AMENDMENT NUMBER ONE
TO THE
SATISFACTION AGREEMENT
BETWEEN
PEACH STATE HEALTH PLAN, INC.
and
_____

This Amendment Number One ("Amendment") is entered into as of _____ day of _____, 2013 by and between Peach State Health Plan, Inc. ("HMO") and _____("Provider"), collectively referred to herein as the "Parties".

WHEREAS, HMO and Provider have previously entered into a Satisfaction Agreement (the "Agreement") with date of _____ (defined in the Agreement as the "Effective Date"); and

WHEREAS, the Parties desire to amend the Agreement;

NOW THEREFORE, in consideration of the promises and mutual covenants herein contained, the Parties agree as follows:

1. The "Disputed Services" defined in Recital #2 of the Satisfaction Agreement shall consist of "…all claims for services rendered to HMO's members with dates of service ranging from June 1, 2009 to January 31, 2013…".

2. Exhibit 1, Additional Voluntary Payment, and Exhibit 2, Claims Processing shall be attached to and incorporated in the Satisfaction Agreement as Amendment One to the Satisfaction Agreement.

3. Paragraph 3 of the Satisfaction Agreement shall be revised as follows:

   In consideration of HMO's and Provider's execution and delivery of this Satisfaction Agreement and payment of the amounts provided in Section 2 of this Satisfaction Agreement, each of the Parties does hereby release and forever discharge each other and each other's respective officers, directors, employees and other agents from any and all actions, causes of action, suits, debts, accounts, damages, judgments, claims and demands whatsoever, whether at law or in equity, whether known or unknown, which HMO or Provider ever had, now have or may or might in the future have against the other or against any of the entities or individuals hereby released, which relate to, or arise out of, the Settled Matter, except that TRS, and any claims that Provider may have against TRS are not subject to this Satisfaction Agreement and the release in this amended Paragraph 3. The Parties do not intend this release and discharge to have any effect on any claims other than those included as part of the Settled Matter. Further, this release will not apply to any claims or causes of action that they may have against the others for indemnity or

contribution related to medical malpractice or to a cause of action that may be the result of fraud on the part of any Party.

4. Add Paragraph 11 to Satisfaction Agreement to read as follows:
   Provider agrees not to disparage Peach State in any manner in connection with the events surrounding the execution of this Satisfaction Agreement and any amendments thereto.

5. Add Paragraph 12 to the Satisfaction Agreement to read as follows:

   This Satisfaction Agreement as amended and revised contains all the terms and conditions agreed upon by the parties, and supersedes all other agreements, express or implied, regarding the subject matter hereof.

6. All other terms and conditions of the Agreement and any amendments thereto, if any, shall remain in full force and effect. If the terms of this Amendment conflict with any of the terms of the Satisfaction Agreement, the terms of this Amendment shall prevail.

IN WITNESS WHEREOF, the Parties hereto have executed this Amendment effective as of the date first set forth above.

HMO:

By:_____

Name: Patrick Healy

Title: President & Chief Executive Officer

Date:_____

PROVIDER:

By:_____

Name:_____

Title:_____

Date:_____

Tax Identification Number:_____

EXHIBIT 1

ADDITIONAL VOLUNTARY PAYMENT

1. HMO shall offer a voluntary payment to Provider for incurred claims which were previously authorized with dates of service prior to February 1, 2013. HMO will accept signed Satisfaction Agreements and/or Amendment One to the Satisfaction Agreements March 29, 2013. Provider and HMO agree that HMO will use its best efforts to make its payment for claims verified using TRS documentation within 75 days after the March 29, 2013 deadline. HMO shall make such voluntary payment based upon claims for services authorized and rendered under open prior authorizations approved by TRS that:
   a. HMO can verify based upon its review of TRS's records or documentation from Provider deemed satisfactory by HMO. HMO shall have sole discretion to determine whether the documentation submitted by Provider is satisfactory and such approval shall not be unreasonably withheld;
   b. were not previously billed by Provider, subject to timely filing limits;
   c. were for evaluations performed by Provider but not paid by TRS; and
   d. may have been approved for payment by TRS and TRS has provided HMO with verification that such payment was processed by TRS but was reversed.
2. Claims for services rendered and billed under approved open authorizations that have been denied and appealed or denied and not yet appealed on or after December 15, 2012 may be resubmitted for reconsideration on or before March 29, 2013, provided all supporting documentation is submitted for review by HMO on or before March 29, 2013. Provider and HMO agree that HMO will use its best efforts to make any payments it determines is owed to Provider within 75 days after of its receipt of all of the Provider's claims and supporting documentation.
3. HMO's payment rate shall be 85% of the current contracted rate.
4. HMO's payment will not include reimbursement for bank fees associated with payments reversed or cancelled by TRS.
5. Payment amounts identified by HMO shall be full and final and shall not be subject to negotiation or appeal except as provided in Paragraph 1, 2 and 6.
6. HMO's consideration of claims for services rendered under open authorizations which were not billed to TRS before the termination of the TRS contract with HMO is limited to those claims specified in this Satisfaction Agreement and this Amendment One and that meet timely filing requirements. Claims that have been previously rejected or denied by TRS prior to December 15, 2012 are ineligible for consideration. HMO retains the right to present claims it suspects were submitted with the intent to defraud to its corporate Special Investigations Unit or any other government entity for investigation.
7. Claims reconsideration referenced in Paragraphs 1, 2, and 6 shall be limited to the process outlined in Exhibit 2.
8. HMO shall meet transition of care requirements as outlined in Contract Number #0653 with the Georgia Department of Community Health, Section 4.11.4.1 by processing claims for payment with dates of service between February 1, 2013 and February 28, 2013 authorized and rendered under open prior authorizations approved by TRS that HMO can verify (see Paragraphs 1, 2 and 6) and based upon its review of TRS's records or records submitted by

providers as specified and permitted in this Amendment One. Such claims payments will be made at HMO's current contracted rate.

9. Provider and HMO further agree that as part of this Satisfaction Agreement and all subsequent amendments, and after said payment identified above is made, no Party to this Satisfaction Agreement and all subsequent amendments shall seek recovery from the other Party for unpaid, overpaid or underpaid amounts, including any prompt pay penalty, for any claim or claims that are included in the Settled Matter.

Peach State Health Plan™

3200 Highlands Parkway SE
Suite 300
Smyrna, GA 30082
Phone: 678-556-2300
Fax: 770-803-0043

EXHIBIT 2

TRS CLAIMS SUBMISSION INSTRUCTIONS
FEBRUARY 25, 2013

To facilitate correct filing of claims and avoid delays in payment referenced in Amendment One to the Satisfaction Agreement, please review and comply with this attachment carefully. The following are instructions for submitting therapy claims associated with Amendment One to the Satisfaction Agreement:

Claims with dates of services prior to February 1, 2013 that were not addressed in the Satisfaction Agreement must be filed with Peach State in the following manner:

- Claims must be filed **electronically** to Peach State
- Claims must meet the eligibilty criteria outlined in Paragraph 1, Amendment One to the Satisfaction Agreement
- Claims must be received by Peach State no later than March 29, 2013.
  - For tracking puposes, you must also provide an Excel spreadsheet listing the affected claims
  - The Excel spreadsheet must contain the following headers: TRS Authorization Number, Provider TIN, Provider Name, Member Last Name, Member First Name, Member Medicaid ID Number, Date of Service, CPT Code, Modifier(s), Units, Billed Charges. Please contact Robin Taylor at rotaylor@centene.com for an electronic template.
  - The Excel spreadsheet must be sent via secure email to Robin Taylor at rotaylor@centene.com
- Peach State provides two options for filing these claims:
  - PSHP Provider Web Portal: https://provider.pshpgeorgia.com
  - EDI/Electronic claim submission
  - Providers who do not have access to the web portal or EDI capabilities should contact Robin Taylor at (678)556-2311 for instructions.

Denied/Appeal Claims Consideration Process:

- Claims for services rendered and billed to TRS on or after December 15, 2012 under approved open authorizations that have been denied and appealed or denied and not yet appealed may be resubmitted for reconsideration on or before March 29, 2013 provided all supporting documentation is submitted for review by Peach State. Claims that have been previously rejected or denied by TRS prior to December 15, 2012, are ineligible for consideration. Claims must include the following information:

  - Copy of the original claim
  - Copy of the remittance advice from TRS with denial reason listed
  - Copy of appeal letter submitted to TRS, if applicable
  - Justification documentation to support the claim was denied inappropriately
  - Information must be received by Peach State at the address below on or before March 29, 2013 in order to be considered:

Peach State Health Plan
Attention: Robin Taylor
3200 Highlands Parkway
Suite 300
Smyrna, GA 30082

Claims with dates of service February 1, 2013 through February 28, 2013, (Continuity of Care period) with a valid TRS or Peach State Authorization may be filed with Peach State in the following manner:

- Peach State provides two options for filing these claims:
  - PSHP Provider Web Portal: https://provider.pshpgeorgia.com
  - EDI/Electronic claim submission

Listed below are Peach State Health Plan's approved EDI Clearinghouse Vendors

Clearinghouse Vendor	Payer ID
Availity/THIN (Medical)	68069
CPSI	97245
Emdeon/WebMD/Envoy	68049
McKesson/HBOC (Medical)	68049
MedAvant/ProxyMed (Medical)	68049
PayerPath	97245
SSI Group	97245

Please contact Peach State Provider Services at 1-866-874-0633 for questions and assistance with the electronic claims submission process.