaid, to the name or title and the address provided pursuant to the Notices section of the Agreement. Evernorth may also notify Provider by sending an electronic notice with automatic receipt verification to Provider's e-mail address if mutually agreed upon and provided pursuant to the Notices section of the

Agreement. Either party can change the name, title or address for notices by giving written notice of the change to the other in the manner just described.

(13) Medical Management Program. In addition to the distribution of the Medical Management Program as set forth in the Agreement, Evernorth will provide its Medical Management Program in hard copy, CD or other electronic format, or by web posting, prior to the execution or amendment of the Agreement, and annually.

(14) Amendments. In addition to the negotiated terms of the Amendment provision as set forth in the Agreement, Evernorth shall send any contract amendment to the Notice Contact identified in the Agreement proposing to change any term of this Agreement which modifies a fee schedule, including terms incorporated by reference. No such contract amendment shall be conveyed by use of an electronic medium of communication. An amendment under this section shall be dated, labeled "Amendment," signed by Evernorth, and shall include an effective date. Provider shall have at least sixty (60) days from the date of receipt to object to the proposed amendment. The amendment shall be effective upon Provider failing to object in writing within sixty (60) days. Should Provider object, the amendment will not be effective, and Evernorth shall be entitled to terminate the Agreement upon sixty (60) days written notice.

(15) Credentialing. When applying for participation in the network, North Carolina professionals will be sent the North Carolina Uniform Credentialing Form. Within sixty (60) days of receipt of a completed application and all necessary supporting documents, Evernorth shall assess and verify the applicant's qualifications and notify the applicant of its decision. In the event that the application is not complete, needed documents are missing, or verification information is unavailable, the applicant will be informed in writing of the delay, the reason for the delay, and the name and phone number of a staff participant to contact if the applicant has questions. In the event that missing information or documents have not been received within sixty (60) days of initial receipt of the application, the applicant's file will be closed or pended, and the applicant informed of this fact in writing. Included in this correspondence will be the length of time the application will be pended, if applicable, and the name and phone number of a staff person to contact with questions.

NORTH DAKOTA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of North Dakota regarding provider contracts with providers rendering health care services in the State of North Dakota. To the extent that such North Dakota laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such North Dakota laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

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1. The definition for Emergency Services, if any, shall comply with North Dakota laws and regulations to the extent applicable.

2. In addition to the negotiated terms of the Agreement establishing limits on billing Participants, the following shall apply in accordance with applicable laws and regulations:

> Provider agrees, in the event of Evernorth's insolvency, to continue to provide Covered Services to a Participant through the period for which a premium has been paid to Evernorth and until the Participant's discharge from an inpatient facility.

3. Evernorth and Provider shall provide at least sixty (60) days written notice to each other before terminating the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by either party, such longer notification period will apply.

OHIO REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Ohio regarding provider contracts with providers rendering health care services in the State of Ohio. To the extent that such Ohio laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Ohio laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined herein shall have the same meaning as set forth in the Agreement.

(A) (1) Provider shall be duly licensed in the State of Ohio.

(2) Upon request, Evernorth or its designee shall notify Provider of Covered Services, including any limitations or conditions thereon, in writing and/or telephonically.

(3) (a) Pursuant to Section 3963.03 (A)(1)(a)(ii) of the Ohio Revised Code, information pertinent to the fee schedule of procedure codes reasonably expected to be billed by Provider for services provided and the associated payment or compensation for each procedure code is available at www.Provider.Evernorth.com.

(b) Pursuant to Section 3963.03 (A)(1)(a)(iii) of the Ohio Revised Code, information pertinent to the effect, if any, on payment or compensation if more than one (1) procedure code applies to the service is available at www.Provider.Evernorth.com.

(c) Pursuant to Section 3963.03 (A)(2) of the Ohio Revised Code, the identity of the contracting entity or payer responsible for the processing of Provider's compensation or payment is available at www.Provider.Evernorth.com.

(4) The Agreement may permit network rental arrangements which allow the selling, renting, or giving the contracting entity's rights to the services of the Participating Provider, to a third party (including other preferred provider organizations), and the third party accessing the Participating Provider's services is any of the following:

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

(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 that is in compliance with Section 3963.02 (A)(1)(c) of the Ohio Revised Code, 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; or

(c) 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.

(5) (a) Evernorth or its designee may recover overpayments if the recovery process is initiated not later than two (2) years after the payment was made to Provider. Evernorth or its designee shall inform Provider of its determination of overpayment by providing notice in accordance with Section 3901.388(C) of the Ohio Revised Code. Evernorth or its designee shall give Provider an opportunity to appeal the determination. If Provider fails to respond to the notice sooner than thirty (30) days after the notice is made, elects not to appeal the determination, or appeals the determination but the appeal is not upheld, Evernorth or its designee may initiate recovery of the overpayment. Such recovery may include deducting the amount of the overpayment from other payments owed to Provider or by taking action pursuant to any other remedy available under the Ohio Revised Code. Evernorth shall permit Provider to repay the amount by making one (1) or more direct payments to Evernorth or its designee or by having the amount deducted from other payments owed to Provider.

(b) To the extent required by § 3901.388(A) of the Ohio Revised Code, if Provider believes a Covered Service has been underpaid, Provider must submit a written request for an appeal or adjustment with Evernorth or its designee within two (2) years from the date of Payor's payment or explanation of payment. The request must be submitted in accordance with the terms of the Agreement and the Medical Management Program. Requests for appeals or adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Evernorth, the Payor or the Participant for those services.

(6) Provider shall give Evernorth ten (10) days prior written notice of cancellation, reduction or termination of general and professional liability insurance.

(7) (a) Evernorth shall provide Provider with at least ninety (90) days written notice of the effective date of a Material Amendment to the Agreement.

"Material Amendment" means an amendment to an Agreement that: a) decreases Provider's payment or compensation; b) changes the administrative procedures in a way that may reasonably be expected to significantly increase Provider's administrative expense; or c) adds a new product.

A Material Amendment does not include: (a) a decrease in payment or compensation resulting solely from a change in a published fee schedule upon which the payment or compensation is based and the date of applicability is clearly identified in the Agreement; (b) a decrease in payment or compensation that was anticipated under the terms of the Agreement, if the amount and date of applicability of the decrease is clearly identified in the Agreement; (c) an administrative change that may significantly increase Provider's administrative expense, the specific applicability of which is clearly identified in the Agreement; (d) changes to an existing prior authorization, precertification, notification, or referral program that do not substantially increase Provider's administrative expense; (e) changes to an edit program or to specific edits, if Provider is provided notice of the changes pursuant to division (A) (1) of Section 3963.04 of the Ohio Revised Code and the notice includes information sufficient for the provider to determine the effect of the change; or (f) changes to the Agreement described in division (B) of Section 3963.04 of the Ohio Revised Code.

If Provider objects in writing to the Material Amendment within fifteen (15) days of receipt and there is no resolution of the objection, Evernorth or Provider may terminate the Agreement upon written notice to the other party but no later than sixty (60) days prior to the effective date of the Material Amendment.

If Provider does not object to the Material Amendment within fifteen (15) days of receipt, the change shall be effective as specified in the notice.

(b) If an amendment to the Agreement is not a Material Amendment, Evernorth shall provide Provider notice of the amendment at least fifteen (15) days prior to the effective date of the amendment.

(c) Subsections (a) and (b) above shall not apply if the delay caused by compliance with the requirements could result in imminent harm to a Participant, if the Material Amendment to the Agreement is required by state or federal law, rule, or regulation, or if Provider affirmatively accepts the Material Amendment in writing and agrees to an earlier effective date than otherwise required for such Material Amendment.

In addition, subsections (a) and (b) above shall not apply under any of the

following circumstances:

(i) Provider's payment or compensation is based on the current Medicaid or Medicare physician fee schedule, and the change in payment or compensation results solely from a change in that physician fee schedule.

(ii) A routine change or update of the Agreement is made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change is made by any third party source.

"Service code, procedure code, or reporting code" means the current procedural terminology (CPT), current dental terminology (CDT), the healthcare common procedure coding system (HCPCS), the international classification of diseases (ICD), or the drug topics redbook average wholesale price (AWP).

"Third party source" means the American Medical Association, American Dental Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, the Department of Health and Human Services Office of the Inspector General, the Ohio Department of Insurance, or the Ohio Department of Medicaid.

(d) Notwithstanding anything in this section, Evernorth may amend the Agreement by operation of law as required by any applicable state or federal law, rule, or regulation.

(8) In the event of termination of the Agreement and to the extent applicable, the provisions of Section 3963.02 (E) of the Ohio Revised Code shall apply.

(9) Notwithstanding anything to the contrary set forth in the Agreement, Section 1753.09 of the Ohio Revised Code applies to the termination of a Participating Provider's Agreement for any of the causes described in divisions (A), (D), and (F) (1) and (2) of Section 1753.09 of the Revised Code.

(10) Notices required under this Agreement shall be in writing and shall be deemed to have been duly given a) on the date of service if served personally on the party to whom notice is to be given; b) on the date of delivery if sent via overnight courier to the party to whom notice is to be given and properly addressed as specified in the Agreement; c) with respect to notifications of termination of this Agreement, on the third day after deposit in the United States mail, if mailed via certified mail, postage prepaid, and properly addressed as specified in the Agreement; d) with respect to notifications other than notifications of termination, on the third day after deposit in the United States mail, if mailed postage prepaid and properly addressed as specified in the Agreement; or e) with respect to notifications by Evernorth other than notifications of termination, on the date Evernorth sends an electronic notice to Provider with an automatic receipt verification to Provider's e-mail address as

specified in the Agreement.

(11) (a) When the arbitration issues are limited to issues that only concern the enforcement of the contract rights conferred by Section 3963.02, divisions (A) and (D) of Section 3963.03, and Section 3963.04 of the Ohio Revised Code, the arbitrator may award reasonable attorney's fees and costs for arbitration relating to the enforcement of this section to the prevailing party.

(b) A party shall not simultaneously maintain an arbitration proceeding as described in division (F)(1) of Section 3963.02 of the Ohio Revised Code and pursue a complaint with the Superintendent of Insurance to investigate the subject matter of the arbitration proceeding. However, if a complaint is filed with the Department of Insurance, the Superintendent of Insurance may choose to investigate the complaint or, after reviewing the complaint, advise the complainant to proceed with arbitration to resolve the complaint. The Superintendent of Insurance may request to receive a copy of the results of the arbitration. If the Superintendent of Insurance notifies an insurer or a health insuring corporation in writing that the superintendent has initiated a market conduct examination into the specific subject matter of the arbitration proceeding pending against that insurer or health insuring corporation, the arbitration proceeding shall be stayed at the request of the insurer or health insuring corporation pending the outcome of the market conduct investigation by the superintendent.

(B) With respect to Covered Services rendered to Participants covered under a Plan insured by a Health Insuring Corporation (as that term is defined under Ohio law), the following provisions shall apply:

(1) The definition for Emergency Services, if any, shall comply with Ohio laws and regulations to the extent applicable.

(2) In the event of Evernorth's insolvency or discontinuance of operations: (1) Provider shall continue to provide Covered Services to Participants as needed to complete any Medically Necessary procedures commenced but unfinished at the time of such insolvency or discontinuance of operations (the completion of Medically Necessary procedures shall include the rendering of all Covered Services that constitute Medically Necessary follow-up care for that procedure); and (2) if a Participant is receiving necessary inpatient care at a hospital, Provider shall continue to provide such care until the earlier of the following: (a) the day the Participant is discharged from the hospital, (b) the day the Participant's attending physician determines that such inpatient care is no longer medically indicated, (c) the day the Participant has reached the benefit limit under the applicable Plan, (d) the effective date of Participant's new coverage; or (d) thirty (30) days after such insolvency or discontinuance of operations.

Provider is not required to continue to provide Covered Services after the occurrence of any of the following: (a) the end of the thirty (30) day period following the entry of a liquidation order under Chapter 3903 of the Ohio Revised Code; (b) the end of the Participant's period of coverage for a contractual prepayment or premium; (c) the Participant obtains equivalent coverage with another Health Insuring Corporation or insurer, or the Participant's employer obtains such coverage for the Participant; (d) the Participant or the Participant's employer terminates coverage under the Plan; or (e) a liquidator effects a transfer of the Health Insuring Corporation's obligations under the contract under division (A) (8) of Section 3903.21 of the Ohio Revised Code.

(3) Evernorth and Provider shall observe, protect and promote the rights of Participants.

(4) Those terms used in the Agreement that are defined in Ohio Revised Code Chapter 1751 (Health Insuring Corporations) are used in the Agreement in a manner consistent with those definitions.

(C) Ohio House Bill 1:

(1) Ohio House Bill 1 requires that claims received electronically be paid electronically. In order to comply with this law, Evernorth will contact its Participating Providers three (3) times a year to ensure that they have the opportunity to provide Evernorth with the necessary information on file to issue an electronic payment.

(2) To register for direct deposit of electronic payment, log in to Provider.Evernorth.com > My Practice and click "Enroll" to create an account. If Provider is not yet registered for the Evernorth for Health Care Professionals website, visit Provider.Evernorth.com and click "Register Now." For step-by-step registration directions, go to Provider.Evernorth.com and click "Learn How to Register and Log In." When Provider registers for electronic payments, be certain to supply all TINs that apply to Provider and Provider's practice.

OKLAHOMA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Oklahoma regarding provider contracts with providers rendering health care services in the State of Oklahoma. To the extent that such Oklahoma laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Oklahoma laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) Payor may only retroactively deny reimbursement to Provider during the twenty-four (24) month period after the date Payor paid the claim. However, this provision shall not apply: (a) if the payment was made because of fraud by Provider; or (b) if Provider has otherwise agreed to make a refund to Evernorth for overpayment of a claim.

(2) A. If Provider voluntarily chooses to terminate the Agreement, Provider shall give Evernorth ninety (90) days prior written notice of the disaffiliation. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, the longer notification period will apply.

B. In the event Evernorth terminates the Agreement for reasons other than for cause, Provider shall continue to provide Covered Services under the terms of the Agreement for ninety (90) days from the date of notice to the Participant, for a Participant who is under Provider's care at the time of such termination and who has a degenerative and disabling condition or disease, or is terminally ill. With respect to a Participant who is under Provider's care at the time of such termination and who has entered the third trimester of pregnancy, additional coverage of services shall continue through at least six (6) weeks of postpartum evaluation. Provider shall be compensated for continued services in accordance with the compensation arrangements under the Agreement for the ninety (90) day period from the date of notice to Participants. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

C. In the event Provider voluntarily chooses to terminate the Agreement, Provider shall continue to provide Covered Services under the terms of the Agreement for a Participant who is under Provider's care at the time of such termination for ninety (90) days from the date of such notice of termination to Evernorth; or for a period that includes delivery and postpartum care, if the Participant has entered the third

trimester of pregnancy at the time of disaffiliation. Provider shall be compensated for continued services in accordance with the compensation arrangements under the Agreement for the ninety (90) day period from the date of the termination notice to Evernorth. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

OREGON REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Oregon regarding provider contracts with providers rendering health care services in the State of Oregon. To the extent that such Oregon laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Oregon laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

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(1) Evernorth, upon request by Provider, shall give Provider an annual accounting accurately summarizing the financial transactions between the parties for that year.

(2) Provider may withdraw from the care of a Participant when, in the professional judgment of Provider, it is in the best interest of the Participant to do so.

(3) Except in the case of misrepresentation, precertification determinations shall be subject to the following requirements:

(1) Precertification determinations relating to benefit coverage and medical necessity shall be binding on Evernorth if obtained no more than thirty (30) days prior to the date the service is provided.

(2) Precertification determinations relating to Participant eligibility shall be binding on Evernorth if obtained no more than five (5) business days prior to the date the service is provided.

(4) Upon request by Provider, the criteria used in the utilization management review process and the method of development of the criteria shall be made available for review.

(5) Evernorth shall employ or retain a physician licensed under O.R.S. Sec. 677.100 to 677.228 who shall be responsible for all final medical and mental health decisions relating to coverage or payment made pursuant to the Agreement.

(6) Provider will be paid for Covered Services rendered to Participants in accordance with O.R.S. Sec. 743B.450 and O.R.S. Sec. 743B.452.

(7) In the event Evernorth fails to pay for health care services covered by the Plan, Provider shall not bill or otherwise attempt to collect from Participants amounts owed by Evernorth, and Participants shall not be liable to Provider for any sums owed by Evernorth.

(8) Evernorth may not terminate or otherwise financially penalize Provider for:

(1) Providing information to or communicating with a Participant in a manner that is not slanderous, defamatory or intentionally inaccurate concerning:

(a) Any aspect of the Participant's medical condition;

(b) Any proposed treatment or treatment alternatives, whether covered by the Participant's Plan or not; or

(c) Provider's general financial arrangement with Evernorth.

(2) (a) Referring a Participant to another provider, whether or not that provider is under contract with Evernorth. If Provider refers Participant to another provider, Provider shall:

(i) Comply with Evernorth's written policies and procedures with respect to any such referrals; and

(ii) Inform the Participant that the referral services may not be covered by Evernorth.

(b) Allocation of costs for referral services shall be a matter of contract between Provider and Evernorth. Allocation of costs to Provider by contract shall not be considered a penalty under this section.

(9) Evernorth and Provider shall provide continuity of care to Participants as provided in O.R.S. Sec. 743B.225.

(10) Except in cases of fraud or abuse of billing, Payor may not request a refund from Provider of a payment previously made to satisfy a claim unless Payor does so in writing, specifying the reasons for the request, within eighteen (18) months after the date the payment was made. If Payor requests a refund for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim, the request for refund must be made in writing, specifying the reasons for the request, within thirty (30) months after the date the payment was made. If

Provider fails to contest the request for a refund in writing to Evernorth or Payor within thirty (30) days of receipt, the request for refund shall be deemed accepted and the refund must be paid.

(11) Except in cases of fraud, Provider may not request additional payment from Payor to satisfy a claim unless Provider does so in writing, specifying the reasons for the request, within eighteen (18) months after the date the claim was denied or the payment intended to satisfy the claim was made. If Provider requests additional payment from Payor to satisfy a claim for reasons related to coordination of benefits with another health insurer or entity responsible for payment of a claim, the request for additional payment must be made in writing, specifying the reasons for the request, within thirty (30) months after the date the claim was denied or payment intended to satisfy the claim was made.

(12) The Agreement may permit network arrangements which grant access to Evernorth's rights as a contracting entity, as defined in applicable state laws and regulations, to Provider's health care services and discounted rates to a third party, as defined in applicable state laws and regulations, provided that the third party accessing Provider's health care services and discounted rates is contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement.

(13) Confidentiality Protocols:

(1) Confidentiality protocols to redirect protected health information for customers residing in Oregon:

(a) Chapter 470, Oregon laws 2015 addresses a customer's right to have protected health information ("PHI") redirected to an alternate location. It requires health insurance companies to implement protocols to accommodate a customer's request to have protected health information sent directly to the person(s) whom the customer has identified as authorized recipients via their express consent, as permitted by law. This restriction prohibits disclosure of PHI to any other person insured under the same policy, including the person who pays for the health insurance plan (the primary account holder), unless the customer expressly consents to disclosure of the PHI.

(2) Request to have PHI redirected to an alternative person and location:

(a) The Oregon Request for Confidential Communication form is available on the Oregon Insurance Division website at www.insurance.oregon.gov. To make this request, the customer must complete, sign, and fax or email the form to Evernorth's Central Health Insurance Portability and Accountability Act (HIPAA) Unit:

Fax: 1.877.815.4827, or 1.859.410.2419
Email: CHUSI@Evernorth.com

To assist Provider's patients with these requests, please refer them to the Oregon Insurance Division > Get help > Health > Patient right to privacy > Oregon Request for Confidential Communication.

(14) OneHealthPort Oregon:

(1) In cooperation with the Oregon Health Leadership Council, Evernorth and OneHealthPort have launched OneHealthPort Oregon. OneHealthPort offers secure access to participating Oregon health plan and other payor administrative websites, including Evernorth for HealthCare Professionals (Provider.Evernorth.com), through a single login process.

(2) Evernorth providers may go to the OneHealthPort website and log in using their OneHealthPort user ID and password. Once Provider selects the Evernorth for Health Care Professionals link, Provider may proceed through security steps to ensure Provider's identity. When finished, access is granted to the Evernorth website. There are a few Evernorth for Health Care Professionals functions that still require direct login to Provider.Evernorth.com. These services include fee schedule inquiries.

(15) Credentialing: Effective June 1, 2020, Evernorth will make a determination approving or denying a credentialing application submitted to Evernorth no later than ninety (90) days after receiving a complete application from a health care provider. All determinations made by Evernorth in approving or denying credentialing applications will average no more than sixty (60) days.

(16) Coordination of Benefits: When applicable, Evernorth coordination of benefits activities are subject to Oregon Administrative Rules 836-020-0770 – 836-020-0801, which provides that:

(1) If an agreement cannot be reached, Evernorth will share equally the allowable expenses between the plans according to 836-020-0785.

(2) If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been the primary plan.

(17) Precertification: In accordance with Oregon state law O.R.S. 836-053-1200 (6), a prior authorization determination shall be binding on the insurer for the lesser of the following periods: (a) five (5) business days, or (b) the period during which the enrollee's coverage remains in effect, provided that when the insurer issues the prior authorization, the insurer

has specific knowledge that the enrollee's coverage will terminate sooner than five (5) business days following the day the authorization is issued and the insurer specifies the termination date in the authorization; and for the period during which the enrollee's coverage remains in effect beyond the time period established pursuant to subsection (a) of this section, up to a maximum of thirty (30) calendar days. For purposes of counting days, day 1 occurs on the first business or calendar day, as applicable, following the day on which Evernorth issues a prior authorization determination. Evernorth will not impose a restriction or condition on its prior authorization determinations that limits, restricts or effectively eliminates the binding force established for such determinations.

PENNSYLVANIA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Pennsylvania regarding provider contracts with providers rendering health care services in the State of Pennsylvania. To the extent that such Pennsylvania laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Pennsylvania laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) Evernorth's administrative guidelines applicable to the Agreement are found in the provider reference manual entitled "Behavioral Medical Management Program."

(2) (A) The following definition of Emergency Services is applicable to the Agreement:

Emergency Services means any health care service provided to a Participant after the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity or severe pain, such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one or more of the following:

(a) placing the health of the Participant, or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
(b) serious impairment to bodily functions; or
(c) serious dysfunction of any bodily organ or part.

Coverage for Emergency Services provided during the period of the emergency shall include evaluation, testing, and if necessary, stabilization of the condition, emergency transportation and related emergency care provided by a licensed ambulance service.

(B) If the patient is admitted to a hospital or other health care facility, the emergency provider shall notify Evernorth of the emergency services delivered within forty-eight (48) hours or on the next business day, whichever is later. An exception to this requirement will be made where the medical condition of the patient precludes the provider from accurately determining the patient's benefit plan.

(3) Evernorth acknowledges and agrees that practitioners or other individuals

conducting utilization management are not compensated for approvals or denials of Covered Services.

(4) The "Charges to Participants" provision survives termination of this Agreement, regardless of the reason for termination, is intended to be for the benefit of Participants, and supersedes any oral or written agreement to the contrary now existing or hereafter entered into between Provider and a Participant or persons acting on the Participant's behalf. Provider hereby agrees that in no event, including, but not limited to non-payment by Payor, Payor's insolvency or breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Participants or persons acting on the Participant's behalf (other than Payor) for Covered Services provided pursuant to this Agreement. This provision shall not prohibit collection of any applicable Copayments, Deductibles or Coinsurance billed in accordance with the terms of a Plan or fees for non-Covered Services.

(5) Termination of the Agreement With Notice: Neither party to the Agreement is permitted to terminate the Agreement with notice upon less than sixty (60) days' prior written notice to the other party. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement with notice, such longer notification period will apply.

(6) Notwithstanding anything to the contrary set forth in the Agreement:

(A) Evernorth shall not penalize or restrict a health care provider from discussing:
   (1) the process that Evernorth, Plan, or any entity contracting with Evernorth or Plan uses or proposes to use to deny payment for a health care service;
   (2) Medically Necessary and appropriate care with or on behalf of a Participant, including information regarding the nature of treatment; risks of treatment; alternative treatments; or the availability of alternate therapies, consultation or tests; or
   (3) Evernorth's or Plan's decision to deny payment for a health care service.

(B) A provision to prohibit or restrict disclosure of Medically Necessary and appropriate health care information contained in a contract with a health care provider is contrary to public policy and shall be void and unenforceable.

(C) Evernorth shall not terminate a contract with a health care provider for any of the following:
   (1) advocating for Medically Necessary and appropriate health care consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care;
   (2) filing a grievance pursuant to the procedures set forth in Pennsylvania law; or
   (3) protesting a decision, policy or practice that the health care provider, consistent with the degree of learning and skill ordinarily possessed by a reputable health care provider practicing according to the applicable legal standard of care, reasonably believes interferes with the health care provider's ability to provide

Medically Necessary and appropriate health care.

(D) Nothing in this provision shall:
(1) prohibit Evernorth or Plan from making a determination not to pay for a particular medical treatment, supply or service, enforcing reasonable peer review or utilization review protocols or making a determination that a health care provider has or has not complied with appropriate protocols;
(2) be construed as requiring Evernorth or Plan to provide, reimburse for or cover counseling, referral, or other health care services if Evernorth or Plan: (i) objects to the provision of that service on moral or religious grounds; and (ii) makes available information on its policies regarding such health care services to Participants and prospective Participants.

(E) Nothing in this provision shall be construed to permit Evernorth to sanction, terminate or fail to renew a health care provider's participation for any of the following reasons:
(1) advocating for Medically Necessary and appropriate health care services for a Participant;
(2) filing a grievance on behalf of and with the written consent of a Participant, or helping a Participant to file a grievance;
(3) protesting an Evernorth decision, policy or practice the health care provider believes interferes with its ability to provide Medically Necessary and appropriate health care;
(4) the health care provider has a practice that includes a substantial number of patients with expensive medical conditions;
(5) the health care provider objects to the provision of or refuses to provide a health care service on moral or religious grounds; or
(6) taking another action specifically permitted by sections 2113, 2121, and 2171 of the act (40 P.S. sections 991.2113, 991.2121 and 991.2171).

(7) Except in the event of Evernorth's termination of the Agreement for cause, including breach of the Agreement, fraud, criminal activity or posing a danger to Participants or the health, safety or welfare of the public as determined by Evernorth, if Evernorth initiates termination of the Agreement with Provider, a Participant may continue an ongoing course of treatment with Provider, at the Participant's option, for a transition period of up to sixty (60) days from the date the Participant was notified by Evernorth of the termination or pending termination. Evernorth in consultation with Participant and Provider, may extend the transitional period if determined to be clinically appropriate. In the case of a Participant in the second or third trimester of pregnancy at the time of notice of the termination or pending termination, the transitional period shall extend through postpartum care related to the delivery. Any health care service provided under this provision shall be covered by Evernorth under the same terms and conditions applicable prior to the termination of the Agreement. Nothing in this provision shall require Evernorth to cover health care services that are not otherwise covered under the terms and conditions of the Plan.

(8) Evernorth has three (3) types of internal resolution processes to resolve the various

disputes which may arise between Evernorth and Pennsylvania providers.

(A) Overview of Dispute Resolution Process:

a. Termination Dispute Resolution Process. Disputes pertaining to the termination of the Agreement (including termination resulting from Provider's failure to provide Evernorth with requested recredentialing information on a timely basis and Evernorth's termination of the Agreement for business reasons) will be resolved through this process.

b. Informal Dispute Resolution Process. If Provider does not have the Participant's consent to appeal a payment denial, or if the Participant is covered by a service agreement which is not subject to Act 68 (for example, the Participant is covered by a self-funded plan) Provider may appeal a denial of payment for a health care service (on the grounds of medical necessity or for administrative reasons) in accordance with this process.

(B) Details of Dispute Resolution Process:

a. Termination Disputes Resolution Process. For all disputes pertaining to the termination of the Agreement (including termination resulting from Provider's failure to provide Evernorth with requested recredentialing information on a timely basis and Evernorth's termination of the Agreement for business reasons), Evernorth has a two (2) level internal appeal process and an arbitration of disputes process:

i. Internal Review of Disputes:

1. First Level Review. In the event that Provider has a dispute with respect to termination of the Agreement, the dispute shall be submitted for review and resolution to the Evernorth designee identified by Evernorth in Evernorth's termination letter, as applicable (the "First Level Review"). Provider must submit a request for a First Level Review of a termination dispute within thirty (30) days of the date of the termination letter. The appeal will be scheduled within thirty (30) days of receipt of request for the appeal. A panel of at least three (3) providers who were not involved in the original decision will decide the appeal of the termination. Provider may bring third parties with them to the appeal and may present information to the panel. The decision shall be communicated to Provider within five (5) days. There is no cost to Provider for requesting a First Level Review.

2. Second Level Review. If Provider is not satisfied with the resolution at the First Level Review, Provider may submit the matter for a second level review to the Evernorth designee identified in the First Level Review decision letter (the "Second Level Review"). Provider must submit a request for a Second Level Review within sixty (60) days of the date of the letter communicating the First Level Review decision. The Second Level Review is sent to the National Medical Director or his designee and is reviewed by a committee of nurses and providers employed by Evernorth, at the next available meeting

of such committee. The decision of the committee shall be communicated to Provider within five (5) days of the decision. There is no cost to Provider for requesting a Second Level Review. The Second Level Review decision will be binding on Evernorth and Provider if the resolution is accepted by Provider.

ii. Arbitration of Disputes. In the event that Provider's termination dispute as described above is not resolved through the aforementioned process, Provider may initiate arbitration by providing written notice to Evernorth. Written acknowledgment of Provider's request for arbitration shall be made within fifteen (15) days after the receipt of the request for arbitration. If Provider initiates arbitration as provided above, the proceeding shall be held in the jurisdiction of the provider's domicile. The parties will jointly appoint a mutually acceptable arbitrator. If the parties are unable to agree upon such an arbitrator within thirty (30) days after a party has given the other party written notice of its desire to submit a dispute for arbitration, then the parties shall prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service ("AHLA ADR Service") along with the appropriate administration fee. In accordance with the Codes of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of ten (10) arbitrators along with a background and experience description, references and fee schedule for each. The ten (10) will be chosen by the AHLA ADR Service on the basis of their experience in the area of the dispute, geographic location and other criteria as indicated on the request form. The parties to the dispute will review the qualifications of the ten (10) suggested arbitrators and rank them in order of preference from 1 to 9. Each party has the right to strike one (1) of the names from the list the person with the lowest total will be appointed to resolve the case. Each party shall assume its own costs, but the compensation and expenses of the arbitrator(s) and any administrative fees or costs shall be borne equally by the parties. Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive, and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s). Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction. The Agreement will remain in full force and effect during any such period of arbitration unless otherwise terminated pursuant to the terms of this Agreement. If Provider fails to request a First Level Review, Second Level Review, or Arbitration of Provider's termination dispute within the applicable timeframes, Evernorth's last determination regarding the dispute shall be binding on Provider.

b. Informal Dispute Resolution ("IDR") Process. If Provider does not have the

Participant's consent to appeal a payment denial, or if the Participant is covered by a service agreement which is not subject to Act 68 (for example, Participant is covered by a service agreement between Evernorth or Evernorth affiliate and a self-funded payor), Provider may appeal a denial of payment for a health care service in accordance with this process. Examples of disputes that may be resolved through this process include:

1. Denied inpatient stays/length of stay or level of care challenges where Provider has NOT indicated that Provider is appealing on behalf of the Participant
2. ClaimCheck challenges
3. Fee/discount discrepancies
4. Untimely claim filing denials
5. Denials based upon Provider's failure to contact Evernorth to secure any required prior authorization
6. Denials based on violation of any "Delayed Treatment Days" provision

The IDR Process includes two internal levels of review and an arbitration of disputes process.

i. First Level IDR Review. If Provider wishes to appeal pursuant to the IDR process, Provider submits the appeal of the payment dispute to the Evernorth designee identified by Evernorth in Evernorth's explanation of payment (the "First Level IDR Review"). Provider must submit a request for a First Level IDR Review within one hundred eighty (180) days of the date of the initial explanation of payment, or if the appeal relates to a claim that was adjusted by Evernorth, within one hundred eighty (180) days from the date of the last payment adjustment. The First Level IDR Review shall be completed within thirty (30) days after receipt of the request for such review. The decision shall be communicated to Provider within fifteen (15) days of completion of the First Level IDR Review. An appeal processor or a nurse reviews administrative appeals (i.e. untimely claim filing, claim check challenges). A nurse initially reviews medical-necessity appeals. If the nurse cannot overturn the appeal, it is reviewed and decided by a provider. There is no cost to Provider for requesting a First Level IDR Review.

ii. Second Level IDR Review. If Provider is not satisfied with the resolution at the First Level IDR Review, Provider may submit the matter for a second level review to the Evernorth designee identified in the First Level Review decision letter (the "Second Level IDR Review"). Provider must submit a request for a Second Level IDR Review within sixty (60) days of the date of the letter communicating the First Level IDR Review decision. The Second Level IDR Review shall be considered within thirty (30) days after the receipt of the request for such review. Administrative appeals (i.e., untimely claim filing, claim check challenges) are reviewed by an appeal processor or a nurse. A nurse initially reviews medical necessity appeals. If the nurse cannot

overturn the appeal, it is reviewed and decided by a provider. The decision shall be communicated to Provider within fifteen (15) days of completion of the Second Level IDR Review. The Second Level IDR Review decision will be binding on Evernorth and Provider if the resolution is accepted by Provider. There is no cost to Provider for requesting a Second Level IDR Review.

iii. External Review/Arbitration of Disputes. In the event that Provider is not satisfied with the Second Level IDR Review decision payment dispute Provider may initiate arbitration by providing written notice to Evernorth. With respect to a provider payment dispute, Provider must submit a request for arbitration within one (1) year of the date of the letter communicating the Second Level IDR Review decision. Written acknowledgment of Provider's request for arbitration shall be made within fifteen (15) days after the receipt of the request for arbitration. If Provider initiates arbitration as provided above, the proceeding shall be shall be held in the jurisdiction of Provider's domicile. The parties will jointly appoint a mutually acceptable arbitrator. If the parties are unable to agree upon such an arbitrator within thirty (30) days after a party has given the other party written notice of its desire to submit a dispute for arbitration, then the parties shall prepare a Request for a Dispute Resolution List and submit it to the American Health Lawyers Association Alternative Dispute Resolution Service ("AHLA ADR Service") along with the appropriate administration fee. In accordance with the Codes of Ethics and Rules of Procedure developed by the AHLA ADR Service, the parties will be sent a list of ten (10) arbitrators along with a background and experience description, references and fee schedule for each. The ten (10) will be chosen by the AHLA ADR Service on the basis of their experience in the area of the dispute, geographic location and other criteria as indicated on the request form.

   The parties to the dispute will review the qualifications of the ten (10) suggested arbitrators and rank them in order of preference from 1 to 9. Each party has the right to strike one (1) of the names from the list. The person with the lowest total will be appointed to resolve the case. Each party shall assume its own costs, but the compensation and expenses of the arbitrator(s) and any administrative fees or costs shall be borne equally by the parties. Arbitration shall be the exclusive remedy for the settlement of disputes arising under this Agreement. The decision of the arbitrator(s) shall be final, conclusive, and binding, and no action at law or in equity may be instituted by either party other than to enforce the award of the arbitrator(s). Judgment upon the award rendered by the arbitrator(s) may be entered in any court of competent jurisdiction. The Agreement will remain in full force and effect during any such period of arbitration unless otherwise terminated pursuant to the terms of this Agreement.

iv. If Provider fails to request a First Level IDR Review, Second Level IDR

Review, or Arbitration of Provider's payment dispute within the applicable timeframes, Evernorth's last determination regarding the dispute shall be binding on Provider. Provider shall not bill the Participant for payments that are denied on the basis that Provider failed to submit the request for review or arbitration within the required timeframes.

(9) For amendments other than those required by changes to state or federal laws or regulations, Evernorth shall provide Group with thirty (30) days advance written notice of the amendment.

(10) Specific Pennsylvania requirements relating to Provider's agreements with each of its providers are found in Section 9.725 of Title 28 of the Pennsylvania Code.

(11) With respect to quality management:
   (A) Evernorth shall evaluate its quality management program annually and include a report to the board of directors, or the quality assurance or quality improvement committee, which addresses the appropriateness of clinical criteria; the consistency of decision making through the conduct of reliability studies of staff application of utilization criteria; staff resources and training; and the timeliness of decisions.

(12) With respect to the credentialing process:
   (A) At a minimum, for primary care physicians ("PCPs") and specialists, the following credentialing elements shall be verified:
      a. Current licensure
      b. Education and training
      c. Board certification status
      d. Drug enforcement administration certification status
      e. Current and adequate malpractice coverage
      f. Malpractice claims history
      g. Work history
      h. Hospital privileges if the provider provides services at hospitals
      i. Any other information the Department of Health may require
   (B) At a minimum, for non-PCPs and non-specialists, current licensure and malpractice coverage shall be verified, to the extent licensure and coverage is required by Pennsylvania or federal law.

RHODE ISLAND REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Rhode Island regarding provider contracts with providers rendering health care services in the State of Rhode Island. To the extent that such Rhode Island laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Rhode Island laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

(1) The definition for Emergency Services, if any, shall comply with Rhode Island laws and regulations to the extent applicable.

(2) Urgent Care shall have the same meaning as the term "Urgent Health Care Services" contained in the rules and regulations promulgated pursuant to Chapter 12.3 of Title 42, as may be amended from time to time, and shall include those resources necessary to treat a symptomatic medical, mental health or substance abuse or other health care condition requiring treatment within a 24 hour period of the onset of such a condition in order that the patient's health status not decline as a consequence. This does not include those conditions considered to require Emergency Services.

(3) The following item is added to the list of for cause reasons for which Evernorth may terminate the Agreement:

Lack of need by Evernorth due to economic considerations.

(4) In the event of termination of the Agreement by either party, the written notice of termination must include the reason(s) for such termination.

(5) <u>(A) Right to a Hearing</u>. If Evernorth proposes to terminate the Agreement, Evernorth will notify Provider of this decision in writing including the reason(s) for the proposed termination and a notice of Provider's right to request a hearing or review. The proposed termination will not be effective until the appeal process has been completed. The above rights regarding notice and hearing may be waived, in writing, by Provider. Evernorth shall not require Provider to waive notice and hearing rights as a condition of the Agreement.

(B) Immediate Harm to Participant's Health or Safety. When Evernorth has reason to suspect there is immediate danger to Participants as a result of conduct by Provider, Evernorth shall notify the Director of Health of the State of Rhode Island Department of Health immediately and shall take appropriate action to protect Participants.

(C) Notice to Participants. In the event the Agreement is terminated by Provider, Provider shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.

(6) In addition to the terms of the Agreement governing Provider responsibilities regarding referrals, Participants shall be held harmless from any liability attributable to the failure of a referring provider to adhere to Evernorth's referral process including by failing to submit any required referral documents to Evernorth when there is evidence that the Participant sought and received a referral from Provider.

(7) In addition to the conditions and requirements of the Agreement governing limitations on billing Participants, in no event shall Provider bill, charge, collect a deposit from, or seek compensation, remuneration or reimbursement from Participant including but not limited to facility or administrative fees added to a Participant for Covered Services rendered by Provider.

(8) In the event of termination of the Agreement, Participant shall be held harmless for Covered Services except for Copayments, Coinsurance, and Deductibles for the duration of an active course of treatment, as defined by applicable laws or regulations, or up to one (1) year, whichever is earlier, subject to the terms and conditions of the Agreement, unless Provider is able to safely transition Participant to a network provider. For a period of active treatment, Participant shall only be responsible for in-network cost share under the Participant's Plan and not otherwise prohibited by applicable laws and regulations.

II

(1) Evernorth shall reimburse Provider for Covered Services rendered by Provider to Participants following the first day after Evernorth's acceptance of Provider's application for participation as a Participating Provider, provided that Provider is a health care provider as defined under applicable state laws and regulations, and returns a signed participating provider Agreement within fifteen (15) business days of receipt from Evernorth.

(2) Evernorth may amend the Agreement with Provider subject to the requirements of this section if Provider is a professional provider as defined under applicable state laws and regulations. These changes shall include, but not be limited to, effects upon utilization review and management activities or payment or coverage policies. Any such proposed

contractual changes must include the following: (a) an explanation of the contractual changes, including the impact of the proposed changes in non-technical terms; and (b) notice must be sent to Provider in writing by mail.

Provider shall have an opportunity to amend or terminate the Agreement as a result of the proposed changes within sixty (60) calendar days of receipt of the notice of the changes. Any decision to terminate the Agreement by Provider shall be effective fifteen (15) calendar days from the mailing of the notice of the termination. Notice of termination by Provider must be made in writing by mail to Evernorth.

In the event that state or federal law or regulation, or an arbitration or judicial interpretation of same, should require that the terms, benefits and conditions of the Agreement must be changed accordingly, then upon notice from Evernorth, Provider shall continue to perform services under the Agreement as modified.

(3) Evernorth shall not require Provider, if Provider is a physician as defined under applicable state laws and regulations, to participate in any financial or reimbursement incentive program, commonly referred to as pay-for-performance programs, unless such program meets the principles and guidelines for pay-for-performance programs endorsed by the national quality forum and adopted by the AQA Alliance or the hospital quality alliance, or similar principles and guidelines for pay-for-performance programs approved by the Office of the Health Insurance Commissioner of the State of Rhode Island.

III

(1) Covered Practitioners in Rhode Island

a. Evernorth shall:

i. provide coverage for the services of a Certified Registered Nurse Practitioner, practicing collaboratively, or in the employ of a physician licensed and psychiatric and mental health nurse clinical specialists, to Participants, if the services are within the Certified Registered Nurse Practitioner's or psychiatric and mental health nurse clinical specialist's area of professional competence and are currently reimbursed when rendered by any other licensed health care provider.

ii. provide Participants with an opportunity to select a Certified Registered Nurse Practitioner, who is a participating provider, as a primary care provider to provide primary care, intermediate, home, long-term and inpatient care, when said Certified Registered Nurse Practitioner is a participating provider and practicing within the scope of his/her professional license.

iii. ensure that all participating primary care provider Certified Registered Nurse Practitioners are included on any publicly accessible list of participating providers for the respective organization.

SOUTH CAROLINA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of South Carolina regarding provider contracts with providers rendering health care services in the State of South Carolina. To the extent that such South Carolina laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such South Carolina laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

1. With respect to claim payments made on or after June 11, 2009:

Evernorth may not initiate overpayment recovery efforts more than eighteen (18) months after the initial claim payment was received by Provider; however, this time limit does not apply to the initiation of overpayment recovery efforts:

(1) based upon a reasonable belief of fraud or other intentional misconduct;

(2) required by a self-insured plan; or

(3) required by a state or federal government program.

2. In addition to the requirements of the Agreement and to the extent required by S.C. Code § 38-71-243, upon termination of the Agreement and upon written attestation by the treating physician, on a form prescribed by the South Carolina Department of Insurance, that a health condition or illness exists that requires medical attention where failure to provide the current course of treatment through Provider would place a Participant's health in serious jeopardy, Provider shall, if requested by a Participant, continue to provide Covered Services for ninety (90) days or until the termination of the benefit period, whichever is greater. Provider shall accept the negotiated rate under the Agreement as payment in full for such services rendered. Except for applicable Deductible, Copayment or Coinsurance, Provider shall not bill or otherwise hold a Participant financially responsible for Covered Services rendered by Provider in the continuation of care, unless Provider has not received payment pursuant to the Agreement and in accordance with applicable law.

SOUTH DAKOTA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of South Dakota regarding provider contracts with providers rendering health care services in the State of South Dakota. To the extent that such South Dakota laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such South Dakota laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

1. The definition for Emergency Services, if any, shall comply with South Dakota laws and regulations to the extent applicable.

2. In addition to the negotiated terms of the Agreement establishing obligations related to services after termination of the Agreement, the following shall apply in accordance with applicable laws and regulations:

   Evernorth shall, upon request from Provider who has chosen to leave the network or is terminated without cause or from a Participant, permit Participant to continue, upon agreement by Provider follow all applicable network requirements, an ongoing course of treatment from Provider for ninety (90) days following the effective date of the termination of the Agreement. Continuation of network coverage through Provider for Participant that has entered a second trimester of pregnancy at the time the Agreement is terminated shall extend to the provision of postpartum care directly related to the delivery.

3. In no event shall Provider collect or attempt to collect from a Participant any money owed to Provider by Evernorth, nor may Provider have any recourse against a Participant for any Covered Services charges in excess of the Copayment, Coinsurance, or Deductible amounts specified in the coverage, including Participants who have a health savings account.

4. Evernorth and Provider shall provide at least sixty (60) days written notice to each

other before terminating the Agreement without cause. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

5. In addition to the negotiated terms of the Agreement establishing requirements for records:

Provider shall make health records available to Evernorth upon request. Such requests shall be limited to 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. Evernorth shall maintain the confidentiality of such records and may not make such records available to any other person who is not legally entitled to such records.

II

This section shall apply only if Provider is an intermediary as defined by applicable South Dakota laws and regulations including but not limited to SDCL § 58-17F-1(13), as may be amended from time to time.

1. Nothing in the Agreement shall be construed to delegate or assign to Provider Evernorth's statutory responsibility to monitor the offering of Covered Services to Participants.

2. In accordance with applicable laws and regulations, Evernorth shall have the right to approve or disapprove the participation status of a subcontracted provider in Evernorth's or Provider's contracted network for the purpose of delivering Covered Services to Evernorth's Participants.

3. In accordance with applicable laws and regulations, Evernorth shall have the right, in the event of Provider's insolvency, to require the assignment to Evernorth of the provisions of
Provider's contract addressing Provider's obligation to furnish Covered Services.

4. In addition to the negotiated terms of the Agreement, Evernorth shall have access to all Provider's subcontracts, and shall have the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from Evernorth.

5. In addition to the negotiated requirements of the Agreement, Provider shall maintain the books, records, financial information and documentation of services provided to Participants and shall preserve them for examination pursuant to applicable law.

6. Provider shall allow the director of the division of insurance access to Provider's books,

records, financial information and any documentation of services provided to Participants, as necessary to determine compliance with applicable laws and regulations.

7. If applicable under the terms of the Agreement, Provider shall transmit utilization documentation and claims paid documentation to Evernorth as set forth in the Agreement. Evernorth shall monitor the timeliness and appropriateness of payments made to Provider and health care services received by Participants.

TENNESSEE REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Tennessee regarding provider contracts with providers rendering health care services in the State of Tennessee. To the extent that such Tennessee laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Tennessee laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

1. The definition for Emergency Services, if any, shall comply with Tennessee laws and regulations to the extent applicable.

2. Based on guidance provided by the State of Tennessee, the duties of Clinics/PHO and its Represented Providers shall comply with Tennessee HMO laws and regulations to the extent applicable. Clinic/PHO represents and warrants that is employs and is authorized to act on behalf of its Represented Providers. Represented Providers shall comply with the terms and conditions of the Agreement to the extent applicable and shall look to the clinic/PHO for compensation for Covered Services.

3. (a) Within thirty (30) calendar days after Payor's receipt of Provider's claim, if submitted in paper form, Payor shall: (i) if the claim is a clean claim as defined below, pay for any fee-for-service amounts owing under the Agreement for such health care services provided; (ii) pay the portion of the claim that is clean and not in dispute and notify Provider in writing of the reason or reasons why the remaining portion of the claim will not be paid; or (iii) notify Provider in writing of all reasons why the claim is not a clean claim and will not be paid and what substantiating documentation and information is required to adjudicate the claim as a clean claim.

   (b) Within twenty-one (21) calendar days after Payor's receipt of an electronic submission of Provider's claim Payor shall: (i) if the claim is a clean claim as defined below, pay for any fee-for-service amounts owing under the Agreement for such health care services provided; (ii) pay the portion of the claim that is clean and not in dispute and notify Provider in writing of the reason or reasons why the remaining

portion of the claim will not be paid; or (iii) notify Provider in writing of all reasons why the claim is not a clean claim and will not be paid and what substantiating documentation and information is required to adjudicate the claim as a clean claim.

(c) If Payor fails to comply with the applicable requirements of subsection (a) or (b) above, Payor shall pay 1% interest per month, accruing from the day after the day payment was due, on that amount of the claim that remains unpaid.

(d) As used herein clean claim means a claim received by Payor which requires no further information, adjustment or alteration by the provider of services in order to be processed and paid by Payor. A claim is clean if it has no defect or impropriety (including any lack of any required substantiating documentation) or particular circumstances requiring special treatment that prevents timely payment from being made on Provider's claim. A clean claim does not include a duplicate claim. A duplicate claim means an original claim and its duplicate when the duplicate is filed within thirty (30) days of the original claim. A clean claim does not include any claim submitted more than ninety (90) days after the date of service. The definition of clean claim includes resubmitted paper form claims with previously identified deficiencies corrected.

(e) Provider shall file a claim for reimbursement for a health care service within one hundred twenty (120) days of the date of service. Evernorth or Payor may deny the claim in full for a claim submitted more than one hundred twenty (120) days after the date of service.

4. Pursuant to the requirements of Tennessee Code Annotated Section 56-7-110:

(a) Payor shall not be required to correct a payment error to Provider, if Provider's request for a payment correction is filed more than eighteen (18) months after the date that Provider received payment for the claim from Payor.

(b) Except in cases of fraud committed by Provider, Payor may only recoup reimbursements to Provider during the eighteen (18) month period after the date that Payor paid the claim submitted by Provider.

(c) If Payor recoups reimbursement to Provider under this section, Payor shall give Provider a written or electronic statement specifying the basis for the recoupment and the statement shall contain, at a minimum, the information required by subsection (f) below.

(d) If Payor determines that payment was made for services not covered under Participant's Plan, Payor shall give written notice to Provider of its intent to recoup a previously paid claim and may:

(1) Request a refund from Provider; or

(2) Make a recovery of the payment from Provider in accordance with subsection (f).

The notice required by this subsection may be included in the results of an audit submitted to Provider.

(e) Notwithstanding subsection (b) above, if Payor or an agent contracted to provide eligibility verification verifies that an individual is a Participant and if Provider provides health care services to the individual in reliance on such verification, Payor may not thereafter recoup a claim on the basis that the individual is not a Participant unless such recoupment occurs within six (6) months of the date that Payor paid the claim; otherwise Payor is barred from making such recoupment unless there was fraud by Provider.

(f) If Payor chooses to recoup from Provider amounts previously paid pursuant to subsections (b) or (d), Payor shall provide Group or Represented Provider written documentation that specifies:

(1) The amount of the recoupment;

(2) The person's name to whom the recoupment applies;

(3) Patient identification number;

(4) Date(s) of service;

(5) The health care service or services on which the recoupment is based; and

(6) The pending claims being recouped or that future claims will be recouped.

(g) Payor shall provide at least thirty (30) days notice prior to initiating recovery of any payments pursuant to this section.

5. If the Agreement is terminated by Provider or Evernorth without cause, then Provider and Evernorth shall allow a Participant who retains eligibility under a Plan and who is:

(a) Under active treatment for a particular injury or sickness, to continue to receive Covered Services from Provider for such injury or sickness for a period of one hundred twenty (120) days from the date of notice of termination,

(b) In the second trimester of pregnancy to continue care with Provider until completion of postpartum care,

(c) Being treated at an inpatient facility to remain at the facility until Participant is

discharged.

The terms, conditions and compensation arrangement of the Agreement shall apply during the period of continued care.

6. Any change to the fee schedule of the Agreement shall be made available to Provider at least ninety (90) days prior to the effective date of the amendment. However, this requirement shall not apply to changes in standard codes and guidelines developed by the American Medical Association or a similar organization.

7. If required by the Agreement, where precertification is not required for a hospital admission, Provider must notify Evernorth or its designee within twenty-four (24) hours after the admission; if such notification or admission occurs on a weekend or federal holiday, Provider will notify Evernorth or its designee within one (1) business day of the conclusion of the weekend or federal holiday.

8. The Agreement may permit network rental arrangements which allow the selling, renting, or otherwise grant access to Evernorth's rights to Provider's services to a third party provided that the third party accessing Provider's services is contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement, and the third party is any of the following:

   (a) A payer, a third-party administrator, or another entity that administers or processes claims on behalf of the payer;

   (b) A preferred provider organization or preferred provider network, including a physician organization or physician hospital organization; or

   (c) An entity engaged in the electronic claims transport between the Evernorth and the payer that does not provide access to the provider's services and a discount to any other covered entity.

9. Unless otherwise set forth in the Agreement as permitted by TCA § 56-32-104(a)(3)(E)(iii), for agreements for the provision of healthcare services subject to TCA § 56-32-104(a)(e)(E), Provider shall look solely to Evernorth for payment for Covered Services except for Copayments, Coinsurance and Deductibles.

10. If Provider is a hospital, then the following provisions shall apply:

    (a) With respect to the process for the appointment of an arbitrator from the list of suggested arbitrators chosen by the American Arbitration Association (section 6.4 of the Agreement):

    If Provider wants to use three (3) arbitrators instead of one (1) and Provider agrees to bear the costs for such additional arbitrators, then the two (2) arbitrators with the next two (2) lowest total scores will also be appointed to help resolve the case. Each party

shall assume its own costs, but the compensation and the expenses of one (1) arbitrator and any administrative fees or costs shall be borne equally by the parties.

(b) Evernorth will provide Provider with at least sixty (60) days advance notice of material changes made to the Medical Management Program.

(c) Provider may terminate the Agreement if Evernorth has materially changed the Medical Management Program and such change is unacceptable to Provider provided that Provider gives Evernorth notice of rejection of such change within sixty (60) days of receipt by Provider of Evernorth's notice concerning the change and Evernorth does not withdraw the change to the Medical Management Program or the parties do not reach an agreement with respect to a mutually acceptable change to the Medical Management Program within the timeframe set forth in the Agreement.

TEXAS REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Texas regarding provider contracts with providers rendering health care services in the State of Texas. To the extent that such Texas laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Texas laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for Emergency Services, if any, shall comply with Texas laws and regulations to the extent applicable.

(2) To the extent required by applicable Texas statutes and rules pertaining to the prompt payment of Clean Claims, the following provisions shall apply:

(A) Effect of Filing a Clean Claim.

(1) The Statutory Claims Payment Period begins to run upon receipt by Evernorth of a Clean Claim from Provider as determined under Texas law. The date of claim payment is as determined under Texas law.

(2) After the receipt of a Clean Claim from Provider at the address designated by Evernorth and prior to the expiration of the applicable Statutory Claims Payment Period (subject to any extensions of time permitted under Texas law):

(a) Payor shall pay the total amount of the Clean Claim in accordance with the terms of the Agreement;

(b) The Clean Claim shall be denied in its entirety after a determination that Payor is not liable for the Clean Claim and
Provider shall be notified in writing why the Clean Claim will not be paid;

(c) Provider shall be notified in writing that the entire Clean Claim will be audited and Payor shall pay 100% of the Contracted Rate on the claim to Provider; or

(d) Payor shall pay the portion of the Clean Claim for which liability is

acknowledged in accordance with the terms of the Agreement, and;

(i) the remainder of the Clean Claim shall be denied after a determination that Payor is not liable for the remainder of the Clean Claim and Provider shall be notified in writing why the remainder of the Clean Claim will not be paid; or

(ii) Provider shall be notified in writing that the remainder of the Clean Claim will be audited and Payor shall pay 100% of the Contracted Rate on the unpaid portion of the Clean Claim to Provider.

(3) Requests for Additional Information From Treating Provider. If necessary to determine whether a claim is payable, Evernorth may, within thirty (30) days of receipt of a Clean Claim, request additional information from the treating provider. The time period to request additional information may be extended as allowed under Texas law. In the event that Evernorth requests information under this section, Evernorth shall determine whether the Clean Claim is payable and Payor shall pay or Evernorth will deny the Clean Claim or audit the Clean Claim on or before the later of:

(a) the 15th day after the date Evernorth receives the requested information from the treating provider along with a copy of Evernorth's written request for information or with the name of the patient, patient identification number, the claim number as provided by Evernorth, the date of service and the name of the treating provider (If Evernorth submitted the request for additional information electronically in accordance with federal requirements concerning electronic transactions, the treating provider must submit the response in accordance with those requirements);

(b) the 15th day after the date Evernorth receives a written response from the treating provider that the treating provider does not possess the requested information; or

(c) the latest date for determining whether the claim is payable under subsections (1) and (2) above.

(4) Requests for Additional Information From Other Sources. If Evernorth requests additional information from a person other than Provider, Evernorth will provide Provider with a notice containing the name of the physician, provider or other entity from whom Evernorth is requesting information. Payor may not withhold payment beyond the applicable Statutory Claims Payment Period pending receipt of information under this section. If on receiving information requested under this section Evernorth determines that there was an error in payment of the claim, the overpayment may be recovered pursuant to section F. below.

(5) To the extent applicable, Evernorth will not refuse to process or pay an electronically submitted Clean Claim because the claim is submitted with or in a batch submission with a Clean Claim that is deficient. A "batch submission" is a group of electronic claims submitted for processing at the same time within HIPAA standard ASC X12N 837 Transaction Set and identified by a batch control number.

(B) Effect of Filing a Deficient Claim.

If a submitted claim is determined by Evernorth to be deficient, Provider shall be notified that the claim is deficient within forty-five (45) calendar days of Evernorth's receipt of the claim at the address designated by Evernorth or within thirty (30) days of receipt by Evernorth of an electronic claim. If the deficient claim is a claim for a prescription benefit, Evernorth will notify Provider that the claim is deficient within twenty-one (21) calendar days of receipt of the nonelectronic claim by Evernorth, or within eighteen (18) days of receipt of an electronic claim. The failure to notify Provider that a claim is deficient within the timelines specified in this section shall not render a deficient claim a Clean Claim.

(C) Audit Procedures.

If Payor is unable to pay or deny a Clean Claim, in whole or in part, within the applicable Statutory Claims Payment period and intends to audit the Clean Claim to determine whether it is payable, Evernorth will notify Provider that the claim is being audited and Payor shall pay 100% of the Contracted Rate within the applicable Statutory Claims Payment Period. Payment of 100% of the Contracted Rate is not an admission that liability is acknowledged on that claim. Evernorth will complete the audit within one hundred eighty (180) calendar days from receipt of the Clean Claim. Upon completion of any audit of a Clean Claim, Evernorth will notify Provider of the results of the audit and:

(1) If Evernorth determines that additional payment is due to Provider, such additional payment shall be paid by Payor within thirty (30) calendar days after the completion of the audit;

(2) If Evernorth determines that a refund is due from Provider, such refund shall be made by Provider within thirty (30) calendar days of the later of notification to Provider of the results of the audit or exhaustion of any Participant appeal rights, if a Participant appeal is filed before the thirty (30) calendar day refund period has expired, and may be made by any method, including chargeback against Provider.

(D) Failure to Meet Statutory Claims Payment Period.

(1) If Evernorth determines that a Clean Claim is payable and Payor fails to pay any amount due and owing on the Clean Claim within the statutory time frames, Payor shall pay to Provider, in addition to the Contracted Rate owed, a penalty as follows:

(a) if the claim is paid on or before the 45th day after the end of the applicable Statutory Claims Payment Period, the lesser of:

(i) 50% of the difference between the Billed Charge and the Contracted Rate: or

(ii) $100,000.

(b) if the claim is paid on or after the 46th day and before the 91st day after the end of the applicable Statutory Claims Payment Period, the lesser of:

(i) 100% of the difference between the Billed Charge and the Contracted Rate: or

(ii) $200,000.

(c) if the claim is paid on or after the 91st day after the end of the applicable Statutory Claims Payment Period, a penalty computed under subsection (1)(b) above plus 18% annual interest on the penalty amount. Interest under this subsection accrues beginning on the date the claim was required to be paid and ending on the date the claim and the penalty are paid in full.

(d) Notwithstanding any other provision of section (2), this subsection governs the payment of a penalty under section (2)(D).

(i) For a penalty relating to a clean claim submitted by a physician or other provider other than an institutional provider, Evernorth shall pay the entire penalty to the physician or provider, except any interest computed under subsection (2)(D)(1)(c) above which Evernorth shall pay to the Texas Department of Insurance or as otherwise required by applicable laws or regulations.

(ii) For a penalty relating to a clean claim submitted by an institutional provider, Evernorth shall pay 50 percent of the total penalty amount computed under section (2)(D) above, including interest, to the institutional provider and the remaining 50 percent of that amount to the Texas Department of Insurance or as otherwise required by applicable laws or regulations. Institutional Provider means a hospital or other medical or health-related service facility that provides car for the sick or injured or other care that may be covered in an evidence of coverage.

(2) If Evernorth determines that a Clean Claim is payable and Payor pays only a portion of the amount of the Clean Claim on or before the applicable Statutory Claims Payment Period and pays the balance of the Contracted Rate owed for the Clean Claim after that date, Payor shall pay to Provider, in addition to the Contracted Rate owed, a penalty as follows:

(a) if the balance of the Clean Claim is paid on or before the 45th day after the applicable Statutory Claims Payment Period, the lesser of:

(i) 50% of the underpaid amount; or
(ii) $100,000.

(b) if the balance of the Clean Claim is paid on or after the 46th day and before the 91st day after the end of the applicable Statutory Claims Payment Period, the lesser of:

(i) 100% of the underpaid amount; or

(ii) $200,000.

(c) if the balance of the Clean Claim is paid on or after the 91st date after the end of the applicable Statutory Claims Payment Period, a penalty computed under subsection (2)(b) above plus 18% annual interest on the penalty amount. Interest under this subsection accrues beginning on the date the claim was required to be paid and ending on the date the claim and the penalty are paid in full.

(d) For purposes of this subsection 2, the underpaid amount is calculated on the ratio of the amount underpaid on the Contracted Rate as applied to an amount equal to the Billed Charge submitted minus the Contracted Rate.

(3) No penalty shall be owed:

(a) if the failure to pay the claim in accordance with the applicable Statutory Claims Payment Period is a result of a catastrophic event that Evernorth certified in accordance with Texas law; or

(b) if the claim was paid in accordance with statutory time frames but for less than the Contracted Rate, and

(i) Provider notifies Evernorth of the underpayment after the 270th day after the date the underpayment was received; and

(ii) Payor pays the balance of the claim on or before the 30th day after the

date Evernorth received notice of the underpayment.

(4) Subsection 3 above does not relieve Payor of any obligation to pay the remaining unpaid Contracted Rate owed.

(E) Claims Filing Deadline.

Provider must submit a claim to Evernorth not later than the 95th day after the date of discharge with regard to the medical care or health care services for which the claim is made. For a claim for which coordination of benefits applies, the 95 day period does not begin for submission of the claim to the secondary payor until Provider receives notice of the payment or denial from the primary payor. If Provider fails to submit a claim in compliance with this section, Provider forfeits the right to payment unless Provider has certified in accordance with Texas law that the failure to timely submit is a result of a catastrophic event. The date of receipt of a claim and whether the method of submission of a claim is appropriate shall be determined in accordance with Texas law. Provider may not submit a duplicate claim prior to the date that the applicable Statutory Claims Payment Period has passed. If Evernorth receives a duplicate claim prior to such date, such claim shall not be subject to the requirements set forth above relating to the effect of filing a Clean Claim and failure to meet the Statutory Claims Payment Period.

(F) Overpayment of Claims.

(1) A refund due to overpayment or completion of audit may be recovered if:

(a) Evernorth notifies Provider of the overpayment not later than the 180th day after the date of receipt of the overpayment; or

(b) Evernorth notifies Provider of the completion of an audit in accordance with section (C) above.

(2) Notification under this provision shall:

(a) be in written form and include the specific claims and amounts for which a refund is due and for each claim the basis and specific reasons for the request for refund;

(b) include notice of the Provider's right to appeal; and

(c) describe the methods by which Evernorth intends to recover the refund.

(3) Provider may appeal a request for refund by providing written notice of disagreement with the refund request not later than forty-five (45) days after receipt of notice under subsection (2) above. Upon receipt of a written notice under this

subsection, Evernorth shall begin Evernorth's internal appeal process as provided in the Medical Management Program to the Agreement.

(4) A refund may not be recovered under this section until:

(a) for overpayments, the later of the 45th day after notification under subsection (1) (a) of this section or the exhaustion of any Provider appeal rights under subsection (3) of this section where Provider has not made arrangements for payment with Evernorth; or

(b) for audits, the later of the 30th day after notification under subsection (1) (b) of this section or the exhaustion of any Provider appeal rights under subsection (3) of this section where the Provider has not made arrangements for payment with Evernorth.

(5) If Payor is a secondary payor and pays a portion of a claim that should have been paid by the primary payor and that was paid to Provider by the primary payor, Payor may recover the amount of overpayment from Provider pursuant to this section (F).

(6) This section (F) does not affect Payor's ability to recover any overpayment in the case of fraud or a material misrepresentation by Provider.

(G) Terms.

The terms Clean Claim, Statutory Claims Payment Period, Billed Charge and Contracted Rate shall have the same meaning as defined under applicable Texas law.

(3) Evernorth's claims submission processes are set forth in Evernorth's Medical Management Program, as amended from time to time.

(4) Upon request and to the extent required by Texas law, Evernorth will provide Provider with the information necessary to determine that Provider is being compensated in accordance with the Agreement.

(5) If Provider is compensated on a discounted fee basis, the Participant's financial obligation for Deductibles or Coinsurance shall be determined based upon the discounted fee and not upon the full billed charge.

(6) If Provider is not a hospital or ancillary provider, the following shall apply:

(A) If Represented Provider is a primary care physician and is reimbursed on a capitated basis, Payor shall begin payment of capitated amounts calculated from the date of a Participant's enrollment no later than the 60th day following the date the Participant has selected or has been assigned to the primary care physician. If selection or

assignment does not occur at the time of enrollment, capitation which would otherwise have been paid to a selected primary care physician had a selection been made shall be reserved as a capitation payable until such time as Participant makes a selection or Evernorth assigns a primary care physician.

(B) If a Participant does not select a primary care physician at the time of application or enrollment, Evernorth may assign the Participant to a primary care physician. If Evernorth elects to assign a Participant to a primary care physician, the assignment shall be made to a primary care physician located within the zip code nearest the Participant's residence or place of employment and, to the extent practicable given the zip code limitation, shall be done in a manner that results in a fair and equal distribution of Participants among Evernorth's primary care groups in the applicable Evernorth network. Evernorth shall inform a Participant of the name, address and telephone number of the primary care physician to whom the Participant has been assigned and of the Participant's right to select a different primary care physician. A Participant shall have the right at any time to reject the primary care physician assigned and to select another physician from the list of primary care groups for the applicable Evernorth network. An election by a Participant to reject an assigned physician shall not be counted as a change in providers under the Texas Insurance Code. Evernorth shall notify Provider or the primary care physician of the selection of such primary care physician by a Participant within thirty (30) working days of the selection or assignment of the Participant to a primary care physician by Evernorth.

(7) Provider acknowledges and agrees that the Agreement does not contain any financial incentive or make any payment that acts directly or indirectly as an inducement to limit Medically Necessary services. This provision shall not prohibit the savings from cost effective utilization of health services by contracting physicians or health care providers from being shared with physicians or health care providers in the aggregate.

(8) Provider shall post a notice to Participants at the Provider's location on the process for resolving complaints with Evernorth. The notice must include the Texas Department of Insurance's toll-free telephone number for filing complaints.

(9) Evernorth shall not engage in any retaliatory action, including termination of or refusal to renew the Agreement, because Provider, on behalf of a Participant, reasonably filed a complaint against Evernorth or has appealed a decision of Evernorth.

(10) (A) Evernorth will not as a condition of the Agreement or in any other manner prohibit, attempt to prohibit or discourage Provider from discussing with or communicating in good faith to a Participant who is a current, prospective or former patient or a party designated by such Participant, with respect to: a) information or opinions regarding the Participant's health care including the Participant's medical condition or treatment options; b) information or opinions regarding the provisions, terms, requirements or services of the Participant's health

benefit plan as they relate to the medical needs of the Participant; c) the fact that a Provider's contract with Evernorth has terminated or that a Provider will otherwise no longer be providing care for Evernorth Participants; or d) the fact that, if Medically Necessary Covered Services are not available through Participating Providers, Evernorth must, upon the request of the Provider, and within time appropriate to the circumstances relating to the delivery of the services and the condition of the Participant, but in no event to exceed five (5) business days after receipt of reasonably requested documentation, allow referral to a non-Participating Provider.

(B) Evernorth will not in any way penalize or terminate Provider or refuse to compensate Provider for Covered Services for communicating with a Participant who is a current, prospective or former patient, or a party designated by Participant, in any manner protected by this provision.

(11) (A) If Evernorth terminates the Agreement, Evernorth shall give Provider not less than ninety (90) days' prior written notice of the termination, except in the case of imminent harm to patient health, action against license to practice, or fraud, in which case termination may be immediate. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Evernorth, such longer notification period will apply.

(B) Notice and Hearing. If Evernorth should choose to terminate the Agreement, Evernorth will notify Provider of this decision in writing. The notice will include the reason(s) for the termination and a notice of Provider's right to request a hearing or review. On request and before the effective date of the termination, but within a period not to exceed sixty (60) days, Provider shall be entitled to a review of the proposed termination by an advisory review panel.

When Evernorth chooses to terminate Provider's participation with respect to its commercial HMO plans, the advisory review panel shall be composed of physicians and providers appointed by Evernorth, including at least one (1) representative in the affected Provider's specialty or a similar specialty, if available, who serve on a standing quality management committee or utilization management committee.

The decision of the advisory review panel must be considered but is not binding on Evernorth. On request, a copy of the recommendation of the advisory review panel and Evernorth's determination shall be given to Provider. If Provider is unsatisfied with the determination, Provider may appeal the decision further pursuant to the Dispute Resolution procedures specified in the Agreement and Medical Management Program.

(C) The requirements regarding notice and hearing set forth in subsection (B) above do not apply in the case of imminent harm to patient health, action against license to practice, or fraud.

(D) (1) In the event the Agreement is terminated by Provider, Evernorth, in accordance with Insurance Code § 843.309, shall give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.

(2) Evernorth will provide assistance to Provider in the event the Agreement is voluntarily terminated by Provider, and Provider, in accordance with Insurance Code § 1301.160, must give reasonable advance notice of such termination to those Participants whom Provider is currently treating and who are affected by the termination.

(3) In the event the Agreement is terminated by Evernorth, Evernorth will notify those Participants whom Provider is currently treating and are affected by the termination. Evernorth may notify such Participants of Provider's termination immediately if the Agreement is terminated for reasons related to imminent harm.

(E) (1) If the Agreement is terminated for reasons other than medical competence or professional conduct, Provider shall continue to provide Covered Services for those Participants who retain eligibility under a Plan and whom 1) Provider has identified to Evernorth as having special circumstances (i.e. persons with a disability, acute condition, life-threatening illness, past the 24th week of pregnancy or a condition such that Provider reasonably believes that discontinuing care could cause harm to the Participant); and 2) Provider has requested to continue treatment. Provider shall be compensated for Covered Services provided pursuant to this provision in accordance with the compensation arrangements under the Agreement for a period of nine (9) months for those Participants diagnosed with a terminal illness at the time of termination of the Agreement, through delivery, immediate post- partum care and the follow-up checkup within the first six (6) weeks of delivery for Participants past the 24th week of pregnancy at the time of termination, and for a period of ninety (90) days following termination for all others.

(2) Provider shall not seek payment from the Participant with respect to services rendered pursuant to this provision of amounts for which the Participant would not be responsible if Provider were still a Participating Provider.

(12) Nothing in the Agreement shall be construed to require Provider to indemnify Evernorth for any tort liability resulting from acts or omissions of Evernorth.

(13) Provider shall hold Participants harmless for payment of the cost of Covered Services in the event Payor fails to pay Provider for such Covered Services.

(14) Nothing in the Agreement shall be construed to require a referring Provider to bear the expenses of a referral for specialty care in or out of Evernorth's provider panel.

Savings from cost-effective utilization of health services may, however, be shared with physician and health care providers in the aggregate.

(15) To the extent that Evernorth conducts, uses or relies upon economic profiling to terminate the Agreement, Evernorth shall make available to Provider on request the economic profile of Provider, including the written criteria by which Provider's performance was measured. An economic profile will be adjusted to recognize the characteristics of Provider's practice that may account for variations from expected costs.

(16) Quality assessment (as that term is defined under Texas law) shall be conducted through a panel of not less than three (3) physicians selected by Evernorth from among a list of participating physicians which list is to be provided by participating physicians in the applicable service area.

(17) Provider may be required pursuant to procedures contained in the Medical Management Program, when referring a Participant to another provider, to disclose to Participant that the physician, provider or facility to whom Participant is referred might not be a Participating Provider; and, if applicable, that the referring Provider has an ownership interest in the facility to which Participant is referred. Such disclosure shall not be required when referring for emergency care, and as necessary to avoid interruption or delay of Medically Necessary care. Nothing in this section or in the Medical Management Program shall be construed to limit access to non- Participating Providers.

(18) Provider shall, except for instances of emergency care as defined under state law, when referring a Participant to a facility for surgery: notify Participant that out-of-network providers may provide treatment and that Participant can contact Evernorth for more information; notify Evernorth that surgery has been recommended; and, notify Evernorth of the facility that has been recommended for the surgery.

(19) Provider shall, except for instances of emergency care as defined under state law, when scheduling a Participant for surgery: notify Participant that out-of- network providers may provide treatment and that Participant can contact Evernorth for more information; and, notify Evernorth that surgery has been scheduled.

(20) Provider shall comply with all applicable requirements of Insurance Code § 1661.005. Provider must refund the amount of an overpayment to a Participant no later than the 30th day after the date Provider determines that an overpayment has been made.

(21) If Provider is a hospital, Provider shall, in accordance with the notice requirements of the Agreement, give notice as soon as reasonably practicable but not later than the 5th business day following the termination of a contract between Provider and a hospital based physician group that is an Evernorth Participating Provider.

(22) To the extent applicable, Provider may request, pursuant to procedures contained in the Medical Management Program, a waiver of any requirement for the use of information technology established or required by Chapter 1661 of the Texas Insurance Code as may be changed from time to time. A waiver granted under this section will expire September 1, 2013, or as otherwise permitted by applicable laws and regulations. If Provider has fewer than five full-time- equivalent employees, Provider is not required, pursuant to Texas Insurance Code § 1661.0055, to use information technology as required by Chapter 1661 of the Texas Insurance Code.

(23) To the extent applicable, Provider may request, pursuant to procedures contained in the Medical Management Program, a waiver of any requirement for electronic submission established or required by Chapter 1213 of the Texas Insurance Code as may be changed from time to time.

(24) To the extent applicable, nothing in this Agreement shall be construed to permit Evernorth or Payor to directly or indirectly charge or hold Provider responsible for a fee for the adjudication of a claim.

(25) The Agreement permits Evernorth to contract with another party to provide access to Evernorth's rights and responsibilities under this Agreement. Upon request, Evernorth will provide information necessary to determine whether a particular party has been authorized to access Provider's health care services and contractual discounts under this Agreement. Any party authorized to access the health care services and contractual discounts under this Agreement must comply with all applicable terms, limitations, and conditions of the Agreement.

(26) The fee schedule for each type of Plan is included in the exhibits to this Agreement. Notwithstanding the foregoing, Evernorth may at its option provide the fee schedule for any Plan to Provider electronically.

(27) Upon the request of Provider, Evernorth will provide Provider with such information as is necessary to allow Provider to determine that a Payor is authorized to access the reimbursement rates under this Agreement.

(28) Evernorth shall cause each Payor that accesses Provider's discounts under this Agreement to comply with all applicable terms, limitations and conditions of this Agreement.

U.S. VIRGIN ISLANDS REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the U.S. Virgin Islands regarding provider contracts with providers rendering health care services in the U.S. Virgin Islands. To the extent that such laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

Participant Billing and Liability Collection Guidelines:

a. Copayments: Copayment Plans require Participants to pay a fixed dollar amount (Copayment) per service. Copayment amounts are indicated on the patient's Evernorth ID card. Provider shall collect applicable Copayment amounts indicated on the ID card at the time of service. Deductibles may apply to these types of Plans.
b. Coinsurance & Deductibles:
    i. For Participants with Plans that have Deductibles or require Participants to pay a percentage of the covered charges (Coinsurance) after satisfying any Deductible amount, Provider shall submit claims to Evernorth or its designee and receive an explanation of payment (EOP) indicating the Participants' responsibility before billing patients. Coinsurance and Deductibles may also be collected at the time of service. Accessing the Evernorth Cost of Care Estimator described below will give Provider an estimate of the Deductible and Coinsurance obligations of the Participant and Provider may print a copy of the estimate to give to the Participant at the time of service.
    ii. The Evernorth Cost of Care Estimator tool, available on the Evernorth for Health Care Professionals website (Provider.Evernorth.com) helps eliminate financial surprises by estimating the cost of the medical service, highlighting the Participant's anticipated payment responsibility, and providing Provider and Provider's patients with an itemized, printable Explanation of Estimate. It is fast to use, easy for Provider's patients to understand, and can be used anytime during Provider's patient's visit: prior to care, at check in, or at checkout.
    iii. By entering the CPT code(s) or identifying information about the procedure along with the Plan Participant's Evernorth identification number and date of birth, Provider will receive a personalized Explanation

of Estimate that contains the following information:

1. Total cost of the service
2. Plan Participant's Deductible/Coinsurance/Copayment responsibility
3. Plan Participant's anticipated payment from their health account (HSA, HRA, FSA) when automatic claim forwarding is enabled
4. Plan Participant's estimated amount owed out of pocket

iv. The Estimator is available to participating providers in the Evernorth network. To use it, Provider may log in to Provider.Evernorth.com > Patients > Search Patients > Select a Patient > Estimate Costs.

v. The estimate Provider receives represents Provider's patient's anticipated out-of-pocket expense if the services billed are covered under their medical Plan. It does not guarantee coverage or payment, but allows Provider to have a financial discussion with Provider's patient and set realistic financial obligations for them.

vi. Provider cannot bill Participants for Covered Services or for services for which payment was denied due to Provider's failure to comply with the Agreement or Medical Management Program, including Evernorth utilization management requirements and timely filing requirements.

UTAH REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Utah regarding provider contracts with providers rendering health care services in the State of Utah. To the extent that such Utah laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Utah laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for Emergency Services, if any, shall comply with Utah laws and regulations to the extent applicable.

(2) In accordance with Utah state regulation, UCA 31A-26-301.6:

- Except in cases of fraud, Evernorth and Provider shall request payment adjustments for incorrectly processed claims (overpayments or underpayments) within the following timeframes: (1) within twenty-four (24) months of the amount improperly paid for a coordination of benefits error; or (2) within twelve (12) months of the amount improperly paid for any other reason; or (3) within thirty-six (36) months of the amount improperly paid when the improper payment was due to a recovery by Medicaid, Medicare, the Children's Health Insurance Program, or any other state or federal health care program.
- Provider should submit requests for review of incorrectly processed claims as per the Dispute Resolution guidelines outlined in the Agreement.

(3) (a) Upon Evernorth's insolvency, the rehabilitator or liquidator may require Provider to continue to provide Covered Services under the Agreement between Provider and Evernorth until the earlier of: (1) ninety (90) days after the date of the filing of a petition for rehabilitation or the petition for liquidation; or (2) the date the term of the Agreement ends.

(b) The rehabilitator or liquidator may reduce the fees Provider is otherwise entitled to receive under the Agreement during the time period described above. Provider shall accept the reduced payment as payment in full and relinquish the right to collect additional amounts from the Participant. However, the rehabilitator or liquidator may not reduce a fee to less than seventy-five percent (75%) of the regular fee set forth in

the Agreement and the Participant shall continue to pay the same Copayments, Deductibles, and other payments for services received from Provider that the Participant was required to pay before the filing of the petition for reorganization or petition for liquidation.

(4) Nothing in the Agreement shall be construed to require Provider to notify Evernorth of a hospital inpatient emergency admission within a period of time that is less than one (1) business day of the hospital inpatient admission, if compliance with the notification requirement would result in notification by Provider on a weekend or a federal holiday.

VERMONT REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of Vermont regarding provider contracts with providers rendering health care services in the State of Vermont. To the extent that such Vermont laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all provider governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Vermont laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for Emergency Services, if any, shall comply with Vermont laws and regulations to the extent applicable.

(1.1) "Material Change" or "Material Adverse Change" shall mean a change that could reasonably be expected to have a material adverse impact on the aggregate level of payment by Evernorth or Payor to Provider for Covered Services under this Agreement, or on Provider's administration of their services.

(1.2) "Timely Notice" shall mean the timeframe or timeframes established by the parties for prior written notice of an amendment to the Agreement as set forth in the Amendment section, or any other provisions of the Agreement governing changes or amendments to the Agreement.

(2) Evernorth shall not prohibit Provider from, or penalize Provider for discussing treatment options with Participants regardless of Evernorth's position on the treatment options, or advocating on behalf of Participants within the utilization review or grievance process established by Evernorth, nor shall it penalize Provider because Provider in good faith reports to state or federal authorities any act or practice by Evernorth that jeopardizes Participant health or welfare.

(3) Provider will comply with the Medical Management Program including but not limited to the rules, policies and procedures established by Evernorth and required by state laws and regulations, including but not limited to the Consumer Protection and Quality Requirements for Managed Care Plans, as may be amended from time to time. Provider will comply with the Medical Management Program governing grievance procedures and the credentialing process. Provider may give feedback to Evernorth, on an ongoing basis, for Evernorth's use in assessing and enhancing Evernorth's quality management

program, utilization management program, Participant appeal procedures, and dispute resolution process. In addition, Provider will be invited to give input annually in the form of a written survey.

(4) A. Payor shall not retrospectively deny a previously paid claim or any part of a previously paid claim, unless:

(a) Payor has provided at least thirty (30) days' notice of any retrospective denial or overpayment recovery or both in writing to Provider. The notice must include:
  (i) the patient's name;
  (ii) the service date;
  (iii) the payment amount;
  (iv) the proposed adjustment; and
  (v) a reasonably specific explanation of the proposed adjustment.

(b) the time that has elapsed since the date of payment of the previously paid claim does not exceed twelve (12) months.

B. The retrospective denial of a previously paid claim shall be permitted beyond twelve (12) months from the date of payment for any of the following reasons:

(a) Evernorth has a reasonable belief that fraud or other intentional misconduct has occurred;
(b) the claim payment was incorrect because Provider was already paid for the health services identified in the claim;
(c) the health care services identified in the claim were not delivered by Provider;
(d) the claim payment is the subject of adjustment with another health plan; or
(e) the claim is the subject of legal action.

C. For routine recoveries as described below, retrospective denials or overpayment recovery of any or all a previously paid claim shall not require thirty (30) days' notice before recovery may be made. A recovery shall be considered routine only if one of the following situations applies:

(a) duplicate payment to Provider for the same service;
(b) payment with respect to an individual who was not a Plan Participant as of the date the service was provided;
(c) payment for a noncovered, not to include services denied as not Medically Necessary, experimental, or investigational in nature, or services denied through a utilization review mechanism;
(d) erroneous payment for services due to a plan administrator error;
(e) erroneous payment for services where the claim was processed in a manner inconsistent with the data submitted by Provider;
(f) payment where Provider provides Evernorth with new or additional information demonstrating an overpayment;
(g) payment to Provider at an incorrect rate or using an incorrect fee schedule;
(h) payment of claims for the same Plan Participant that are received by Evernorth out of the chronological order in which services were performed;
(i) payment where Provider has received payment for the same services from another payer whose obligation is primary; or
(j) payments made in coordination with a payment by a government payer that require

adjustment based on an adjustment in the government-paid portion of the claim.

D. Recoveries which, in Evernorth's reasonable judgment, would be likely to affect a significant volume of claims or accumulate to a significant dollar amount shall not be deemed routine, regardless of whether one or more situations above apply.

(5) Pursuant to Vermont laws, Evernorth shall, to the extent applicable, be bound by and comply with the Consumer Protection and Quality Requirements for Managed Care Plans, as may be amended from time to time.

(6) A. In the event of Evernorth's insolvency or other cessation of operations, Covered Services to Participants shall continue through the contract period for which premiums have been paid on behalf of the Participant or until the Participant's discharge from an inpatient facility, whichever period is greater. Covered Services to Participants confined in an inpatient facility on the date of insolvency or other cessation of operations will continue until the Participant's continued confinement in the facility is no longer Medically Necessary. This provision shall be construed in favor of the Participant, shall survive the termination of the Agreement regardless of the reason for termination, including the insolvency of Evernorth, and shall supersede any oral or written contrary agreement between Provider and Participant or Participant's representative.

B. Upon termination of the Agreement without cause, Provider shall continue to provide Covered Services for specific conditions for which a Participant was under Provider's care at the time of such termination as follows: (a) Participants with life-threatening, disabling or degenerative conditions shall be allowed to continue undergoing a course of treatment for sixty (60) days from the date of termination or until Evernorth's provision for the assumption of such treatment by another provider, whichever is shorter; and (b) Participants who are in the second or third trimester of a pregnancy shall be permitted to continue to receive Medically Necessary Covered Services from Provider until the completion of postpartum care. The terms and conditions of the Agreement shall continue to apply. Provider shall be compensated for such continued care in accordance with the compensation arrangements that were in effect under the Agreement prior to termination. Participants shall not be liable to Provider for any amounts owed for Covered Services provided during the period of continued care other than Copayments, Deductibles or Coinsurance. Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

C. Notwithstanding any provision in the Agreement to the contrary, within five (5) business days of the date Provider either gives or receives notice of termination of the Agreement, either with or without cause, Provider shall, in accordance with applicable laws and regulations, supply to Evernorth a list of Participants seen by Provider.

D. Provider shall notify Evernorth of any changes that would impact Provider's

credentialing status or ongoing availability to Participants.

(7) The Agreement may permit network rental arrangements which allow the selling, renting, or otherwise grant access to Evernorth's rights to Provider's services to a third party provided that the third party accessing Provider's services is contractually obligated to comply with all applicable terms, limitations and conditions of the Agreement, and the third party is any of the following:
(a) a payer, a third-party administrator, or another entity that administers or processes claims on behalf of the payer;
(b) a preferred provider organization or preferred provider network, including a physician organization or physician hospital organization; or
(c) an entity engaged in the electronic claims transport between the Evernorth and the payer that does not provide access to the provider's services and a discount to any other covered entity.

(8) A. The Agreement may be amended by mutual agreement of the parties. Absent mutual agreement, Evernorth shall provide Provider with a written notice of a proposed amendment and the amendment in writing not later than sixty (60) days prior to the effective date of the amendment. The written notice shall be conspicuously entitled "Notice of Amendment to Contract," and shall contain a summary of the amendment as required by applicable law. The notice period may be extended by mutual agreement of the parties.

B. Provider shall have sixty (60) days after receipt of the notice and amendment to object in writing to the proposed amendment. If Provider objects in writing and there is no resolution of the objection within sixty (60) days of Evernorth's receipt of the objection, Evernorth or Provider may terminate the Agreement upon written notice to the other party. The terms of the Agreement shall remain in effect through the termination period and shall be unaffected by the proposed amendment.

C. If Provider does not object to the proposed amendment as specified in subsection B, the amendment shall be effective as specified in the notice.

D. Subsections A and B shall not apply under the following circumstances:
1. the delay caused by compliance with the requirements could result in imminent harm to a Participant;
2. the amendment is required by a state or federal law, rule, or regulation that includes an effective date for the amendment;
3. Provider affirmatively accepts the amendment in writing and agrees to an earlier effective date than specified in the notice;
4. Provider's payment or compensation is based on the current Medicaid or Medicare reimbursement schedule, and the change in payment or compensation results solely from a change in that reimbursement schedule;
5. the amendment is a routine change or update of the Agreement made in response to any addition, deletion, or revision of any service code, procedure code, or reporting code, or a pricing change made by a third party source.

(a) For purposes of this subsection, "service code, procedure code, or reporting code" means the American Medical Association's Current Procedural Terminology, the American Dental Association's Current Dental Terminology, the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System, the World Health Organization's International Classification of Diseases, or the Drug Topic Red Book average wholesale price. For purposes of this subsection, "third party source" means the American Medical Association, the American Society of Anesthesiologists, the American Dental Association, the Centers for Medicare and Medicaid Services, the National Center for Health Statistics, the U.S. Department of Health and Human Services Office of the Inspector General, the Vermont Department of Financial Regulation (DFR), or the Vermont Agency of Human Services.

E. Notwithstanding anything in this section, Evernorth may modify the Agreement by operation of law as required by any applicable state or federal law, rule, or regulation.

(9) A. Evernorth shall provide such information sufficient for Provider to determine compensation or payment terms for Covered Services. Such information shall include: the manner or payment; on request, the fee-for-service dollar amount allowable for each CPT code for those CPT codes that Provider typically uses or actually bills.

B. Evernorth shall provide a readily available mechanism that includes information on the commercially available claims editing software used, standards used for claims edits, payment percentages for modifiers, and any significant edits to the claims software.

(10) If included in the Agreement, a "Most Favored Nation" provision or any other provision prohibited by 18 V.S.A. § 9418e is hereby deleted in its entirety.

(11) Participant Access to Care:

A. The Vermont Department of Financial Regulation requires Evernorth to maintain Vermont specific policies and procedures outlining travel and wait times for Participants accessing care. Evernorth maintains the following standards in Vermont:
   a. Travel times for Participants under normal conditions from their residence or place of business generally should not exceed the following:
      i. Thirty (30) minutes to routine, office-based mental health and substance abuse services;
      ii. Thirty (30) minutes to an outpatient facility for mental health or chemical dependency; and
      iii. Sixty (60) minutes to intensive outpatient, partial hospitalization, residential or inpatient mental health and substance abuse services.
   b. Waiting times for appointments should generally not exceed the following:
      i. Immediate access to emergency care for conditions that meet the definition of emergency medical condition;

ii. In Vermont, Evernorth shall use the following definition of "Emergency": a condition or illness of a participant, if not treated immediately, presents a serious risk of harm to himself or herself, others or property.
iii. Twenty-four (24) hours for urgent care;
iv. Two (2) weeks for the initial treatment of non-emergency or non-urgent care, with prompt follow-up care as necessary, including referrals for specialty services.

c. Annually, Evernorth analyzes data on where plan participants live and compares that to the location of our contracted network. Evernorth evaluates the availability of psychiatrists, non-physician therapists and facilities against geographic standards for rural and urban/suburban market areas. Evernorth also reviews the number of professionals available per covered Participant.
d. Evernorth measures geographic convenience by drive time for the State of Vermont. The time standards include: one (1) professional within thirty (30) minutes, one (1) outpatient facility within thirty (30) minutes and one (1) inpatient facility within sixty (60) minutes.

B. Providing Clinical Information:
a. Evernorth strives to obtain all necessary clinical information from the Provider in order to make a utilization review decision. If there is insufficient information on which to make a determination, Evernorth will ensure there are at least three (3) attempts to obtain needed information over no more than two (2) business days. When additional information is not available, the determination must be made based on available information.
b. In cases where the Provider or Participant will not release the necessary information, Evernorth may not authorize coverage. In no event will Evernorth penalize Provider for failing to provide a Participant's medical records when the Participant has not authorized release of the records and the Provider is not otherwise obligated by law or regulation to disclose the records.

C. Facility Standards:
a. Evernorth-credentialed facilities must have one of the following in order to be considered for network participation: Accreditation from a nationally recognized and Evernorth-approved accreditation organization (e.g. JCAHO, CARF), a state survey certification, or designation as a rural location as identified by the U.S. Census Bureau. Evernorth actively monitors the accreditation status of its network facilities.

(12) Healthplan Quality Committee for Vermont: As a provider in Vermont, Provider has the opportunity to provide input on Evernorth policies, serve on Evernorth's Healthplan quality committee and volunteer to participate in focus groups and surveys. Should Provider wish to provide feedback to the Quality Management Department about Evernorth's published provider satisfaction and preventive health reports or receive more information about the Evernorth Quality Management Program, the annual

program evaluation or other chronic case or preventive health measures, Provider should call 800.591.9407.

(13) Emergency Room Results: Specialty and/or emergency room providers are responsible for ensuring that ER results/records will be forwarded to the PCP for all ER visits to ensure appropriate follow-up care.

(14) Covered Practitioners for Vermont: As required by the State of Vermont, Evernorth recognizes athletic trainers as covered practitioners and covers services provided within the scope of their practice. Naturopathic physicians may serve as PCPs in Vermont and should contact Evernorth at 800.88Evernorth (882.4462) to request PCP status in the Evernorth network. Evernorth accepts claims submitted directly by physician assistants or nurse practitioners who are billing within the scope of their licensure or certification. Additionally, a health insurance plan or health benefit plan providing maternity benefits must provide coverage for services rendered by a licensed midwife or an licensed advanced practice registered nurse licensed who is certified as a nurse midwife for services within their scope of practice and provided in a hospital or other health care facility or at home. Evernorth will continue to accept qualified licensed midwives or licensed advanced practice registered nurses who wish to contract and be credentialed with Evernorth. To request an application or for further information, contact Evernorth at 800.88Evernorth (882.4462).

(15) Medical Records: Provider must allow patients with Evernorth ID cards access to their medical records and make them available at no charge beyond the cost of copying.

(16) Credentialing Requirements: As required by Vermont statute, Evernorth has implemented the use of the CAQH credentialing application form for the initial application, and for applications for re-credentialing.

(17) Web Based Prior Approval: As of January 1, 2011, the State of Vermont Rule H-2008-04 requires that providers use the web-based system to request prior authorization. Evernorth has a web-based tool on website and if Provider does not have the ability to request online, Provider should contact Customer Service at 800.88Evernorth (882.4462).

(18) Vermont's Uniform Prior Authorization Form for Medical Services: According to Vermont statute, each insurer must accept either a national standard transaction information for prior authorizations electronically via online portal or accept the uniform prior authorization form approved by DFR for requests for medical procedures (including mental health services) and medical tests when prior authorization is required beginning on or after March 1, 2014. To review the statute, click the following link: https://legislature.vermont.gov/statutes/section/18/221/09418b. The statute also requires that the Vermont Uniform Prior Authorization Form(s) must be available on DFR's website and the websites of each health insurer. *Providers requesting prior authorization must send or fax a completed form to the Participant's Plan in advance of the proposed services. Please refer to information provided on each Plan's website for submission instructions and contact information.* Provider may access the standard prior authorization

process or obtain a uniform medical or prior authorization form from Evernorth, including submission instructions and contact information at Provider.Evernorth.com

If Provider has any questions, please contact:
800.926.2273

(19) Communication of Health Care Professional termination: Per the State of Vermont Rule H-2009-03: A managed care organization and its contracted health care professionals shall provide at least sixty (60) days final written notice to each other before terminating a contract without cause. Such notices shall not issue unless and until negotiations have concluded and a final decision on termination has been reached. Within five (5) working days of the date that the health care professional either gives or receives final notice of termination, either for or without cause, the health care professional shall supply the managed care organization with a list of his or her patients that are customers of the managed care organization.

VIRGINIA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Virginia regarding provider contracts with providers rendering health care services in the State of Virginia. To the extent that such state laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Virginia laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

I

1. The definition for Emergency Services, if any, shall comply with Virginia laws and regulations to the extent applicable.

2. Pursuant to Code of Virginia Section 38.2-3407.15, to the extent applicable and/or not otherwise preempted by federal law, Evernorth shall comply with the following minimum fair business standards in the processing and payment of claims for Covered Services:

    a. A carrier shall pay any claim within 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:

        1. 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

        2. The claim was submitted fraudulently.

        Each 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.

b. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. 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 to timely 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. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

c. 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 the necessity of demand, at the time the claim is paid or within 60 days thereafter.

d. 1. Every carrier shall establish and implement reasonable policies to permit any 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) precertification 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, down-coding, 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.

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. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either: (1) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy; or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to 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, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received. The paragraph below contains the disclosure of information concerning Evernorth's claim bundling and down-coding practice and policies.

   Payments for Covered Services under the Agreement are subject to Evernorth's payment policies. Payment policies are the guidelines adopted by Evernorth for calculating payment of claims under the Agreement. Such guidelines include Evernorth's standard claim coding and bundling methodology and claims processing policies and procedures. Evernorth's payment policies may change from time to time. Provider may obtain up-to-date information regarding payment policies by visiting the Evernorth website www.cigna.com . Providers should contact Provider Services at 800.926.2273 to request a copy of their fee schedule. (Evernorth reserves the right to rename these website addresses and such change shall not require a modification to this addendum so long as Evernorth communicates the name of the new website address to Provider). Provider may access this secure website tool twenty-four (24) hours a day, seven (7) days a week, by logging on through the Evernorth website. Provider may also use this website tool to e-mail Evernorth with specific questions about claim coding, fee schedules, Covered Services and coverage criteria. Provider may appeal a payment policy issue in accordance with the dispute resolution process described in the Agreement and the Medical Management Program. The Medical Management Program contains the rules, policies and procedures adopted by Evernorth or a Payor to be followed by Provider in providing services and doing business with Evernorth and Payors under the Agreement.

3. Every carrier shall make available to such providers within 10 business days of receipt of a 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. In the event that 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.

e. 1. Every 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:

1. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

2. The carrier's refusal is because: (i) another payor is responsible for the payment, (ii) Provider has already been paid for the health care services identified on the claim,
(iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to 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

3. During the post-service claims process, it is determined that the claim was submitted fraudulently.

e.2. 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 the health care provider discovers clinical evidence prompting Provider to perform a less or more extensive or complicated procedure than was previously authorized, then the 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 carrier's post-service claims process, including required timing for submission to carrier.

f. No carrier shall impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial, and: (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because Provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by Provider, or (ii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of: (a) 12 months, or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

Evernorth requires that claims subject to Code of Virginia Section 8.2-3407.15 must be submitted within twelve (12) months of the date of service and that claims received after that date may be denied for payment.

g. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any 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 written communication shall also contain an explanation of why the claim is being retroactively adjusted.

h. No provider contract shall fail to include or attach at the time it is presented to the provider for execution: (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid that 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 subdivision 4) 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.

i. No amendment to any provider 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 60 calendar days before the effective date and the provider has failed to notify the carrier within 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.

j. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to Provider.

k. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

l. Evernorth shall not be in violation of the above provisions if its failure to comply is caused in material part by Provider or if Evernorth's compliance is rendered impossible due to matters beyond Evernorth's reasonable control (such as an act of God, insurrection, strike, fire or power outages) which are not caused in material part by Evernorth.

m. Evernorth shall not terminate or fail to renew the Agreement or otherwise penalize Provider for invoking any of Provider's rights under this section of the Agreement.

2. Nothing in the Agreement shall be construed to:

a. Require Provider to refuse to provide treatment which the Provider believes to be Medically Necessary and appropriate and which is provided with respect to others with similar conditions.

b. Require that Provider indemnify Evernorth for Evernorth's negligence, willful misconduct or breach of contract, if any.

c. Require Provider, as a condition of participation on Evernorth's panel, to waive any right to seek legal redress against Evernorth.

d. Prohibit, impede or interfere in the discussion of medical treatment options between Provider and Participants. The Agreement expressly permits and requires Provider to discuss medical treatment options with Participants.

3. a. Evernorth shall give Provider notice at least ninety (90) days prior to the date of termination of Provider, except when Provider is terminated for cause. To the extent that the Agreement provides for a notification period longer than ninety (90) days, such longer notification period will apply, except when Provider is terminated for cause.

b. Provider shall give Evernorth at least sixty (60) days' prior notice of termination of the Agreement. Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the Agreement by Provider, such longer notification period will apply.

c. In the event the Agreement is terminated by Provider, Provider shall give reasonable advance notice of such termination to those Participants who are Provider's patients.

d. In the event that the Agreement is terminated by either Provider or Evernorth and is not terminated for cause, Provider shall give affected Participants notice of the right to continue to receive care from Provider to the extent applicable.

e. In the event the Agreement is terminated and is not terminated for cause, Provider shall, upon Participant's request, continue to provide Covered Services to Participants who retain eligibility under the Plan as follows:

(i) for those Participants who were in an active course of treatment prior to the notice of termination, until the earlier of completion of such services or the expiration of ninety (90) days from the date of the notice of termination.

(ii) for those Participants who have entered the second trimester of pregnancy at the time of termination, through the provision of postpartum care directly related to the delivery.

(iii) for those Participants determined to be terminally ill (as defined under Section 1861 (dd) (3) (A) of the Social Security Act) at the time of termination, for the remainder of the Participant's life for care directly related to the treatment of the terminal illness.

Compensation for Covered Services rendered pursuant to this subsection e. shall be in accordance with the reimbursement provisions of the Agreement in effect immediately prior to the date of termination.

Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

II

Pursuant to the prior authorization requirements for a health care provider with prescriptive authority (hereinafter "prescriber") of Code of Virginia § 38.2-3407.15:2, as may be amended from time to time, to the extent applicable and/or not otherwise preempted by federal law, Evernorth shall:

1. In a method of the carrier's choosing, 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. Communicate to the prescriber or his designee within 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;

3. Communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation;

4. Communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied;

5. Communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by subdivision 3 or 4, as applicable, the reasons for the denial;

6. Prior authorization approved by another carrier shall 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 30 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;

7. Carrier shall use a tracking system for all prior authorization requests and the identification information shall be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon the carrier's response to the prior authorization request;

8. 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 requests forms accepted by the carrier shall be available through one central location on the carrier's website and such information shall be updated by the carrier seven days of approved changes;

9. Honor a prior authorization issued by Evernorth for a drug, other than an opioid, regardless of changes in dosages of such drug, provided such drug is prescribed consistent with FDA labeled dosages;

10. Honor a prior authorization issued by Evernorth for a drug regardless if the covered person changes plans with the same carrier and the drug is a covered benefit with the current health plan;

11. Identify the specific information required when requiring a prescriber to provide supplemental information that is in the Participant's health record or electronic health record; and

12. Require that no prior authorization be required for at least one (1) 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.

WASHINGTON REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Washington regarding provider contracts with providers rendering health care services in the State of Washington. To the extent that such Washington laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. For the avoidance of doubt, to the extent such Washington laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

The parties hereby agree to the following modifications to the terms of the Agreement:

1. The following definition is added to the Section of the Agreement entitled Definitions:

   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 such claim.

2. The following provision is added to Section 4 of the Agreement entitled Compensation:

   (a) Ninety-five percent (95%) of the monthly volume of Clean Claims shall be paid within thirty (30) days of receipt by the responsible carrier or agent of the carrier; and

   (b) Ninety-five percent (95%) of the monthly volume of all claims shall be paid or denied within sixty (60) days of receipt by the responsible carrier or agent of the carrier, except as agreed to in writing by Evernorth and Provider on a claim-by-claim basis.

   (c) Should Evernorth fail to pay claims within the above standards, Evernorth shall apply interest on undenied and unpaid clean claims more than sixty-one (61) days old at the rate of one percent (1%) per month.

   (d) Evernorth shall not deny payment to Provider for a Covered Service that Evernorth has prior-authorized under Evernorth's written policies and procedures, except if the claim for the Covered Service was submitted fraudulently or negligently or Provider was already paid for the Covered Service.

3. The following shall replace and supersede the section of the Agreement entitled Charges to Participants:

   (a) Provider hereby agrees that in no event, including, but not limited to nonpayment by Evernorth, Evernorth's insolvency, or breach of this Agreement shall Provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement

from, or have any recourse against a Participant or person acting on their behalf, other than Evernorth, for services provided pursuant to this Agreement. This provision shall not prohibit collection of Deductibles, Copayments, Coinsurance and/or non-Covered Services, which have not otherwise been paid by a primary or secondary carrier in accordance with regulatory standards for coordination of benefits, from Participants in accordance with the terms of the Participant's health plan.

(b) Provider agrees, in the event of Evernorth's insolvency, to continue to provide the services promised in this Agreement to Participants of Evernorth for the duration of the period for which premiums on behalf of the Participant were paid to Evernorth or until the Participant's discharge from inpatient facilities, whichever time is greater.

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

(d) Provider may not bill the Participant for Covered Services (except for Deductibles, Copayments, or Coinsurance) where Evernorth denies payments because Provider have failed to comply with the terms or conditions of this Agreement.

(e) Provider further agrees (i) that the provisions of WAC 284- 170-421(3) (a), (b), (c), and (d) shall survive termination of this Agreement, regardless of the cause of termination and shall be construed to be for the benefit of Evernorth's Participants, and (ii) that this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Provider and Participants or persons acting on their behalf.

(f) If Provider contracts with other providers or facilities who agree to provide Covered Services to Participants of Evernorth with the expectation of receiving payment directly or indirectly from Evernorth or Payor, such providers or facilities must agree to abide by the provisions of WAC 284-170-421(3) (a), (b), (c), (d) and (e) and all requirements of this Agreement.

Provider acknowledges that willfully collecting or attempting to collect an amount from a Participant knowing that collection to be in violation of the Agreement constitutes a class C felony under the Revised Code of Washington (RCW) Section 48.80.030(5).

Effective July 25. 2021, if Provider intends to bill a Covered Person's health plan for an audio-only telemedicine service, Provider must obtain patient consent from the Covered Person for the billing in advance of the service being delivered.

4. The following provision is added to Section 7 of the Agreement entitled Access to Books and Records:

The parties agree that any provisions in the Agreement relating to one party's right to audit the records of the other party shall (i) be limited to health information and other similar records relating only to Evernorth Participants, (ii) be limited only to those records that are necessary to perform the audit, and (iii) apply mutually to both parties.

5. a. The following is added to Section 4 of the Agreement entitled Compensation:

When applicable, Evernorth overpayment recovery activities are subject to the Revised Code of Washington Section 48.43.600:

Except in the case of fraud, Payor may not: (a) request a refund from Provider of a payment previously made to satisfy a claim unless it does so in writing to Provider within twenty-four (24) months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request must specify why Payor believes Provider owes a refund. If Provider fails to contest the request in writing to the carrier within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid.

Payor 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 from Provider of a payment previously made to satisfy a claim unless it does so in writing to Provider within thirty (30) months after the date that the payment was made; or (b) request that a contested refund be paid any sooner than six (6) months after receipt of the request. Any such request must specify why Payor believes Provider owes the refund, and include the name and mailing address of the entity that has primary responsibility for payment of the claim. If Provider fails to contest the request in writing to Payor within thirty (30) days of its receipt, the request is deemed accepted and the refund must be paid.

Payor may at any time request a refund from 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) Payor is unable to recover directly from the third party because the third party has either already paid or will pay Provider for the health services covered by the claim.

b. The following is added to Section 4 of the Agreement entitled Compensation:

Except in cases of fraud, Provider may not request additional payment from Payor, unless it does so in writing during the twenty-four (24) month period after the date Payor denied or paid the claim submitted by Provider. If Provider request an additional payment for reasons related to coordination of benefits with another carrier or entity responsible for payment of a claim, the request for an additional payment must be made in writing within thirty (30) months of the payment.

6. The parties agree that those provisions entitled Dispute Resolution Procedure in Section 12 of the Agreement shall not apply to the resolution of disputes between the parties. Such disputes shall be submitted to the internal dispute resolution process described in Paragraph 7 below. No alternative resolution process may be required by Evernorth to the exclusion of judicial remedies.

7. The parties agree to resolve disputes arising during the term of this Agreement in accordance with the following procedures:

Provider Payment Appeals Process
To initiate a first-level review, Provider must submit the following information in writing within one hundred eighty (180) calendar days of the date of the initial payment or denial notice:

- A completed request for provider payment appeal (form available at Provider.Evernorth.com) or a provider payment appeal letter indicating the reason for the appeal;

- A copy of the original claim and EOP or EOB, if applicable;

- For reviews with a clinical component, such as services denied for no prior authorization for not being medically necessary, supporting documentation should include a narrative describing the situation, an operative report and medical records, as applicable;

After preparing the necessary documentation, Providers should contact their local customer service representative for specific appeal-designee mailing information. Providers may also visit the Evernorth provider website at Provider.Evernorth.comfor specific address information.

Second-Level Review
Providers who are not satisfied with the resolution of the first-level review may submit the appeal to a second-level review within sixty (60) calendar days of the date of the first-level review determination as follows:

- Repeat steps above, indicating a second-level request on the appeal form or letter.

- Include any additional or pertinent supporting documentation.

Providers must return the completed documentation as directed in the first-level determination notice. Providers may also contact their local customer service representative for assistance or visit the Evernorth provider website at Provider.Evernorth.com. .

Providers should submit one (1) appeal per form.
Evernorth must render a decision on provider payment appeals within sixty (60) days of the appeal.

Provider Termination Appeals Process
First-Level Review
To initiate a first-level review of a provider termination, Provider must submit the following information in writing within thirty (30) calendar days of the date of the provider termination notice:

- A completed provider termination appeal form or provider termination appeal letter indicating the reason for the appeal;

- A copy of the original termination notice;

- Supporting documentation for reconsideration.

To safeguard the sensitive nature of Provider's information, Provider must follow the contact instructions in the termination notice. Returning the completed documentation as directed will help insure confidentiality.

Second-Level Appeal

Providers who are not satisfied with the resolution of the first-level review may submit the appeal to the second-level review within sixty (60) calendar days of the date of the first-level review determinations follows:

- Repeat steps above, indicating a second-level request on the form or letter.
- Include any additional or pertinent supporting documentation.

Providers must follow contact instructions in the first-level review decision letter. Returning the completed documentation as directed in the first-level review decision letter will help ensure confidentiality.

If Evernorth fails to grant or reject a request within thirty (30) days after it is made, the complaining Provider may proceed as if the complaint had been rejected. A complaint that has been rejected by Evernorth may be submitted to nonbinding mediation. Mediation shall be conducted under the Uniform Mediation Act, Title 7, Chapter 7.07 of the Revised Code of Washington (RCW), or any other rules of mediation agreed to by the parties. This section is solely for resolution of provider complaints. Complaints by, on behalf of, a Participant are subject to the grievance processes in RCW 48.43.530.

The disclosures set forth in (1) through (3) below are being provided pursuant to directions received from the Washington State Office of the Insurance Commissioner beginning in April 2021, requiring Evernorth to include within an Agreement a statement with regard to RCW 48.43.420(Chapter 171, Laws of 2019; eff. July 28, 2019).

(1) Evernorth acknowledges its obligation under RCW 48.43.420 to provide access to a clear, readily accessible, and convenient process to request an exception to the prescription drug management process.
(2) Evernorth acknowledges its obligation under RCW 48.43.420 to provide sixty (60) days' notice for any new policies or procedures applicable to prescription drug utilization management protocols.
(3) Program Requirements or updates may be posted on the Evernorth f provider website at Provider.Evernorth.com or communicated through notifications delivered by mail, email, phone, fax, or in person.

The disclosures set forth in (1) through (5) below are being provided pursuant to regulations adopted by the Washington State Office of the Insurance Commissioner November 22, 2021, to implement the health plan reimbursement requirements for telemedicine services found in RCW 48.43.735 as amended in July 2021.

(1) Payor shall reimburse Hospital for a Covered Service provided to a Covered Person through telemedicine, as defined in applicable law, or store and forward technology as set forth in applicable law including, but not limited to RCW 48.43.735 and WAC 284-170-433, as may be amended from time to time.

(2) Where required by applicable law, including, but not limited to RCW 48.43.735 and WAC 284-170-433, as may be amended from time to time, Payor shall reimburse Hospital for a Covered Service provided to a Covered Person through telemedicine, as defined in applicable law, the same amount of compensation as Payor would pay Hospital if the Covered Services was provided in person by Hospital, unless Hospital is eligible under applicable law to elect to negotiate, and has negotiated, an amount of compensation that

differs from the amount of compensation for in-person services.

(3) To the extent required by applicable law and regulations, as may be amended from time to time, an originating site for a telemedicine health care service shall include a: hospital; rural health clinic; federally qualified health center; physician's or other health care provider's office; licensed or certified behavioral health agency; skilled nursing facility; home, or any location determined by the individual receiving the service including, but not limited to a pharmacy or a school-based health center; or a renal dialysis center.

(4) Hospital shall, consistent with applicable state and federal laws, obtain patient consent from a Covered Person for the billing of an audio-only telemedicine service in advance of the service being delivered should Hospital intend to bill a Covered Person or a Covered Person's health plan.

(5) Evernorth acknowledges its obligations under applicable state regulations, as may be amended from time to time, to ensure that access to telemedicine services is inclusive for those patients who may have disabilities or limited-English proficiency for whom the use of telemedicine technology may be more challenging.

The disclosures set forth below are being provided pursuant to directions received from the Washington State Office of the Insurance Commissioner in November 2022, requiring Evernorth to include the following additional provisions to support the implementation of the health plan reimbursement requirements for telemedicine services found in RCW 48.43.735.

(A) Effective January 1, 2023 for health plans subject to RCW 48.43.735, Payor shall reimburse Hospital for audio-only telemedicine if the Covered Person has an established relationship with Hospital. An established relationship shall be defined as set forth in RCW 48.43.735 and WAC 284-170-130, as the laws and regulations are amended or revised from time to time.

(B) Unless otherwise set forth in applicable laws and regulations, established relationship means the Provider providing audio-only telemedicine has access to sufficient health records to ensure safe, effective, and appropriate care services and: (i) For health care services included in the essential health benefits category of mental health and substance use disorder services, including behavioral health treatment: (A) The Covered Person has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the Provider providing audio-only telemedicine or with a Provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the Provider providing audio-only telemedicine; or (B) The Covered Person was referred to the Provider providing audio-only telemedicine by another Provider who has had, within the past three years, at least one in-person appointment, or at least one real-time interactive appointment using both audio and video technology, with the Covered Person and has provided relevant medical information to the Provider providing audio-only telemedicine; (ii) For any other health care service: (A) The Covered Person has had, within the past two years, at least one in-person appointment, or, until January 1, 2024, at least one real-time interactive appointment using both audio and video

technology, with the Provider providing audio-only telemedicine or with a Provider employed at the same medical group, at the same clinic, or by the same integrated delivery system operated by a carrier licensed under chapter 48.44 or 48.46 RCW as the Provider providing audio-only telemedicine; or (B) The Covered Person was referred to the Provider providing audio-only telemedicine by another Provider who has had, within the past two years, at least one in-person appointment, or, until January 1, 2024, at least one real-time interactive appointment using both audio and video technology, with the Covered Person and has provided relevant medical information to the provider providing audio-only telemedicine.

8. The following is added to Section 13 of the Agreement:

   To the extent applicable, pursuant to WAC 284-170-401, Provider shall maintain agreements with each subcontracted provider or facility requiring subcontracted provider or facility to comply with all of the terms and conditions of this Agreement.

9. The following is added to Section 13.b. of the Agreement entitled Amendment:

   Evernorth may amend this Agreement by providing at least sixty (60) days prior written notice for changes that affect Provider compensation or health care service delivery unless changes to federal or state law or regulations make such advance notice impossible, in which case notice shall be provided as soon as possible.

10. A. If Provider is not a hospital, the following shall replace and supersede the section of the Agreement entitled Coordination of Benefits:

    Certain claims for Covered Services are claims for which another payor may be primarily responsible under coordination of benefit rules. Provider may pursue those claims in accordance with the process set out in the Medical Management Program . When a Participant's coverage under a Benefit Plan is secondary, Payor will pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. However, in no event shall the Payor be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare, Part A, Part B, Part C, or Part D is primary, Medicare's allowable amount is the allowable expense.

    B. When applicable, Evernorth coordination of benefits activities are subject to Washington Administrative Code 284-51-215, which provides that:

    - When Provider notifies Evernorth that more than one (1) plan covers an enrollee who has submitted a claim, Evernorth will resolve with the other plan within thirty (30) days which plan is primary. This deadline may be extended in situations involving court orders for dependent coverage, if the court order contains information needed to determine which plan is primary and has not been provided to the issuer. If an agreement cannot be reached, Evernorth will share equally the allowable expenses between the plans according to Washington Administrative Code 284-51-205(4) (f).
    - If Evernorth is the secondary plan and receives a claim without the primary plan's explanation of benefits or other necessary payment details, Evernorth will notify Provider within thirty (30) days that the claim is incomplete.
    - If the primary plan has not adjudicated a claim within sixty (60) days of receipt, then

Provider may submit the claim to Evernorth and Evernorth will process the claim as primary within thirty (30) days.

11. If Provider is not a hospital or ancillary provider, the following sentence is added to Section 10.a of the Agreement:

    If Provider is a primary care physician whose contract is being terminated without cause, Evernorth will continue to reimburse the primary care provider for Covered Services rendered to Participants (whether or not they are suffering from a chronic condition) for at least sixty (60) days following the termination, or until the next open enrollment period of the Participants requesting continuity of care.

12. The following provision is added to Section 8 of the Agreement entitled Relationship of Parties:

    Evernorth shall not in any way preclude or discourage Provider 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 Participant's health benefit plan. Evernorth shall not prohibit, discourage, or penalize Provider otherwise practicing in compliance with the law from advocating on behalf of a Participant with Evernorth. Nothing in this section shall be construed to authorize Provider to bind Evernorth or Payor to pay for any service. Evernorth may not preclude or discourage Participants or those paying for their coverage from discussing the comparative merits of different health carriers with their Provider. This prohibition specifically includes prohibiting or limiting Provider from participating in those discussions even if critical of a carrier.

13. The following provision is added to the Agreement as specified below:

    (A) The following provision is added to Provider duties under Section 3 of the Agreement:
    (1) Under the terms of the Agreement and subject to WAC 284-170-470, as may be amended from time to time, Provider shall have the right to make a prior authorization request.

    (B) The following provision is added to the Agreement:
    (1) Emergency Fill, as defined by WAC 284-43-0160, as may be amended from time to time, shall mean a limited dispensed amount of medication that allows time for the processing of a preauthorization request, and only applies to those circumstances where a patient presents at a contracted pharmacy with an immediate therapeutic need for a prescribed medication that requires preauthorization.
    (2) Evernorth, in accordance with the requirements of WAC 284-170-470, as may be amended from time to time, will authorize an Emergency Fill by a dispensing pharmacist and approve the claim payment. Emergency Fill is only applicable when: the dispensing pharmacy cannot reach Evernorth's prior authorization department by phone as it is outside the department's business hours; or, Evernorth is available to respond to phone calls from the dispensing pharmacy regarding a covered benefit, but Evernorth cannot reach the prescriber for full consultation.
    (3) Evernorth will provide an authorization number to Provider after approval of a prior authorization request and upon receipt of a claim for that approved medication.

14. If Provider is an independent practice association, the following shall be added

to Section 3 of the Agreement:

Provider represents and warrants that it is authorized to act on behalf of its providers and will provide evidence of such authority upon request. To the extent that such providers are not employed by Provider but are independently contracted with Provider, Provider shall maintain agreements with such providers requiring the providers to comply with the terms and conditions of this Agreement to the extent applicable. The form of Provider's standard agreement(s) and all applicable compensation schedules or exhibits with such providers shall conform to the requirements of and shall contain all provisions required by applicable law, including but not limited to chapter 284-170 WAC, subchapter B, and shall include a Participant and Payor hold harmless provision acceptable to Evernorth, consistent with applicable law, and which provides, among other things, that such providers shall look solely to Provider for compensation for Covered Services if payments for Covered Services under this Agreement are directed to Provider. Such forms and all applicable compensation schedules or exhibits and any material amendments thereto must be approved in advance by the Office of the Insurance Commissioner pursuant to RCW 48-43-730, WAC 284-170-480, and any other applicable laws and regulations. Provider shall make available to Evernorth and to any applicable regulatory authority for review and approval by Evernorth and any applicable regulatory authority a copy of each such provider agreement, all applicable compensation schedules or exhibits, and any subsequent changes or amendments thereto prior to use. Provider shall require that each such provider execute an election to participate form. Upon request, Provider shall provide Evernorth with copies of all executed elections to participate.

15. If Provider is an independent practice association, the following shall replace and supersede the section of the Agreement entitled Assignment and Subcontracting:

    Neither Evernorth nor Provider may assign any rights or delegate any obligations under this Agreement without the written consent of the other party; provided, however, that any reference to Evernorth includes any successor in interest and Evernorth may assign its duties, rights and interests under this Agreement in whole or in part to an Evernorth affiliate or may delegate any and all of its duties to a third party in the ordinary course of business. Provider shall, prior to requesting Evernorth's consent to delegate any function performed under the Agreement, include the requirements of chapter 284-170 WAC, subchapter B in its contracting documents with the subcontractor in accordance with WAC 284-170-240 as may be amended from time to time; Evernorth shall retain the right to approve, suspend or terminate the arrangement. Provider's contracting documents shall be subject to review and approval by the Office of the Insurance Commissioner if required by applicable laws and regulations.

16. The section of the Agreement entitled Compensation is modified as follows; the underscored language reflects the changes made to the Agreement to conform to applicable state laws:

    Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, the rates in the Agreement will be payment in full for all Covered Services furnished to Participants under the Agreement.

17. The section of the Agreement entitled Compensation is modified as follows; the

underscored language reflects the changes made to the Agreement to conform to applicable state laws:

Notwithstanding any provision to the contrary set forth in the Compensation section of the Agreement, or any similar provision in the Agreement, or a rate exhibit, the rates in this Agreement apply to all Covered Services provided to Participants in the Plan types covered by this Agreement, including services covered under a Participant's in or out-of-network benefits and whether the Payor or Participant is financially responsible for payment.

18. Credentialing: In accordance with Washington Administrative Code Section 284-170-411(1), Evernorth shall not establish selection criteria (a) that would allow Evernorth to avoid risk by excluding providers or facilities because they are located in geographic areas that contain populations presenting a risk of higher than average claims, losses, or health services utilization; or (b) that would exclude providers or facilities because they treat or specialize in treating persons presenting a risk of higher than average claims, losses, or health services utilization or because they treat or specialize in treating minority or special populations; or (c) discriminate regarding participation in the network solely based on the provider or facility type or category if the provider is acting within the scope of their license.

    Evernorth will make a determination approving or denying a credentialing application submitted to Evernorth no later than ninety (90) days after receiving a complete application from a health care provider.

    Effective June 1, 2020, Evernorth will make a determination approving or denying a credentialing application submitted to Evernorth no later than ninety (90) days after receiving a complete application from a health care provider. All determinations made by Evernorth in approving or denying credentialing applications will average no more than sixty (60) days.

19. Medical Management:

    (a) Coverage Determinations: In accordance with Washington Administrative Code Section 284-43-2000(7), Evernorth will not penalize Provider by reducing future payments or terminating Provider's contract simply because Provider disputes the determination of coverage or payment for health care services.

    (b) Precertification: In accordance with Washington Administrative Code Section 284-43-2000(4), Evernorth (the "issuer"), when conducting utilization review, shall:

        - Accept information from any reasonably reliable source that will assist in the certification process;
        - Collect only the information necessary to certify the admission, procedure or treatment, length of stay, or frequency or duration of services;
        - Not routinely require providers or facilities to numerically code diagnoses or procedures to be considered for certification, but may request such codes, if available;
        - Not routinely request copies of medical records on all enrollees reviewed;
        - Require only the section(s) of the medical record during concurrent review necessary in that specific case to certify medical necessity or appropriateness

of the admission or extension of stay, frequency or duration of service;

- For concurrent review, base review determinations solely on the medical information obtained by the carrier at the time of the review determination;
- For retrospective review, base review determinations solely on the medical information available to the provider or facility at the time the health service was provided;
- 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 unless the prior authorization was based upon a material misrepresentation by the provider or facility;
- Not retrospectively deny coverage or payment for care based upon standards or protocols not communicated to the provider or facility within a sufficient time period for the provider or facility to modify care in accordance with such standard or protocol; and
- Reverse its certification determination only when information provided to the issuer is materially different from that which was reasonably available at the time of the original determination.

(c) Medical Necessity Services: In accordance with Washington Administrative Code Section 284-170-270, Evernorth will cover the services of every category of heath care provider as long as the service is covered and is Medically Necessary, clinically efficacious and cost effective and the provider is operating within the scope of their license. However, Evernorth may determine that particular services for particular conditions by particular categories of providers are not cost-effective or clinically efficacious, and may exclude such services from coverage or reimbursement under a health plan. Services for acupuncture/acupressure and massage therapy will be reviewed for consistency with these requirements.

20. OneHealthPort: Evernorth is a participating partner with OneHealthPort. Use of most of Evernorth's online capabilities through OneHealthPort is a key component to reducing the complexity of doing business with Evernorth and minimizing administrative costs. OneHealthPort offers an easy and secure way to access the websites of local health plans, hospitals and other participating organizations using one common security solution. Subscribers register only once and are issued a digital ID that provides single sign-on access across all participating sites.

    (a) How It Works:

    Evernorth uses the added protection of OneHealthPort's "Browser Second Factor" when accessing the Evernorth provider website through Provider's OneHealthPort login. This security feature adds an additional layer of identity verification to protect personal health information online.

    To begin, log in to the OneHealthPort website, www.onehealthport.com, select the Cigna link and enter Provider's OneHealthPort user ID and password. If Provider does not have an OneHealthPort user ID, Provider can register for free at www.onehealthport.com/register. After logging in, Provider will be asked to register Provider's browser as part of the Browser Second Factor security feature.

Some of Evernorth's online tools still require that Provider log in directly to the Evernorth

provider website, Provider.Evernorth.com. This includes requesting fee schedule information. For questions about using the Evernorth provider website, call Provider Service at 800.926.2273

Call OneHealthPort Customer Service at 800.973.4797 (toll-free) for questions about accessing Evernorth's online services through OneHealthPort.

(b) Credentialing: Providers in Washington may now use OneHealthPort to access Medversant ProviderSource - a free credentialing data collection service. ProviderSource is an easy-to-use online portal to the OneHealthPort Provider Data Service, a statewide system hosted by OneHealthPort for centralized collection, verification and distribution of all provider data to be used for credentialing and privileging. Each hospital and health payor will still manage their own credentialing, privileging and committee work, but they will collect all data and documents needed via the ProviderSource application. The service is free for practitioners inputting data.

WEST VIRGINIA REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred as "Provider") to comply with legislative and regulatory requirements of the State of West Virginia regarding provider contracts with providers rendering health care services in the State of West Virginia. To the extent that such West Virginia laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such West Virginia laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

A. (1) The definition for Emergency Services, if any, shall comply with West Virginia laws and regulations to the extent applicable.

(2) To the extent required, both parties agree to comply with applicable law with respect to the administration of claims, including but not limited to, W. Va. Code § 33-45-2. Provider shall accept as full payment the compensation as set forth in the Agreement.

(3) Any retroactive denial of claims, including any recoupment process utilized by Cigna, shall be administered in accordance with applicable law, including but not limited to, W. Va. Code § 33-45-2.

(4) No amendment to the Agreement or to any exhibit, addenda, schedule or policy that relates to payment, delivery of care, or the range of health care services provided by Provider shall be effective as to Provider unless Provider fails to notify Cigna in writing within twenty (20) business days of receipt of such amendment of Provider's intention to terminate the Agreement at the earliest date permitted under the Agreement.

(5) Cigna shall establish policies and procedures applicable to Provider in accordance with applicable law. Provider shall comply with and be bound by all such policies and procedures, including but not limited to, Cigna's policies relating to administrative requirements, utilization management, credentialing, quality management, payment and reimbursement, precertification and authorization of coverage decisions and claims processing.

(6) Nothing in the Agreement shall be construed to permit Cigna to terminate or fail to renew the Agreement or otherwise penalize Provider for invoking any of its rights under the Agreement or applicable law.

(7) "Experimental Medical Care" means medical, surgical or other health care procedures and treatments which are experimental or investigational, as determined by the Healthplan Medical Director in accordance with consensus derived from peer review

medical and scientific literature and the practice of the national medical community, including (i) any procedures or treatments which are not recognized as conforming to accepted medical practice; (ii) any procedures or treatments in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness has not been established; and (iii) any procedures or treatments for which the required approval of a governmental agency has not been granted at the time the services are rendered. Covered Services do not include Experimental Medical Care.

However, to the extent applicable, Covered Services include the patient cost to a Participant in a clinical trial, as a result of:

(a) treatment provided for a life-threatening condition; or
(b) prevention, early detection, and treatment studies on cancer.

Coverage shall be required if:

(1) The treatment is being provided or the studies are being conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or the treatment is being provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any other life-threatening condition.
(2) The treatment is being provided in a clinical trial approved by:
    (i) one of the National Institutes of Health;
    (ii) a National Institutes of Health cooperative group or a National Institutes of Health center;
    (iii) the FDA in the form of an investigational new drug application;
    (iv) the federal Department of Veterans Affairs; or
    (v) an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutions of Health.
(3) The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise.
(4) There is no clearly superior noninvestigational treatment alternative.
(5) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Covered Services include the patient cost incurred for drugs and devices that have been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient's particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device.

An entity seeking coverage for treatment in a clinical trial approved by an institutional review board under subsection (2)(v) above shall post electronically and keep up-to-date a list of the clinical trials meeting the requirements of this section. The list shall include for each clinical trial: (a) the phase for which the trial is approved; (b) the entity

approving the trial; (c) whether the trial is for treatment of cancer or another life-threatening disease and, if not cancer, the particular disease; and the estimated number of patients in the trial.

B. If Provider is an Intermediary as defined by W.Va. Code § 33-53-1, the following provisions shall apply to the Agreement as required by W.Va. Code § 33-53-5, as may be amended from time to time.

(1) Nothing in the Agreement shall be construed to delegate or assign to Provider Evernorth's statutory responsibility to monitor the offering of Covered Services to Participants.
(2) In accordance with applicable laws and regulations, Evernorth shall have the right to approve or disapprove the participation status of a Represented Provider in Provider's contracted network for the purpose of delivering Covered Services to Evernorth's Participants.
(3) In addition to the negotiated terms of the Agreement, Evernorth shall have access to all Provider's subcontracts, and shall have the right to make copies to facilitate regulatory review, upon twenty (20) days prior written notice from Evernorth.
(4) If applicable under the terms of the Agreement, Provider shall transmit utilization documentation and claims paid documentation to Evernorth as set forth in the Agreement. Evernorth shall monitor the timeliness and appropriateness of payments made to providers and health care services received by Participants.
(5) In addition to the negotiated requirements of the Agreement, Provider shall maintain the books, records, financial information and documentation of services provided to Participants at its principal place of business in the state and shall preserve them for two years in a manner that facilitates regulatory review.
(6) Provider shall allow the commissioner of insurance access to Provider's books, records, financial information and any documentation of services provided to Participants, as necessary to determine compliance with applicable laws and regulations.
(7) In accordance with applicable laws and regulations, Evernorth shall have the right, in the event of Provider's insolvency, to require the assignment to Evernorth of the provisions of a Represented Provider's contract addressing the provider's obligation to furnish Covered Services. Should Evernorth require such assignment, Evernorth shall remain obligated to compensate such provider for furnishing Covered Services under the same terms and conditions as Provider prior to the insolvency.
(8) Notwithstanding any other provision of this Section IV, to the extent that Evernorth has delegated any of its responsibilities to Provider, Evernorth shall retain full responsibility for Provider's compliance with the requirements of this section.

C. With respect to Covered Services rendered to Participants covered under an HMO Plan:

If Provider elects to terminate the Agreement for any reason, Provider must give sixty (60) days' advance written notice to Evernorth and the State of West Virginia Commissioner of Insurance before terminating the Agreement. Nonpayment for goods or services rendered by Provider is not a valid reason for avoiding the sixty (60) day notice period.

Notwithstanding the foregoing, to the extent that the Agreement provides for a longer notification period with respect to termination of the agreement by Provider, the longer notification period will apply.

WISCONSIN REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as "Provider") to comply with legislative and regulatory requirements of the State of Wisconsin regarding provider contracts with providers rendering health care services in the State of Wisconsin. To the extent that such Wisconsin laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Wisconsin laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) The definition for Emergency Services, if any, shall comply with Wisconsin laws and regulations to the extent applicable.

(2) Upon termination of the Agreement, unless Provider no longer practices in the Plan's service area, or the Agreement is terminated for misconduct on the part of Provider, Provider shall continue to provide Covered Services for Participants undergoing a course of treatment for the following period of time: (i) if maternity care is the course of treatment and Participant is in the second or third trimester of pregnancy when the Agreement terminates, until the completion of postpartum care for Participant and infant; or (ii) for all other courses of treatment, for the remainder of the course of treatment or for ninety (90) days after the Agreement is terminated, whichever is shorter, except that Provider is not required to provide Covered Services beyond: (i) the end of the current plan year, for a Participant of a Plan with no open enrollment period; or (ii) the end of the plan year for which it was represented that Provider was, or would be, a Participating Provider, for a Participant of a Plan with an open enrollment period.

Provider shall be compensated for Covered Services provided to any such Participant in accordance with the compensation arrangements under the Agreement until ninety (90) days following termination, and compensation thereafter for continued Covered Services authorized by Evernorth shall be as mutually agreed.

Provider has no obligation under the Agreement to provide services to individuals who cease to be Participants.

WYOMING REGULATORY ADDENDUM FOR PROVIDERS

The provisions set forth in this Addendum are being added to the Agreement between Evernorth Behavioral Health, Inc. (hereafter referred to as "Evernorth") and the provider named in the Agreement (hereafter referred to as the "Provider") to comply with legislative and regulatory requirements of the State of Wyoming regarding provider contracts with providers rendering health care services in the State of Wyoming. To the extent that such Wyoming laws and regulations are applicable and/or not otherwise preempted by federal law, the provisions set forth in this Addendum shall apply and, to the extent of a conflict with a provision in the Agreement, shall control. The provisions of this Addendum shall apply to all providers governed by the Agreement, unless the context dictates otherwise. For the avoidance of doubt, to the extent such Wyoming laws and regulations are not applicable, the terms of the Agreement shall control. The provisions set forth in this Addendum do not apply with regard to Covered Services rendered to Participants covered under self-funded plans. Unless otherwise defined in this Addendum or applicable laws and regulations, capitalized terms used but not defined in this Addendum shall have the same meaning as set forth in the Agreement.

(1) In accordance with Wyo. Stat. § 26-22-504, Evernorth shall not refuse to re-contract with, or compensate Provider for Covered Services solely because Provider in good faith communicated with a Participant regarding the provisions, terms, or requirements of the Payor's products as they relate to the needs of that Participant.

(2) To the extent required by applicable law, Evernorth, Payor and Provider shall comply with Wyo. Stat. § 26-15-124 and any successor provisions regarding payment of claims.