UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

IN RE: EVANSTON NORTHWESTERN CORPORATION ANTITRUST LITIGATION	)	No. 07-cv-04446
	)	Judge Edmond E. Chang

ORDER

I. Background

Evanston Northwestern Healthcare merged with Highland Park Hospital and later became NorthShore University HealthSystem. Seven years after the merger, this class action was filed, alleging that the merger violated federal antitrust laws.[1] Two years into this case, in mid-2009, NorthShore filed its first motion to compel arbitration. R. 270. That motion was directed at managed care organizations (MCOs) who, by virtue of paying NorthShore for their clients' medical care, are members of the class. In response, the (then putative) Class argued that, by waiting two years, NorthShore had waived its right to compel arbitration. R. 273. The previously assigned judge determined that an arbitration decision would be premature before class certification, so the arbitration debate was tabled. R. 283. It stayed that way until, four years later, the Class was certified. R. 587. Then, another ten months passed while the Court and the parties worked out discovery issues and certification-related issues, like the notice plan. Finally, a briefing

[1]The Court has subject-matter jurisdiction under 28 U.S.C. § 1331. Pleadings, orders, briefs and other items on the docket are cited as "R." followed by the docket number and the page or paragraph number.

schedule was set for NorthShore's renewed motion to compel arbitration. R. 626. On the deadline, NorthShore filed, not one, but six separate motions. R. 641-47.

Those six motions name 43 MCOs that NorthShore wants to force into arbitration. For each targeted MCO, NorthShore should have identified (a) which contract bound the MCO to arbitrate; (b) why, assuming the MCO did not itself sign the contract (many did not), the MCO was bound by it; (c) where was the arbitration clause in the contract, (d) what the arbitration clause said; and (e) why, for contracts NorthShore did not sign, NorthShore was entitled to enforce the contract. But much of this evidence and argument was not provided. NorthShore mentioned 22 of the 43 MCOs only in footnotes. In an omnibus brief, the Class responded to the various arguments and as to the various MCOs. R. 693. Now, after digesting all of the briefs, along with all of the contracts that were provided, the Court denies in part and grants in part NorthShore's motions. The motions are granted as to 10 entities and denied as to 33. A summary chart with the ultimate decisions, MCO-by-MCO, is attached as Appendix A to this Order.

II. Standard

Under the Federal Arbitration Act, 9 U.S.C. § 1 *et seq.*, if the parties have an arbitration agreement and the asserted claims are within its scope, a motion to compel arbitration must be granted. 9 U.S.C. §§ 3–4; *Sharif v. Wellness Int'l Network, Ltd.*, 376 F.3d 720, 726 (7th Cir. 2004) (citing *Kiefer Specialty Flooring, Inc. v. Tarkett, Inc.*, 174 F.3d 907, 909 (7th Cir.1999)). The Act "establishes that, as a matter of federal law, any doubts concerning the scope of arbitrable issues should

be resolved in favor of arbitration." *Moses H. Cone Mem'l Hosp. v. Mercury Constr. Corp.*, 460 U.S. 1, 24–25 (1983). Accordingly, § 3 of the Act requires granting a motion to stay a lawsuit where "the issue involved in such suit ... is referable to arbitration" under a written agreement. 9 U.S.C. § 3. And Section 4 requires that the court order the parties to proceed in arbitration if there is an agreement to arbitrate. 9 U.S.C. § 4.

III. Analysis

A. Waiver (and Cigna and Unicare)

Contrary to the Class's argument, R. 693 at 13, NorthShore has not waived its right to compel arbitration. The Class's waiver arguments are the same as they were when the issue came up during the class-certification decision-making. *Compare* R. 693 at 13-18 *with* R. 274 at 6-9, R. 479 at 8-9, *and* R. 507 at 3-6. The Class admits as much by framing its argument as a request for reconsideration. R. 693 at 13. The gist of the argument is, and has always been, that NorthShore waived its arbitration rights by litigating this case for two years before bringing its first motion to compel. R. 270. The Court adopts its prior reasoning in rejecting this argument. R. 587 at 7-13.

The Class does cite to a few new cases—decided between the class certification order and now—but the cases do not change the outcome. Both cases are distinguishable because both cases involved classes that were much more homogeneous than this one. *Edwards v. First Am. Corp.*, 289 F.R.D. 296, 306 (C.D. Cal. 2012); *Elliott v. KB Home N. Carolina, Inc.*, 752 S.E.2d 694, 695 (N.C. Ct. App.

2013). *Edwards* involved a class of insureds suing an insurer. 289 F.R.D at 299. In *Elliot*, a class of a home builder's customers sued the builder. 752 S.E.2d at 695. Each customer "entered into two [form] contracts" with the builder when they hired it. *Id*. In both *Edwards* and *Elliot*, the defendants could readily tell that they had arbitration agreements with the class members because each defendant had just one or two form contracts with each class member. Not so here. This class includes those who have contracts with NorthShore, and those that do not. And, as far as the Court can tell from the contracts NorthShore filed, the contracts are all different. Under those circumstances, it was much harder for NorthShore than it was for the insurer (in *Edwards*) or the home builder (in *Elliot*) to evaluate its arbitration options.

Because NorthShore has not waived arbitration, its motion must be granted as to Cigna and Unicare. Both entities argued only waiver. R. 724 at 3. Since that argument fails, the motion is granted as to both.

B. Footnote-Only MCOs

The Court denies NorthShore's motions to compel as to every MCO named only in a footnote. *Harmon v. Gordon*, 712 F.3d 1044, 1053 (7th Cir. 2013) ("We have often said that a party can waive an argument by presenting it only in an undeveloped footnote … ."). Here, NorthShore named 22 of the 44 MCOs it wants to compel to arbitrate only in footnotes. And the footnotes lack the necessary evidence—for each MCO, including the 22 mentioned only in footnotes, NorthShore should have: (1) identified which contract or contracts subjected the MCO to

mandatory arbitration; (2) explained how the MCO was bound to the contract; (3) explained why NorthShore was entitled to enforce the contract; (4) identified where in the contract the arbitration clause was; and (5) provided a copy of the arbitration clause with the motion. Most of these critical pieces of information—especially (2) through (5)—are missing from NorthShore's footnotes. Scattered across several of NorthShore's motions, the footnotes ask the Court to compel into arbitration "each MCO that [the MCO named above the line] has acquired both before and during the pendency of the class period." R. 641 at 1, n.1 (MCOs acquired by Aetna); R. 644 at 1, n.1 (MCOs acquired by Cigna); R. 645 at 1, n.1 & 2 (MCOs acquired by MultiPlan); R. 646 at 1, n.1 (MCOs acquired by United Healthcare Inc.); R. 647 at 1-3, n.1-3 (MCOs acquired by APS, HealthSmart, and Stratose). The footnotes then identify which company acquired which MCO and when, and cite to, typically, an online press release or article about the deal. In some cases, the footnotes also mention that, before the acquisition, NorthShore already had a contract—arbitration clause presumably included—with the acquired entity. (NorthShore did not quote the arbitration provisions of those contracts. Nor did it file them until the Court ordered it to do so. R. 716.)

In particular, NorthShore's failure to explain how it and the targeted entity were bound by any particular contract is the most gaping hole in the argument. Determining when companies are bound by the obligations of their predecessors can be tricky. *See, e.g.*, *Tsareff v. Manweb Servs. Inc.*, 794 F.3d 841, slip op. at 5, (7th Cir. 2015) (analyzing successor liability). But NorthShore's motion assumes that it

can enforce any contract entered into by its predecessor. And it does so even though many of the contracts contain language prohibiting *exactly* that type of rights-assignment absent written consent of the other party. *E.g.*, R. 641-2, Hospital Services Agreement § 9.6 ("This Agreement relates solely to the provision of Hospital Services by [NorthShore's predecessor by merger] and does not apply to any other organization which succeeds to Hospital assets, by merger, acquisition or otherwise … . Neither party may assign its rights … under this Agreement without the prior written and informed consent of the other Party … ."). Likewise, NorthShore assumes that a contract entered into by the acquiring MCO automatically applies to the acquired MCO. But that is not right. By submerging its motions to compel these 22 MCOs in footnotes and then failing to offer needed information and argument, NorthShore has failed to develop the motions, and the Court must deny them as to these MCOs.

C. MCOs Not Shown to be Class Members

NorthShore's motion is also denied as to Choice Care Network, Health Preferred of Mid-America, Inc., MetraComp, Inc., Principal Health Care, Inc., and Three Rivers Provider Network. In its response brief, the Class argued that NorthShore failed to establish that these entities were members of the class. R. 693 at 5. Being a class member is a prerequisite to being compelled to arbitrate. R. 587 at 8 (citing *Daniels v. Bursey*, 430 F.3d 424, 428 (7th Cir. 2005)). The Class said that it "lack[ed] sufficient information to determine" if these entities were in the class and asked that NorthShore's motion be denied as to these entities because

NorthShore "failed to establish this Court's jurisdiction" over them. R. 693 at 5. NorthShore made no response to this argument. "Because of its failure to respond to these arguments, [NorthShore] has conceded these points." *Noble Roman's, Inc. v. Puzzles Fun Dome, Inc.*, 2015 WL 1210969, at *3 (S.D. Ind. Mar. 16, 2015) (citing *Bonte v. U.S. Bank, N.A.*, 624 F.3d 461, 466 (7th Cir.2010)). And so NorthShore's motion is denied as to these entities. To be clear: the Court is not definitively ordering them excluded from the class. The Class has not conceded that they are not members, but rather argued—successfully—that they cannot be compelled to arbitrate unless NorthShore shows that they are. And because NorthShore failed to meet that burden, its motion must be denied.[2]

D. Non-Class Member MCOs

The next group that can be whittled away are those entities, targeted by NorthShore's motions, that the parties agree are not class members. This category includes MultiPlan, Inc., Private Health Care Systems, Inc., CorVel Corp., and Stratose, Inc. R. 693 at 3-6; R. 647 at 8 (citing R. 602 at 211-12); and R. 704 at 3-4 and Exh. 1. The Class provided documentation and argument that these entities are not Class members. R. 693 at 3-6 and Exhs. A-F. NorthShore expressly agrees with Class counsel as to MultiPlan, and NorthShore appears to agree to the others as well. R. 704 at 3-4. Accordingly, the motion is denied as to these entities. Because they are not class members, they are not before the Court and cannot be compelled to arbitrate. R. 587 at 8 (citing *Daniels*, 430 F.3d at 428).

[2]It is conceivable that NorthShore's failure to respond to the Class's argument about these entities was due to an excusable lack of information about them, but NorthShore has not made that point.

E. MCOs that Concede

Next are the entities that have conceded NorthShore's motion. This group is comprised of United Behavioral Health, Inc., United HealthCare, Inc., and Aetna Health of Ill., Inc. United Behavioral and United HealthCare conceded by stipulation. R. 683. After the Court invited Aetna to clarify its position, R. 717, it chose to "take[] no position on NorthShore's motion." R. 724 at 3. In this context, a failure to respond is the equivalent of conceding. *See Noble Roman's, Inc.*, 2015 WL 1210969, at *3 (citing *Bonte*, 624 F.3d at 466).

F. Missing Contracts

There are two entities that will not be compelled to arbitrate because NorthShore failed to identify any contract that binds them to do so. NorthShore moved to compel both HealthSmart, Inc. and Magellan Health Services to arbitrate. R. 647. For HealthSmart, NorthShore pointed to a "DirectCare America, Inc., Preferred Hospital Agreement" and provided a weblink (not the document itself) to a "Provider Manual," saying that these documents contained binding arbitration provisions applicable to HealthSmart. R. 647 at 5.

Neither document compels HealthSmart to arbitrate. The Court downloaded the Provider Manual and looked it over—in vain—for the word arbitration. It was not there,[3] so the manual cannot support NorthShore's position. Similarly, the Preferred Hospital Agreement contains no arbitration provision, only an agreement to cooperate with "grievance procedures," which are undefined. R. 718-33 § 2.15.

[3]The copy of the manual that the Court downloaded is attached as Appendix B. It was downloaded on July 6, 2015.

And it is not an agreement with HealthSmart at all, but with another company called DirectCare America. R. 718-33 at 2 ("This Agreement is entered into … between DirectCare America, Inc. … and Evanston Hospital Corporation"). NorthShore fails to explain how the DirectCare contract binds HealthSmart. At one point, NorthShore says that HealthSmart was formerly DirectCare, R. 647 at 3 ("HealthSmart, Inc. (formerly 'Direct Care America' …)"), and elsewhere, NorthShore claims that HealthSmart acquired DirectCare, R. 647 at 1, n.2 ("This motion applies to any and all claims of each MCO that HealthSmart has acquired … including DirectCare America"). Perhaps those two statements are different ways of saying the same thing, but evidence and analysis is needed before leaping to the conclusion that the DirectCare contract binds HealthSmart.

NorthShore runs into a similar problem with Magellan. Its briefing points to a "Health Facility Participation Agreement." R. 647 at 5. This contract does contain an arbitration provision. R. 718-40 § X.F. But it has nothing to do with Magellan. Rather, it is between NorthShore's predecessor (by merger) and a company called Medco Behavioral Care Systems Corporation. R. 718-40 at 2 ("This Health Facility Participation Agreement … is made … by and between Evanston Hospital Corp. … and Medco Behavioral Care Systems Corporation."). There does not appear to be anything in any contract or brief submitted by NorthShore to explain what relationship, if any, Magellan has with Medco or this contract. NorthShore's motion is denied as to Magellan and HealthSmart.

G. Blue Cross Blue Shield

NorthShore's motion to compel Blue Cross Blue Shield of Illinois is granted as to the PPO, but not the HMO. In opposition to NorthShore's motion, Blue Cross Blue Shield made three arguments. R. 724 at 2. First, it adopted the general waiver argument that the Court already rejected. That rejection stands. Second, Blue Cross Blue Shield made a waiver argument specific to it. It argued that NorthShore waived any arbitration rights as to Blue Cross Blue Shield by asking this Court to apply a contractual statute of limitations. This argument is rejected because it came in a Court-ordered supplement, but went beyond the scope of the order. The order requesting the supplement asked Class Counsel to clarify which arguments Blue Cross Blue Shield was advancing but it did not give leave to make entirely new arguments. R. 717. Third, Blue Cross Blue Shield notes that the contract was with its PPO not its HMO, so that only the PPO can be compelled to arbitrate. R. 693 at 21. NorthShore did not respond to this argument, so the Court accepts it. *Noble Roman's, Inc.,* 2015 WL 1210969, at *3 (citing *Bonte*, 624 F.3d at 466). The motion is granted, but only as to the PPO, not the HMO.

H. Four Remaining MCOs

There are four remaining MCOs to consider: ComPsych Employee Assistance Program, Inc.; Principal Health Care of Illinois, Inc.; ValueOptions, Inc.; and APS Healthcare, Inc. NorthShore's motion as to each is granted. The Class raises, generally speaking, two arguments against arbitration: the arbitrability of antitrust claims, R. 693 at 5-6, n.6; and whether the antitrust claims here are within the

scope of the four relevant arbitration provisions, R. 693 at 5-6. Neither argument is a winner.

1. Arbitrability

Antitrust claims are arbitrable. This conclusion rests on *Shearson/Am. Exp., Inc. v. McMahon*, 482 U.S. 220, 226-27 (1987). *McMahon* established the general rule that, unless a federal statute says otherwise, federal statutory claims are arbitrable: "[T]he Arbitration Act, standing alone, … mandates enforcement of agreements to arbitrate statutory claims. [But l]ike any statutory directive, the Arbitration Act's mandate may be overridden by a contrary congressional command. The burden is on the party opposing arbitration, however, to show that Congress intended to preclude a waiver of judicial remedies for the statutory rights at issue." *Id*. The Class has not argued that "Congress intended to preclude a waiver of judicial remedies" for the federal antitrust statutes. It did not cite or discuss *McMahon*. Neither did NorthShore, but one of the cases it cited relied on *McMahon* to reach this conclusion. *Chicago Tribune Co. v. Palermo*, 1988 WL 90844, at *2 (N.D. Ill. Feb. 25, 1988).

This conclusion is also on the side of an emerging consensus. *Seacoast Motors of Salisbury, Inc. v. DaimlerChrysler Motors Corp.*, 271 F.3d 6, 10 (1st Cir. 2001) (holding antitrust claims arbitrable) (collecting cases). And the consensus is in line with the statements (albeit not expressed as direct holdings) in a seminal Supreme Court opinion on arbitration, *Gilmer v. Interstate/Johnson Lane Corp.*, 500 U.S. 20, 20-21 (1991) ("Various other laws, including antitrust … laws …, are designed to

advance important public policies, but claims under them are appropriate for arbitration."), and additional statements in Seventh Circuit dicta, *Baxter Int'l, Inc. v. Abbott Labs.*, 315 F.3d 829, 831-32 (7th Cir. 2003) ("Arbitrators regularly handle claims under federal statutes. We do not see any reason why things should be otherwise for antitrust issues."); *Sanjuan v. Am. Bd. of Psychiatry & Neurology, Inc.*, 40 F.3d 247, 250 (7th Cir. 1994), *as amended on denial of reh'g* (Jan. 11, 1995) ("Producers may agree to arbitrate their antitrust disputes—certainly so for international transactions, and likely so for domestic transactions … .").

The only whiff of contrary authority is the lingering influence of *American Safety Equipment Corp. v. J. P. Maguire & Co.*, 391 F.2d 821, 825-27 (2d Cir. 1968). *American Safety* held that antitrust claims are not arbitrable. *Id.* ("We do not believe that Congress intended such claims to be resolved elsewhere than in the courts."). Two Seventh Circuit cases followed *American Safety*. *Applied Digital Tech., Inc. v. Cont'l Cas. Co.*, 576 F.2d 116, 117 (7th Cir. 1978) (relying on *American Safety*); *Univ. Life Ins. Co. of Am. v. Unimarc Ltd.*, 699 F.2d 846, 850-51 (7th Cir. 1983) ("Federal antitrust issues, however, are nonarbitrable … .") (citing *Applied Digital*). If *Applied Digital* and *Unimarc* had held, expressly, that antitrust claims were non-arbitrable, then this Court would be obliged to follow them no matter the contrary dicta and even in spite of *McMahon*. *See, e.g.*, *Levin v. Madigan*, 41 F. Supp. 3d 701, 704 (N.D. Ill. 2014) (citing *Rodriguez de Quijas v. Shearson/Amer. Express, Inc.*, 490 U.S. 477, 484 (1989) ("If a precedent of this Court has direct application in a case, yet appears to rest on reasons rejected in some other line of

decisions, the Court of Appeals should follow the case which directly controls, leaving to this Court the prerogative of overruling its own decisions.")).

But they did not so hold. *Applied Digital* turned on the so-called "permeation" doctrine, the gist of which is that, "if the antitrust issues permeate the entire case, the district court should proceed on the antitrust issues before the [the non-antitrust issues in the] case [are] submitted to an arbitrator." *Applied Digital*, 576 F.2d at 117. The parties there did not contest that the doctrine applied and—more importantly—did *not* contest whether antirust issues were arbitrable in the first place. *Id*. ("[T]he parties are in apparent agreement that the permeation doctrine … is well-settled law."). Thus, the opinion can fairly be read as merely assuming non-arbitrability, and not deciding the point. Similarly, *Unimarc* affirmed an order compelling arbitration to go forward over a permeation-doctrine objection. 699 F.2d at 847, 853. It discussed *Applied Digital* and the arbitrability of antitrust claims, but did not render a holding on the question. So, strictly speaking, the slate is clean. Neither the Supreme Court nor the Seventh Circuit has explicitly held that the antitrust claims here[4] are not arbitrable. So the Court is free to follow *McMahon*'s holding and the tea leaves in *Gilmer*, *Baxter*, and *Sanjuan* and hold that they are.

[4]The Supreme Court did hold international antitrust claims were arbitrable. *Mitsubishi Motors Corp. v. Soler Chrysler-Plymouth, Inc.*, 473 U.S. 614, 640 (1985). But these claims are domestic, and *Soler* expressly left domestic claims for another day. *Id*. at 629 ("We find it unnecessary to assess the legitimacy of the *American Safety* doctrine as applied to agreements to arbitrate arising from domestic transactions.").

2. Scope

The antitrust claims are within the scope of the relevant arbitration provisions. "[I]n interpreting the construction of the contract language, 'any doubts concerning the scope of arbitrable issues should be resolved in favor of arbitration.'" *Matthews v. Rollins Hudig Hall Co.*, 72 F.3d 50, 53 (7th Cir. 1995) (quoting *Moses H. Cone*, 460 U.S. at 24–25).[5] "An order to arbitrate the particular grievance should not be denied unless it may be said with positive assurance that the arbitration clause is not susceptible of an interpretation that covers the asserted dispute. Doubts should be resolved in favor of coverage." *Id.* (quoting *United Steelworkers of America v. Gulf Navigation Co.*, 363 U.S. 574, 582 (1960)). In this case, it cannot be said with "positive assurance" that these four arbitration clauses are "not susceptible" of an interpretation that encompasses antitrust claims.

Rather, each clause readily appears to encompass the antitrust claims here. This should be no surprise: the antitrust claims here are—in essence—claims to recover alleged overpayments made pursuant to the contracts containing the clauses. It would be odd for a contractual provision on dispute resolution to exclude from its scope claims involving payments made under the contract. But even if the claims did not so directly arise from the contractual relationships between the MCOs and NorthShore, it would still be difficult to say that these four clauses are "not susceptible" of an interpretation in NorthShore's favor.

[5]Although no authority supports their position, the Class argued that Illinois law, not federal law, determines the scope of the arbitration provisions at issue. Per *Matthews*, that is not so.

ValueOptions' clause says "The parties agree that the exclusive remedy for unresolved disputes between the parties under this Agreement, including without limitation a dispute involving interpretation of any provision of this Agreement, questions regarding application and/or interpretation of applicable state and/or federal laws, rules, or regulations, the parties' respective obligations under this Agreement, or otherwise arising out of the parties' business relationship, shall be resolved by binding arbitration." R. 718-46 § 9.7(a)(i). This is the easiest case of the four. This clause is broad and, in particular, the phrase "arising out of the parties' business relationship" encompasses the antitrust claims here.

ComPsych's clause says "In the event a dispute is not settled through the good faith efforts, through informal discussions between the parties, all matters in controversy shall be submitted to binding arbitration." 718-9 § 19. Here, the Court cannot rule out an interpretation in NorthShore's favor because there is no language describing what kinds of disputes or controversies are covered other than "all." "All" is reasonably susceptible to a broad interpretation that includes the antitrust claims here.

Principal Health's clause provides that, absent informal agreement, the parties "agree to arbitrate" "any problems or disputes that may arise under this Agreement." R. 718-10 § 13.2. APS's clause says "In the event that any problem or dispute [that may arise under this Agreement,] other than a grievance decision … is not satisfactorily resolved, [the parties] agree to arbitrate." R. 718-32 § 9.1.2. These clauses are similar. Although not as broad as "arising out of or relating to" clauses,

they are still broad enough that the Court cannot rule out an interpretation calling for arbitration here. Both are tied to disputes that "arise under" the "agreements." The agreements both concern the MCOs paying NorthShore for hospital services. And the antitrust claims also concern those payments.

The Class's contrary cases do not help it. In *Home Quarters Real Estate Grp., LLC v. Michigan Data Exch., Inc.*, 2007 WL 2984120, at *2-4 (E.D. Mich. Oct. 12, 2007), the antitrust claim was held to be outside the scope of arbitration provision encompassing "contractual issues and questions, and *specific non-contractual issues* [like] entitlement to commissions and compensation in cooperative transactions." (emphasis added). Here, there is no similar limiting language. In *Thomas v. Am. Gen. Fin., Inc.*, "the subject matters of the arbitration provisions were the loan transactions. Thomas' complaint, however, arises from the alleged unauthorized access of credit information that is wholly unrelated to the Agreements." 2009 WL 781078, at *4 (N.D. Ill. Mar. 23, 2009). Thus, in *Thomas*, the contracts were unrelated to the claim. Not so here.

The Class cited one more case worth discussing. *Allied Signal* affirmed an order denying a motion to compel an antitrust claim into arbitration where the arbitration clause was, like those at issue here, broad: "any claim or controversy arising out of or relating to [the] Agreement." *AlliedSignal, Inc. v. B.F. Goodrich Co.*, 183 F.3d 568, 572 (7th Cir. 1999). But context is critical to understanding the decision. The plaintiff sold airplane parts. It sued two defendants, competitors in the airplane parts business, to stop their merger, alleging that the merger would

violate federal antitrust law. Wholly apart from the merger, the plaintiff had a contract with one defendant obligating that defendant and the plaintiff to share information and cooperate in preparing joint bids for airplane projects. This contract contained the arbitration clause at issue in the case. The contract had nothing to do with either the plaintiff or that defendant buying or selling anything from each other—it was just about seeking business opportunities together. This was key: the cooperation agreement just did not have anything to do with the antitrust claim. *AlliedSignal*, 183 F.3d at 573. The same is not true here. The contracts here are about the MCOs paying NorthShore for care that NorthShore provides to the MCOs members. The antitrust claim alleges that the MCOs paid too much *under those contracts*. Unlike in *Allied*, the contract and the antitrust claim here are related.

I. Future Arbitration Motions

NorthShore said that it expects to file additional motions to compel arbitration against additional MCOs: "Pending further discovery—and after the Court rules on the pending motions to compel arbitration against the MCOs—NorthShore intends to move to compel each MCO's self-funded entities, including named-plaintiff Painters District Council No. 30 Health & Welfare Fund, to arbitrate any and all claims they have against NorthShore." R. 648 at 10, n.3. Before it does so, NorthShore must ask for leave. The Court ordered NorthShore to file its motion to compel arbitration on a date certain. R. 626. That scheduling order can only be modified for good cause. Fed. R. Civ. P. 16(b)(4) ("A schedule may be

modified only for good cause and with the judge's consent."). Thus, if NorthShore wants to file additional motions, it must show good cause. And, to make that showing, NorthShore must explain why it could not have, with reasonable diligence, moved to compel the other MCOs by the initial deadline.

IV. Conclusion

NorthShore's motions to compel arbitration, R. 641, 642, 643, 644, 645, 646, 647, are denied in part and granted in part as explained above and as summarized on the chart attached as Appendix A.

ENTERED:

s/Edmond E. Chang
Honorable Edmond E. Chang
United States District Judge

DATE: September 4, 2015

Appendix A

Target MCO	Mot.	Ruling
Admar Corp.	R. 645	Denied
Aetna Health of Illinois, Inc.	R. 641	Granted
APS Healthcare, Inc.	R. 647	Granted
BCE Emergis	R. 645	Denied
Beech Street Corp.	R. 645	Denied
Blue Cross Blue Shield of Ill., PPO	R. 642	Granted
CCN Mangaged Care, Inc.	R. 641	Denied
Choice Care Network	R. 647	Denied
Cigna	R. 644	Granted
Coalition America	R. 647	Denied
Cofinity, Inc.	R. 641	Denied
ComPysch Employee Assistance Program, Inc.	R. 643	Granted
CorVel Corp.	R. 647	Denied
Coventry Health and Life Ins. Co.	R. 641	Denied
DirectCare America	R. 647	Denied
First Health Group Corporation (FKA Affordable Health Care Concepts)	R. 641	Denied
ForMost LLC	R. 645	Denied
Great-West Healthcare	R. 644	Denied
Health Preferred of Mid-America, Inc.	R. 647	Denied
HealthSmart, Inc.	R. 647	Denied
HealthStar/ppoNEXT	R. 645	Denied
HFN, Inc.	R. 647	Denied
Magellan Health Services	R. 647	Denied
MedAvant Healthcare Solutions	R. 647	Denied
MetraComp, Inc.	R. 647	Denied
Multiplan, Inc.	R. 645	Denied
National Provider Network	R. 647	Denied
One Health Plan of Ill.	R. 644	Denied
Oxford Health Plan	R. 646	Denied
Preferred Plan	R. 647	Denied
Principal Behavioral Healthcare, Inc.	R. 647	Denied
Principal Health Care of Ill.	R. 643	Granted
Principal Health Care, Inc. PPO	R. 647	Denied
Private Health Care Systems Inc.	R. 645	Denied
Stratose (FKA Coalition America)	R. 647	Denied
Three Rivers Provider Network	R. 647	Denied
Unicare	R. 647	Granted
United Behavioral Health	R. 643	Granted
United Healthcare, Inc.	R. 646	Granted
United Payor & United Providers	R. 645	Denied
ValueOptions, Inc.	R. 647	Granted
Viant, Inc.	R. 645	Denied
Wellmark Healthnetwork	R. 645	Denied

Appendix B

HealthSmart

Table of Contents

Provider Quick Reference Guide

Customer Service	800.687.0500
Verify Eligibility	Refer to the member ID card and call the telephone number printed on the card to verify benefits and eligibility.
Pre-Certification	Refer to the member ID card for precertification instructions.
Claims Submission - Paper	Refer to member ID card for claims filing instructions or mail to: **HealthSmart Benefit Solutions** **P.O. Box 53010** **Lubbock, TX 79453-3010**
Claim Submission – Electronic	Refer to member ID card for claims filing instructions.
Electronic Data Interchange (EDI)	Refer to member ID card for claims filing instructions.
Claim Appeals	Phone: 800.687.0500 Email: priority.service@healthsmart.com Fax: 214.574.3992
Client List	Visit www.healthsmart.com for the most current list of clients. *(select Providers, under Quick Links, select Client List)*
EDI Payor List	Visit www.healthsmart.com for the most current list of Payors. (From the home page, go to Solutions & Services. Under Information Systems, click Payor List)

Provider Relations (listed by state in which provider practices)	Submit Provider Relations inquiries to the regional emails below.
IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com
AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com

Email Contacts

About HealthSmart

For more than 40 years, HealthSmart has offered a wide array of customizable and scalable health plan solutions for self-funded employers. Our comprehensive suite of services address healthcare from all angles. We offer claims and benefits administration, provider networks, pharmacy benefit management services, business intelligence, onsite employer clinics, care management, wellness initiatives and web-based reporting.

We work closely with our clients and business partners to achieve better treatment outcomes. Our innovative strategies bring balance back to healthcare plans. Although our solutions are offered on a standalone basis, HealthSmart is an industry leader because of the ability to integrate services according to each client's needs.

We are headquartered in Irving, Texas, with service hubs throughout the country. Last year, our 1,600+ associates paid more than $6 billion in medical claims for more than 1,000,000 members, and we were ranked by the Business Insurance Journal as the largest independent third party administrator in the nation. In addition, HealthSmart's ongoing expansion strategy has brought greater economies of scale and additional capabilities to our clients. Our mission is to improve member health and reduce healthcare costs.

Vision and Mission

Our Vision. To be the healthcare industry's leading provider of innovative solutions

Our Mission. To lower the cost of healthcare and improve the health of our members

Core Values

Quality. We are committed to providing superior healthcare products and services to our customers, clients and brokers.

Productivity. We strive for an approach that provides excellent results and continued growth.

Fulfillment. We maintain a positive work environment and work hard to develop the career paths of our team members.

Value. We create value for our shareholders by maintaining a work culture that delivers positive financial results.

Community. We are dedicated to the communities and charities we share with our associates and clients.

Provider Data Submission Guide

Participating Providers are the foundation of all HealthSmart network programs. It is vital that we maintain accurate and timely information that affect patient referrals and claims administration. Click here to go directly to the provider update page.

Please notify HealthSmart with provider data updates and/or changes via the following methods:

EMAIL:

Provider Relations (listed by state in which provider practices)	Submit Provider Relations inquiries to the regional emails below.
IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com
AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com

U.S. POSTAL SERVICE:

Mail: HealthSmart | Attn: Provider Relations | 222 W. Las Colinas Blvd., Suite 500 N | Irving, TX 75039

FAX:

Fax: 214.574.2368, Attn: HealthSmart Provider Relations

We will need the following information:

- Name
- TIN
- NPI
- Specialty
- New information to add or change
- ID information (if information is being replaced or changed)
- Effective date of the change or addition

Delegated Provider Data Submission Instructions

The delegated group shall provide a roster of groups' practitioners with changes from the previous roster highlighted and readily identifiable on a regular or as-needed basis. The master list will serve as notice of change in name, address, phone number, fax number, specialty and termination status. The delegated group may submit a request to update its group information, including provider addition, termination and changes via the following:

EMAIL:

cgc.data@healthsmart.com

Please submit updates in an Excel file and include the following data:

- Name
- TIN
- NPI
- Specialty
- New information to add or change
- Old information (if information is being replaced or changed)
- Effective date of the change or addition

U.S. POSTAL SERVICE:

Mail: HealthSmart

Attn: Provider Relations

222 W. Las Colinas Blvd., Suite 500 N

Irving, TX 75039

FAX:

Fax: 214.574.2368, Attn: HealthSmart Provider Relations

Utilization Review & Case Management Precertification

Determinations are made by a licensed, registered or certified healthcare professional employed by the Utilization Management program and ensure that the services rendered by a Participating Provider meet the requirements of care, treatment and medical necessity.

Concurrent Review

After the admission, the Utilization Management Department will monitor services on a concurrent basis. If the Eligible Person is not discharged within the number of days initially approved, the Utilization Review personnel will contact the attending physician for additional medical information. Both care and services for each case are monitored. Further certification will depend upon the establishment of medical necessity.

Case Management

Case Management is a service designed to identify Eligible Persons that can benefit from close review and management due to length, severity, complexity and/or cost of healthcare. Case Managers locate and assess medically appropriate settings for the Eligible Persons and manage their health care benefits as efficiently as possible.

The goals of Case Management are to ensure that care is provided in the most appropriate setting at a competitive price. Quality of care should not be compromised. The Case Manager will work closely with the hospital, the physician, the family and ancillary providers to coordinate services that meet the specific needs of the Eligible Person in need of Case Management services.

Since early identification is essential to proactive Case Management, the company providing Utilization Management provides referral of Eligible Persons through precertification and concurrent review process. An identified list of illnesses, injuries and other medical treatments with high potential for Case Management is used to aid in this process. This list does not limit application of the program to Eligible Persons who may be in need of Case Management services.

Clinical Appeals

When a determination is made not to approve or certify a health care service, written notification is sent to the attending physician, hospital, Eligible Person and Payor. The notification will include the reason for the non-certification and a mechanism for the physician and Eligible Person to appeal. The appeal may be initiated by phone but the follow up must be in writing and must be received within 60 days from the date of the original determination. There are no specific documents required to initiate an appeal; however, the Eligible Person may be requested to complete a release of information form if medical records are needed.

Upon return of this form, the Utilization Management Department will request the medical records from the appropriate provider(s). Upon receipt of an appeal, the Utilization Management Department personnel will obtain all information necessary for the appeal and record the process. The information will then be forwarded to a physician consultant of the same or similar specialty as the attending physician. The review will be conducted by a physician who has not previously reviewed the case. If requested, an expedited appeal for emergency care non-certification, and non-certification of continued stay of hospital for Eligible Persons will be completed within one working day following appeal request and receipt of all information necessary to complete the appeal. If the appeal is requested after discharge or services are provided, the appeal process will be completed with written notification of the outcome. This will be sent no later than 30 days from the receipt for the appeal request and necessary documentation needed to complete the appeal process. The physician, Eligible Person, hospital, and Payor will be notified within one working day of decision to either uphold the non-certification or approve the requested admission, procedure, service or continued stay.

Discharge Planning

Discharge Planning is the process that assesses an Eligible Person's needs for treatment after hospitalization in order to help arrange for the necessary services and resources to effect an appropriate and timely discharge from the hospital. Discharge planning is also designed to identify those Eligible Persons who will need care after discharge from the hospital. This care may include home health services, extended care facilities or home I.V. therapy. Early identification will ensure timely discharge thus providing less expensive yet quality care.

Emergency Admissions

Notification of Emergency Admission must take place within 48 hours of the admission.

Maternity Admissions

The Eligible Person should contact HealthSmart Care Management Solutions or the company providing UM Services for HealthSmart Network Payor early in the pregnancy with the expected date of delivery. The Utilization Review personnel will work closely with the physician to monitor the pregnancy for potential high risk. If the pregnancy is determined to be high risk, the case should be referred to a Case Management Nurse for potential intervention. The Utilization Management Department should be notified when the Eligible Person is admitted for labor and delivery. Any other admissions prior to delivery, such as complications of pregnancy, require separate notification. The Utilization Management Department should also be notified if the baby is not going to be discharged with the mother.

Medical Criteria

A system used by Utilization Management Department personnel utilizes clearly established, nationally recognized criteria for determining the appropriateness of medical services provided or to be provided. The criteria are reviewed at least annually and revised as indicated. The criteria may contain length of stay parameters based upon expected outcomes of care as specified in Milliman Care Guidelines.

Outpatient Surgery

The company providing Utilization Management will review selected procedures for recommendation of outpatient surgical setting. When a call is received to pre-certify a surgical procedure and hospital stay, the Utilization Management Department checks all medical information against established medical criteria to determine whether the procedure may be done safely on an outpatient basis. The Utilization Management Department personnel will then discuss the possibility of using an outpatient facility with the Eligible Person's physician.

The company providing Utilization Management may suggest that pre-admission testing be done whenever hospitalization is necessary. Pre-admission testing allows the patient to have routine tests such as x-rays, lab tests, EKGs, etc., done on an outpatient basis prior to the hospital confinement, which usually results in saving one night's stay in the hospital. During precertification, the attending physician will be asked to determine if testing may be performed on an out-patient basis.

Preventable Errors

In rendering Covered Services, Participating Provider shall not be entitled to compensation from Payor or Eligible Person(s) if such services or treatment were Medically Necessary as a result of Participating Provider’s preventable error(s), including but not limited to, error(s) arising from surgery, use of medical devices or products, inadequate patient protection, inadequate care management, or unclean or unsafe environmental conditions.

Retrospective Review

The company providing Utilization Management recognizes that there will be Eligible Persons who will not have precertification and concurrent review performed. These cases will be reviewed retrospectively focusing on day of admission and continued hospital stay. The Utilization Management Department personnel will contact the hospital or attending physician to obtain all necessary information. Using established medical criteria, the Utilization Management Department personnel will determine the medical necessity of the hospitalization. If the criteria are met, the hospital admission will be certified. If the medical criteria are not met, the denial and appeal procedures for precertification and concurrent review will be followed.

Review Guidelines

Review Guidelines will be conducted in accordance with the following National Database: Healthcare Screening Criteria for Utilization Management, Geographic Annualized Volume - Milliman Care Guidelines.

Utilization Management

Utilization Management is the process of evaluating proposed hospital admissions and medical services to identify patterns of treatment for quality and appropriateness. This is accomplished through pre-admission certification, concurrent review, retrospective review, discharge planning and Case Management.

Utilization Review

Utilization Review is a program established by HealthSmart Care Management Solutions or on behalf of a HealthSmart Network Payor under which a request for care, treatment and/or supplies may be evaluated against established clinical criteria for medical necessity, appropriateness and efficiency.

Network Participation

Network Credentialing Guidelines

HealthSmart maintains the highest quality provider network. This commitment involves credentialing and re-credentialing of each provider in accordance with the standards established by National Committee for Quality Assurance (NCQA). All providers are required to complete a Provider Application and Agreement. Provider application may be obtained by contacting HealthSmart, or the following web site: www.healthsmart.com. All requested information must be received to process the application.

Verification of each state license and a query of the National Practitioner Data Bank will be used to determine whether registration has been suspended or revoked. Malpractice insurance will be verified. Pending, settled, closed or awarded cases may be reviewed by a peer committee. Complete malpractice information must be provided on each malpractice case/suit/settlement (s) that a Participating Provider was involved in for the past five (5) years for initial credentialing or the past three (3) years for re-credentialing.

Provider liability Insurance minimum requirements are based on state and industry standards per policy year for ALL HealthSmart Providers. Participating Provider shall also insure that his/her employees maintain the applicable general and professional liability insurance coverage.

The following information must be active (as applicable) and unrestricted:

- State License
- DEA
- Controlled Substance Certificate
- Malpractice Insurance Certificate

Credentialing Applications

Credentialing Applications are required by HealthSmart in order to join a HealthSmart network. If a given state has a standard application form, HealthSmart will accept the form in lieu of completing a HealthSmart provider application.

Delegated Credentialing Requirements

HealthSmart *o*ffers delegated credentialing for provider groups that meet NCQA guidelines for initial and re-credentialing of practitioners. Prior to granting delegated status, HealthSmart will review the group's credentialing policy and procedures for compliance with NCQA standards and may review a random sample of the group's credentialing files. In addition, delegated provider groups, agree to an annual audit process, submission of provider updates at the minimum on a semi-annual basis, and provide update to changes to their credentialing policy and procedures. Upon approval by Health*Smart's* Medical Advisory Committee, the groups are granted delegation status and will sign a Delegated Credentialing Agreement.

The delegated entity agrees to the following:

Reporting

On a monthly basis, the delegated group shall submit to HealthSmart a report capturing any actions taken related to providers which include changes in licensing status, additions, changes and/or terminations pertaining to the group and/or any other changes that is significant to individuals in the credentialing or re-credentialing process.

The delegated group shall provide a roster of groups' practitioners with changes from the previous roster highlighted and readily identifiable on a regular or as-needed basis. The master list will serve as notice of change in name, address, phone number, fax number, specialty and termination status.

The delegated group may submit a request to update its group information, including provider addition, termination and changes via the following:

Delegated Provider Data Submission Instructions

EMAIL:

cgc.data@healthsmart.com

Please submit updates in an Excel file and include the following data:

- Name
- TIN
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- Specialty
- New information to add or change
- Old information (if information is being replaced or changed)
- Effective date of the change or addition

U.S. POSTAL SERVICE:

Mail: HealthSmart | Attn: Provider Relations | 222 W. Las Colinas Blvd., Suite 500 N | Irving, TX 75039

FAX:

Fax Number: 214.574.2368, Attn: Provider Relations

Compliance

All credentialing and re-credentialing services will comply with current NCQA guidelines as well as Health*Smart* standards or other mandatory regulatory body requirements and standards as appropriate.

Program Change Notification

The delegated group will provide 15 days advance notice to HealthSmart of any material changes to the organization or to its performance of any of the delegated functions.

Physician Status Notification

The delegated group will notify HealthSmart within 10 days if a hospital revokes or suspends the clinical privileges of a physician except in the case of non-compliance with medical record requirements.

Audit

HealthSmart reserves the right to annually monitor and audit delegated entities performance of credentialing and re-credentialing by examining credentialing files and member's medical records. Monitoring and/or audits will be conducted electronically, or on site with a 30 day advance written notice. HealthSmart's access to files will not include information related to peer review committees, or any other confidential information unrelated to credentialing.

Corrective Action

If deficiencies in service are identified by HealthSmart, the delegated group will provide a written response within 15 days that either:

- Disputes the deficiency and provides supporting evidence or;
- Submits a corrective action plan, including procedures and timelines.

In the event that the parties fail to reach an agreement on the existence of a deficiency, or the appropriate corrective action and timeframe, HealthSmart reserves the right to terminate the Delegated Credentialing agreement with a 15 day notice.

Dispute and Complaint Resolution

Provider Status Appeals:

The dispute resolution and/or appeal resolution mechanism is available to any Participating Provider that wishes to initiate the process. If a Participating Provider has a grievance or complaint related to a change in the provider's status within the network, or any action taken by HealthSmart related to a practitioner's professional competency or conduct, they may contact the Health*Smart* Medical Director, Credentialing Manager, Quality Management Coordinator or any HealthSmart staff person to initiate the dispute process. If the matter cannot be resolved informally within a reasonable time to the Provider's satisfaction, the Participating Provider may submit a written grievance to the HealthSmart Credentialing Manager within 30 days of the date of notification requesting reconsideration.

If the Participating Provider submits a written request for reconsideration within 30 days, the matter will be discussed during the next Medical Advisory Committee (MAC) meeting. If the MAC upholds the original decision of the Committee, the Provider may request an appeal within 20 days of notification of the decision. An Ad Hoc Committee will be developed that consists of three qualified individuals, of which at least one will be a participating practitioner who is otherwise not involved in network management, who was not involved with the original decision rendered, and one who is a clinical peer of the Participating Provider who filed the dispute. Once a decision is rendered on behalf of the Ad Hoc Committee, the HealthSmart Credentialing Manager will send a letter to the appealing Provider notifying him/her of the decision. If the Participating Provider is still not satisfied with the outcome, he or she may send in a written request within 30 days of the receipt of the letter, requesting a second level of appeal.

The second level of appeal will be considered by a separate Ad Hoc Committee which will be comprised of three qualified individuals of which at least one will be a participating practitioner who is otherwise not involved in network management, who was not involved in the original or first level of appeal decision, and one who is a clinical peer of the Participating Provider who filed the dispute. The final decision of the second-level appeal Ad Hoc Committee will be final and binding. HealthSmart will automatically remove any Participating Provider from the network, if the Participating Provider poses an immediate threat to the health or safety of HealthSmart Eligible Persons until further investigation can be conducted.

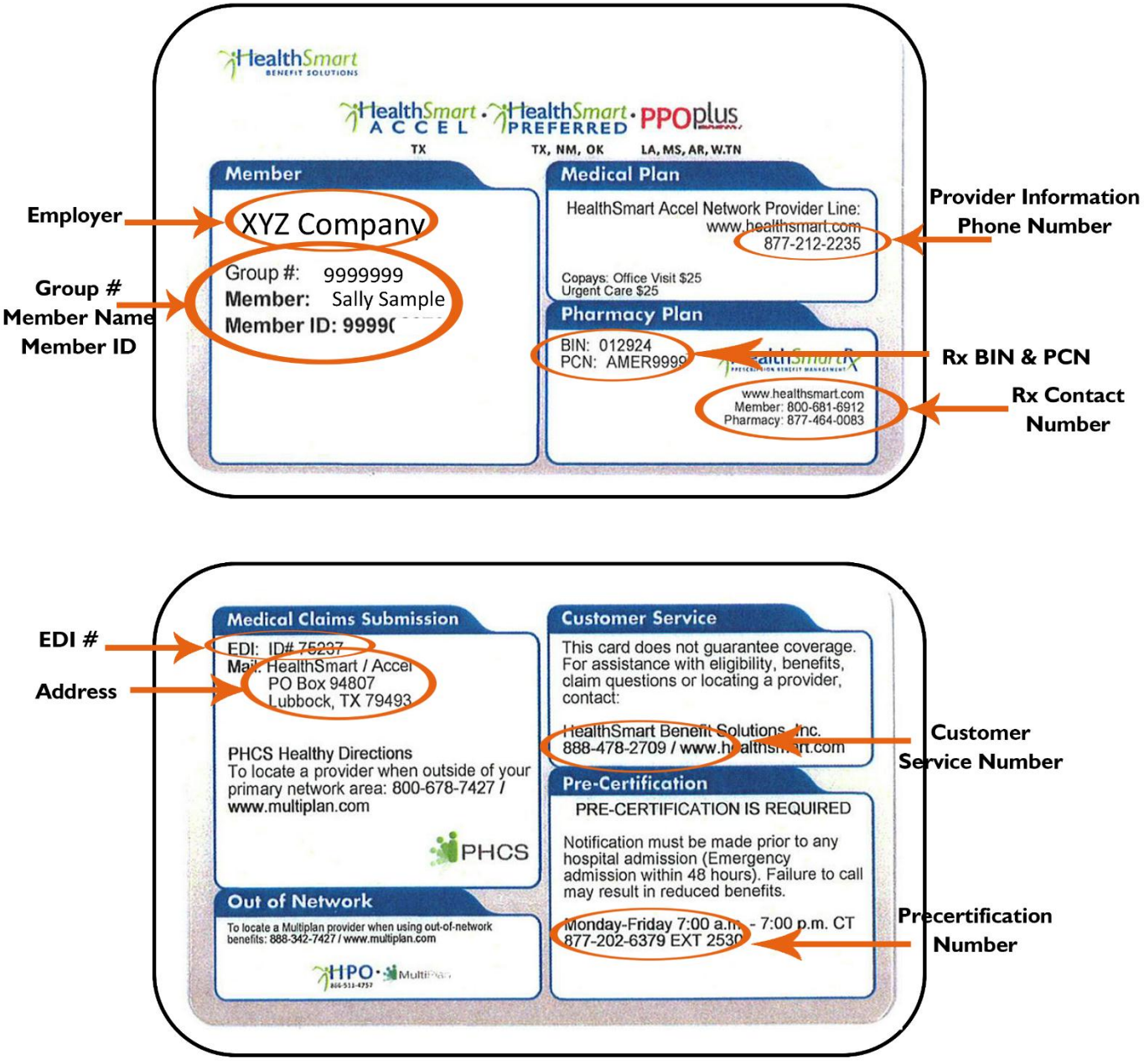
The specific Participating Provider being investigated may be reviewed by the HealthSmart Medical Advisory Committee and the Medical Director.

Provider Responsibility for Complaint Resolution

Participating Provider and/or Provider Representatives will cooperate with HealthSmart in regards to the investigation of inquiries and complaints. Participating Provider will notify HealthSmart if complaints are received against provider and/or practice.

Network Products

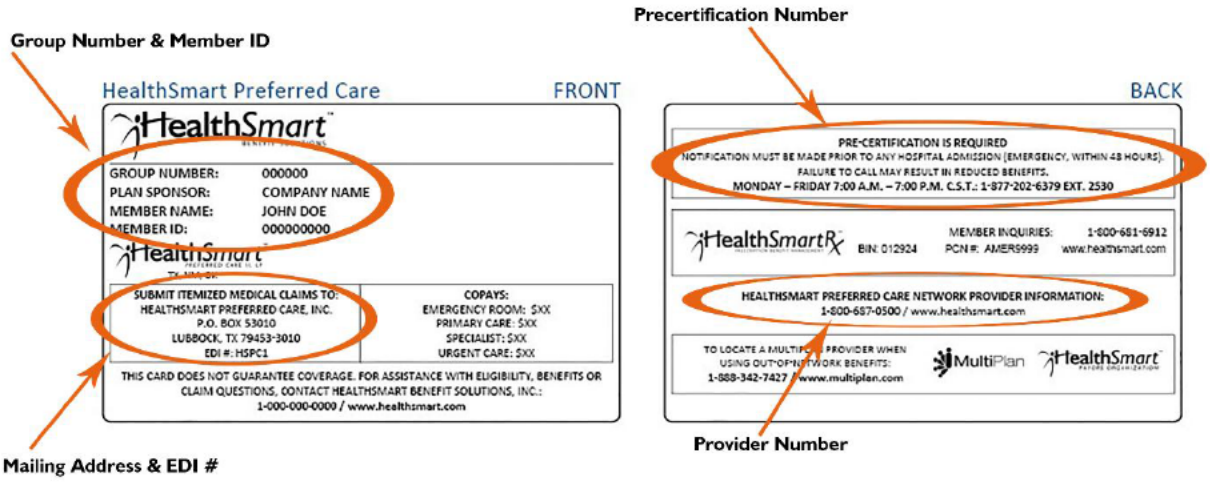
HealthSmart owns and manages several provider networks such as HealthSmart Preferred Care, Accel, Health Payors Organization, Interplan Health Group, Emerald Health Network and SelectNet, among others that bring together nationwide healthcare coverage, credentialed providers, seamless administration, state-of-the-art healthcare management services, and a dedication to making a positive impact on our customers.



Sample ID card (combo)

HealthSmart Group Health Networks

HealthSmart Preferred Care



Sample ID card

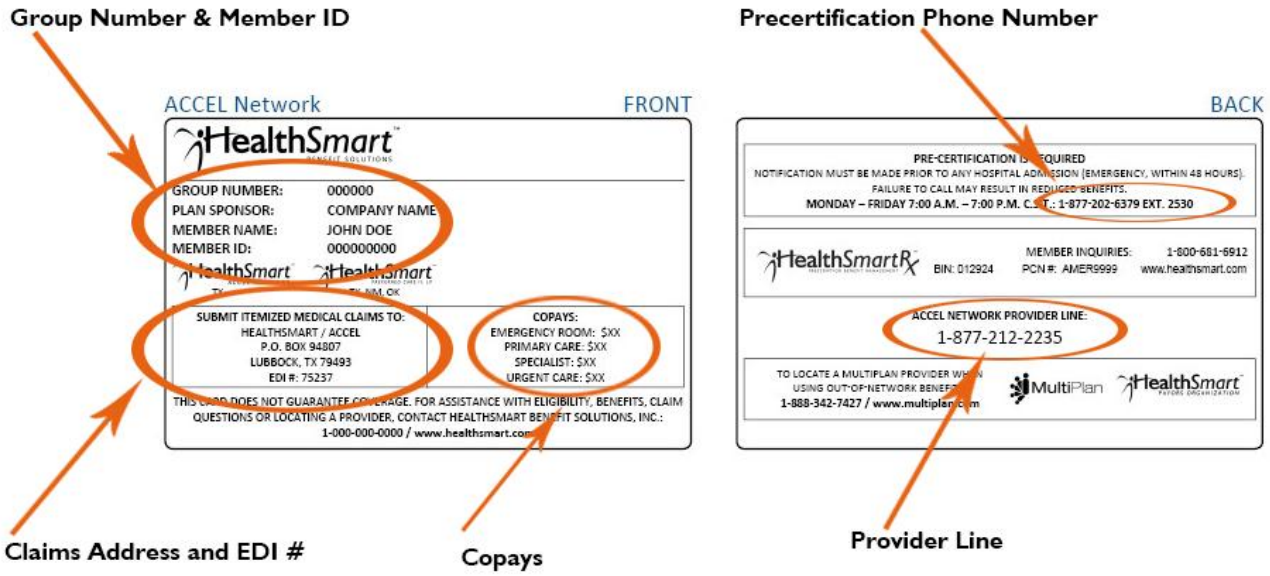
About HealthSmart Preferred Care

The HealthSmart Preferred Care Network is a nationwide Preferred Provider Organization (PPO) formed in 1993 to meet the ever-changing and growing need for effective management of cost and quality in the healthcare delivery system. Eligible Person(s) may receive medical care from any licensed healthcare provider. Eligible Person(s) will not be required to select Primary Care Physician (PCP) and referrals are not required. With a strong focus on customer service, HealthSmart Preferred Care creates a productive and effective business environment to meet the various needs of the health care delivery system for providers, employers, payors, and third party administrators.

In the fall of 2007, HealthSmart acquired the Interplan Health Group companies, which included the following networks: Interplan Health Group, the Emerald Health Network, Preferred Plan, Inc., Health Payors Organization and Superien Health Network. The Interplan Health Group companies were merged into HealthSmart Preferred Care. The names and logos of Interplan Health Group (IHG), Emerald Health Network (EHN) and Preferred Plan, Inc. (PPI), changed to HealthSmart Preferred Care effective September 1, 2010. HealthSmart Payors Organization (HPO) remained the same. HealthSmart clients updated their identification cards to reflect the HealthSmart Preferred Care logo.

If you are a legacy Interplan Health Group (IHG), Emerald Health Network (EHN) and Preferred Plan, Inc. (PPI) participating provider and would like to transition onto a HealthSmart Preferred Care Provider Agreement, you can contact the Provider Relations Department at HealthSmart.

HealthSmart Accel Network



Sample ID card

About the HealthSmart Accel Network

HealthSmart Accel is a superior managed care provider network designed to facilitate cost containment while offering excellent hospital and physician access. The Accel Network offers an unparalleled solution to meet the various needs of our clients in the areas of network management, pharmacy management and other managed care services. Accel delivers market leading discounts to our clients in exchange for accurate and timely payments to our providers – joining together the provider's services with real cash flow.

Accel Highlights

Eligible Person(s) may receive medical care from any licensed healthcare provider. The enrolled Eligible Person(s) will not be required to select Primary Care Physician (PCP) and referrals are not required.

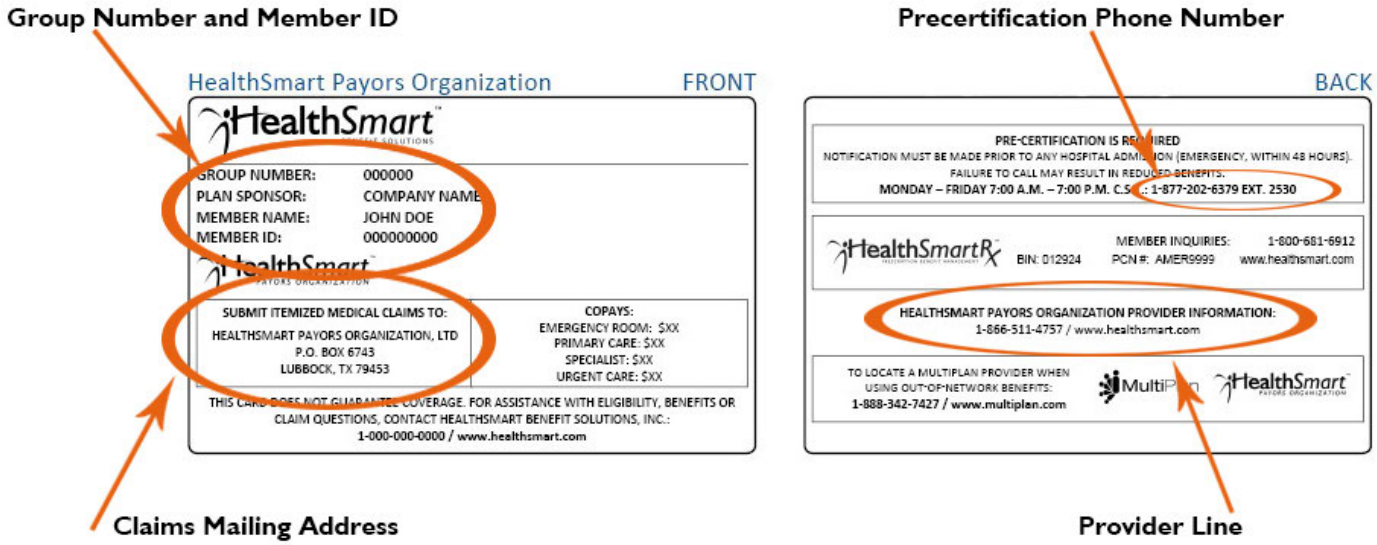
Accel Participating Providers shall make best efforts to refer within the Accel Network. Benefits may be limited on services rendered outside of the Accel Network. Services received outside of the network will be reimbursed at an RBRVS based fee schedule which will result in a higher member financial responsibility. Precertification will be driven by the Eligible Person(s) benefit design.

Accel Guidelines

- Accel product will be identified on the member's ID card.
- Electronic claim processing, submission, remittance and fund transfer will be available, as well as online claim status and eligibility.
- Adjudication of all facility claims without requiring an invoice.
- HealthSmart will reprice all claims submitted by the Provider.

- Payment and Audit Guidelines consistent with Carrier Guidelines
- Network and Payor will adhere to predefined payment and service terms as agreed to in the Accel Network agreement.

HealthSmart Payors Organization: An Out-of-Network Claims Solution



Sample ID card

As more financial responsibility shifts to the patients, providers are finding it increasingly difficult to collect the rising patient responsibility. Providers find that managing debt is costly and labor intensive. They may notice Payors applying usual and customary, Medicare or other unpredictable reductions, when a contractual reimbursement is not in place.

The HealthSmart Payors Organization (HPO) extends access to patients who wish to receive care from providers that are not in their primary network. Participation in HPO will assist in reducing the time and expense associated with out-of- network claims. HPO customers include national and regional health plans, TPAs, self-insured employers and more. The program focuses on partnering with our network providers by offering solutions which include competitive rates and contract terms. Benefits typically apply at a reduced or out-of-network benefit level, based on the patient benefit plan.

HPO Highlights

- Participation can reduce bad debt because Payors pay directly to the provider instead of the patient.
- Participation allows claims to be priced at a fair contractually negotiated rate resulting in fewer unpredictable reductions.
- Payors recognize the importance of, and agree to, timely payment provisions.
- In summary, you know what you will be paid and when you will be paid.

Workers' Compensation Network

When a worker is injured, nothing is more important than returning him or her to the workplace as quickly and cost effectively as possible. The strength of our contracts is what significantly differentiates HealthSmart from our competition.

The primary strength of our network is savings which considerably impacts the cost of claims. Our Workers' Compensation Network is comprised of 38,000 directly contracted providers with a broad range of specialties who are committed and experienced in treating work-related injuries. Many of our providers are focused on working with Payors and employers not only in addressing medical issues, but also returning the injured employee to the workplace quickly and with optimal outcomes.

Services/Providers Include:

- Primary care physicians
- Occupational health and rehabilitation therapists
- Dental Providers
- Behavioral health care specialists
- Ancillary providers
- Hospitals
- Diagnostic Networks
- Neurologists
- Occupational Specialists
- Chiropractors
- Physical Therapy
- Alternative Medicine practitioners
- Pharmacy Networks

Relationships That Work

Because we own direct contracts with our facilities and providers, we have been able to establish efficient and positive working relationships. Our diligence in this area has earned us a reputation as the premier Workers Compensation Network in the western region. What's more, we're also one of the most cost effective. For example, the strength of our facility contracts includes provisions with unique outliers that positively impact the cost of medical treatment. Further, our retrospective and prospective pharmacy network partner provides significant savings through superior workers compensation contracts and state-of-the-art technology.

Broad Coverage

Not only do we provide broad network coverage that spans the western region, we are also able to carve out specialized networks to meet our customers' requirements in California, Washington and Nevada, with Oregon and Arizona soon to be added. We are also in the process of adding significant workers compensation coverage in the Southeast, Midwest and Southwest

High-Tech and High-Touch

Technology is a key component in providing a superior workers' compensation network focused on better outcomes for our customers. Our versatile and adaptable infrastructure enables us to deliver network data easily to our customers for use in channeling and in their bill review processes. We focus on electronic provider and customer connectivity and technology, and our web based re-pricing system allows us to stay at the forefront of customer workers compensation needs. Individual websites provide information based on geography and specialty, while serving as tools to support the claims process.

California Workers' Compensation Program

Senate Bill 863 & Medical Provider Networks (MPN)

The State of California passed Senate Bill 863 in 2012, which makes a comprehensive change to California's workers' compensation system. The first phase of the bill became effective on January 1, 2013, with other provisions taking effect on January 1, 2014. Senate Bill 863 also put new regulatory requirements on certified California Medical Provider Networks (MPNs).

If you would like detailed information regarding Senate Bill 863, please refer to the website link to the CA Department of Workers' Compensation: http://www.dir.ca.gov/dwc/SB863/SB863_Overview.htm.

Medical Provider Network (MPN)

The MPN program became effective Jan. 1, 2005 and employees can be covered by an MPN once a plan has been approved by the DWC administrative director. As defined by the California Department of Workers Compensation (DWC), a medical provider network (MPN) is an entity or group of health care providers set up by an insurer or self-insured employer and approved by DWC's administrative director to treat workers injured on the job. Under state regulations, each MPN must include a mix of doctors specializing in work-related injuries and doctors with expertise in general areas of medicine. MPNs are required to meet access to care standards for common occupational injuries and work-related illnesses.

Medical treatment guidelines known as MTUS (Medical Treatment Utilization Schedule) are established by the DWC and shall allow employees a choice of provider(s) in the network after their first visit. The MPN Utilization Review vendor must follow and enforce MTUS and ACOEM (American College of Occupational and Environmental Medicine) practice guidelines, which an MPN provider must understand and follow when providing or requesting authorization for treatment.

For additional information about MPN, MTUS and ACOEM practice guidelines, please refer to the website links below:

http://www.dir.ca.gov/dwc/mpn/dwc_mpn_main.html

http://www.dir.ca.gov/dwc/mtus/mtus_regulationsguidelines.html

Acknowledgement for California Workers' Compensation Network Providers

If you are a Participating Provider in the HealthSmart Workers' Compensation preferred provider network, you will be included as a Participating Provider in HealthSmart's affiliated MPNs. The list of HealthSmart affiliated MPNs can be found by visiting http://www.healthsmart.com. The HealthSmart's MPN client list may be updated from time to time. In addition, you may request to decline participation from any specific HealthSmart affiliated MPN by sending an email requesting to be excluded from the specific MPN to west.region@healthsmart.com. Please include Participating Provider's name, tax identification number and the HealthSmart MPN client(s) network(s) in which Participating Provider elects to be excluded.

Requirements for Being a HealthSmart Bureau of Workers' Compensation Participating Provider in Ohio

The following information is taken from the Ohio BWC website (http://www.bwc.ohio.gov/) and is intended for new providers wanting to participate in the HealthSmart Workers' Compensation Network and treat patients that have sustained injuries or illnesses in the work setting.

In Ohio, HealthSmart requires all practitioners that wish to participate in the HealthSmart Workers' Compensation Network and receive reimbursement for treating HealthSmart members who have been injured or become ill in the workplace become BWC certified through the following certification process:

Complete and submit the Application for Provider Enrollment and Certification (MEDCO-13) along with all required documentation.

1. We will review the information to ensure you meet the minimum certification criteria as defined in OAC 4123-6-02.2. Providers must meet all licensing, certification and accreditation requirements necessary to provide services.
2. Other minimum credentials are based on provider type. If you meet all the credentialing criteria and sign the provider agreement (section 5) of the application, we'll certify you.

Exceptions

Not all providers are eligible to become certified. These are generally not medical providers but business or vocational plan service providers. They must complete the **Application for Provider Enrollment-Non Certification (MEDCO-13A)**.

Note: Provider group practices enroll with this application. All BWC-certified providers, along with group practices, are listed in our Provider look-up.

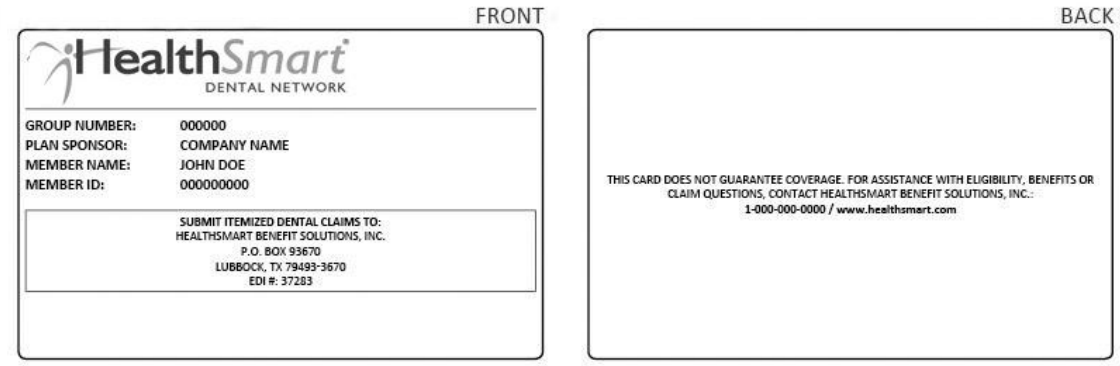
Ohio Worker's Compensation Frequently Asked Questions

Q&A #1	**What is a BWC-certified provider?** A BWC-certified provider is a credentialed provider whom we've approved to participate in HPP and who has signed a provider agreement with BWC.
Q&A #2	**Do I need to be a BWC certified to see injured workers and be reimbursed?** To treat and be eligible for reimbursement, per OAC 4123-6-10 (except for state-fund claims with dates of injury prior to Oct. 20, 1993, emergencies, initial visits or as otherwise defined) injured workers must see a BWC-certified provider. For claims with dates of injury prior to Oct. 20, 1993, injured workers may continue to be treated by their physicians of record even if they are not BWC-certified. However, in the case of a claim prior to Oct. 20, 1993, if injured workers change providers, they are required to see one that is BWC-certified.
Q&A #3	**How long does the enrollment/certification process take?** Generally, allow four to six weeks after BWC receives the required information.
Q&A #4	**May providers request an address change over the phone?** All requests for address or tax identification changes must be submitted in writing. You may complete the Request to Change Provider Information (MEDCO-12), and send it to BWC at the address or fax listed on the form.
Q&A #5	**If a provider changes from one group practice to another, does his/her provider number change?** An individual servicing provider may keep his/her provider number regardless of changes in his/her affiliation with group practices. Also, we do not systematically link providers to practices; however, we do ask for address updates.
Q&A #6	**If we have more than one provider location, does each location need to be enrolled?** In these cases, each physical location must be enrolled using the MEDCO-13A.

If you have additional questions not covered here call the Ohio Bureau of Worker's Compensation at 1-800-644-6292, and listen to the options.

Once the practitioner has been Ohio BWC certified and the practitioner would like to opt in to participate in the HealthSmart Work Comp Network, they must work with the assigned Network Development contact to complete a HealthSmart Participating Provider Agreement.

HealthSmart Dental Network



Sample ID card

HealthSmart's Dental Network specializes in providing access to dental health care providers for Eligible Persons, insurance companies, employer groups, third party administrators and other defined groups. We are committed to delivering excellent service and customer satisfaction to our clients, participating dentists and Eligible Persons. Our philosophy stresses the importance of preventive dentistry and early intervention. We believe that this approach benefits the Eligible Person's total health and reduces costs which results in the optimization of benefit utilization.

In 1994 Interplan developed and built a dental network in California "Interplan Dental Network". Exercising the theory of "growth by acquisition", Interplan purchased the Innovative Dental Services Network and adopted the trademark name "DentiNex." Since being acquired by HealthSmart Preferred Care in September 2007, the dental network has increased its footprint throughout the continental US and is now recognized as the "HealthSmart Dental Network." HealthSmart's Dental Network currently expands to Arizona, California, Kentucky, Nevada and North Carolina. There are plans to further expand the HealthSmart Dental Network to other states within the near future.

Dental Provider Quick Reference Guide	
Customer Service	800.687.0500
Request New Provider Application	E-mail: West.region@HealthSmart.com **Fax: 209.473.1102** Include: Provider Name, address, phone number and specialty
Verify Benefits / Eligibility	Refer to the member ID card and call the telephone number printed on the card to verify benefits and eligibility.
Pre-Authorization	Refer to the member ID card and call the telephone number printed on the card to obtain Pre-Authorization
Claims Submission - Paper	Refer to member ID card for the most current information.
Claims Submission - Electronic	Refer to member ID card for the most current information
Claim Appeals	Payment appeals may be submitted to HealthSmart: Phone: 800.687.0500 Email: priority.service@healthsmart.com Fax: 214.574.3992
Client List	Visit www.healthsmart.com for the most current list of clients. *(select Providers, under Quick Links, select Client List)* To obtain a more comprehensive listing call Customer Service number
Provider Information Updates	Submit provider demographic updates to Provider Relations via the applicable email box listed below.
Provider Relations (listed by state in which provider practices)	**Submit Provider Relations Inquiries to the regional email box below.**
IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, NJ, RI	pr.east@healthsmart.com
AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, AK, HI	pr.west@healthsmart.com

HealthSmart Ancillary Solutions

SmartNET and Ancillary Care Services (ACS)

ANCILLARY CARE SERVICES

HealthSmart has enhanced its ancillary network services which will positively impact provider, members and client savings. Utilization of ancillary services is growing at twenty five percent (25%) annually due to an aging population and changing technologies that make many of these services an efficient and high-quality alternative to hospital-based settings. The HealthSmart ancillary programs leverage our expertise to lower the administrative costs of ancillary services.

Beginning July 1, 2014, HealthSmart members will have access to the HealthSmart **SmartNET Program** and **Ancillary Care Services (ACS)**. The combination of these two ancillary network products provides our client's savings and gives the Participating Providers direct access to more HealthSmart members.

Ancillary Care Services (ACS) is a network manager of ancillary service providers. ACS has been the primary ancillary network solution for HealthSmart clients for the past ten years.

In October of 2014, American CareSource Holdings, Inc. (ACS) entered into a three-year management services agreement with HealthSmart in which HealthSmart will manage and operate the ACS private networks and its operations. ACS has more than 4,800 ancillary service providers with over 35,000 treatment sites nationwide. This **new arrangement** will improve combined network administration and generate greater value for the providers in the networks. There will be no disruption or changes to the ACS Provider Agreements and no change to the processes being followed today.

HealthSmart Ancillary Solutions, cont'd.

Ancillary services represent one of the fastest growing components of healthcare costs. Because ACS brings additional savings of 8%-15% to our clients, HealthSmart automatically implements the ACS network on all eligible HealthSmart Benefit Solution clients. It is a valuable addition to our robust suite of services. This grants the participating providers primary access to our members.

In October of 2014, HealthSmart began requiring its clients to place the logo for Ancillary Care Services on all HealthSmart member ID cards. This initiative will be completed on or before October 31, 2015. ACS providers are also included in HealthSmart's provider directories.

ACS offers cost effective alternatives to physician and hospital-based services. It is positioned to lower ancillary healthcare costs and serve our members with high quality, cost effective network of providers. The ACS network includes 30 specialties:

Acupuncture	Ambulatory Surgery Center	Cardiac Monitoring
Chiropractic Care	Diagnostic Imaging	Dialysis
Durable Medical Equipment	Hearing Aids	Home Health
Hospice	Implantable Devices	Infusion Services
Lab	Lithotripsy	Long-Term Acute Care
Massage Therapy	Occupational Therapy	Orthotics and Prosthetics
Pain Management	Physical Therapy	Podiatry
Rehab – Inpatient/Outpatient	Sleep Therapy	Skilled Nursing Facility
Specialty Pharmacy	Speech Therapy	Transportation
Urgent Care Center	Vision	Walk-In Clinic

Auto Medical Program

With a comprehensive Auto Medical provider network, we understand successful outcomes should include timely access to experienced providers treating trauma-related injuries and special medical needs with maximum cost efficiency.

The strength of our contracts is what differentiates us from our competition. The primary strength of our network is savings, which considerably impacts the cost of claims. Our network connects members to over 51,000 direct providers and offers a deep contract structure, broad coverage and a level of customer service that fosters professional and efficient working relationships between all entities. The Auto Medical Program is specifically defined as a product line under HealthSmart's Participating Provider Agreement.

Because we own direct contracts with our facilities and providers, we have been able to establish efficient and positive working relationships. Our diligence in this area has earned us a reputation as the most cost-effective premier network in the western region.

World Trade Center Health Program

The James Zadroga 9/11 Health and Compensation Act of 2010 is legislation passed by the United States Congress that created the World Trade Center Health Program (WTCHP). The law authorizes:

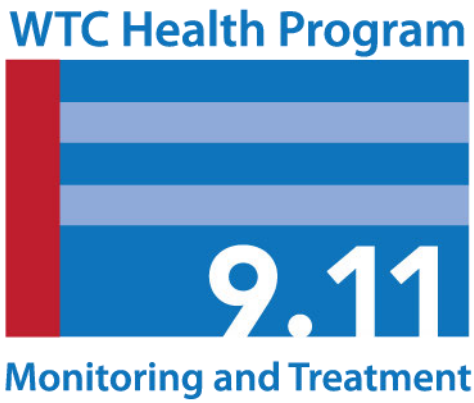
- Education and outreach for people who are eligible for WTCHP
- The collection and analysis of physical and mental health data with patient's permission
- Research to better understand health conditions linked to the attacks

The World Trade Center Health Program (WTCHP) administered by The National Institute for Occupational Safety and Health (NIOSH) and the US Centers for Disease Control and Prevention (CDC), provides free, confidential monitoring and treatment services to responders (rescue, recovery & volunteers) and survivors of the aftermath of the 9/11 disaster. It includes individuals who worked in response and recovery operations at the World Trade Center, the passenger-jet crash site near Shanksville, PA, and residents and other building occupants and area workers who were directly impacted and adversely affected by such attacks on September 11, 2001.

The World Trade Center Health Program is governed by Title III of the Public Health Service Act. The Act mandated the establishment of Clinical Centers of Excellence (CCEs) to provide WTCHP healthcare services to WTCHP eligible members.

HealthSmart has partnered with 7 Clinical Centers of Excellence (CCEs) with the goal of establishing an administrative infrastructure that supports WTCHP eligible members as it relates to healthcare services. HealthSmart is a third party administrator providing claims, clinical and provider network support services.

HealthSmart's role is to build, develop and maintain a provider network inclusive of contracting and credentialing, claims administration, file transmission and clinical case management for NISOH certified diagnosis and associated treatment especially focused on cancer diagnosis.



World Trade Center Health Program FAQs

Q&A #1	**Will the authorization process change as a result of this partnership?** No, the initial authorization process remains the same; however there will be additional requirements for the WTC certified cancer population. Information regarding requirements for the WTC certified cancer population will be supplied to you in the treatment planning process. Note that the authorization number provided to you is required to be submitted with the claim to ensure successful claims submission.
Q&A #2	**Will claims transmission process change?** FDNY – The process will remain the same. All other Clinical Centers of Excellence – The process has changed. If you have questions regarding which CCE your patient is affiliated with, call our Provider Services Department at: **877-813-6366** For electronic claim submission, HealthSmart's EDI Payor number is **31172**. For paper claims submission, HealthSmart's address is: **HealthSmart Benefit Solutions, Inc.** **WTC Claim Administration** **10303 E. Dry Creek Rd., Suite200** **Englewood, CO 80112**
Q&A #3	**How can I track my claims status?** FDNY - claims inquiries can be directed to the FDNY portal at www.claimconnect.us All other Clinical Centers of Excellence - Claims can be tracked and monitored through HealthSmart's WTC dedicated provider portal. Registration and access to the provider portal is described below. In the provider portal, claims can be tracked from their initial submission to HealthSmart through the CCE review process and subsequent submission to CMS for final claim payment.
Q&A #4	**How do I register on the provider portal?** FDNY – Login to www.claimconnect.us if you are a provider. Click on the **Join today** link. All other Clinical Centers of Excellence - Log in to: https://secure.healthx.com/wtchome.aspx if you are a provider. Scroll down to the new user link at the bottom of the page and follow the registration process. If you have any questions or require assistance in accessing the portal, please contact HealthSmart's WTC Provider Services Department at: **877-813-6366.**

World Trade Center Health Program, cont'd.

Process for Submitting Provider Updates and New Provider Adds

Providers may submit notification of changes to demographic and billing information. Updates pertaining to billing information such as Tax Identification number and billing address must be submitted with an updated W-9. Demographic updates should include old information and new information to ensure that appropriate changes are made to record. All notifications should include an effective date of the change.

New Provider Adds: Must include provider name, Specialty, Practice Location, Practice Phone, TIN, NPI for identification purposes (if available) and the completed Banking form. **Also include the name of the CCE and whether provider is authorized for all other CCEs.**

Provider demographic changes: Must include provider name, TIN, NPI for identification purposes. Also include old information, new information and effective date of change.

Provider billing changes: Must submit updated banking form, current W-9 and effective date of change.

Provider Terminations: Must include provider name, Specialty, Practice Location, Remit Address, Practice Phone, TIN, NPI for identification purposes (if available). Include effective date of termination.

Notifications regarding new adds, notification of demographic and billing updates may be sent as follows:

Fax: 214.574.1114

Please send to the attention of WTC PR

Email: wtcpr@healthsmart.com

Mail: HealthSmart

Attn: WTC Provider Relations

222 W. Las Colinas Blvd., Suite 600 N

Irving, TX 75039

C-8 (PFOA) Medical Monitoring Program

HealthSmart has been chosen as the independent contractor to provide health care provider network services for the C-8 (PFOA) Medical Monitoring Program ("the Program").

In February 2005, The Wood County Circuit Court in West Virginia approved a class action settlement ("the Settlement") between the Plaintiffs and E.I. du Pont de Nemours and Co. ("DuPont"), the defendant, in a civil class action lawsuit styled *Jack Leach, et al. v. E.I. du Pont de Nemours and Co., Civil Action No. 01-C-608* pending in the Circuit Court of Wood County, West Virginia ("the Litigation"). The Litigation involves claims arising from alleged contamination of human drinking water supplies with a chemical known as ammonium perfluorooctanoate (hereinafter "C-8") attributable to releases from DuPont's Washington Works Plant in Wood County, West Virginia.

As part of the Settlement, Class Counsel and DuPont selected an independent panel of three epidemiologists ("the Science Panel") to conduct and evaluate studies to answer the question whether a "Probable Link" exists between exposure to C-8 among Class Members and serious human disease ("Human Disease"). After lengthy studies, in which many class members participated, the Science Panel found that there is a "Probable Link" between exposure to C-8 and the following Human Diseases: (1) pregnancy-induced hypertension (including preeclampsia), (2) kidney cancer, (3) testicular cancer, (4) thyroid disease, (5) ulcerative colitis, and (6) diagnosed high cholesterol (hypercholesterolemia). The Settlement Agreement defines a "Probable Link" to mean that, based upon the weight of the available scientific evidence; it is more likely than not that there is a link between exposure to C-8 and these Human Diseases. The Science Panel did not find that a Probable Link exists for any other Human Diseases.

As a Participating Provider in the HealthSmart network, you may be contacted by a HealthSmart program scheduler on behalf of an Eligible Class Member to schedule an appointment for the screening tests recommended by the independent Medical Panel. **Each Eligible Class Member is required to meet with a participating physician and have all the required screening documents completed and signed by a participating physician for the program.** Eligible Class Members will not present the standard member identification card. Instead, they will have an Eligible Class Member packet with four forms that include a unique member identification number and HealthSmart network logos: 1) a Class Member Screening and Questionnaire Form; 2) Instructions for Physicians; 3) Diagnosis Form and 4) a HIPAA Form. Covered medical services provided for C-8 monitoring are paid by the Program in accordance with your HealthSmart Participating Provider Agreement.

C-8 (PFOA) Medical Monitoring Program, cont'd.

The highest concentration of potential Class Members reside in West Virginia and Ohio, however, potential Class Members are located across the United States. It is critical that you and your office staff review and familiarize yourself with this program so that you are prepared to perform the screening should you receive calls from Eligible Class Members. When covered services are provided to an Eligible Class Member, **you must sign and return Program documents to the Program Administrator** as notated in the Instructions for Physicians and the Participating Provider C-8 Program Guide. This information is also documented within the Provider Quick Reference Guide.

Below are Program resources specifically for HealthSmart providers and office staff that offer more details about the C-8 Program. The resources prepared for your office are listed below:

- Participating Provider C-8 (PFOA) Program Guide
- Quick Reference Guide for Provider
- Provider Frequently Asked Questions
- Information on the C-8 (PFOA) Program
- Prepared by the Medical Panel for the C-8 Class Members
- Lab Requisition Form for C-8 (PFOA) Testing
- Lab Requisition Form for Other recommended testing
- Screening and Follow Up Testing Form
- Diagnosis Form
- C-8 (PFOA) Medical Monitoring Program Coding

You may obtain these resources and other Program related documents and information by visiting www.healthsmart.com. Information regarding upcoming dates for webinars designed to offer program details will also be published on our website. If you have questions regarding the program, you may contact Customer Service at **800.222.1368**. You may also email Provider Relations at providerrelations@healthsmart.com.

QUICK REFERENCE GUIDE FOR C-8 PROVIDERS	
Identifying Eligible Class Members:	Participants will present a C-8 Medical Monitoring Program packet that will include the following: Class Member Screening & Questionnaire Form Instructions for Physicians Form Screening and Follow Up Testing Form HIPAA Form Diagnosis Form The program documents must be completed, signed by the Provider and returned to the Program Administrator (see address below)
Customer Service / Claim Inquiries	800.222.1368
Send Signed and Completed Program Documents To:	Completed, Signed Program documents must be sent to the address or fax number listed below: Administrator C-8 (PFOA) Medical Monitoring Program c/o GCG PO Box 10030 Dublin, OH 43017-6630 Fax: 614.553.1222
Electronic Provider Claims Submissions and Appeals:	HealthSmart Benefit Solutions Electronic Payor ID: 87815. Member Program ID: 8888xxxxxxx (where 8888X number is the Class Member's registration number listed on all Program documents)
Paper Provider Claims Submissions (CMS 1500 &UB92):	Administrator C-8 (PFOA) Medical Monitoring Program c/o GCG PO Box 10030 Dublin, OH 43017-6630
Paper Provider Claims Appeals (CMS 1500 & UB92):	HealthSmart Benefit Solutions Phone: 800.222.1368 Email: client.services@healthsmart.com Fax: 214.574.2368
Exclusive Lab provider:	Laboratory Corporation of America (LabCorp)
Assistance Locating a Lab Provider in Area:	800.222.1368
Lab Requisition for C-8 Testing:	Go to website at www.healthsmart.com click Providers, then select option for All Other HealthSmart members
Provider Relations Inquiries:	providerrelations@healthsmart.com

Program Update: Effective May 7, 2015

All Eligible Class Members of the C-8 Medical Monitoring Program ("the Program") will be sent a letter from the Program informing them the Medical Panel has recommended the Program pay for follow up appointments, and the covered diagnostic tests, due to symptoms listed below for thyroid disease, ulcerative colitis, testicular cancer, or kidney cancer that your patients are experiencing that were not present at the time of their initial screening appointment with you. The Medical Panel has recommended that patients call their screening physicians for an appointment if the following symptoms occur. Accordingly, you may be receiving phone calls from Class Members to schedule a follow-up appointment to their initial screening appointment.

1. Thyroid Disease

a. Clinical hypothyroidism (thyroid hormone too low): develop several symptoms that include severe fatigue, cold intolerance, unintentional weight gain, constipation, dry skin, muscle pain or weakness, and menstrual irregularities.

b. Clinical hyperthyroidism (thyroid hormone too high): develop several symptoms that include anxiety, tremor (shakes), heart palpitations, heat intolerance, increased perspiration, and weight loss despite a normal or increased appetite.

2. Ulcerative Colitis

a. Diarrhea (with or without blood) that lasts more than 10 days.

b. Waking up at night to move your bowels.

c. Feeling you have to get to the bathroom urgently to have a bowel movement and that you might not make it in time for more than half of your stools over a six week period.

3. Testicular Cancer

a. Testicular abnormality such as pain, fullness, mass, stone or change in size.

b. Gynecomastia (male breast enlargement)

4. Kidney Cancer

a. Blood in your urine.

b. Pain in your abdomen on most days in the last two months.

c. A fever on most days for the past two weeks.

d. Recent loss of weight without trying

5. High Cholesterol

There are no specific symptoms associated with this condition.

6. Pregnancy Induced Hypertension and Preeclampsia

There are no specific symptoms associated with these conditions. All pregnant women should be screened for these conditions as part of regular health care for these conditions during each pregnancy.

If a Class Member has been previously diagnosed with a particular disease, they would not be eligible for coverage for further testing of that particular disease under the Program. Those services should be billed to the patient's primary insurance policy. For more information, please call the C-8 Customer Service line at 800.222.1368.

Sincerely,
HealthSmart Network Development

HealthSmart C-8 (PFOA) Medical Monitoring Program FAQs

General Information	
Q&A #1	**What is the C-8 (PFOA) Medical Monitoring Program?** In February 2005, The Wood County Circuit Court in West Virginia approved a class action settlement ("the Settlement") between the Plaintiffs and E.I. du Pont de Nemours and Co. ("DuPont"), the defendant, in a civil class action lawsuit styled *Jack Leach, et al. v. E.I. du Pont de Nemours and Co., Civil Action No. 01-C-608* pending in the Circuit Court of Wood County, West Virginia ("the Litigation"). The Litigation involves claims arising from alleged contamination of human drinking water supplies with a chemical known as ammonium perfluorooctanoate (hereinafter "C-8") attributable to releases from DuPont's Washington Works Plant in Wood County, West Virginia. As part of the Settlement, Class Counsel and DuPont selected an independent panel of three epidemiologists ("the Science Panel") to conduct and evaluate studies to answer the question whether a "Probable Link" exists between exposure to C-8 among Class Members and serious human disease ("Human Disease"). After lengthy studies, in which many class members participated, the Science Panel found that there is a "Probable Link" between exposure to C-8 and the following Human Diseases: (1) pregnancy-induced hypertension (including preeclampsia), (2) kidney cancer, (3) testicular cancer, (4) thyroid disease, (5) ulcerative colitis, and (6) diagnosed high cholesterol (hypercholesterolemia). The Settlement Agreement defines a "Probable Link" to mean that, based upon the weight of the available scientific evidence; it is more likely than not that there is a link between exposure to C-8 and these Human Diseases. The Science Panel did not find that a Probable Link exists for any other Human Diseases. *This Settlement does not pertain to The Elk River contamination of 4-methylcyclohexane methanol, or MCHM, and polyglycol ethers, known as PPH, discovered on January 9, 2014 in Charleston, West Virginia.*
Q&A #2	**Does an Eligible Class Member have to be seen by a participating HealthSmart Provider?** Yes. For covered tests/services to be paid for by the C-8 (PFOA) Medical Monitoring Program, Eligible Class Members must be seen by a participating provider in the HealthSmart network. Upon the Program Administrator's determination of eligibility, those Eligible Class Members will be instructed to contact a HealthSmart Customer Service Representative to help them identify a HealthSmart Participating Provider and also call those Participating Provider offices to schedule the Eligible Class Member screening appointments. For assistance identifying a participating network provider, you may visit www.healthsmart.com or call **800.222.1368**.
Q&A #3	**Are fees for missed appointments covered under the Program?** When Eligible Class Members schedule an appointment with a participating provider and are not able to make the appointment, they must provide 24-hours advanced notice to cancel or reschedule the appointment. If the appointment is not canceled or rescheduled with 24-hours advanced notice and participating provider charges a "missed appointment" or a "No Show" fee, this fee is NOT covered by the Program. The Eligible Class Member is expected to pay this fee. Refer to C-8 (PFOA) Medical Monitoring Program Coding for covered services.

Q&A #4	**What is the process for scheduling the screening appointment with a Provider?** Upon the Program Administrator's determination of eligibility, those Eligible Class Members will be instructed to contact a HealthSmart Customer Service Representative to help them identify a HealthSmart Participating Provider and also call those Participating Provider offices to schedule the Eligible Class Member screening appointments. In most cases, the Eligible Class Member will be on the line with the customer service representative when the appointment is being scheduled. The customer service representative will be able to provide the following information that is typically required in order for the appointment to be scheduled. • Eligible Class Member Name • Eligible Class Member DOB • Eligible Class Member Program Identification Number (an 11 digit Registration Number beginning with 8888 found on the Eligible Class member documents) • Information regarding the Program • Eligible Class Member's Other Insurance Information (when available) • All Other Eligible Class Member Information Required to Schedule Appointments Please note that an Eligible Class Member may contact your office directly to schedule an appointment. In this event, please remind the Eligible Class Member to bring the required documents to the screening appointment.
Member Identification	
Q&A #5	**How will a Provider identify an Eligible Class Member?** Eligible Class Members will arrive to their scheduled appointments with C-8 Medical Monitoring Forms that include on each page the Eligible Class Member's unique identifying number and HealthSmart network logos *(referred to as registrants ID number on all Program documents, where 8888xxxxxxx number is the member's registration number listed on all Program documents)* The three Forms which must be filled out and signed include: 1. A Class Member Screening Questionnaire which the Class Member must complete and sign; 2. A HIPAA Authorization Form allowing the provider to disclose health information to the Administrator of the C-8 Medical Monitoring Program which the Class Member must sign; and 3. The Instructions for Physicians Form that includes information for the provider including screening and follow up tests and referral form. This Form must be completed and signed by the Physician. As stated in the Instructions for Physicians Form, all of these forms must be returned to the Administrator of the C-8 (PFOA) Medical Monitoring Program at the following address: Administrator C-8 (PFOA) Medical Monitoring Program c/o GCG PO Box 10030 Dublin, OH 43017-6630 Fax: 614.553.1222

Referrals for Screening and Diagnostic Testing	
Q&A #6	**Am I required to send member to a specific lab within the HealthSmart provider network for the C-8 Screening and other recommended tests?** Yes. Laboratory Corporation of America (Lab Corp) is the clinical reference laboratory established to perform the C-8 (PFOA) Blood Test for the Program. The Eligible Class Member will bring two LabCorp requisition forms to the appointment for your convenience. You may also obtain copies of the LabCorp requisition forms at www.healthsmart.com. In addition, Eligible Class Members can visit www.labcorp.com to locate the nearest patient service center. If there are no convenient Lab Corp patient service centers in your area, please contact Lab Corp directly to make arrangements for courier service from your office.
Q&A #7	**I normally draw certain lab specimens in my office and send them to lab for testing. Can I continue this practice or am I required to send member to a patient service center of a participating lab?** You should continue to practice as usual and draw lab specimens in your office. The lab requisition for the C-8 Blood Test provides specific instructions for handling. The requisition can be found in the packet that the Eligible Class Member brings to the appointment or at www.healthsmart.com. Specimens for other covered tests should be sent to LabCorp as stated above.
Q&A #8	**What is the process for ordering a blood pressure monitoring device?** If an Eligible Class Member that is pregnant expresses concern about gestational hypertension, medical care providers should recommend home monitoring of blood pressure in between prenatal visits beginning at the 20th week of gestation. Member should be given a prescription for the digital blood pressure monitoring device. Once purchased, the Eligible Class Member should submit the receipt for purchase directly to the Program Administrator for reimbursement along with a physician's order.

Claim Submission and Program Reimbursement	
Q&A #9	**Is authorization required for services covered by the C-8 (PFOA) Medical Monitoring Program?** Authorization for covered services is not required. Please refer to C-8 (PFOA) Medical Monitoring Program Coding which provides a list of services and procedures that are covered under the C-8 (PFOA) Medical Monitoring Program. These documents can also be found at www.healthsmart.com NOTE: Only the covered services and procedures are paid under the Program, however if an Eligible Class Member is diagnosed with any of the Human Diseases as defined by the Program, the Eligible Class Member is encouraged to comply with the prescribed treatment plan under a physician's care. Any services or procedures not covered by the Program should be billed to the Eligible Class Members personal insurance for consideration.
Q&A #10	**What is the medical monitoring program reimbursement for covered services?** Covered Services will be paid in accordance with your HealthSmart participating provider agreement. A complete list of covered CPT codes is provided in your Participating Provider Program Guide or can be found on our website at www.healthsmart.com. If you have any questions regarding the reimbursement amounts, you may contact provider relations by email at **provider.relations@healthsmart.com** or by phone at **800.222.1368**. NOTE: Only the covered services and procedures are paid under the Program, however if an Eligible Class Member is diagnosed with any of the Human Diseases as defined by the Program, the Eligible Class Member is encouraged to comply with the prescribed treatment plan under a physician's care. Any services or procedures not covered by the Program should be billed to the Eligible Class Members personal insurance for consideration.
Q&A #11	**Is there Program documentation that is required in order for the Provider claim to be processed and eligible for reimbursement?** To ensure that your provider claim is processed and paid timely, the following Program documents must be submitted to the Program Administrator. • Instructions for Physicians • Member Screening Questionnaire Form For Probable Link Conditions • Screening and Follow Up Testing Form • HIPAA Authorization for Disclosure of Protected Health Information

Q&A #12	**What is the process for submitting provider claims for services covered by the C-8 (PFOA) Medical Monitoring Program?** For ease and efficiency, provider claims should be submitted electronically. Provider claims should be submitted as listed below. Electronic Provider Claim Submission should be sent to: HealthSmart Benefit Solutions Electronic Payor ID: **87815** Member Program ID: **8888xxxxxxx** *(where 8888xxxxxxx number is the member's registration number listed on all Program documents)* Paper Provider Claims Submission should be sent to: Administrator C-8 (PFOA) Medical Monitoring Program c/o GCG PO Box 10030 Dublin, OH 43017-6630 Fax: 614.553.1222 For additional questions related to provider claims, you may contact customer service at **800.222.1368.** Note: The address listed above is only to be used for Provider Claims submitted to the C-8 (PFOA) Medical Monitoring Program. All other provider claims for HealthSmart members with a standard member ID Card should be submitted to the claim address listed on the ID card.
Q&A #13	**What is the process for recommended follow-up tests for the C-8 (PFOA) Medical Monitoring Program?** Recommended follow-up tests are to be ordered using the C-8 (PFOA) Medical Monitoring Program Follow-Up Testing Form which is included with the Physician Instructions that the Eligible Class Member will bring to the appointment. This form can also be found at www.healthsmart.com.
Q&A #14	**Who do I contact for status of Provider claims?** To get information regarding status of provider claims, you may contact customer service at **800.222.1368.**
Q&A #15	**Who do I contact to determine if a test/procedure is covered under the C-8 (PFOA) Medical Monitoring Program or private insurance?** For details regarding services covered by the Medical Monitoring Plan, please see Probable Link Conditions and Medical Monitoring Program CPT Coding documents. These documents can be found at www.healthsmart.com. You may also contact customer service at **800.222.1368**.

Q&A #16	**Which follow-up visits will be reimbursed by the C-8 (PFOA) Medical Monitoring Program?** The C-8 Medical Monitoring Program will reimburse the physician for a single office visit to cover the screening interface with an Eligible class member. All subsequent office visits will only be reimbursed under the C-8 (PFOA) Medical Monitoring Program when the recommended follow-up test or procedure requires an office visit to be billed in order to perform the specific follow up test/procedure. NOTE: Only the covered services and procedures are paid under the Program, however if an Eligible Class Member is diagnosed with any of the Human Diseases as defined by the Program, the Eligible Class Member is encouraged to comply with the prescribed treatment plan under a physician's care. Any services or procedures not covered by the Program should be billed to the Eligible Class Members personal insurance for consideration.
Q&A #17	**What happens if the lab value is inconclusive and requires a repeat test?** If a repeat test is needed, use the Lab Corp requisition form to order the follow up test. Once the lab results are received, you must submit the results along with a signed Follow Up Testing Form to the C-8 (PFOA) Medical Monitoring Program claims address noted above in Q12.

HealthSmart Patient Procedures & Services

Patient Identification (ID) Cards

HealthSmart Eligible Persons are issued an identification card by the Health*Smart* Payor. Although each card will differ depending on the HealthSmart Payor, the Health*Smart* logo or name should be visible.

Eligibility

Always contact the HealthSmart Payor to obtain eligibility and benefit information before rendering services. Health Plan design may vary and restrictions may apply. At the time of service obtain an estimate of patient's coinsurance, deductible, plan design and copay information to determine Eligible Person's payment responsibility.

Utilization Review

To achieve maximum reimbursement for Eligible Person, proposed medical care must be certified by the HealthSmart Payor's Utilization Review (UR) service. This UR confirmation process can be a combination of telephone, written, or online communication. Depending on the urgency of the medical care, notification requirements will vary.

Certifying treatment does not guarantee payment for services rendered to any Eligible Person. When a determination is made not to approve or certify a health care service, written notification is sent to the attending Physician, Hospital, Eligible Person and Payor. The notification will include the reason for the non-certification and a mechanism for the Physician and Eligible Person to appeal.

The appeal may be initiated by phone but the follow up must be in writing and must be received within 60 days from the date of the original determination. There are no specific documents required to initiate an appeal; however, the Eligible Person may be requested to complete a release of information form if medical records are needed.

Upon return of this form, the Utilization Management Department will request the medical records from the appropriate provider(s). Upon receipt of an appeal, the Utilization Management Department personnel will obtain all information necessary for the appeal and record the process. The information will then be forwarded to a physician consultant of the same or similar specialty as the attending physician. The review will be conducted by a physician who has not previously reviewed the case.

Referrals

To assist Eligible Persons avoid a potential reduction in health benefits, please make best efforts to refer Eligible Persons to HealthSmart Participating Providers. In addition, Participating Providers shall admit Eligible Persons to participating facilities within the HealthSmart Network except in the case of an emergency. Please contact HealthSmart Provider Customer Service at 800.687.0500

Claims Submission and Reimbursement

Claims Submissions

The HealthSmart Provider Networks are not an insurance company, guarantor, or payor of claims and is not liable for payment of any claims. As a Preferred Provider, you agree to submit clean claims, in a timely manner, for services rendered to Eligible Persons.

HealthSmart Accepts these Claim Forms:

- CMS-1500 or successor form
- UB-04 or successor form
- ANSI 837P
- ANSI 837I

Submitting Claims by Mail

Claims must be submitted to the address as identified on the Eligible Persons ID card.

Submitting Claims Electronically

If the network accessed has the ability to accept claims electronically, then the CMS-1500 and UB-04's may be submitted electronically through transaction networks and clearinghouses in a process known as Electronic Data Interchange (EDI). This method is recommended as it is faster and more accurate. The following routing number must be used on all EDI Claims:

HSPC1

Carevu and Availity

75250

Emdeon (Web MD)

34167

Emdeon (WebMD)

Prompt processing and payment is contingent upon provider completing each claim form accurately and completely. In order for HealthSmart to identify and process the claim, we must have all the necessary patient and insured information. Claims must be submitted within industry standard time frames unless specified in contract.

Claims Reimbursement

Participating Providers should bill for services for an Eligible Person at the normal retail rate. The HealthSmart Payor will reimburse once benefits are applied. You will receive an Explanation of Payment (EOP) detailing payment. You may not charge an Eligible Person for Covered Services beyond copayments, coinsurance or deductibles as described in their benefit plans.

You may charge an Eligible Person for services that are considered as Non Covered under the applicable benefit plan, provided you first obtain the Eligible Person's written consent. Such consent must be signed and dated by the Eligible Person prior to rendering the specific service(s) in question. Retain a copy of this consent in the Eligible Person's medical record.

Each HealthSmart Payor's plan may exclude or reduce benefits for some types of medical care, again please verify an Eligible Person's plan design by calling the appropriate HealthSmart Payor. Eligible Persons should be billed directly for services which are not covered by the HealthSmart Payor's health benefits plan design. If an error has been made in the adjudication of Eligible Person's benefits, please contact the appropriate HealthSmart Payor listed on the Eligible Person's ID card or Explanation of Payment (EOP).

Multiple Procedures

In a case where multiple surgical procedures are scheduled, please obtain benefit information from the HealthSmart Payor for each procedure.

Coordination of Benefits

Eligible Persons are sometimes covered by more than one insurance policy. Always obtain complete benefit information from each Payor when verifying an Eligible Person's health plan benefit.

Complaint & Appeal Procedures

Mail to the following address:

HealthSmart

Attn: Provider Relations

222 W. Las Colinas Blvd, Suite 600N

Irving, Texas 75065

Email: priority.service@healthsmart.com.

Please contact the Provider Relations department if you encounter any problems or have any questions concerning the HealthSmart provider network or contract:

Provider Relations *(listed by state in which provider practices)*	**Submit Provider Relations Inquiries to the email boxes below.**
IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com
AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com

This team can provide:

- Information regarding contract terms, reimbursement, & effective dates
- Product details & payor information
- Escalated issue resolution
- Information about network participation or how to add a new provider
- Onsite orientation and educational visits

ICD10 Readiness and Compliance

On January 16, 2009, the U.S. Department of Health and Human Services (HHS) released a final rule mandating that entities covered by the Health Insurance Portability and Accountability Act (HIPAA) must transition from ICD-9 code sets and adopt ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes as the standard. The transition to ICD-10 is occurring because ICD-9 produces limited data about patients' medical conditions and hospitals inpatient procedures. ICD-9 has outdated terms and is inconsistent with current medical practices. The structure of ICD-9 limits the number of new codes that can be created. On April 1, 2014, the President signed the Protecting Access to Medicare Act of 2014. A component of the Act prevents the Secretary of Health and Human Services to adopt ICD-10 code sets as the standard for code sets before October 1, 2015. The Act defers the previously delayed implementation date by 12 months.

In accordance with the published ruling from the Department of Health and Human Services that requires all HIPAA-covered entities to use ICD-10 code sets, HealthSmart has developed a proactive implementation strategy to ensure a seamless transition.

HealthSmart will be ICD-10 compliant for all of our lines of business by October 1, 2015.

A steering committee was assembled to identify, study, and describe the necessary modifications and the effect of the changes. The steering committee is comprised of representatives from functional areas across the enterprise to confirm overall readiness and compliance.

In preparation for this upcoming deadline, all of our contracted vendors, affiliates, clients and you the participating providers will be required to send and receive ICD-10 codes on claims for services performed on or after October 1, 2015.

Any and all non-compliant claims, including but not limited to claims for group health, auto medical and worker's compensation product lines will be rejected.

Our intent is to deploy a code mapping strategy that is revenue neutral. Our studies indicate we achieved the desired result. Our methodology does not materially deviate from the industry standards being deployed across the nation. The HealthSmart code mapping crosswalks are published on our website at www.HealthSmart.com. If your HealthSmart Provider Agreement uses ICD-9 diagnosis or procedure coding to map to a reimbursement amount, we strongly urge you to review these documents at your earliest convenience.

We have begun end-to-end testing using our established code set across all of our administrative systems to ensure a successful launch. Your organizations' commitment to being prepared for the transition represents a critical factor in preserving operational fitness.

HealthSmart will continue to provide information and support to our entire constituency throughout this important transition. Please visit our website for additional resources and information to aid in our collective preparedness.

ICD-10 Readiness Frequently Asked Questions

Q&A #1	**Will HealthSmart implement ICD10 in 2014 now that the timelines have changed?** HealthSmart, like most of you, was scheduled to be ICD-10 compliant by October 1, 2014. Our internal steering committee will reassemble to identify, study, and describe the necessary modifications and the effect of the changes. We will publish any revisions to that plan as soon as possible. We will, however, be ready on or before October 1, 2015 as all HIPPA-covered entities are required to transition to ICD-10 on that date.
Q&A #2	**Will HealthSmart accept claims coded with ICD-10 prior to the new 2015 implementation date?** HealthSmart is scheduled to be ICD-10 ready in 2014. However, prior to making this available to providers, we must vet and validate our clients' and vendors' state of readiness. All of these components must be aligned so we do not negatively impact your operations.
Q&A #3	**What if a HealthSmart TPA client or vendor is not ready and delays claims processing?** HealthSmart is working in conjunction with its clients and vendors so that the transition will be successful enterprise-wide. We have notified all clients and contracted vendors that they must be compliant and are not exempt from timely payment penalties if claims are not processed and paid timely.
Q&A #4	**Do you have a plan to accommodate both ICD-9 and ICD-10 claims after the implementation date?** HealthSmart will accept claims coded ICD-9 for dates of service through September 30, 2015. • Inpatient claims with a discharge date on or after October 1, 2015 must be submitted using ICD-10 code sets for the entire claim. • Outpatient claims with dates of service that span the implementation date must be split and billed separately using the appropriate code sets for each. • Claims submitted with dual code sets will be rejected. All claims must be submitted using a single code set.
Q&A #5	**Will HealthSmart require workers' compensation and auto injury bills to be compliant with new ICD-10 coding?** Yes. Our objective is to transition all our lines of business together. Work Comp and Auto Medical bills will be subject to the HealthSmart ICD-10 requirements. We acknowledge that HHS does not consider Worker's Compensation plans "Covered Entities"; however, they do encourage all providers to code any and all claims using the ICD-10 code sets. Many States are mandating that Worker's Compensation claims to be subject to the HHS rulings.
Q&A #6	**Will HealthSmart implement new EDI rejections or other claim edits in support of ICD-10 compliance?** Yes. Upon the implementation date and using the dates of service on a claim as the indicator, HealthSmart will reject non-compliant EDI claims at the clearinghouse. Our pricing engine is programmed to reject paper claims with dates of service on or after the implementations date that are not ICD-10 compliant.
Q&A #11	**Will HealthSmart offer training to its provider networks about its ICD-10 requirements?** Yes. We will continue to publish documents, such as this FAQ, on our website and will be posting schedules for providers to participate in training webinars in the months and weeks prior to the implementation date.
Q&A #12	**When should I start using ICD-10 coding for precertification and predeterminations?** Our internal steering committee will reassemble to identify, study, and describe the necessary modifications and the effect of the delayed implementation. We will publish any revisions to that plan as soon as possible. We will, however, be ready on or before October 1, 2015 as all HIPPA-covered entities are required to transition to ICD-10 on that date.
Q&A #13	**What methodology was used for HealthSmart's ICD-9 and ICD-10 mapping?** Our methodology is proprietary to HealthSmart but does not deviate from the industry standards being deployed across the nation. The HealthSmart code mapping crosswalks and other helpful information about our processes are published on our website for you to review.

Q&A #15	**Do the ICD-10 PCS code sets replace CPT coding?** No, the transition to ICD-10 does not affect CPT coding for outpatient procedures and physicians services. Like ICD- 9 procedure codes, ICD-10 PCS codes are for hospital inpatient procedures only.
Q&A #16	**What is the difference between ICD-10 CM and ICD-10 PCS codes?** 1. ICD-10 CM is used for diagnosis coding. Diagnosis coding under ICD-10 CM uses 3-7 digits instead of 3-5 digits used with ICD-9 CM, but the format of the code set is similar. 2. ICD-10-PCS used for inpatient procedure coding exclusively. Inpatient procedure coding under ICD-10-PCS uses 7 alphanumeric digits instead of 3 or 4 numeric digits under ICD-9 CM procedure coding. Coding under ICD-10-PCS is much more specific and substantially difference from ICD-9 CM coding.
Q&A #14	**Where can I find detailed mapping documents?** The HealthSmart code mapping crosswalks and other helpful information about our processes are published on our website for you to review.

Electronic & Online Services

Electronic Data Interchange (EDI) Clearinghouse

HealthSmart offers a Full Service Healthcare EDI Clearinghouse, which is open to all providers in the healthcare community. Our goal at HealthSmart is to give our network providers the highest level of customer service possible.

EDI Services

- Commercial claims (Aetna, CIGNA, Humana, etc…) to providers
- Free government claims to participating carriers
- Eligibility verifications
- Claim status inquiry
- Electronic remittance advice (ERA) for auto payment posting
- Referral and authorization requests
- e-Paper (Print-Mail Services)
- Patient statements

EDI Benefits

By utilizing the above features, providers experience the following benefits:

- Faster reimbursement
- Reduce rejected claims (Clean Claims)
- Decrease time-intensive manual tasks
- Increase productivity and efficiency
- Improve cash flow

Electronic Data Interchange Frequently Asked Questions

Q&A #1	**What are HealthSmart EDI Routing Numbers?** • HSPC1 (CareVu & Availity) • 75250 (Emdeon) • 75237 Accel Network
Q&A #2	**How can I contact HealthSmart Information Systems?** • Email: support.his@healthsmart.com • Phone: 888.744.6638 • Fax: 806.473.2425
Q&A #3	**What is the mailing address for HealthSmart Information Systems?** HealthSmart Information Systems 2002 West Loop 289, Suite 110 Lubbock, TX 79407
Q&A #4	**What type of claims do you receive?** At this time, we receive HCFA-1500s, UB-92s and UB-04s electronically.
Q&A #5	**What other clearinghouses work with HealthSmart?** Our list of clearinghouses is constantly changing. For the most accurate answer, please contact HealthSmart Information Systems at 888.744.6638
	Are there other Online Services and Resources? • Claim status (contracted providers only) HealthSmart • Provider Look Up • Provider Manual • Repricing Reason Codes • Request Information (fee schedule, network access application, etc.) • Update Demographic Information • Search for Participating Providers • Provider Links • Applications • Peer-Review and Editorial Board • News Services • Decision Making Tools

HealthSmart Web Portals

Registering for Online Claim Status:

- When registering for Online Claim Status, make sure the contact information is complete and accurate
- Email address must include: .com, .net, etc.
- All fields are required
- After completion, the system will acknowledge your registration
- Email confirmation will be sent in three business days
- Fax back confirmation by Provider must be received prior to activation
- Click here to register

Online Claims: Getting There

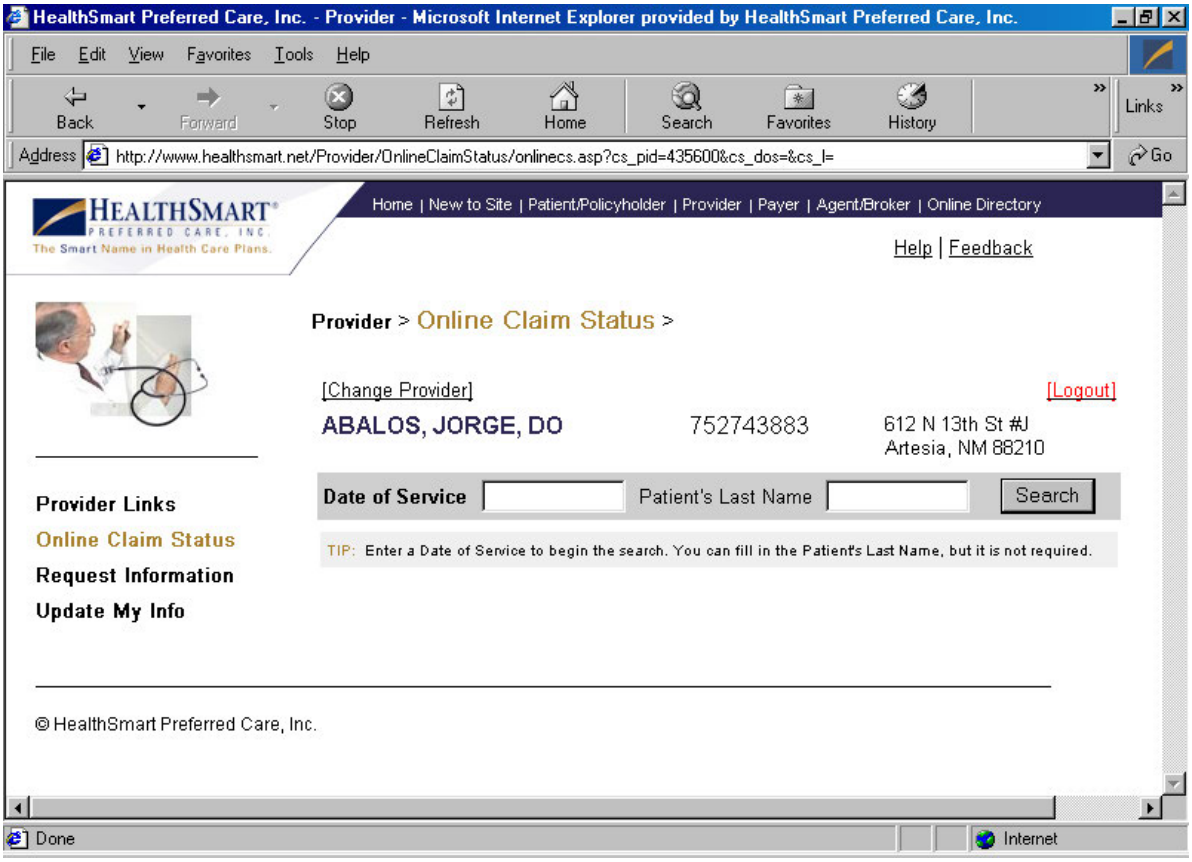
1. Go to HealthSmart.com
2. Click on providers
3. Click on **select service**
4. Select your claims portal

Selecting an Online Claim on the HealthSmart Portal

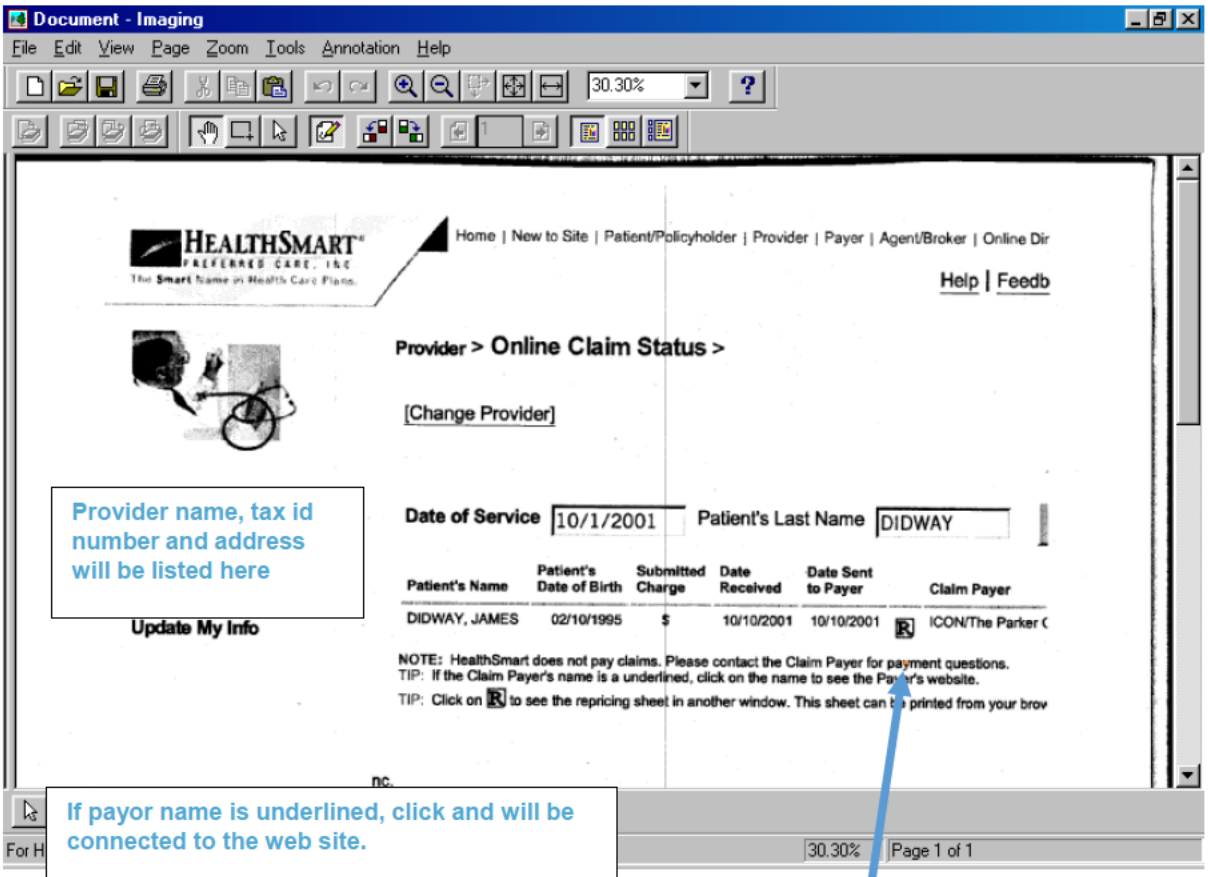
1. Click on the appropriate provider's name

2. Enter Date of Service

3. For a quick search, we recommend that you do not enter the patient's last name.



Viewing an Online Claim



FREQUENTLY ASKED QUESTIONS ABOUT ONLINE CLAIMS

Q&A #1

How do I confirm network participation of a provider?

By calling the HealthSmart Customer Service Department. They may be reached at 800.687.0500 (Health Smart Preferred Care)

Q&A #2

How do I update my Preferred Provider information: address, Tax ID number, etc.?

If you are contracted directly with HealthSmart, an update can be made online (hyperlink), by email, fax, or hard copy mail. If you are contracted through a provider group, then the update must come from said group.

Provider Relations *(listed by state in which provider practices)*	***Submit Provider Relations Inquiries to the I email boxes below.***
IA, IL, IN, KS, MO, MN, ND, NE, SD, WI	pr.central@healthsmart.com
CT, DE, KY, MA, MD, ME, MI, NH, NY, OH, PA, TN, VA, VT, WV, RI, NJ	pr.east@healthsmart.com
AL, AR, FL, GA, LA, MS, NC, NM, OK, SC, TX	pr.south@healthsmart.com
AZ, CA, CO, ID, MT, NV, OR, UT, WA, WY, HI, AK	pr.west@healthsmart.com

Fax Number: 214.574.2368

Mail: HealthSmart

Attn: Provider Relations

222 W. Las Colinas Blvd., Suite 500 N

Irving, TX 75039

Q&A #3

How do I verify benefits?

HealthSmart does not verify membership or determine which healthcare services or benefits are covered. Always refer to the member ID card and call the telephone number printed on the card to verify benefits and eligibility.

Q&A #4

Where do I submit a hard copy claim?

Please refer to the member ID card for the most current information or mail to:

HealthSmart Benefit Solutions

P.O. Box 53010

Lubbock, TX 79453-3010

Q&A #5

Can claims be filed electronically?

Yes, please refer to member ID card for the most current information.

Q&A #6

How can I receive a copy of a re-pricing sheet?

For HealthSmart Preferred Care contracted providers that have gone through the HealthSmart online registration process, utilizing the Online Claim Status at https://secure.healthsmart.com/ocs/ocslogin.aspx.

Q&A #7

How do I obtain payment status?

For payment status, please contact the Plan Administrator or Payor located on the patient's ID card.

Q&A #8	**How do I appeal a payment?** Payment appeals may be submitted to HealthSmart as follows: Phone: 800.687.0500 Email: priority.service@healthsmart.com Fax: 214.574.3992
Q&A #9	**How can I obtain an Approved Client Listing?** An Approved Client Listing may be obtained by visiting our web site www.healthsmart.com or by submitting a written request to: HealthSmart Network Solutions Attn: Provider Relations 222 W. Las Colinas Blvd., Suite 600 N Irving, Texas 75039
Q&A #10	**Why are claims returned or rejected by HealthSmart?** In order to process a claim, please ensure that the information filed on the claim is complete and accurate (to the best of your ability). Some examples for returned or rejected claims are listed below: • Unable to identify employer group listed on the claim • Employer group is not effective for the date of service • Employer group terminated prior to this date of service • Patient no longer has access to the HealthSmart network • Patient/Insured not valid for this date of service for this group • Payor has requested that claims be submitted directly to them • Missing claim elements

Reference Materials

1. Integration Letter
2. Territories Map
3. Frequently Asked Questions

October 15th, 2011

RE: HealthSmart Holdings, Inc. advances integration of InterPlan Health Group and announces new network names and logos

Dear Provider:

In the fall of 2007, the parent organization of InterPlan Health Group, Inc. ("IHG") was acquired by HealthSmart Holdings, Inc. Since that time, HealthSmart has been working diligently to integrate its various provider networks, including IHG. As a result of those efforts, IHG is excited to announce that effective July 1, 2011, IHG has been renamed "**HealthSmart Preferred Network II Inc**." This reabranding is a vital step toward HealthSmart's goal to fully integrate its network products throughout the United States.

As a result of the changes described above, IHG network identification and logos are being phased out in favor of a more universally recognized HealthSmart Network logo. This process will begin July 1, 2011. Over the next 12 months, HealthSmart Network clients will be updating their identification cards to reflect the HealthSmart Network logo. **During this transition period, HealthSmart asks that you please continue to accept both the IHG and HealthSmart Network logo(s).** Please see the attached logo guide to assist your office team in identifying HealthSmart/IHG members.

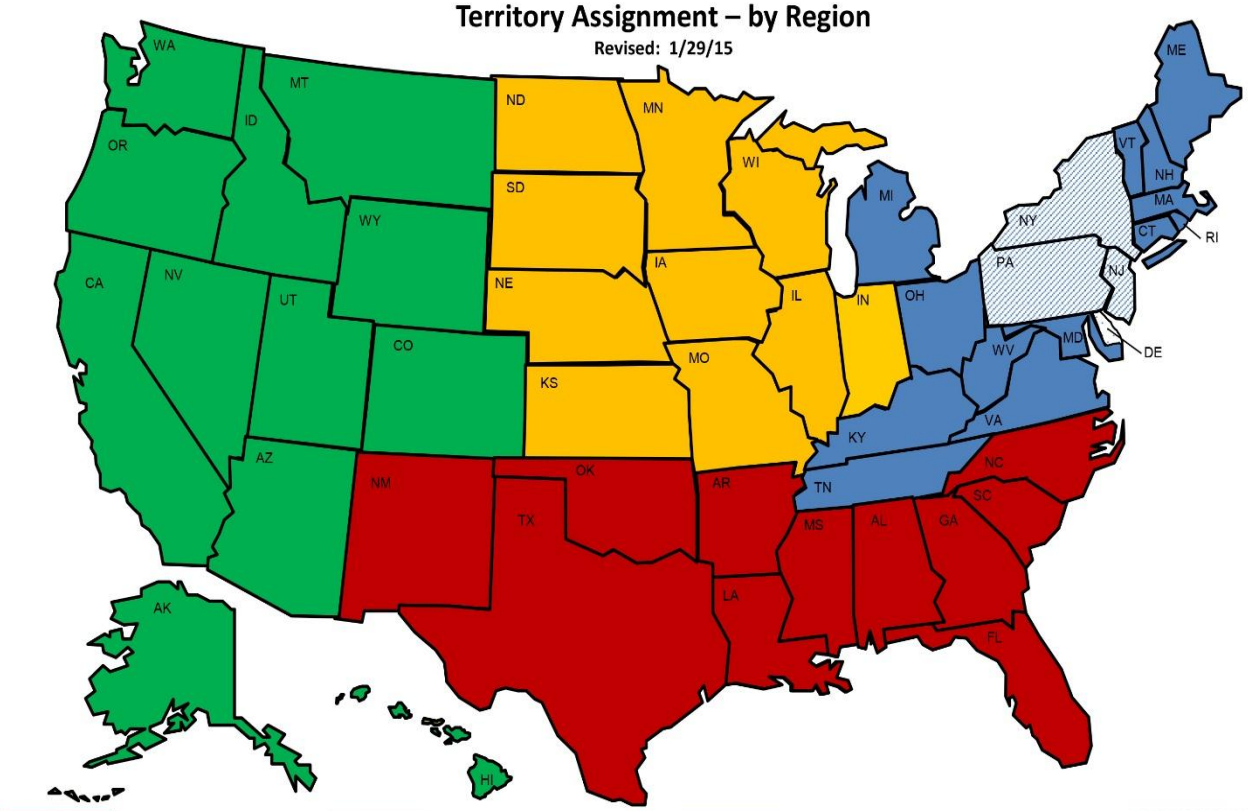
Please note that there will be no change in your current product participation or reimbursement as a result of these changes, and your current agreement remains in full force. If your organization is a provider with both an IHG and HealthSmart Preferred Care II, LP ("HSPC") active contract, your HSPC agreement and rates will prevail for any common products and your IHG contract rates will remain active for all other products. As part of a larger **HealthSmart** network, you will now be able to see **all HealthSmart affiliated** members, some of which previously could not access your practice. Membership now includes participants in the HSPC, IHG, Preferred Plan, Inc., and Emerald Health Network, Inc. preferred provider networks.

Please reference the attached Frequently Asked Questions or monitor our Provider Integration Page at www.healthsmart.com/NetworkIntegration.aspx for updated information regarding the integration.

We are excited about our future and look forward to making HealthSmart a nationally recognized and respected name in the healthcare industry with you as a partner. Please contact our customer service team at 866.659.9314 from 7 am to 7 pm CST with any questions that may arise.

For internal use only

Provider Relations
Territory Assignment – by Region
Revised: 1/29/15



WEST Region

Email: pr.west@healthsmart.com
Fax: 214-574-2368
Transfer Calls to:
IRV PR Workgroup

SOUTH Region

Email: pr.south@healthsmart.com
Fax: 214-574-2368
Transfer Calls to:
IRV PR Workgroup

CENTRAL Region

Email: pr.central@healthsmart.com
Fax: 214-574-2368
Transfer Calls to:
IRV PR Workgroup

EAST Region | **WTC Svc Area**

Email: pr.east@healthsmart.com
Fax: 214-574-2368
Transfer Calls to:
IRV PR Workgroup

HealthSmart Network Integration FAQs

Q&A #1	**Who is HealthSmart?** HealthSmart is a group of managed healthcare companies dedicated to providing comprehensive and innovative health care solutions to meet client needs. We offer an inventory of wholly-owned products and services: **HealthSmart Benefits Solutions**, delivers comprehensive healthcare benefit administrative services **HealthSmart Care Management Solutions**, a full-service care management company **HealthSmart Rx**, a full-service prescription benefit manager **HealthSmart Primary Care Clinics**, manages on-site employer-sponsored healthcare clinics **HealthSmart Information Systems**, a healthcare IT provider with over 200 million EDI transactions **HealthSmart Provider Networks**, PPO networks which encompasses several directly-contracted provider networks such as HealthSmart ACCEL, HealthSmart Preferred Care, HealthSmart Payors Organization, Auto Liability and Worker's Compensation.
Q&A #2	**What is HealthSmart Preferred Care?** The HealthSmart Preferred Care network is one of our wholly-owned nationwide preferred provider organizations (PPO). HealthSmart formed HealthSmart Preferred Care in 1993. Beginning as a network with a significant presence in the Southwest, it is now available throughout the United States.
Q&A #3	**Why are you integrating your networks – Emerald Health Network, Interplan Health Group, and Preferred Plan, Inc. & Select Care – into HealthSmart Preferred Care?** Over the years, HealthSmart has either built or acquired several provider networks. Prior to integration, each network has operated independently, which led to operational inefficiencies. The effort and expense of maintaining these independent systems, processes and personnel kept us from offering our customers the best price possible for our services. With this network integration, HealthSmart is utilizing a new state-of-the-art PPO management system, reconfiguring our infrastructure and cross-training our support teams, all in an effort to offer a stronger, more efficient, more responsive network product to our customers. HealthSmart is very excited about the full implementation of this system and the high-level of service this and many other network initiatives will bring to our providers and clients.
Q&A #4	**Why we will be using HealthSmart Preferred as the name of the integrated network?** We could have chosen any name for the combined network, but HealthSmart Preferred is a network brand that our company built from the ground up and grew over the last 17 years. In addition, both our company and the network share the HealthSmart name.
Q&A #5	**Will providers need to sign a new agreement with HealthSmart Preferred?** No. Your current agreement as a provider with Interplan Health Group, Emerald Health or Preferred Plan, Inc. will remain in full force. We do, however, encourage you to move to a HealthSmart Agreement.
Q&A #6	**Will the fee schedule or reimbursement change?** No. There are no changes to your current reimbursement schedule.
Q&A #7	**How will providers identify patients as members of HealthSmart Preferred network?** Members using HealthSmart networks are issued Identification (ID) Cards. Please accept members with ID Cards displaying legacy logos as well as the HealthSmart Preferred Network logo. For more details on logos, see the enclosed page titled Network Guidelines. Note that members are issued ID Cards by payor companies and each card will differ depending on the payor. In addition, it is the decision of the payor when to reprint member ID Cards with the updated logo.

Q&A #8	**Where do providers submit paper claims or electronic claims?** Please submit paper claims to the address on the member's ID card. If no address is visible or otherwise indicated on the ID card, please submit paper claims to PO Box 53010, Lubbock, Texas 79453-3010. You can also submit electronic claims. HealthSmart offers a full service EDI Clearinghouse, which is open to all healthcare providers. For more information, email support.his@healthsmart.com or call 888.744.6638. HealthSmart Preferred EDI number is HSPC1 or 75250.
Q&A #9	**Will the network indicator listed on the EOP-EOB change?** No, the network indicator on the EOB or EOP will remain unchanged as HealthSmart Preferred or HealthSmart.
Q&A #10	**How will you keep providers appraised of the status of the integration?** For detailed information about our network integration efforts, please visit our website at www.healthsmart.com/NetworkIntegration.aspx.
Q&A #11	**What is the website that I should access for information?** You can access information and all of the latest updates regarding our integration at http://www.healthsmart.com/NetworkIntegration.aspx. In addition to integration information, you can go to our provider section of www.healthsmart.com to access the following information, forms and tools: • Provider Credentialing Applications • Provider Manual • Online Claim Status (available for contracted providers only) • Update Provider Information • Re-pricing Reason Codes • Client Listings • Provider Lookup with Sample ID Cards
Q&A #12	**Where is the HealthSmart Preferred Care provider directory located?** Please access www.healthsmart.com and select the Provider Lookup link at the top of each webpage or go direct to http://providerlookup.healthsmart.com/SearchProviders.aspx.
Q&A #13	**When will clients be notified of the integration?** HealthSmart wanted to be sure our providers were notified first. HealthSmart began contacting all of our clients in July, 2011.
Q&A #14	**Where should I submit provider demographic changes, updates and terminations?** There are no changes to your current submission request process. Please continue to submit your requests to the same email address you are currently using.