STATE EXHIBIT TO THE COMMERCIAL ADDENDUM

MARYLAND

The following State Exhibit sets forth certain state regulatory requirements that will apply only in the state of Maryland and applicable solely to fully-insured Commercial Covered Prescription Services. In the event of any conflict between the terms and conditions of the Provider Manual or Agreement with those of this State Exhibit, this State Exhibit shall supersede, govern, and control to the extent required by Maryland law.

A. Definitions
   1. "Provider Agreement" means a contract for health care and related services to be provided to members of a Plan by physicians, physician groups, hospitals, laboratories, skilled nursing or other facilities, behavioral health or other health professionals and other facilities and providers through an agreement with a third party company providing administrative services to Plan.
   2. "Provider" means health professionals providing services to Plan members including pharmacists, physicians, hospitals, laboratories, pharmacies, mental and behavioral health professionals, and other health care facilities and providers which have agreed to provide services to Plan members either directly or through a Provider Agreement with a third party.
   3. "Administrator" means a third party entity that provides pharmacy benefit management services to members of the Plan through Provider Agreements entered into with Providers to furnish such services. For the purposes of this Addendum, the Administrator is OptumRx, Inc. .
   4. "Clean Claim" means a claim for payment submitted to Administrator with the data elements required under the applicable federal or state law or regulation and any attachments reasonably requested by Administrator, consistent with applicable federal or state law or regulation. This term includes a claim for payment for Covered Services on any payment basis which is authorized under the terms of this Agreement and prepared, delivered and supported in accordance with applicable state or federal regulations, and in accordance with Administrator's policies, protocols and procedures included herein, as amended from time to time. This term shall not include a claim from a health care physician or provider who is under investigation for fraud or abuse regarding that claim.
   5. "Plan" means any benefit plan offered and/or administered by an HMO for whom Administrator has agreed to provide services including health care services to be provided by Providers to members of the HMO benefit plan.

B. Maryland State Law Coordinating Provisions. For a Provider Agreement involving the delivery of health care services in the State of Maryland, the provisions noted below shall apply.
   1. Experimental Care. As required by MD Ann. Code, Ins. Article §15-123, the following is added to this Addendum:
      a. Experimental Medical Care means services that are not recognized as efficacious as that term is defined in the edition of the Institute of Medicine Report on Assessing Medical Technologies that is current when the care is rendered. Experimental Services do not include Controlled Clinical Trials.
   2. Termination. As required by MD Ann. Code, Ins. Article § 15-112.2, the following is added to this Addendum:
      a. Discretionary Termination.
         i. This Provider Agreement may be terminated in the sole discretion of either party by the provision of written notice at least ninety (90) days prior to the date of termination; and
         ii. If Provider elects to terminate the Provider Agreement, Provider shall, for at least ninety (90) days after the date of the notice of termination, continue to furnish health care services to Plan members for whom the Provider was responsible for the delivery of health care services before the notice of termination.
      b. Termination for Cause. As required by MD Ann. Code, Ins. Article § 15-112(b), the following is added to this Addendum:

i. This Provider Agreement may be terminated by Administrator upon written notice to Provider immediately upon becoming aware of any of the following:
    - Provider's license or certificate to render health care services is put on probation, suspended or revoked;
    - Provider's right to prescribe controlled substances is put on probation, suspended or revoked;
    - Provider engages in fraud or deception, or knowingly permits fraud or deception by another in connection with Provider's obligations under this Provider Agreement;
    - Provider's continued participation represents a potential risk of imminent harm or danger to the health and/or safety of Plan members;
    - Provider is determined to be incompetent to provide Covered Services to members or is believed to have committed patient abuse.

3. Network Participation. As required by MD Ann. Code, Ins. Article § 15-112.2(b) and § 15-125 (b) and (c) the following is added to this Addendum:
    a. *Network Participation and Requirements*.
        i. Administrator may, in its sole discretion, include Provider as a network provider in any or all network(s) provided, however, that Administrator not (i) make it a condition of participating in a non-HMO provider panel that a Provider participate in an HMO provider panel or (ii) make it a condition of participating in a provider panel that the Provider also serve on a provider panel of workers' compensation services since Provider has the right to elect not to serve on a panel for workers compensation services or (iii) assign, transfer or subcontract a Provider's contract in whole or in part to an insurer that offers personal injury protection coverage of this article without first informing the health care provider and obtaining the Provider's express written consent. If more than one fee schedule is included with the Provider Agreement, the Administrator may not require as a condition of participation that the Provider accept each schedule of applicable fees included in the Provider Agreement.
4. Client Listing. As required by MD Ann. Code, Ins. Article § 15-112.2(c) the following is added to this Addendum:
5. Client BIN information is set forth in the Provider Manual, which is incorporated into and part of the Pharmacy Agreement.Claims. As required by MD Ann. Code, Ins. Article § 15-1005 and § 15-1009 the following is added to this Addendum:
    a. *Submission and Payment.*
        i. *Submission of Claims*. Provider shall submit claims for payment within one hundred eighty (180) days of furnishing health care services. Claims received after this time period may be denied for payment by Administrator, and Provider shall not bill Administrator, or Plan member for such denied claims. Provider follows the claims submission procedures contained in the administrative handbook(s). A Clean Claim shall be deemed to have been received by Administrator: (i) on the date that such Clean Claim is transmitted to Administrator if transmitted by electronic means; or (ii) three (3) working days following the deposit of such Clean Claim in the U.S. Mail, first class postage prepaid and addressed to Administrator at such address set forth on the Participant's identification card. Upon request, Provider shall furnish to Administrator, all information reasonably required to verify the health care services provided by Provider and the charges for such services. If Administrator wholly or partially denies a claim for reimbursement, Administrator shall permit Provider a minimum of ninety (90) working days after the date of denial of the claim to appeal the denial.
        ii. Preauthorized Claims. If Administrator authorizes or certifies the

performance of covered Service for a Plan member by a Provider, Administrator shall not rescind or modify the amount of reimbursement due pursuant to a retrospective review by Administrator unless:

- The information submitted to Administrator regarding the Covered Service delivered to the Plan member was fraudulent or intentionally misrepresentative;
- Critical information requested by Administrator regarding the Covered Service to be delivered to the Plan member was omitted such that Administrator's determination would have been different had it known the critical information;
- A planned course of treatment for the Plan member that was approved by Administrator was not substantially followed by the Provider; or
- On the date the preauthorized health care service was delivered:
    - The Plan member was not covered by the Plan;
    - Administrator maintained an automated eligibility verification system that was available to the Provider by telephone or via the internet; and
    - According to the verification system, the Plan member was not covered by the Plan.

iii. Prospective modification by Administrator of the prior authorization for Covered Services pursuant to a concurrent review for services requested beyond the course of treatment that has been preauthorized shall not be deemed to be retrospective review pursuant to this Section.

b. Retroactive Denial. As required by MD Ann. Code, Ins. Article § 15- 1008(c) the following is added to this Addendum

i. If Administrator retroactively denies reimbursement to Provider, the Administrator:

- May only retroactively deny reimbursement for services subject to coordination of benefits with another carrier, the Maryland Medical Assistance Program, or the Medicare Program during the 18-month period after the date that the carrier paid the health care provider; and
- Except as provided above in this paragraph, may only retroactively deny reimbursement during the 6-month period after the date that Administrator paid the Provider.

ii. If Administrator retroactively denies reimbursement to Provider under paragraph (i) of this subsection they shall provide the Provider with a written statement specifying the basis for the retroactive denial.

iii. If the retroactive denial of reimbursement results from coordination of benefits, the written statement shall provide the name and address of the entity acknowledging responsibility for payment of the denied claim.

c. Disputed Claims. As required by MD Ann. Code, Ins. Article § 15-1005(c)(e) and (f) the following is added to this Addendum:

i. Pre-Payment Disputed Claims. Administrator shall have the right, within thirty (30) days of Administrator's receipt of a claim and prior to payment of said claim, to provide Provider with written notification that a claim is not a Clean Claim containing all complete and accurate information required for adjudication or if Administrator has some other stated dispute with the claim. Administrator shall pay or arrange for payment to Provider at the Contract Rate(s) for Covered Services for all portions of the claim not in dispute. Provider shall provide the complete and accurate information requested within ninety (90) working days of Administrator's request, and Administrator shall pay or arrange for payment to Provider for Covered Services within thirty (30) days of receipt of the additional and/or corrected information.

ii. Post-Payment Disputed Claims. Provider may challenge payment to Provider within ninety (90) working days following Provider's receipt of such payment from Administrator, otherwise such payment shall be deemed final. If the claim is erroneously denied due to a claims processing error, and the Provider notifies Administrator of the potential error within one (1) year of the denial, the claim can be reprocessed without the requirement that the Provider resubmit the claim, and without regard to the submission deadlines above.

6. Payments. As required by MD Ann. Code, Ins. Article § 15-1005(c) the following is added to this Addendum:
   a. *Claim Payments*.
      i. Within 30 days after receipt of a claim for reimbursement from Provider entitled to reimbursement Administrator shall:
         - Mail or otherwise transmit payment for the claim in accordance with this section; or
         - Send a notice of receipt and status of the claim that states:
            - that Administrator refuses to reimburse all or part of the claim and the reason for the refusal;
            - 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
            - that the claim is not clean and the specific additional information necessary for the claim to be considered a clean claim.
   b. Prescription drug compensation. As required by MD Ann. Code, Ins. Article §15-1628(a)(1), the following is added to this Addendum:
      i. Notwithstanding anything in the Agreement to the contrary, any Prescription Drug Compensation, including prices communicated at the POS system will be in accordance with the agreed upon terms of the Agreement or otherwise require at least 30 (thirty) working days' prior written notice by Administrator to Provider of any change to the Prescription Drug Compensation.

7. Hold Harmless. As required by MD Ann. Code, Health-General Article § 19- 710(i) the following is added to this Addendum:
   a. *Plan Members Held Harmless*.
      i. Provider agrees that, in no event, including, but not limited to, non-payment by Administrator, Administrator's or HMO's insolvency, or Administrator's breach of this Agreement, shall Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Plan members or any person acting on their behalf, for services provided pursuant to this Provider Agreement. Provider will look solely to the Client HMO Plan for compensation for HMO Covered Services provided to Plan members under this Provider Agreement. Provider further agrees that (i) this provision shall survive the termination of this Provider Agreement regardless of the cause giving rise to termination, including insolvency of the Client HMO Plan or Administrator and shall be construed to be for the benefit of the Plan member and (ii) this provision supersedes any oral or written agreement now existing between the Provider and any member or persons acting on behalf of any Plan member insofar as such contrary agreement relates to liability for payment for Covered Services provided under the terms and conditions of this Provider Agreement. This provision shall not be construed to prohibit Provider from collecting or pursuing collection of copayments, coinsurance, deductibles or charges for non-Covered Services in accordance with the terms and conditions set forth herein.

ii. Notwithstanding anything stated herein to the contrary, Provider may directly bill Plan members for non-Covered Services: If the Plan member is informed before the services are rendered: (a) of the specific services to be rendered; (b) that the services are not covered by the Plan in which Plan member is enrolled; (c) of the estimated charges for the services; and (d) that the Client HMO Plan or Administrator will not pay for the service and (e) the Plan member will be personally responsible for payment for the services. The Plan member must agree in writing to be financially responsible for the services. Provider shall hold harmless, indemnify and defend the Client HMO Plan and/or Administrator relative to any claims or expenses arising from the provision of such non-Covered Services.

b. Administrator and HMO Not Held Harmless. As required by MD Ann. Code, Health-General Article § 19-710(t), the following is added to this Addendum:

i. HMO or Administrator may not require a provider to indemnify HMO or Administrator or hold HMO or Administrator harmless from a coverage decision or negligent act of HMO or Administrator.

8. Amendments. Per MD Ann. Code, Ins. Article § 15-1628, the following is added to this Addendum:

a. This Agreement may be modified or amended as follows:

i. Upon at least thirty (30) working days prior written notice from Administrator to Provider. Such amendment by Administrator shall be effective as of the effective date specified in the notice ("Amendment Effective Date") unless Provider gives written notice to Administrator, within fifteen (15) days from the receipt of such notice, rejecting the proposed amendment. If Provider rejects the proposed amendment, this Agreement will terminate ninety (90) days from the date of the rejection of the notice.

ii. Upon written agreement executed by both parties.

9. Information Supplied to Providers. As required by MD Ann. Code, Ins. Article § 15-1004(d) (1) the following is added to this Addendum:

a. Claims Filing Procedures.

i. Administrator shall provide and update, as appropriate, Provider on request, with a manual or other document that sets forth the claims filing procedures, including:

- The address where the claims should be sent for processing;
- The telephone number at which providers' questions and concerns regarding claims may be addressed;
- The name, address, and telephone number of any entity to which the Administrator or HMO has delegated the claims payment function, if applicable; and
- The address and telephone number of any separate claims processing center for specific types of applicable services.

C. MAC Appeals

As required by MD. Ann. Code. Ins. Article § 15-1628.1(f)(3), Administrator will make available on its website *https://professionals.optumrx.com/resources/manuals-guides/appeals-submission-guide.html* the following information about the appeal process, including:

(i) a telephone number at which the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager to speak to an individual or leave a message for an individual who is responsible for processing appeals;

(ii) an e-mail address of the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and

(iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e-mail made by a contracted pharmacy to the individual within 3 business days or less of receiving the call or e-mail.

A Network Pharmacy Provider must obtain, fully complete and submit the MAC Form to Administrator within twenty-one (21) days of the initial adjudicated claim. Administrator will investigate, resolve the MAC Appeal and contact the Network Pharmacy Provider within twenty-one (21) calendar days after the completed MAC Form is received by Administrator. If the MAC Appeal is resolved in favor of the Network Pharmacy Provider, Administrator will adjust the MAC for the drug as of the date of the original claim for payment without requiring the appealing Network Pharmacy Provider to reverse and rebill the claims, provide reimbursement for the claim and any subsequent and similar claims under similarly applicable contracts with Administrator: a) for the original claim, in the first remittance to the pharmacy after the date the appeal was determined; and b) for subsequent and similar claims under similarly applicable contracts, in the second remittance to the pharmacy after the date the appeal was determined. In addition, Administrator will for a similarly situated Network Pharmacy Provider contracted in the State: a) adjust the MAC for the drug as of the date the appeal was determined; and b) provide notice to the Network Pharmacy Provider or pharmacy's contracted agent that an appeal has been upheld and without filing a separate appeal, the Network Pharmacy Provider or the pharmacy's contracted agent may reverse and rebill a similar claim.

MAC Appeals contact information:
Hours of Operation: Monday–Friday, 6 a.m. to 4 p.m. (Pacific Time)
To review the summary and guidelines for appealing MAC prices / pharmacy reimbursement, as well as downloading the form for submitting appeals, visit the Pharmacist section of the OptumRx Health Care Professionals Portal or the contact information below.

- Telephone: 1-800-613-3591 Ext. 9
- Fax: 1-866-285-8652
- Email address: MAC@optum.com

Website:professionals.optumrx.com

As required by MD. Ann. Code. Ins. Article § 15-1628.1(f)(4), if Administrator upholds the MAC Pricing of the particular Covered Prescription Service Drug Product at issue, Administrator shall provide Network Pharmacy Provider the reason for the denial of the MAC Appeal, identify the NDC of a Drug Product which may be purchased by Network Pharmacy Provider at a price at or below the MAC price determined by Administrator and provide the name of the referenced national or regional pharmaceutical wholesaler operating in the state and the mathematical calculation used to determine the MAC. If the Network Pharmacy Provider has any additional questions about the MAC Appeal Process, please contact the MAC Appeal Department as noted on the website.

D. Cost pricing appeals and reimbursements disputes

As required by MD. Ann. Code. Ins. Article § 15-1628.2(a)(2), for disputes regarding cost pricing and reimbursement under the Agreement, a Network Pharmacy Provider may access OptumRx website at *https://professionals.optumrx.com/resources/manuals-guides/appeals-submission-guide.html* to obtain information about the appeal process including the following:

(i) the contracted pharmacy may directly contact the department or office responsible for processing appeals for the pharmacy benefits manager at 1-800-613-3591 Ext. 9 to speak to an individual or leave a message for an individual who is responsible for processing appeals;

(ii) e-mail to MAC@optum.com, the department or office responsible for processing appeals to which an individual who is responsible for processing appeals has access; and

(iii) a notice indicating that the individual responsible for processing appeals shall return a call or an e-mail made by a contracted pharmacy to the individual within 3 business days or less after receiving the call or e-mail.

As required by MD. Ann. Code. Ins. Article § 15-1628.2, a Network Pharmacy Provider must obtain, fully complete and submit the dispute or appeal form to Administrator within twenty-one (21) calendar days from the date a direct or indirect remuneration fee is charged; or another date as determined by the commissioner. Administrator will provide the Network Pharmacy Provider the reason for the appeal denial and the mathematical calculation used to determine the amount of reimbursement. If an appeal is upheld, Administrator will make adjustments as necessary to comply with the Prescription Drug Compensation in the Agreement as of the date the appeal was determined and provide notice to the Network Pharmacy Provider or its contracted agent that an appeal has been upheld. Administrator will not retaliate against a Network Pharmacy Provider for exercising its right to appeal or filing a complaint with the commissioner. Administrator will not charge a Network Pharmacy Provider a fee related to the re-adjudication of a claim or claims resulting from the upholding of an appeal.

E. Arbitration

Notwithstanding language in section 10.4 of the Agreement, arbitration shall be conducted in Maryland.

F. Governing Law

Notwithstanding language in section 11.11 of the Agreement, the Provider Agreement and this Addendum shall be governed and interpreted under Maryland law.

G. Audits

Notwithstanding anything in the Agreement to the contrary, audits conducted by Administrator of the Network Pharmacy Provider shall be in compliance with Maryland Code of Insurance section 15-1629.

H. Retroactive Denial or Modification of Reimbursement

Notwithstanding anything in the Agreement to the contrary, except for overpayments as defined in section 15-1629 (h) of the Maryland Code of Insurance, any retroactive denial or modification of reimbursement by Administrator to the Network Pharmacy Provider shall be in accordance and in compliance with Maryland Code of Insurance section 15-1631.

I. PBM Program Requirements or Rules Changes

Notwithstanding anything in the Agreement to the contrary, Administrator will comply with Maryland Code, Health General section 19-712.2 as it relates to changes in PBM program requirements or rules changes regarding thirty days advance written notice to the Network Pharmacy Provider for exclusions of coverage for classes of drugs specified by the Agreement, if any, changes in prior authorization, and selection of a new prescription claims processor.

J. MAC Specific Requirements. To assure the MAC list accurately reflects market pricing and the availability of Generic Drugs, Administrator utilizes multiple sources to determine MAC pricing. The sources are the market pricing benchmark data of AWP and WAC from Medi-span®; Cardinal Health™ and McKesson wholesaler information on pricing and market availability, CMS' NADAC survey of retail acquisition costs, Predictive Acquisition Cost® industry analytics, and from pharmacy inquiries and manufacturers.