BlueCross BlueShield of Oklahoma

Blue Traditional[SM] Network Participating Group Agreement

This Agreement is made and entered into by and between Blue Cross and Blue Shield of Oklahoma, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association ("The Plan"), to provide health benefits through administered contracts, and the undersigned medical group, whose members are duly licensed by the State of Oklahoma and authorized to practice as physicians and health care professionals, ("Group").

Any notice given pursuant to the terms and provisions of this Agreement (except credentialing-related correspondence) shall be sent as follows:

Notice to Group:

Group's payee address on record and/or in electronic format.

Notice to The Plan:

Health Care Delivery/Provider Network Operations
Blue Cross and Blue Shield of Oklahoma
P. O. Box 3283
Tulsa, OK 74102-3283

The undersigned parties hereby agree to the terms and conditions contained in this Agreement. This Agreement shall be effective beginning on _____

MANGUM REGIONAL MEDICAL CENTER	BLUE CROSS AND BLUE SHIELD OF OKLAHOMA, A DIVISION OF HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL RESERVE COMPANY
_____	_____
Authorized Signature	Authorized Signature
_____	RICK KELLY
Name of Signatory	Name of Signatory
_____	VICE PRESIDENT HEALTH CARE DELIVERY PROVIDER NETWORK OPERATIONS
Title of Signatory	Title of Signatory
_____	_____
Date Signed	Date Signed

ARTICLE I
DEFINITIONS

1.0 Average Sales Price ("ASP"): A manufacturer's sales of a pharmaceutical or biological to all purchasers in the United States in a calendar quarter divided by the total number of units of the pharmaceutical or biological sold by the manufacturer in that same quarter, as reported to the Centers for Medicare and Medicaid Services ("CMS").

1.1 Average Wholesale Price ("AWP"): A pharmaceutical or biological list price reported by manufacturers. AWP does not account for various rebates, discounts, and purchasing agreements.

1.2 Benefit: The payment, reimbursement, and/or indemnification of any kind received from and through The Plan, as set forth in the Member's Benefit Agreement under a health care plan purchased by the Member or the employer on behalf of the Member.

1.3 Benefit Agreement(s): The written agreement between The Plan or one of HCSC's subsidiaries or affiliates, and an employer group, whether insured or self-funded, or an individual under which The Plan arranges for, indemnifies, or administers health care Benefits for Covered Services, and any written health Benefit plan covering a Member, which includes a detailed explanation of Covered Services.

1.4 BlueCard® Program: A national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan's service area.

1.5 Care Coordinator: A professionally qualified person who is competent to conduct initial review and other functions involving Prior Authorization.

1.6 Cellular Immunotherapy Treatment: The FDA-approved treatment that has been issued an NDC (e.g. Chimeric Antigen Receptor Therapy (CAR-T) such as Kymriah for the treatment of acute lymphoblastic leukemia) that utilizes the body's own immune system cells ("T-Cells") to attack harmful (e.g., cancerous) cells through a process in which T-Cells are harvested from the Member, genetically re-engineered and multiplied in a laboratory, and given to the Member by infusion. For the avoidance of confusion, for purposes of this Agreement, "Cellular Immunotherapy" does not include drugs (outside of the FDA-approved cellular immunotherapy), products or services which are associated with or in addition to the administration of the treatment or other FDA-approved products. Given the rapidly-changing advancements in Cellular Immunotherapy Treatment, as new Cellular Immunotherapy products are FDA-approved, such products will be applied the same methodology.

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1.7 Claim Form: A CMS 1500 or UB-04 form and subsequent revisions, or electronic versions of those forms, or any other legally recognized form for the submission of claims.

1.8 Concurrent Review: The review by The Plan of the Medical Necessity of the services that are in the process of being utilized. Concurrent Review includes, but is not limited to, continuing review of all inpatient care and outpatient procedures and services.

1.9 Coordination of Benefits: The administrative process of determining coverage between health plans when a Member has eligibility under more than one health plan.

1.10 Covered Services: Health care services or supplies specified in the Member's Benefit Agreement or otherwise eligible for Benefits.

1.11 CPT-4 Codes: The American Medical Association's ("AMA") listing of descriptive terms and identifying codes for reporting services and procedures performed by providers. References to CPT-4 Codes include codes set forth in subsequent revisions of AMA's listing of descriptive terms and identifying codes.

1.12 Experimental/Investigational/Unproven: A drug, device, biological product, or medical treatment or procedure is Experimental, Investigational, or Unproven if The Plan determines that:

1.12.0 The drug, device, biological product, or medical treatment or procedure cannot be lawfully marketed without approval of the appropriate governmental or regulatory agency and approval for marketing has not been given at the time the drug, device, biological product, or medical treatment or procedure is furnished; or

1.12.1 The drug, device, biological product, or medical treatment or procedure is the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or

1.12.2 The prevailing opinion among peer reviewed medical and scientific literature regarding the drug, device, biological product, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

1.13 Gene Therapy Treatment: The FDA-approved treatment that has been issued an NDC consisting of a modification or manipulation of the expression of a gene, or an alteration of the biological properties of living cells for therapeutic use, and which may include a specific technique that replaces a faulty gene, or adds in a new gene, in an attempt to cure a disease or improve the Member's ability to fight disease. For the avoidance of confusion, for purposes of this Agreement, "Gene Therapy Treatment" does not include drugs (outside of the FDA-approved gene therapy treatment), products or services which are associated with or in addition to the administration of the treatment.

1.14 Group Participating Health Care Professional: A health care professional, other than a Medical Doctor, Doctor of Osteopathy, Dentist or Podiatrist, who is licensed by the State of Oklahoma to render Covered Services and perform within the scope of such license and is under contract with or employed by Group. Such individuals include but are not limited to certified registered nurse anesthetists (CRNA), physical/occupational therapists, speech and language therapists, social workers, board certified behavioral analysts, nurse practitioners, and physician assistants.

1.15 Group Participating Physician: A physician who is under contract with or employed by Group, and who is a duly licensed Doctor of Medicine, Osteopathy, or other healing art profession defined and authorized by Oklahoma statutes, licensed to practice medicine, surgery, or other procedures and provide services within the scope of such license (to the extent applicable), and who is in good standing with the Oklahoma State Board of Medical Licensure and Supervision, Oklahoma Board of Osteopathic Examiners, or other Oklahoma Board of Physician Examiners appropriate to the specified healing art profession.

1.16 Group Participating Provider: A Group Participating Physician or Group Participating Health Care Professional.

1.17 HCPCS: The Centers for Medicare and Medicaid Services' ("CMS") Common Procedure Coding System which consists of Level 1 Current Procedural Terminology (CPT), Level 2 National Codes, and Level 3 Local Codes. References to HCPCS include codes set forth in subsequent revisions of the coding system.

1.18 HCSC: Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

1.19 Health Information Network: A health information network designated by The Plan that provides secure, online access to patients' community-wide medical data.

1.20 Hospital-Based Provider: A physician or health care professional who performs Professional Services within a hospital. Such providers include, but are not limited to, radiologists, anesthesiologists, ER physicians, pathologists, neonatologists and hospitalists.

1.21 ICD-10-CM Diagnosis Codes: International Classification of Diseases, Tenth Revision, Clinical Modification, a classification system for diseases, procedures, conditions, causes, etc. References to ICD-10-CM Diagnosis Codes include codes set forth in subsequent revisions of the publication.

1.22 Maximum Allowable Cost ("MAC"): A Multi-Source Product price utilizing multiple pricing benchmarks. The Plan utilizes a nationally recognized drug information source for MAC pricing.

1.23 Maximum Reimbursement Allowance: The amount established by The Plan as the maximum allowed amount for Covered Services rendered to Members.

1.24 Medical Director: A licensed physician who is selected by The Plan to assist with The Plan's utilization management program.

1.25 Medical Emergency: A medical condition, including injury or illness or condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a reasonable and prudent lay person could expect the absence of medical attention to result in (1) serious jeopardy to the Member's health; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

1.26 Medical Injectable: Therapy that involves the delivery of medication through a needle or catheter by a health care professional for the safe administration of the product. This includes but is not limited to chemotherapy, immunosuppressive therapy, inhalation therapy, and other therapies provided through non-oral routes such as intramuscular and epidural routes.

1.27 Medically Necessary or Medical Necessity: Health care services that a physician, hospital or other provider, exercising prudent clinical judgment, would provide to a Member for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

1.27.0 in accordance with generally accepted standards of medical practice;

1.27.1 clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Member's illness, injury or disease; and

1.27.2 not primarily for the convenience of the Member, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that Member's illness, injury or disease. For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

1.28 Member:

1.28.0 Any person eligible to receive Professional Services pursuant to the terms of The Plan's underwritten or administered contracts, Medicare supplemental coverage, or any person covered under Benefit Agreements underwritten or administered by other Blue Cross and/or Blue Shield Plans or a participant of a group utilizing The Plan's networks, as described herein, excluding Medicare program beneficiaries.

1.28.1 If Group is a Participating Provider in one or more of The Plan's networks in addition to Blue Traditional, this Agreement applies only to the persons described above who access the Blue Traditional network.

1.29 Multi-Source Product: A pharmaceutical or biological available in multiple brand-name and/or generic versions.

1.30 Noncovered Services: Services not specifically covered by or eligible for Benefits under the Member's Benefit Agreement.

1.31 Participating Provider: A hospital, other health care facility, physician, health care professional, or other provider of medical services, equipment or supplies, under an agreement with The Plan to render Covered Services to The Plan's Members. For purposes of this Agreement a hospital that is a Participating Provider may be referred to as a Participating Hospital.

1.32 Pass-Through Billing: Pass-through billing occurs when Group bills for a service, but the service was performed by another entity or provider who is not a Group Participating Provider.

1.33 Per Diem: A measure of payment for a day of service, including all Covered Services provided to Member, which is the exclusive payment for services provided to Member.

1.34 Point of Use Convenience Kit: A collection of drugs, injection supplies, and components necessary for various injection procedures.

1.35 Preferred Channel Management: Direct utilization of health care resources to a least costly avenue.

1.36 Prior Authorization: The process required by The Plan to establish in advance the Medical Necessity or Experimental/Investigational nature of certain care and services covered under the Member's Benefit Agreement as outlined in Article VI of this Agreement.

1.37 Professional Services: Covered Services provided by a physician or health care professional, rendered within the scope of his/her license.

1.38 Properly Filed Claim: A claim with no defects or improprieties, including a lack of any required substantiating documentation or particular circumstances requiring special treatment.

1.39 Recommended Clinical Review: A voluntary request submitted to The Plan prior to rendering services using the applicable form located on The Plan's website at www.bcbsok.com. The purpose of a Recommended Clinical Review request is to determine whether a specific service is Medically Necessary. A Recommended Clinical Review is not a guarantee of Benefits or a substitute for the Prior Authorization process.

1.40 Reference Laboratory: A laboratory that receives a specimen from another entity or provider and performs one or more tests on such specimen.

1.41 Single-Source Product: A brand-name pharmaceutical or biological available from only one (1) manufacturer.

1.42 Specialty Pharmacy Product/Medications: High cost products that includes injectable, infused, and oral medication therapies used to treat complex conditions and/or have special handling or access requirements. Example drug categories include: growth hormone deficiency, hepatitis C, immune deficiency, hemophilia, multiple sclerosis and rheumatoid arthritis.

1.43 Treatment Plan: A plan submitted by Group to The Plan, or its delegated vendor, for certain services provided to Members who have this requirement in their Benefit Agreement.

1.44 Under-Arrangement Billing: Under-Arrangement billing occurs when Group or Group Participating Provider renders services but allows those services to be billed by a hospital, other entity or other provider as if they were provided by that hospital, other entity or other provider.

1.45 Usual Charge: The fee most commonly charged by Group for services provided to most patients.

1.46 Utilization Review Criteria: Written guidelines used by The Plan in completing Prior Authorization.

1.47 Wholesale Acquisition Cost ("WAC"): A price paid by a wholesaler for pharmaceuticals or biologicals purchased from a supplier. WAC does not account for various rebates, discounts, and purchasing agreements.

1.48 Written Waiver: A document signed by the Member or his/her authorized representative, stating that one or both of them shall be responsible for payment denied by The Plan. Such Written Waiver must specifically identify the services not covered, including but not limited to services not Medically Necessary, Experimental/Investigational/Unproven, or not a Benefit, for which the Member or his/her representative agrees to be financially responsible and must be executed before rendering such services.

ARTICLE II
AGREEMENTS OF GROUP

2.0 Accept Reimbursement: Group agrees to accept as payment in full for Covered Services rendered to Members the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance set forth in Article V and hold Members harmless from any sums in excess of this Maximum Reimbursement Allowance. Group may collect from the Member any amounts for Noncovered Services and the applicable copayment and deductible unless prohibited by law. Until The Plan has determined the Maximum Reimbursement Allowance and notified Group as to the amount due from the Member, if any, under the Member's Benefit Agreement, Group shall not bill or attempt to collect from the Member any coinsurance amounts. The total amount collected from The Plan, or administered accounts, and the Member for copayment, deductible, and coinsurance, but not including Noncovered Services, may not exceed the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Group agrees to promptly refund to the Member any amounts which may have been collected from the Member in excess of the Member's responsibility as shown on The Plan's provider claims summary.

2.0.0 Applicability of Reimbursement: The lesser of Group's Usual Charge or the Maximum Reimbursement Allowance herein shall be paid for services provided to Members unless the terms of a separate network participation agreement and/or addendum supersedes. Group agrees to hold such individuals harmless from any sums in excess of the Maximum Reimbursement Allowance.

2.0.1 Written Waiver: Except where otherwise provided by applicable law, Group shall not bill or attempt to collect from the Member for services denied as not Medically Necessary or Experimental/Investigational/Unproven, unless Group has obtained a Written Waiver prior to rendering services. A Written Waiver cannot be used for Covered Services that The Plan determines are not separately reimbursable.

2.1 Access Standards: Group agrees to provide Members access to care in compliance with the Access Standards determined by The Plan as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement.

2.2 Audit/Review: Group will allow The Plan or its authorized representatives access to medical records, Member financial and billing records and any other documentation necessary to conduct reviews, desk audits and on-site audits. These audits/reviews may consist of but are not limited to evaluating appropriateness and accuracy of: claims coding and billing; medical record documentation; Member billing statements; utilization; Experimental/Investigational/Unproven; Medical Necessity; physical location where services were rendered; level of care; length of stay; health care setting; quality of care; Coordination of Benefits; worker's compensation; other party liability; billing practices; equipment maintenance; general office and facility environment; compliance assessments; and management of practice areas. At The Plan's option, reviews may be conducted on-site. On-site reviews shall be conducted during Group's regular business hours. The audit rights survive termination of this Agreement, and Group shall provide access to records for a period of two (2) years after the termination of this Agreement.

2.2.0 If Group disagrees with the audit/review findings, Group may request an appeal as set forth in *Post Claim Appeals* and *Contractual Inquiries/Appeals* in Article VII. To the extent the audit/review identifies refunds owed, The Plan shall issue a refund request in accordance with *Right of Recovery* in Article VIII.

2.3 Billing Arrangements: Group shall submit claims for Covered Services rendered by Group Participating Provider. Unless specifically authorized by The Plan in advance and in writing, Group shall:

2.3.0 refrain from submitting claims for services rendered by another entity or provider not affiliated with Group; and

2.3.1 prohibit other entities and/or providers from submitting claims for services performed by Group and/or Group Participating Providers.

This section prohibits Pass-Through Billing and Under-Arrangement Billing.

2.4 Call Coverage: Group agrees to provide coverage for Members twenty-four (24) hours per day, seven (7) days per week by a Blue Traditional Participating Provider.

2.5 Claim Filing: Group shall submit Properly Filed Claims to The Plan for all Covered Services rendered to Member at Group's Usual Charge in The Plan's designated format (refer to *Billing Requirements* in Article IV).

2.5.0 Original Claim: Claims shall be submitted within one hundred eighty (180) days of the date of service or within one hundred eighty (180) days of the primary payer's dated provider claims summary. Claims which are not submitted within the timely filing requirements herein will not be honored and Group agrees not to bill The Plan or Member for services associated with such claims.

2.5.1 Corrected Claim: Corrected claims will be accepted by The Plan up to eighteen (18) months following The Plan's adjudication of the original claim.

2.5.2 Request for Medical Records: When The Plan is unable to adjudicate a claim without first reviewing medical records to verify and substantiate the provision of services and the charges for such services, The Plan will deny the claim, with a request for Group to supply applicable medical records. Notwithstanding *Corrected Claim*, above, Group shall submit requested medical records to The Plan within sixty (60) days of receipt of the request for records by The Plan.

2.6 Discontinuing Care: Group Participating Provider may discontinue providing care for a Member who (1) commits fraud or deception or permits misuse of an identification card; (2) continually fails to keep scheduled appointments; (3) continually fails to pay required deductible, copayment, and coinsurance amounts; (4) continually fails to follow recommended treatment, counsel, or procedure; or (5) is continually disruptive, abusive, or uncooperative. Group Participating Provider will provide the Member and The Plan thirty (30) calendar days advance written notice of Group's discontinuance of care and must continue to provide care for such Member during such thirty (30) calendar day period or until the Member makes a new provider selection, whichever is earlier.

2.7 Eligibility Verification: Group accepts the responsibility of verifying the identity, eligibility, coverage and Prior Authorization requirements of the patient or Member applying for Benefits. If Group does not verify the identity, eligibility, coverage and Prior Authorization requirements of the patient or Member applying for Benefits, Group assumes the risk that the claim may be denied by The Plan, or if The Plan pays Benefits in error, The Plan may recoup payment pursuant to *Right of Recovery* in Article VIII.

2.8 Equal Treatment of Members: Group agrees to provide services to Members in the same manner, promptness and equal in quality as those services that are provided to all other patients of Group, without regard to age, race, sex, national origin, health status, economic status, veteran status, disability, or religious conviction.

Group will provide Covered Services to Members without regard to Member's designated network as long as Group is contracted for the Member's network.

2.9 Facilities/Offices Maintained to Code: Group will ensure that its facilities and offices in which Members will be received, screened, and treated meet all applicable federal, state and local codes and are in compliance with Physical Setting and Safety Standards determined by The Plan as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement.

2.10 Group Participating Providers: Group affirms that, as of the effective date of this Agreement, all Group Participating Providers who will be rendering services under this Agreement have been submitted to The Plan for inclusion under this Agreement.

2.10.0 Adding and Removing Group Participating Providers: Subsequent to the effective date of this Agreement, Group shall notify The Plan as set forth on The Plan's website at www.bcbsok.com of providers that join or leave Group at least thirty (30) days prior to the start or end date of employment (or within five (5) business days if such change is due to unanticipated circumstances such as death or illness). The Plan shall remove Group Participating Providers from this Agreement as requested by Group. New Group Participating Providers may be added to this Agreement in the sole discretion of The Plan, subject to completion of The Plan's credentialing process (if appropriate). Such additions will be effective on the date designated by The Plan, with notification sent to Group. If The Plan determines that the provider will not be added to this Agreement, all services rendered by that provider shall be determined to be out of network. If the provider is not added to this Agreement, Group must notify the Member in advance of receiving services that the provider is out of network.

2.10.1 Failure to Provide Information: Group's failure to timely provide or disclose information required by this section constitutes material breach of this Agreement.

2.11 Liability Insurance: Group agrees to maintain or ensure that each Group Participating Provider maintains insurance for the professional liability risk at all times while this Agreement is in effect. For the medical group, the minimum requirement is $1,000,000 per occurrence and $3,000,000 aggregate. For physicians, the minimum requirements are the greater of $500,000 per occurrence and $1,000,000 aggregate or the amounts required by the physician's primary admitting hospital. For certified registered nurse anesthetists, nurse practitioners and physician assistants, the minimum requirements are $500,000 per occurrence and $1,000,000 aggregate. For all other health care professionals, the minimum requirements are $500,000 per occurrence and $500,000 aggregate. Group will provide proof of insurance upon request of The Plan. From time to time, The Plan may revise the limits for minimum coverage. The specific amounts of the liability insurance and the carrier must be specified in the Uniform Credentialing Application. Should such arrangements change during the term of this Agreement, Group must notify The Plan in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.11.0 If Group is an agency or political subdivision of the federal or state government (as defined under either the Oklahoma Governmental Tort Claims Act or the Federal Tort Claims Act), and provides evidence of that fact satisfactory to The Plan, Group will not have to provide the required liability insurance coverage for the location(s) covered by law. However, Group must demonstrate that it carries professional liability insurance sufficient to cover any claims for which it can be liable under the applicable Act. Should Group's status as an agency or political subdivision of the federal or state government change during the term of this Agreement, Group must notify The Plan in writing, and provide, within thirty (30) days of such change, evidence that Group has obtained the required liability insurance coverage.

2.12 Licenses and Certifications: Group agrees to ensure that each Group Participating Provider maintains in good standing while this Agreement is in effect a valid and unrestricted license to practice medicine in the State of Oklahoma, a valid Drug Enforcement Administration (DEA) number with unrestricted prescribing privileges, a valid and unrestricted Bureau of Narcotics and Dangerous Drugs (BNDD) certificate, and certification to participate in the Medicare program under Title XVIII of the Social Security Act, if applicable. Group

Participating Providers must be in good standing with Medicare and Medicaid and be free from any state and/or federal sanctions during the past five (5) years for initial credentialing, and free from any state and/or federal sanctions during the past three (3) years for recredentialing.

2.13 Maintain Association/Admitting Privileges: If a Group Participating Health Care Professional is a certified nurse-midwife who provides delivery services, Group will ensure that he/she is associated with and provides delivery services at one of the following:

2.13.0 a Participating Hospital where the certified nurse-midwife or his/her supervising physician has admitting privileges; or

2.13.1 a licensed birthing center located on the campus of a Participating Hospital; or

2.13.2 a licensed birthing center that is a Participating Provider that is located within ten (10) miles of a Participating Hospital where the certified nurse-midwife or his/her supervising physician has admitting privileges.

2.14 Maintain Staff Privileges: Group agrees to ensure that each Group Participating Physician maintains medical staff privileges at a Participating Hospital. Special consideration will be given to the physician whose specialty does not ordinarily require hospital privileges. Group agrees to notify The Plan of any changes in such staff privileges in writing within thirty (30) days. Failure of Group to provide such notice to The Plan may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.15 No Incentives: Group agrees to collect all copayment, deductible and coinsurance amounts owed by the Member unless prohibited by law, neither waiving nor rebating any portion thereof, nor providing any other such incentives as a means of advertising or attracting Member to Group.

2.16 Notification of Adverse Action: Group agrees to inform The Plan of any actions, policies, determinations, and internal or external developments which may have a direct impact on the provision of services to the Member. Such notification includes, but is not limited to:

2.16.0 any action against any of Group Participating Providers' licenses or certifications;

2.16.1 any legal or government action initiated against Group or Group Participating Provider which affects this Agreement and/or Group Participating Provider's practice of medicine, including but not limited to, any action for professional negligence, fraud, violation of any law, or against any license.

Failure of Group to provide such notice to The Plan within thirty (30) days may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.17 Notification of Incorrect Payments: Notwithstanding *Corrected Claim,* above, Group agrees to notify The Plan of receipt of any incorrect payment of which it is aware, including underpayments, duplicate payments, or overpayments, within thirty (30) days of discovering the incorrect payment. This obligation survives termination of the Agreement. Overpayments shall not be refunded to the Member until The Plan has determined who is entitled to such funds. Group agrees The Plan will be permitted to deduct overpayments (whether discovered by Group or The Plan) from future payments made by The Plan, along with an explanation of the credit action taken.

2.18 Offices/Locations/Entities: Group affirms that, as of the effective date of this Agreement, all provider offices, locations, and entities owned, operated, or utilized by Group or Group Participating Providers have been submitted to The Plan for inclusion under this Agreement.

2.18.0 Notification of Changes: Group shall notify The Plan as set forth on The Plan's website at www.bcbsok.com of any changes to Group's information, including but not limited to changes in corporate entity name or name under which Group does business, address, phone number, office

hours, tax identification number, NPI, and scope of services, at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible, whichever is earliest.

2.18.1 Adding Offices, Locations, or Entities: Subsequent to the effective date of this Agreement, Group shall notify The Plan of any additional offices, locations, or entities owned, operated, or utilized by Group at least thirty (30) days prior to such change, or as soon as legally permissible, whichever is earliest. Group shall notify The Plan as set forth on The Plan's website at www.bcbsok.com for each new office, location, or entity, and The Plan shall determine, in its sole discretion, whether to add the new office, location, or entity to this Agreement.

(a) If The Plan determines that the additional office, location, or entity will not be added to this Agreement, all services at the additional office, location, or entity shall be determined to be out of network unless the office, location, or entity enters into a separate agreement with The Plan. If the additional office, location, or entity is not added to this Agreement and does not enter into a separate agreement with The Plan, Group must notify the Member in advance of receiving services at that location that the location is out of network.

2.18.2 Closing or Sale of Office/Location/Entity: Subsequent to the effective date of this Agreement, Group shall notify The Plan of the closing or sale of a provider office, location or entity as set forth on The Plan's website at www.bcbsok.com at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible, whichever is earliest. The Plan, in its sole discretion, reserves the right to review claims history, and if no claims have been billed for a specific location during a twelve (12) month period, to remove that location with ninety (90) days' advance notice to Group.

2.18.3 Failure to Provide Information: Group's failure to timely provide or disclose information required by this section constitutes material breach of this Agreement.

2.19 Policies and Procedures: Group agrees to abide by The Plan's operational policies and procedures and medical policies as set forth in this Agreement, and as described in the Provider section of The Plan's website at www.bcbsok.com, including but not limited to policies related to payment and coding. The Plan shall use its standard communication channels to provide advance notice to Group of substantive changes to information in the Provider section of its website.

2.20 Protection of Members from Out of Network Charges:

2.20.0 Group Participating Providers shall protect Members against out of network penalties/charges and from balance billing to include but not be limited by the following:

(a) All Members receiving services from Group shall be treated by Group Participating Providers. If a Member receives services at any Group participating office or location from a provider that is not a Group Participating Provider, Group agrees to hold the Member harmless from any sums in excess of the Maximum Reimbursement Allowance.

(b) If any Group Participating Providers are Hospital-Based Providers, Group agrees to participate in all of The Plan's networks applicable to each of the hospitals where Group Participating Providers maintain staff privileges.

(c) When a Group Participating Provider refers a Member to another provider or supplier, Group Participating Provider shall explain to the Member the benefit of treating in-network, including lower out of pocket costs for the Member and protections against balance billing. If a Member chooses to be referred to an out of network provider after being informed of the potential financial impact, the Group Participating Provider must obtain an acknowledgement of referral from the Member that shows written consent.

(d) All samples collected by Group or Group Participating Providers shall be sent to laboratories and pathologists that are Participating Providers in the Member's network.

(e) All radiological films or images produced in office shall be reviewed by Group Participating Providers or Participating Providers in the Member's network.

(f) All durable medical equipment, prosthetics, orthotics, and supplies acquired by Group on behalf of the Member or distributed to the Member by the Group Participating Provider shall be obtained from Participating Providers in the Member's network.

(g) If Group is a hospital-based group contracted with a Participating Hospital where Group renders services, Group shall notify The Plan the earliest of at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible in the event of a termination, expiration or non-renewal of the contract between Group and the hospital.

(h) If Group contracts with a hospital-based group to provide certain services (e.g. anesthesia, emergency services, etc.) Group shall notify The Plan the earliest of at least thirty (30) days prior to such change, within two (2) business days of Group learning of such change, or as soon as legally permissible in the event of a termination, expiration or non-renewal of the contract between Group and the hospital-based group.

2.20.1 Failure to comply with this section constitutes material breach of the Agreement.

2.21 Provider Directories: Group agrees to permit The Plan to publish, distribute and disseminate Group's name and address and/or Group Participating Provider's name and address as a Participating Provider in paper and electronic form. Group also agrees to cooperate with all applicable laws and regulations regarding the accuracy of provider directory information, including but not limited to, The Plan's process to verify provider directory information.

2.22 Provision of Records: Group agrees to furnish, within the requested timeframe and without charge, all information reasonably required by The Plan to verify and substantiate the provision of services and the charges for such services. Group also agrees to provide an internal contact person with appropriate authority to work with The Plan to resolve issues related to records requests. Should The Plan not receive the information within sixty (60) days of the original request, The Plan will continue with its review, which may include a request to refund previously paid amounts. Group shall continue to provide such requested information for a period of two (2) years after the termination of this Agreement (or for such other period as may be required by network accreditation organizations as applicable). The Plan may be billed by Group for subsequent requests for the same information at a rate not to exceed twenty-five cents (25¢) per page. Ownership and access to records of Member shall be controlled by applicable law, with the understanding that each Member, as a condition of enrollment in The Plan, has authorized such disclosure. Repeated failure of Group to provide such information within the time period designated by The Plan in the request may result in termination of this Agreement by The Plan pursuant to Article XI of this Agreement.

2.23 Quality Improvement: Group agrees to cooperate with the quality improvement activities of The Plan. All such quality improvement activities of The Plan are considered to be confidential and will not be released to any other party except where required by applicable state or federal laws. This includes but is not limited to the following:

2.23.0 Infection Control Procedures: Group shall, as applicable, maintain and follow infection control procedures. These procedures will address, at a minimum, staff personal hygiene and health status, isolation precautions, aseptic procedures, cleaning and sterilization of equipment, and methods to avoid transmitting infections.

2.23.1 Monitoring and Evaluating Care: Group shall monitor and evaluate the quality and appropriateness of patient care and/or services, including the performance of employees and other personnel who furnish services under arrangements with Group This shall include, but not be limited to:

(a) Scope and objective of the quality improvement activities;

(b) Methods to identify incidents or patterns;

(c) Mechanisms for taking follow-up action; and

(d) Methods for implementing the monitoring and evaluation activities, for reporting the results, and for monitoring corrective action.

2.23.2 Performance Quality Measurement Programs: Group agrees to cooperate with the performance measurement activities and data requirements of The Plan.

2.23.3 Provision of Medical Records: Group agrees to provide, at no charge, medical records of selected Members to The Plan for purposes of quality improvement. Group shall continue to provide such requested information for a period of two (2) years after the termination of this Agreement.

2.24 Recommended Clinical Review: If Group is not required to obtain Prior Authorization for a Member it may elect to submit a Recommended Clinical Review request for such Member's services. Group shall refer to the back of the Member's identification card for more information, or www.bcbsok.com to obtain a form for requesting a Recommended Clinical Review. A Recommended Clinical Review is not a guarantee of Benefits or a substitute for the Prior Authorization process.

2.25 Record Maintenance: Group shall develop and utilize accurate medical, appointment, financial and billing records of all matters relating to obligations under this Agreement. Group shall maintain medical records for Members in accordance with federal, state and local laws and regulations, and comply with the Medical Records Documentation and Confidentiality Standards determined by The Plan as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement. Ownership and access to records of Member shall be controlled by applicable law.

2.26 Records Release: Once proper credentials of representatives of The Plan who seek access are presented to Group, access shall be allowed, upon request and at reasonable times, to pertinent medical and financial records relating to Member, with the understanding that each Member, as a condition of enrollment in The Plan, has authorized such disclosure. Group shall continue to allow such access for a period of two (2) years after the termination of this Agreement.

2.27 Reference Laboratories: Group is prohibited from operating as a Reference Laboratory under this Agreement and/or from billing for laboratory services rendered on behalf of other entities or providers, unless Group enters into a separate agreement with The Plan for laboratory services. Failure to comply with this section constitutes material breach of this Agreement.

2.28 Remote Access to Electronic Health Records: If Group is able to provide electronic access, Group must establish an agreement with The Plan to enable designated staff access to Group's electronic health record (EHR) system when The Plan is required to conduct regulatory audits such as the Initial Validation Audits (IVA) Department of Health and Human Services' Risk Adjustment Data Validation (HHS-RADV) program, the Healthcare Effectiveness Data and Information Set (HEDIS), and other reviews performed by The Plan. This does not eliminate Group's responsibility to provide records when requested by The Plan.

2.29 Scope of Services: Group Participating Provider agrees to render Covered Services to Members, within the scope of his/her license and consistent with Group Participating Provider's education, training, experience and/or board certification, who are patients identified as requiring, by reason of injury or illness, the intensity of care and level of care which is reasonable, necessary, and appropriate for the Member.

2.30 Utilization Management: Group agrees to cooperate in utilization management activities and ensure that Prior Authorization is obtained or verified as required by the Member's Benefit Agreement and in accordance with Article VI of this Agreement. Group also agrees to provide a clinical liaison to work with The Plan to resolve issues related to Prior Authorization.

2.31 Verification of Credentials: Group will cooperate with The Plan or other entity to which The Plan has delegated responsibility for credentialing, in the initial and ongoing verification of credentials of individuals employed by and/or contracted by Group who will be providing Covered Services under the terms of this Agreement. Notwithstanding anything in this Agreement to the contrary, credentialing-related correspondence, including notices of termination for failure to recredential, will be sent to the credentialing address on the Group Participating Provider's individual credentialing application or the CAQH attestation received by The Plan, whichever is the most recent. Group will report all arrests, criminal actions, disciplinary actions, changes in participation in Medicare or Medicaid programs, changes in admitting privileges and professional licensure of Group Participating Providers, and any changes to the information submitted on Group Participating Provider's initial or recredentialing application to The Plan in writing within ten (10) days of the action. Group further agrees to ensure that all employees and contracted staff who provide direct patient care maintain current licensure and certification. Group shall allow appropriate representatives of The Plan, or other entity to which The Plan has delegated responsibility for credentialing, access to such documentation upon reasonable request.

ARTICLE III
AGREEMENTS OF THE PLAN

3.0 Direct Payment: The Plan agrees to make payment to Group for Covered Services rendered to Member.

3.1 Licenses: The Plan shall ensure its medical director(s) maintain in good standing a current, valid and unrestricted license to practice medicine.

3.2 Member Identification: The Plan agrees to provide appropriate Member identification with sufficient information to allow Group to verify eligibility and Benefits.

3.3 Network Management Representatives: The Plan agrees to provide a staff of local Network Management Representatives to work with Group and/or Group's office staff to develop and maintain a cooperative working relationship.

3.4 Provide Timely Compensation: Unless otherwise permitted by law, The Plan agrees to adjudicate all Properly Filed Claims for Covered Services provided to Member within thirty (30) days from the date of The Plan's receipt. If upon receipt of a claim, The Plan determines it is not a Properly Filed Claim, written notice shall be given to Group within thirty (30) days of receipt of the claim. Upon receipt of the additional information or corrections to make the claim a Properly Filed Claim, the claim shall be processed by The Plan within thirty (30) days, unless otherwise permitted by law. Payment shall be considered made when it is placed in the United States mail or on the date the electronic payment is sent. If payment is due but not made within the time required by law from receipt of a Properly Filed Claim, it shall bear simple interest at the rate of ten percent (10%) per year. The Plan shall pay interest only on claims for services rendered to Members whose Benefit Agreements are underwritten by Blue Cross and Blue Shield of Oklahoma.

3.5 Provider Claims Summary: The Plan agrees to notify Group and the Member of appropriate copayment, deductible, coinsurance, and noncovered amounts that may, if applicable, be collected directly from the Member.

3.6 Provider Directories: The Plan will include Group's name and address and/or Group Participating Provider's name and address in its' current written and electronic listings of Participating Providers in accordance with its policies and procedures and all applicable laws.

3.7 Quality Improvement: The Plan agrees to coordinate activities related to quality improvement as described in the Provider section of The Plan's website at www.bcbsok.com under Quality Improvement.

3.8 Reimbursement: The Plan agrees to reimburse Group in accordance with the reimbursement provisions set forth in Article V for Covered Services provided to Members as of the effective date of this Agreement. This reimbursement shall be applicable to all services arranged, provided, and billed by Group. Unless prohibited by law, The Plan shall deduct any copayment, deductible and coinsurance amounts required by the applicable Benefit Agreement from payment due Group.

ARTICLE IV
BILLING REQUIREMENTS

4.0 Billing Requirements: Group is required to submit a Properly Filed Claim for all Covered Services provided to Member. Group shall use either the CMS 1500 paper claim form, and subsequent revisions, or The Plan's paperless claims entry system (electronically).

4.0.0 Group shall submit all Covered Services rendered for a day on the same claim. If a service is not included on the original claim, Group shall submit a corrected claim which includes all Covered Services rendered. Failure to submit all charges on the same claim may result in The Plan rejecting the claim.

4.0.1 Group shall provide all information necessary to adjudicate the claim, including but not limited to:

(a) Primary and, if applicable, secondary ICD-10-CM Diagnosis Codes as appropriate.

(b) Current and appropriate CPT-4 or HCPCS procedure code(s).

(c) Name of the referring physician or other provider.

(d) Any information concerning other insurance or third-party payor coverage.

(e) Group's billing National Provider Identifier (NPI) as well as the rendering NPI.

(f) NDC code for applicable pharmaceutical products and supplies.

(g) The physical address or location where the services were provided.

(h) All other relevant information required by The Plan to adjudicate claims. For additional information on claims filing requirements, please refer to the Provider section of The Plan's website at www.bcbsok.com under Claims and Eligibility.

4.1 Changes in CPT-4/HCPCS Codes/ICD-10-CM Diagnosis Codes: Codes established subsequent to the effective date of this Agreement will be assigned a Maximum Reimbursement Allowance determined in a manner consistent with Maximum Reimbursement Allowances of comparable CPT-4/HCPCS Codes/ICD-10-CM Diagnosis Codes or a subsequent revision. If a claim is received containing codes which have been deleted or which have become invalid for the dates of service on the claim, the claim may be returned for appropriate coding.

4.2 Provider-Preventable Errors: The Plan will not reimburse for a procedure/service to treat/diagnose a medical condition when the practitioner erroneously performs: 1) a wrong procedure/service on a patient; 2) the correct procedure/service but on the wrong body part; or 3) the correct procedure/service but on the wrong patient. This encompasses all related services provided when the error occurs, including those separately performed by other physicians, and all other services performed during the same visit or other related services. Group shall bill for the appropriate modifier to indicate type of Provider-Preventable Error. Amounts for Provider-Preventable Errors may not be collected from the Member, and Group may not obtain a Written Waiver for these services.

4.3 Report Other Insurance: Group will report to The Plan any fact of which it or its agents have knowledge which indicates that the condition requiring services to the Member arises from any employment related or occupational injury or disease or may be compensated under any State or Federal Worker's Compensation or Employer's Liability law, or that the Member has other insurance in effect which may provide Benefits.

ARTICLE V
MAXIMUM REIMBURSEMENT ALLOWANCES

5.0 Maximum Reimbursement Allowances: The basis for reimbursement for Covered Services rendered to Members will be the lesser of Group's Usual Charge or The Plan's Maximum Reimbursement Allowance. Reimbursement shall be made according to The Plan's medical policies and reimbursement guidelines pertaining to subjects such as multiple surgical procedures, surgical assistance, global surgical services, coding and unbundling.

5.1 Conversion Factors: Except as set forth below, the Maximum Reimbursement Allowance is defined as the Centers for Medicare and Medicaid Services Medicare Resource Based Relative Value System (RBRVS) methodology as published in the Federal Register Vol. 85, No. 248 (dated December 28, 2020), multiplied by the Oklahoma Geographic Index Modifier, including CMS site-of service payment differential methodology, hereinafter referred to as 2021 Medicare allowables, less any applicable amounts for which the Member is responsible. The conversion factors are set forth below:

Provider Type	All Codes
Physician & Optometrist	$48.06
Chiropractor	$45.55
Certified Registered Nurse Anesthetist	$39.72
Anesthesiologist Assistant, Nurse Practitioner, Physician Assistant & Psychologist	$36.53
Speech Therapist	$32.96
Dietician	$30.85
Physical/Occupational Therapist	$30.36
Audiologist, LADC, LCSW & LPC	$27.27

5.2 Other Maximum Reimbursement Allowances: Services having no Relative Value Unit established will be reimbursed as set forth below, or in accordance with The Plan's fee schedule in effect as of the date of service.

5.2.0 Anesthesia:

(a) Anesthesia Rates: The reimbursement for anesthesia services shall be the applicable rate set forth below per (base + time) unit, less any applicable amounts for which the Member is responsible, for Covered Services provided to Members. Time units are in 15 minute increments for the first 2 hours, then 10 minute increments thereafter.

Provider Type	Anesthesia Rate
Physician	$55.00
Certified Registered Nurse Anesthetist	$47.00
Anesthesiologist Assistant	$41.80

(b) Labor Epidurals: Labor epidurals will be reimbursed at the flat rate of nine hundred fifty dollars ($950.00).

5.2.1 Durable Medical Equipment: Durable medical equipment and supplies will be reimbursed in accordance with The Plan's fee schedule in effect as of the date of service.

5.2.2 Pathology/Laboratory: Except as provided below, pathology and laboratory codes listed on the Medicare Clinical Laboratory Fee Schedule will be reimbursed at ninety-five percent (95%) of 2020 Medicare allowables, less any applicable amounts for which the Member is responsible.

(a) Reimbursement for the pathology and laboratory codes not listed on the Medicare Clinical Laboratory Fee Schedule that are based on the RBRVS methodology as published by the Centers for Medicare and Medicaid Services will be paid in accordance with Section 5.1, *Conversion Factors*, above.

(b) Reimbursement for the pathology and laboratory codes not listed in the sources described above will be paid in accordance with The Plan's fee schedule in effect as of the date of service.

5.2.3 Pharmaceutical Products: Pharmaceutical products and supplies shall be reimbursed based on National Drug Codes ("NDC codes"), excluding the noted exceptions. The Plan will update The Plan's NDC fee schedule monthly with the price that is in effect at the time of the update. If ASP is unavailable, pharmaceutical products categorized as Exception will be reimbursed as Single Source or Multi Source. When ASP, WAC, MAC and AWP are unavailable, pharmaceutical products categorized as: Exception, Vaccines and Immunizations, Single Source and/or Multi Source will be reimbursed in accordance with The Plan's NDC fee schedule in effect as of the date of service.

(a) Group A Exception Products: Group A Exception Products include preferred Medical Injectable Products. They will be reimbursed equivalent to the CPT-4/HCPCS Code at ASP+30%. Products in Group A will be identified in The Plan's NDC fee schedule. Information regarding changes to these categories will be published in The Plan's provider newsletter, Blue Review (i.e. Select Medication List) and in the provider section of The Plan's website at www.bcbsok.com.

(b) Group B Exception Products: Group B Exception Products include non-preferred Medical Injectable Products. They will be reimbursed equivalent to the CPT-4/HCPCS Code at ASP+10%. Products in Group B will be identified in The Plan's NDC fee schedule. Information regarding changes to these categories will be published in The Plan's provider newsletter, Blue Review (i.e. Select Medication List) and in the provider section of The Plan's website at www.bcbsok.com.

(c) Group C Exception Products: Group C Exception Products include Specialty Pharmacy Products with Preferred Channel Management, as set forth on The Plan's website at www.bcbsok.com, and new specialty pharmacy drugs to market. Reimbursement will be reflected in The Plan's NDC fee schedule based on The Plan's maximum allowable per package NDC unit (i.e. UN, ML, GR, F2). The Plan shall provide Group with access to Preferred Channel Management resources should Group wish to opt out of purchasing and billing for the Specialty Pharmacy Product. In addition, The Plan shall provide contact information for a vendor through which Group can obtain the Specialty Pharmacy Product. Group C Exception Products without Preferred Channel Management will be reimbursed equivalent to the CPT-4/HCPCS Code at ASP+20%. If ASP is unavailable, then NDC AWP-15% shall apply.

(d) Multi-Source Products: Multi-Source Products, excluding the noted exceptions, will be reimbursed at MAC+25%. If MAC is unavailable, the lower of WAC+9% or AWP-13% shall be reimbursed. If WAC is unavailable, AWP-13% shall apply.

(e) Radiopharmaceuticals: Reimbursement for CPT-4/HCPCS Codes A9500 through A9700 and other radiopharmaceutical CPT-4/HCPCS Codes based on the description as of the date of service of the claim will be reimbursed at the applicable CMS (Medicare) Average Sales Price (ASP) method of pricing drugs and biologicals plus twenty percent (20%). The Plan will update The Plan's NDC fee schedule to reflect changes in the ASP in January and July of each calendar year with the price that is in effect at the time of the update. If ASP is unavailable for any of these codes they will be paid in accordance with The Plan's NDC fee schedule in effect as of the date of service.

(f) Single-Source Products: Single-Source Products, excluding the noted exceptions, will be reimbursed at WAC+9%. If WAC is unavailable, AWP-13% shall apply.

(g) Vaccines and Immunizations: Vaccines and Immunizations, primarily identified as CPT-4/HCPCS Codes 90500 through 90799, will be reimbursed at AWP-5%. Group will bill the applicable CPT-4/HCPCS Code(s) and the appropriate administration code based on the package insert(s) of product tied to the code. If Group obtains the vaccine/immunization from a source that is contracted with The Plan to provide vaccines/immunizations to Participating Providers, Group will be eligible to bill the administration code only.

(h) Cellular Immunotherapy Treatment and Gene Therapy Treatment (C&G) Products: The Plan's standard professional fee schedule rates will default to no coverage, unless an extra-contractual agreement is issued. Given the rapidly-changing advancements in Cellular Immunotherapy Treatment and Gene Therapy Treatment, as new Cellular Immunotherapy Treatment and Gene Therapy Treatment products are FDA-approved, such products will be applied the same methodology.

(i) Point of Use Convenience Kits: Point of Use Convenience Kits are considered equivalent to, but not superior to, the individual drug components. Purchase and use of Point of Use Convenience Kits is subject to Group's preference. Non-drug components include, but are not limited to, alcohol prep pads, cotton balls, band aids, disposable sterile medical gloves, povidone-iodine swabs, adhesive bandages, and gauze. Point of Use Convenience Kits billed with an NOC/NOS code will be reimbursed based on the approximate sum of the individual drug components as identified on The Plan's NDC fee schedule. The Plan will not reimburse separately for the Point of Use Convenience Kits or the items herein.

(j) Administration Fees: If Group obtains the drug product from a source that is contracted with The Plan to provide drug products to Participating Providers, Group will receive the administration fee only. In these situations, Group will bill the applicable administration code.

5.2.4 Services Covered by Per Diem: If Group provides services which are separately reimbursable under a Per Diem, the Per Diem will be the exclusive payment for services provided to the Member. Group is not eligible to bill separately for any services that are also reimbursable under a Per Diem.

5.3 Discontinued or Unrecognized Codes: If Centers for Medicare and Medicaid Services ("CMS") does not recognize or reimburse for a specific code or discontinues use of a specific code, The Plan may not reimburse for the unrecognized or discontinued code or The Plan may reimburse in accordance with The Plan's fee schedule in effect as of the date of service. The Plan may also make a determination to bundle services or pay for services using an alternative or more specific code.

5.4 Rounding: If any calculation set forth in this Attachment V results in numbers positioned more than two (2) places to the right of the decimal, The Plan will round to the nearest penny.

5.5 Written Report: The Plan will not reimburse, nor may Group collect from the Member, any amounts for Professional Services unless such services have been rendered to an identifiable individual patient and are supported by a written report.

ARTICLE VI
UTILIZATION MANAGEMENT

6.0 Objective: The overall objective of the Utilization Management Program is to determine Medical Necessity for delivery of Covered Services. Prior Authorization will only determine if a service is Medically Necessary and does not guarantee Benefits. Services that a physician or other provider prescribes or orders may not be determined by The Plan to be Medically Necessary or a Covered Service.

6.1 Process for Obtaining Prior Authorization: The following process shall be followed in order to obtain Prior Authorization.

6.1.0 Submit Request: Group shall contact The Plan as specified in the Provider section of The Plan's website at www.bcbsok.com or call the number on the back of the Member's identification card. Group shall provide the requested information, including but not limited to:

(a) Group's name, telephone number and the pay to National Provider Identifier (NPI) as well as the rendering NPI.

(b) Member's name, address, date of birth, age and sex

(c) Member's identification number including the employer and group number

(d) Admitting or ordering provider's name, address and telephone number (if not a Group Participating Provider)

(e) Primary diagnosis (ICD-10-CM Diagnosis Code, if known), and complicating secondary diagnosis

(f) Principal procedure (CPT-4 codes, if known), and any secondary procedures

(g) Estimated date of admission and discharge or date(s) of service

(h) Patient's history, lab, and test results pertinent to this hospitalization/procedure

(i) Place of service (e.g. hospital, ambulatory surgery center, provider office, etc.)

6.1.1 Weekends/Holidays/After Hours: If The Plan's Prior Authorization Department is not available (i.e. weekend, holiday or after The Plan's business hours), Group must leave message requesting Prior Authorization on the Prior Authorization Department confidential voicemail. Documentation of date and time of call will serve as proof of Group's attempt to obtain Prior Authorization.

6.2 Responsibilities of Group:

6.2.0 Obtain or Verify Prior Authorization: It is the responsibility of Group to ensure The Plan is contacted and Prior Authorization is obtained or verified as set forth above in *Process for Obtaining Prior Authorization*. If Group does not verify the Prior Authorization requirements of the Member, Group assumes the risk that the claim may be denied by The Plan.

(a) BlueCard Program: For Members participating in the BlueCard Program, Group may refer to the back of the Member's identification card for information regarding authorization requirements.

(b) Concurrent Review: Group shall cooperate with The Plan when conducting Concurrent Review on services that are expected to extend beyond The Plan's approved duration of services. Group shall request Prior Authorization for an extension on or before the last day of the duration of services for which Prior Authorization was previously obtained by Group. The Prior Authorization process shall be the same as described above in *Process for Prior Authorization*.

(c) Hospital Admissions (Emergency and Obstetric): Group shall obtain Prior Authorization for all emergency and obstetric admissions within two (2) business days of the admission.

(d) Hospital Admissions (Non-Emergency and Non-Obstetric) and Outpatient Services: Group shall obtain Prior Authorization for all non-emergency and non-obstetric hospital admissions and outpatient services. To the extent practical, Prior Authorization shall be obtained at least five (5) days in advance of, but not less than one (1) business day prior to, the admission or outpatient service.

(e) Medicare Supplements: If a Member exhausts his/her benefits under Medicare or is otherwise eligible for Benefits under his/her Medicare supplement Benefit Agreement, Group shall follow The Plan's Prior Authorization requirements for such Member as set forth in this Agreement.

(f) Other Settings: Services provided by Group Participating Provider in an office or other outpatient setting must be Medically Necessary and appropriate for the diagnosis and treatment of the Member's medical condition. The Plan has designated certain Covered Services which require Prior Authorization in order for the Member to receive the maximum Benefits possible under their Benefit Agreement. Group may request Prior Authorization for services on behalf of the Member. For more information, refer to The Plan's website at www.bcbsok.com.

6.2.1 Treatment Plans: Group shall submit a Treatment Plan to The Plan, or its delegated vendor, for certain services provided to Members who have this requirement in their Benefit Agreement. The Treatment Plan shall include the required information set forth in the provider section of The Plan's website at www.bcbsok.com.

6.3 Responsibilities of The Plan: The Plan will carry out the following responsibilities with respect to Utilization Management.

6.3.0 Assigning a Reference Number: The Plan will assign a reference number to each request for Prior Authorization for purposes of identifying the request and Member case. The reference number shall be given to the admitting/ordering provider or his/her authorized representative and to the provider of services as applicable. This number is for reference purposes only and does not mean that The Plan has granted Prior Authorization for the services.

6.3.1 Care Coordinators: The Plan shall utilize licensed personnel in medical professions to review requests for Prior Authorization and perform the duties of Care Coordinators. Such Care Coordinators shall have authority to perform Utilization Review per established scientific, evidence-based clinical criteria for the purpose of making a determination as to the Medical Necessity for services under the terms and provisions of the Member's Benefit Agreement. Utilization Review Criteria shall be based on currently established and recognized medical and professional expertise, studies, treatises and literature, and current cumulative information, data and studies on health care services available and provided within the local community.

6.3.2 Determining Medical Necessity: In making any Prior Authorization determination regarding whether an admission or services are Medically Necessary, The Plan shall consider all relevant medical and other information furnished pertaining to the Member and the Member's condition for which the admission or services have been requested. In no event is it intended that the Prior Authorization determination by The Plan will interfere with the provider/patient relationship or Group Participating Provider's decision and determination to order admission of the patient to the hospital or provide other services. The Prior Authorization determination by The Plan is only to make a preliminary determination as to whether such admission or provision of other services are Medically Necessary. Prior Authorization does not guarantee that all care and services a Member receives are eligible for payment of Benefits under the Member's Benefit Agreement. Medical Necessity for an inpatient hospital admission or provision of other services may be denied only upon the order of the Medical Director.

6.3.3 Insufficient Information: If submitted clinical information is insufficient for approval of the hospital admission or services requested, the Medical Director shall deny the request due to insufficient information, subject to reconsideration and other appeal as provided.

6.3.4 Notification of Prior Authorization Determination: The Plan shall respond to requests for Prior Authorization by providing a determination within the timeframes provided by law or accreditation requirements if applicable after receipt of all necessary information. The Plan shall provide notification of Prior Authorization determinations to the admitting/ordering provider, provider of services as applicable, and Member.

6.3.5 Reimbursement for Services: Services that are granted Prior Authorization by The Plan, or by the control plan as required by some Benefit Agreements, which are covered Benefits under the terms of the Member's Benefit Agreement, are determined to be Medically Necessary and will be reimbursed in accordance with the terms of this Agreement. If Prior Authorization is obtained and the information given at that time is accurate, no adjustment to the prior Medical Necessity determination will be made as a result of a subsequent Medical Necessity determination on that specific case, so long as Group adheres to requirements contained in this Article.

6.4 Termination/Denial of Payment: Should Group fail to comply with the above requirements, it may be considered cause for termination of the Agreement and/or payment may be denied for services provided which are not Medically Necessary or found to be Experimental/Investigational/Unproven. Except where otherwise provided by applicable law, such denied charges may not be collected from the Member unless a Written Waiver has been executed prior to rendering services.

ARTICLE VII
APPEALS AND GRIEVANCE PROCEDURES

7.0 Types of Appeals: The Plan has established appeals processes to ensure the timely and organized resolution of provider complaints, grievances and appeals. Complaints and grievances are oral expressions of dissatisfaction with utilization review, network status, and/or quality improvement activities. When permitted by this Agreement, if Group cannot achieve resolution of a complaint or grievance, a written appeal may be filed. The Plan has different appeals processes, depending on the type of appeal and how it is generated.

7.0.0 Utilization Management Appeals are related to clinical services provided to the Member.

7.0.1 Credentialing Committee Appeals are for decisions or actions taken by The Plan's Credentialing Committee ("Credentialing Committee") that result in a change in network status, network cancellation, or the denial of an application for credentials or network participation. These can be for both medical and non-medical reasons.

7.0.2 Contract Termination Requests for Consideration are related to the termination of this Agreement by The Plan, which does not involve a decision or action taken by The Plan's Credentialing Committee.

7.0.3 Contractual Inquiries/Appeals are disagreements relating to this Agreement and all other addendums and amendments, which do not fall into any of the previously stated categories.

7.1 Types of Utilization Management Appeals: Utilization Management (UM) Appeals are related to clinical services provided to the Member and include utilization management decisions. There are two types of UM appeals available to Group: expedited/urgent care or standard. An appeal submitted by Group is a formal process for review or reconsideration of an adverse determination regarding a Recommended Clinical Review or Prior Authorization request. "Adverse determination" means a determination by The Plan that an admission, availability of care, continued stay or other health care service that is a covered Benefit has been reviewed and, based upon the information provided, does not meet The Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service or payment for the service is therefore denied or reduced. If the issue/service has been previously reviewed by

an Independent Review Organization, The Plan will rely on that original opinion in processing any additional appeal requests.

7.1.0 Peer to Peer: Prior to an appeal, the attending or ordering provider may request a peer-to-peer conversation with a Medical Director. Group may call the Health Care Management Department as instructed on the back of the Member's identification card. The Medical Director making the adverse determination or another medical director will be available within one business day to discuss the adverse determination. If the adverse determination is upheld after the conversation, Group has the option to proceed with an appeal.

7.1.1 Expedited Appeals: An expedited or urgent care appeal is a request, usually by telephone or fax, for an additional review of an adverse determination. The review is conducted by a clinical peer who was not involved in the original adverse determination and is not the subordinate of the person making the original adverse determination. An expedited appeal applies to urgent care requests. Urgent care requests are defined as any request for medical care or treatment with respect to which the application of the time periods for making non-urgent care decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. This process does not apply to non-urgent, post-service or retrospective requests. Local specialty providers and independent review organizations are external consultants who may be utilized in the appeal process. A final determination following the expedited appeal will be made within seventy-two (72) hours of receipt of the request. To initiate an expedited appeal:

(a) Call the Health Care Management Department at 1-800-672-2378 or as instructed in the original adverse determination letter.

(b) Have all related clinical information available for the denied services including:

- Name of the requestor
- Phone number of the requestor
- Member name
- Member ID number
- Member reference number if known
- Date of service
- Name of facility where services are being rendered, if applicable
- Name of ordering/attending physician
- Any new clinical/medical record information

7.1.2 Standard Appeals: A standard appeal is a verbal or written request to review an adverse determination. The review is conducted by a peer reviewer who was not involved in the original adverse determination nor is the subordinate of the peer making the original adverse determination. A standard appeal applies to non-urgent, pre-service or retrospective pre-claim requests. Local specialty providers and independent review organizations are review consultants who may be utilized in the appeal process. Standard appeals may be requested within one hundred eighty (180) days from the date of notice of the original adverse determination letter. A final determination following the standard appeal will be made within thirty (30) days of receipt of the request. To initiate a standard appeal:

(a) Call the Customer Service number listed on the back of the Member's ID card or submit in writing as instructed on the original adverse determination letter.

(b) Have all related clinical information available for the denied services outlined in a letter/statement indicating the issue and resolution being sought which includes:

- Name of the requestor
- Phone number of the requestor
- Member name
- Member ID number
- Member reference number if known
- Date of service
- Name of facility where services are being rendered, if applicable
- Name of ordering/attending physician
- Any new clinical/medical record information

Group acknowledges that it will have only one (1) standard appeal opportunity and agrees to submit all relevant clinical information with the appeal. Re-review appeal requests will not be accepted.

7.1.3 Post Claim Appeals: An appeal is a written request to review a non-approved service or procedure that The Plan determines does not meet the requirements for Medical Necessity or is Experimental/Investigational/Unproven. The review is conducted by a peer reviewer who was not involved in the original adverse determination nor is the subordinate of the peer making the original adverse determination. A claim appeal applies to a post-service adverse determination. Local specialty providers and independent review organizations are review consultants who may be utilized in the appeal process. Post claim appeals may be requested within one hundred eighty (180) days from the date of notice of the original adverse determination letter. A final determination following the post claim appeal will be made within sixty (60) days of receipt of request. To initiate a post claim appeal:

(a) All post claim appeals must be submitted in writing using the applicable appeals form or electronic process located in the Provider section of The Plan's website at www.bcbsok.com.

(b) Have all related clinical information available for the denied services outlined in a letter/statement indicating the issue and resolution being sought which includes:

- Name of the requestor
- Phone number of the requestor
- Member name
- Member ID number
- Reference number if known
- Date of Service
- Name of facility where services were rendered, if applicable
- Name of ordering/attending physician
- Any new clinical/medical record information

Group acknowledges that it will have only one (1) appeal opportunity and agrees to submit all relevant clinical information with the appeal. Re-review appeal requests will not be accepted.

7.2 Credentialing Committee Appeals: Credentialing Committee Appeals are for decisions or actions taken by The Plan's Credentialing Committee ("Credentialing Committee") that result in a change in network status, network cancellation, or the denial of an application for credentials, denial of an application for network participation, or denial of re-credentialing. These can be for both medical and non-medical reasons. The Plan has developed an appeals process for all Participating Providers whose network contract(s) are cancelled for either a medical or non-medical reason by the Credentialing Committee. Physicians or health care professionals seeking to become Group Participating Providers who are denied acceptance in a network by the Credentialing Committee also have access to this appeals process. All Credentialing appeals are to be sent to the appropriate address provided in the denial letter.

7.2.0 Credentialing Committee Appeals: If the Credentialing Committee initiates the network cancellation, or if Group or Group Participating Provider is denied credentials or network participation by the Credentialing Committee, Group is notified within ten (10) business days and should submit its appeal to the Credentialing Committee Chair. The appeal will be processed as follows:

(a) Level One (1) Written Appeals: All appeals should be made in writing and submitted to the Credentialing Committee Chair within thirty (30) days of receipt of the denial/cancellation notice. The Credentialing Committee Chair will forward the appeal to the Peer Review Committee (East or West) for review. This Committee will review the written appeal, all additional submitted information and credentialing file documentation pertaining to the deficiencies. At least three qualified individuals of which at least one is a Participating Provider who is not involved with The Plan's management and who is a clinical peer of Group who is filing the appeal (if the appeal is clinical in nature) and not previously involved with the Credentialing Committee decision or action, will participate in the Level One process. Group will be notified by Certified Mail Return Receipt Requested, within ten (10) business days of the Committee's decision.

(b) Level Two (2) Appeals: If the Peer Review Committee upholds the denial/cancellation, Group may request a Level 2 appeal. All appeals should be made in writing and submitted to the Peer Review Committee Chair within thirty (30) days of receipt of the Committee's denial/cancellation notice. It will be heard by the Peer Review Committee (East or West) not involved in the Level 1 appeal or an equivalent Committee. The Committee will review information obtained from the Level 1 Committee and any additional information submitted by Group. At least three qualified individuals of which at least one is a Participating Provider, not involved with The Plan's management, and who is a clinical peer of Group who is filing the appeal (if the appeal is clinical in nature) and who was not involved with the Level 1 Appeal will participate in the Level 2 process. If Group requests a personal appearance before the Committee, the following guidelines will be utilized:

(i) The Chairperson of the committee will select the date for Group representative's appearance before the committee and will notify the provider of the time, date and place for its appearance. Group will be notified of this meeting by Certified Mail Return Receipt Requested.

(ii) At the meeting, the Chairperson will take no more than five (5) minutes to introduce Group representative and give a brief explanation of the appearance.

(iii) Group representative will be given ten (10) minutes to present its appeal.

(iv) The Committee members will be given ten (10) minutes to ask questions.

(v) After the questioning period is completed, the Group representative will be dismissed, the Committee will discuss the issue and a decision/determination will be made.

(vi) Group representative will be notified by Certified Mail Return Receipt Requested within ten (10) business days of the committee's decision. The decision will be final. No other appeal rights are available to Group or Group Participating Provider. The entire appeal process shall be completed within one hundred eighty (180) days of the receipt by The Plan of the appeal, unless extenuating circumstances or request for extension is received.

7.3 Contract Termination Requests for Consideration: Contract termination requests for consideration are related to the termination of this Agreement by The Plan, which does not involve a decision or action taken by The Plan's Credentialing Committee. Termination pursuant to *Immediate Termination by The Plan* or

Termination by Either Party in Article XI or *Amendments* in Article X of this Agreement shall not entitle Group to the Appeals and Grievance Procedures set forth in this Agreement. If this Agreement is terminated by The Plan other than under *Immediate Termination by The Plan* or *Termination by Either Party* in Article XI or *Amendments* in Article X, Group may submit a written request to The Plan to reconsider its decision to terminate this Agreement. Such written request must be received by The Plan within thirty (30) days of the date of the letter notifying Group of the termination. The request will be considered by an authorized representative or representatives of The Plan not involved in the original termination decision. Group will be provided a written response to the request for reconsideration within sixty (60) days of receipt of the request by The Plan. The effective date of termination will not be extended by the appeal process, provided, however, that decisions favorable to Group will be applied retroactively to the original effective date of termination. All requests for reconsideration are to be sent to:

Director, Network Management
Blue Cross and Blue Shield of Oklahoma
1400 South Boston
Tulsa, OK 74119-3612

7.4 Contractual Inquiries/Appeals: Contractual Inquiries/Appeals are disagreements relating to this Agreement, other than those arising under *Amendments* in Article X, and which do not fall into any of the previously stated categories. If Group has a contractual inquiry/appeal, an initial attempt should be made to resolve it by communication with The Plan's Network Management Department. If a resolution cannot be reached, a written appeal process is available.

7.4.0 Inquiry: An inquiry is an initial verbal or written communication requesting additional information, confirmation or clarification regarding Benefits, pricing, claim adjudication, and/or claims processing guidelines. Responses range from a quick and informal exchange of information to a written response. An inquiry is not considered an appeal.

7.4.1 Contractual Dispute Appeal: Contractual Dispute appeals can be requested for reconsideration regarding Benefits, pricing, claims adjudication, and/or claims processing guidelines. All contractual appeals must be submitted in writing using the applicable claim review form or electronic process located in the Provider section of The Plan's website at www.bcbsok.com. Contractual appeals must be received by The Plan within one hundred eighty (180) days of the initial claims adjudication date to be considered. The written request should include the following information:

- Name of the Member
- Member ID number
- Nature of the complaint
- Facts upon which the complaint is based
- Resolution Group is seeking
- The Claim Form, copy of the detail of remittance or any documentation (including medical records) that Group wants to include for consideration.

Appeals should be mailed to the applicable address provided on the form. Group will be notified of a decision for contractual appeals in a timely manner. If the appeal results in additional payment, Group will be notified on the detail of remittance. All other appeal responses will be mailed directly to Group.

7.5 Executive Mediation: Executive mediation is for disputes arising out of this Agreement for which the Utilization Management, Credentialing Committee or Contractual Appeals, as applicable, has been exhausted without resolution, and for all other disputes arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement.

The completion of executive mediation is a condition precedent to the invocation of Dispute Resolution. Executive mediation shall consist of good faith negotiations between executives of The Plan and Group who (a) have full authority to settle the controversy; (b) have not been previously involved in appeals of the dispute, if any, or any previous negotiations between the parties regarding the subject matter of the controversy; and (c) are at a higher level of management than the persons with direct responsibility for administration of the subject of the dispute in question.

Either party may invoke Executive Mediation by written notice to the other party. The notice must (a) expressly demand Executive Mediation; (b) provide a statement of the party's position and a summary of supporting arguments; and (c) identify the name and title of the executive(s) who will represent the party. Within fifteen (15) days after delivery of the notice, the receiving party shall submit to the other a written response containing the same information. Within thirty (30) days after delivery of the receiving party's response, the executives of both parties shall meet at a mutually acceptable time and place, which may be in person or electronically, and thereafter as often as they reasonably deem necessary, to attempt to resolve the dispute.

All negotiations pursuant to this Section shall be confidential and shall be treated as compromise and settlement negotiations for purposes of applicable rules of evidence. These obligations shall survive termination or expiration of this Agreement.

7.6 Dispute Resolution: In order to avoid the cost and time-consuming nature of litigation, any dispute remaining unresolved after exhaustion of the contractual complaint inquiries and appeals process and executive mediation shall be resolved in accordance with the procedures detailed below.

7.6.0 Binding Arbitration: Within one hundred twenty (120) days of the conclusion of the executive mediation, either party may submit the unresolved dispute to final and binding confidential arbitration under the commercial rules and regulations of the American Arbitration Association, subject to the provisions below.

(a) Any disputes arising out of the terms of this Agreement shall be governed by and subject to the laws of the State of Oklahoma.

(b) All arbitrations will be held in Tulsa, Oklahoma.

(c) Unless otherwise agreed by the parties, each dispute may be arbitrated individually or similar claims may be collectively arbitrated to allow a more efficient process for the resolution of claims, which agreement shall not be unreasonably withheld.

(d) If the amount to be arbitrated is less than two hundred fifty thousand dollars ($250,000.00), the arbitration shall be conducted by a single neutral arbitrator selected by agreement of the parties. If the parties are unable to agree on an arbitrator, the arbitrator shall be selected by the ranking process set forth in the applicable section of the rules furnished by the American Arbitration Association. If the amount is $250,000 or more, the dispute shall be heard by a panel of three arbitrators. Within fifteen (15) days after the commencement of arbitration, each party shall select one person to act as arbitrator and the two selected shall select a third arbitrator within ten (10) days of their appointment. If the arbitrators selected by the parties are unable or fail to agree upon the third arbitrator, the third arbitrator shall be selected by the American Arbitration Association.

(e) Unless otherwise determined by the arbitrator, the costs of arbitration, including but not limited to filing fees and arbitrator fees, shall be shared equally by the parties, and each party shall pay its own attorney's fees and other expenses associated with the arbitration.

(f) The Plan and Group agree that each may bring claims against the other only in its individual capacity and not as a plaintiff or class member in any purported class or representative proceeding. Further, unless both The Plan and Group agree otherwise, the arbitrator may

not consolidate Group's claims with the claims of any other provider and may not otherwise preside over any form of a representative or class proceeding.

(g) To the extent of the subject matter of the arbitration, the determination of the arbitrator(s) shall be binding not only on the parties to this Agreement, but also on any other entity controlled by or in control of or under common control with the party, to the extent that such affiliate joins in the arbitration.

(h) Group acknowledges that this Binding Arbitration provision precludes Group from filing an action at law or in equity and from having any dispute arising under this Agreement resolved by a judge or jury. Group further acknowledges that this arbitration provision precludes Group from participating in a class action or class arbitration filed by any other provider or any other plaintiff claiming to represent Group or Group's interest. Group agrees to opt-out of any class action or class arbitration filed against The Plan that raises claims covered by this Agreement to arbitrate.

7.7 Survival: This Article shall survive termination of this Agreement.

ARTICLE VIII
OTHER PROVISIONS

8.0 Acknowledgement: Group hereby expressly acknowledges its understanding that this Agreement constitutes a contract between the Group and The Plan, that The Plan is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an Association of independent Blue Cross and Blue Shield Plans (the "Association"), permitting The Plan to use the Blue Cross and/or Blue Shield Service Mark in the State of Oklahoma, and that The Plan is not contracting as the agent of the Association. Group further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than The Plan and that no person, entity, or organization other than The Plan shall be held accountable or liable to Group for any of The Plan's obligations to the Group created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of The Plan other than those obligations created under other provisions of this Agreement.

8.1 Agreement Not Assignable: This Agreement, or any of the rights, duties, or obligations of the parties hereunder, shall not be assigned by either party without the express written consent and approval of the other party, which consent shall not be unreasonably withheld or delayed. However, The Plan may transfer, assign, delegate, or extend, all or part of its rights or obligations under this Agreement to any subsidiary or affiliate of HCSC without the prior written consent of Group. The Plan's standing or routine contractual arrangements for the acquisition and use of facilities, services, supplies, equipment and personnel from other entities will not constitute an assignment under this Agreement. This Agreement will be binding upon and inure to the benefit of the respective Parties hereto and permitted assigns.

8.2 Appeals and Grievance Procedures: Both The Plan and Group agree to abide by and exhaust the Appeals and Grievance Procedures set forth in Article VII.

8.3 Applicability of Agreement:

8.3.0 BlueCard Program: The terms of this Agreement and all Addendums, including but not limited to the Maximum Reimbursement Allowance, shall be applicable to services provided to individuals having their health insurance Benefits underwritten or administered by any Blue Cross and/or Blue Shield company and their affiliated subsidiaries that are licensed by the Blue Cross and Blue Shield Association to use the words "Blue Cross" and or "Blue Shield" and all Blue Cross and Blue Shield symbols, trademarks, and service marks presently existing or hereafter established. Whether or not specific services are Covered Services, and a Member's eligibility, copayment, deductible and coinsurance, will be governed by the Member's Benefit Agreement, and, therefore, will be determined by the Blue Cross and/or Blue Shield Company underwriting or administering the Member's Benefit Agreement. Details concerning the "Blue Card Program" can be found at

www.bcbsok.com.

8.3.1 Other Networks: In the event that Group has not contracted with The Plan for its other networks, including but not limited to BlueLincs HMO, Blue Preferred PPO or Blue Advantage PPO, the terms of this Agreement, including the Maximum Reimbursement Allowance described herein, shall be applicable to any Covered Services rendered to a Member whose designated network is one in which Group does not participate. Group agrees to hold such Members harmless from any sums in excess of the Maximum Reimbursement Allowance.

8.3.2 Network Access: The terms of this Agreement and all Addendums shall be in effect for individuals and/or employees of employer groups that are covered by plans not underwritten or fully administered by The Plan, but who have access to the networks in which Group participates, and individuals and/or employees of employer groups that have contracts with The Plan to assist with the administration of their health benefits program. All such individuals and employees shall be included in the term "Member" as used herein. Under such arrangements, it is understood that the health plan or its claims administrator is required to honor the terms of the Agreements in effect between The Plan and Group.

8.3.3 Self-Funded Plans: The Plan has a division that performs services as a Third Party Administrator for employer groups which sponsor self-funded employee benefit programs. The terms of this Agreement and all Addendums shall be applicable to services rendered to participants in such self-funded employee benefit programs. From time to time with self-funded groups, The Plan may agree to process claims for dates of service prior to the employer group's effective date. In such cases, the terms of this Agreement and all Addendums shall apply.

8.4 Confidentiality of Member Records and/or Member Information: Both parties will protect the privacy of the Member's medical/clinical records from inappropriate or unauthorized use in accordance with state and federal law. All medical records and Member information shall be treated confidentially and no third party other than Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Oklahoma or another organization affiliated with or contracted with Health Care Service Corporation may obtain such records or Member information except as needed for purposes of quality improvement, utilization management, case management, compliance, and claims processing, or unless otherwise required by law. Member information includes, but is not limited to, any information that identifies an individual and/or relates to the physical or mental health or condition of a Member, or to the provision of health care to the Member (or the payment for such health care).

8.5 Coordination of Benefits: When the Member has another source of healthcare benefits, the following Coordination of Benefits rules shall apply in a manner consistent with *Accept Reimbursement* in Article II and *Applicability of Agreement* in Article VIII of this Agreement:

8.5.0 When The Plan is primary, The Plan shall pay Benefits as if the other payor did not provide benefits.

8.5.1 When The Plan is secondary, unless otherwise provided by the Member's Benefit Agreement or state law, the following provisions shall apply:

(a) The Plan's Benefits will be determined after those of the other payor and may be reduced because of the other payor's benefits, including cost containment reductions;

(b) reimbursement will not be made for any amount for which the Member is contractually held harmless by either payor;

(c) reimbursement will be determined using the lesser of The Plan's Maximum Reimbursement Allowance had The Plan been primary, or the maximum reimbursement allowed by the other payor.

8.5.2 If Medicare is primary and The Plan is secondary, reimbursement will be based upon the Medicare allowable. If Medicare is primary and there is no allowed reimbursement, then reimbursement will be based on The Plan's allowable.

8.6 Credentialing: Acceptance of this Agreement by The Plan is conditioned upon approval by The Plan's credentialing committee. After the effective date of this Agreement, Group's or Group Participating Providers' failure to meet credentialing or recredentialing criteria or receive approval from the credentialing committee may result in termination of this Agreement or removal of one or more Group Participating Providers from this Agreement in accordance with *Immediate Termination by The Plan* in Article XI.

8.7 Data Sharing and Transmittal: The parties acknowledge that health care information pertaining to Members, including "Protected Health Information" as that term is defined in 45 CFR parts 160 and 164 of the federal privacy and security regulations adopted pursuant to the Health Insurance Portability and Accountability Act of 1996 (referred to as the HIPAA "Privacy Rule"), will be disclosed/transmitted to Group in connection with the provision of services to Members pursuant to this Agreement. Accordingly, each party (i) agrees that disclosure transmittals of such information will be made within the requirements of applicable state and federal law, including requirements pertaining to the validation of minimum necessary limitations on such transmittals set forth in the HIPAA and in the American Recovery and Reinvestment Act of 2009 and additional privacy regulations adopted pursuant to ARRA, and (ii) agrees to execute such agreements as are necessary between the parties to enable the disclosure/transmittal of health care information on Members in accordance with state and federal law and regulations.

8.7.0 Group authorizes The Plan to obtain Member PHI and other health care information through a Health Information Network.

8.7.1 Group acknowledges it is a Covered Entity as defined by HIPAA.

8.8 Delegation of Activities: The Plan and Group agree that, to the extent that The Plan delegates to Group the performance of any function, duty, obligation, or responsibility, including reporting responsibilities ("Delegated Activity"):

8.8.0 The Delegated Activity shall be set out in writing, and if such Delegated Activity includes credentialing and/or selection of Participating Providers, such written arrangement shall address The Plan's right to review on an ongoing basis, approve and audit Group's credentialing process and/or right to review on an ongoing basis, approve, suspend and terminate such providers, as applicable;

8.8.1 The Plan shall conduct on-going monitoring and review of Group's performance of the Delegated Activity;

8.8.2 Group's performance of the Delegated Activity shall comply with all applicable laws and this Agreement.

8.8.3 Such delegation shall be subject to the requirements of all applicable laws.

8.8.4 Termination of Delegated Activities: The Plan and Group agree that, with respect to any Delegated Activity delegated to Group, The Plan may revoke the delegation in whole or in part or specify such other remedies as The Plan, in its reasonable discretion, deems appropriate, where The Plan, in its reasonable discretion, determines that Group is not performing such Delegated Activity in a satisfactory manner.

8.9 Enforcement: The provisions of this Agreement may be enforced only by the Group or The Plan. This Agreement is intended for the exclusive benefit of the parties to this Agreement, their respective successors and approved assigns.

8.10 Entire Agreement: This Agreement, together with all attachments, contains the entire Agreement between The Plan and Group relating to the rights granted and the obligations assumed by the parties concerning the

provision of services to Member. Any prior agreements, promises, negotiations, or representations, either oral or written, relating to the subject matter of this Agreement not expressly set forth in this Agreement are of no force or effect.

8.11 Good Faith: The Plan and Group agree that their authorized representatives will timely meet and negotiate, in good faith, to resolve any problems or disputes that may arise in the performance of the terms and provisions of this Agreement.

8.12 Governing Laws: This Agreement shall be governed by the laws of the State of Oklahoma.

8.13 HCSC Divisions and Affiliates: The parties acknowledge that HCSC conducts its insurance business through its respective state operating divisions of Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of Montana, Blue Cross and Blue Shield of New Mexico, Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas. For purposes of this Agreement, the term "HCSC" includes each such operating division, as well as any additional divisions, subsidiaries or affiliates through which it may at any time conduct all or a portion of its group or consumer health insurance business. The term 'affiliate' includes any entity in which HCSC has a material ownership interest or an entity that HCSC controls.

8.14 Health Information Network Participation: Group and The Plan agree to appropriately use the Health Information Network related to the services provided to Members under this Agreement.

8.15 Independent Relationship: None of the provisions of this Agreement are intended to create, nor will be deemed or construed to create, any relationship between The Plan and Group other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Neither of the parties to this Agreement, nor any of their respective employees, will be construed to be the agent, employer, or representative of the other.

8.16 Legal Compliance: Both parties conduct and cause their employee(s) and contractor(s) to conduct, their operations in compliance with all applicable federal, state and local laws and regulations. Both parties further agree to comply with applicable Executive Orders, state and federal laws, regulations or other guidance regarding debarment or exclusion.

8.17 No Solicitation: To protect the legitimate business interests of the Parties, The Plan and Group agree to the following:

8.17.0 Agreement Not to Interfere with Business Relationships: Group agrees that during the term of this Agreement, Group and Group Participating Provider shall not engage in activities, directly or indirectly, whether written, verbal or electronic, that are designed to or result in any of the following: (a) disturb or attempt to disturb any business relationship or agreement between The Plan and any other person or entity, including but not limited to brokers, agents, Participating Providers, group customers, and Members; or (b) solicit or induce, or direct others to solicit or induce, any broker, agent Participating Provider, or group customer with respect to carving out all or some Benefits from health plans offered or administered by The Plan. Activities that interfere with business relationships include but are not limited to:

(a) soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any Member or employer group to disenroll from health plans offered by The Plan;

(b) soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any potential Member or potential employer group to refrain from enrolling in health plans offered by The Plan;

(c) soliciting, influencing, encouraging or inducing or attempting to solicit, influence, encourage or induce any Member, potential Member, employer group or potential employer group to enroll for health benefits with any other health benefit plan or insurer;

(d) advising or encouraging Participating Providers currently under contract with The Plan to cancel, or not renew, said contracts;

(e) directly impeding or interfering with negotiations which The Plan is conducting with any third party relating to The Plan's provision of health Benefits or related services;

(f) using or disclosing to any third party The Plan's membership acquired during the term of this Agreement unless authorized in advance in writing by The Plan, which authorization shall be within The Plan's sole discretion, and following such authorization, use or disclosure is in strict adherence to all privacy and security laws;

(g) mischaracterizing the nature or scope of coverage provided by The Plan.

8.17.1 Nothing in this section is intended or shall be deemed to restrict any communication between Group or a Group Participating Provider and Member relating to medical care and/or treatment options. Additionally, nothing in this section shall be deemed as precluding Group or a Group Participating Provider from advising Members and potential Members of all of the insurance plans and network plans which have contracted with Group, provided such communication shall be done in a manner that is uniform in nature without preference to any insurance or network plans.

8.18 No Third Party Liability: Neither The Plan nor Group nor any agent, employee, or other representative of a party shall be liable to third parties for any act by commission or omission of the other party in performance of this Agreement and the terms and provisions hereunder. Nothing in this Agreement is intended to be construed or be deemed to create any rights or remedies in any third party, including, but not limited to, a Member or a provider other than Group.

8.19 Notification of Operational Changes: Each party shall promptly notify the other of changes of its ownership, including but not limited to joint ventures, mergers, acquisitions, bankruptcy, reorganization, change of licensure or any other operational changes which may impact or affect this Agreement. Group shall also notify The Plan of changes to executive management, or operational disruptions that materially affect Group's ability to provide services to Members. In addition, if Group engages the services of a management company in a way that impacts or affects this Agreement, or a consultant who may in the course of providing such services receive or gain access to this Agreement and/or related confidential information, it shall promptly notify The Plan and ensure that each management company representative executes a confidentiality agreement with The Plan before the terms of this Agreement are disclosed.

8.20 Practice of Medicine: The Plan shall neither dictate nor direct Group Participating Provider in the practice of medicine, nor the exercise of medical judgment, nor engage in making health care treatment decisions. Group shall not hinder The Plan in the conduct of its business. The Plan's quality improvement and utilization management activities as permitted in this Agreement shall not be construed as a violation of this provision. Group Participating Provider may communicate freely with Members under his/her care regarding treatment options available to them, including medication treatment options, regardless of Benefit coverage limitations.

8.21 Proprietary Information: The Plan reserves the right to, and controls the use of, the words "Blue Cross" and/or "Blue Shield" and all Blue Cross and Blue Shield symbols, trademarks, and service marks presently existing or hereafter established. Group agrees that it will not use such words, symbols, trademarks, or service marks in any manner without the prior written consent and approval of The Plan and will cease any and all usage upon termination of this Agreement.

8.22 Provider Resources: The Plan utilizes its website at www.bcbsok.com for communicating additional information to providers, including but not limited to billing information, quality improvement standards, and medical policies. The Plan agrees to maintain its website with current information including policies related to payment and coding and reserves the right to make updates to its website without notice. The Plan shall use its standard communication channels to provide advance notice to Group of substantive changes to

information in the Provider section of its website. Group agrees to refer to the Provider section of The Plan's website for additional information regarding its relationship with The Plan.

8.23 Right of Recovery:

8.23.0 When a Member's coverage is subject to waiting periods, waivers, exclusion of coverage riders, pre-existing condition limitations, and/or exclusions and other Benefit or membership stipulations or is subject to cancellation retroactive to the effective date (e.g., in the event of fraud, misrepresentation, or non-payment of dues), The Plan may determine that Benefits were paid for Noncovered Services or when the Member was not eligible for coverage. Group agrees that, if it is determined the patient or Member is not entitled to Benefits on the basis of the facts pertaining to such Benefit exclusion or membership termination, claims may be denied, and any amounts previously reimbursed may be offset against future payments due to Group from The Plan. The Plan will initiate its recovery efforts within six (6) months after the payment to Group by sending written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made. Group will be given thirty (30) days to refund the amounts requested in the written notice before The Plan exercises its right to offset. In such event, Group can, at its option, pursue payment from the Member or other responsible third party.

8.23.1 In accordance with Oklahoma law, when The Plan has granted Prior Authorization for a service and Group has verified the Member's or patient's eligibility within four (4) days of the service, The Plan will not deny Benefits or offset against future payments any amounts previously reimbursed unless:

(a) the claim or payment was made because of fraud or intentional misrepresentation,

(b) the Member or patient is subject to a pre-existing condition limitation and/or exclusion, or

(c) the Member, patient, employer or group failed to pay the applicable premium and membership is retroactively cancelled.

The Plan will initiate its recovery efforts within six (6) months after the payment to Group by sending Group written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made. Group will be given thirty (30) days to refund the amounts requested in the written notice before The Plan exercises its right to offset. In such event, Group can, at its option, pursue payment from the Member or other responsible party. This provision is subject to change or may be rendered null and void if Oklahoma law is otherwise amended or repealed.

8.23.2 When amounts have been reimbursed in error, other than as described in this *Right of Recovery* provision, such amounts may also be offset against future payments due Group from The Plan. The Plan will initiate its recovery efforts within eighteen (18) months after the payment to Group (or such other time period required by law) by sending Group written notice setting forth the patient's name, service date, payment amount and an explanation of the adjustment to be made. Group will be given thirty (30) days to refund the amounts requested in the written notice before The Plan exercises its right to offset. When Group believes amounts have been reimbursed in error, other than as described in the first subsection of this Right of Recovery provision, Group may submit an inquiry to review a claim up to eighteen (18) months after the date of payment. If The Plan determines that the claim was paid incorrectly, The Plan will reimburse any applicable amount to Group.

The Plan shall not be prohibited from requesting a refund or retracting a payment outside the time frames set forth in this *Right of Recovery* provision if:

(a) the payment was made because of fraud or intentional misrepresentation, or

(b) Group has otherwise agreed to make a refund.

8.24 Severability: The terms and provisions of this Agreement shall be deemed to be severable one from the other, and determination at law or in a court of equity that one term or provision is unenforceable shall not operate so as to void the enforcement of the remaining terms and provisions of this entire Agreement, or any one of them, in accordance with the intent and purpose of the parties hereto.

8.25 Third Party Premium Assistance: The Plan allows premium payments and cost-sharing assistance for Members from: (i) Members and their families; (ii) required third-party entities identified in 45 C.F.R. § 156.1250, as it may be amended from time to time; and (iii) State and Federal Government programs. The Plan may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations make premium or cost-share assistance available to Members (i) regardless of the Member's health status, and (ii) for the entire coverage period of the Member's coverage agreement. The Plan will not accept payments from other third party entities, including, but not limited to, Group, Group Participating Providers, hospitals and other health care providers.

8.25.0 If The Plan discovers that any premium payments were provided directly by, or at the request of, or instruction from, Group or by Group Participating Provider in violation of this section, Group and Group Participating Provider forfeit any and all rights to payment under this Agreement for services rendered to said Member and shall hold the Member harmless for claims for services rendered.

8.25.1 Attempts by the Group or a Group Participating Provider to pay premiums for a patient or Member shall constitute material breach of this Agreement.

8.25.2 This section shall survive termination of this Agreement.

8.26 Unforeseen Circumstances: In the event Group does not have proper facilities to treat a Member due to circumstances beyond Group's reasonable control, such as major disaster, epidemic, war, complete or partial destruction of facilities, disability of a significant number of personnel, or significant labor disputes, civil commotion, government action (whether legal or not), Group shall provide Covered Services to Members to the extent possible according to the best judgment or limitations of such facilities and personnel as are then available, but Group shall have no liability or obligation to The Plan for delay or failure to provide or arrange such services.

8.27 Waiver: The waiver by either party of a breach or violation of any provision of this Agreement shall not operate as or be construed to be a waiver of any subsequent breach thereof or modification of this Agreement. No waiver of any provision of this Agreement shall be valid unless in writing and signed by the parties.

ARTICLE IX
CONFIDENTIALITY AND NON-DISPARAGEMENT

9.0 Confidentiality:

9.0.0 "Confidential Information" means the terms and provisions of this Agreement, any related discussions and negotiations, including contract extension discussions and negotiations, and information of The Plan, in any format, provided or made available by The Plan to Group, including but not limited to the following: information pertaining to business operations, employees, staff, financial information, fee schedules and all Maximum Reimbursement Allowances, technology, suppliers, customers, product administration and management, business practices, trade secrets, policies and procedures, compliance with standards from accreditation and certifying boards or agreements, credentialing applications, project work product, data, any oral discussions or negotiations of the Parties, analyses, compilations, studies or other documents or information prepared by or on behalf of The Plan.

9.0.1 In addition, Confidential Information means correspondence, information, and documents exchanged and statements made by either party or its Representatives during the negotiation of a successor participating provider agreement or any other new agreement, including all exhibits and addendums (a "Proposed Transaction"), including but not limited to proposed rates, charges and

fees, reimbursement methodologies, contractual terms and conditions, and discussions and negotiations. Representatives include officers, directors (including trustees and members of other governing boards of any nature, public or private), employees, agents, accountants, auditors and outside attorneys, and other advisors (collectively, the "Representatives") who the receiving party determines have a need to know such Confidential Information in connection with evaluating the Proposed Transaction and who have been advised of the obligation of confidentiality and are obligated to keep the information confidential, subject to a binding obligation at least as restrictive as this Agreement. Notwithstanding the foregoing, if Group retains a third party specifically to evaluate, and to assist Group in the negotiation of, a Proposed Transaction, who may in the course of providing such services receive or gain access to proprietary information disclosed by The Plan, or a third party under contract to provide management services to Group ("Consultant") after the effective date of this Agreement, Group shall promptly notify The Plan and ensure that each Consultant executes a confidentiality/non-disclosure agreement with The Plan before any Confidential Information or other protected information of The Plan is disclosed to Consultant.

9.0.2 The Plan will remain the sole and exclusive owner of any and all Confidential Information it provides to Group.

9.0.3 Group agrees that the Confidential Information disclosed under this Agreement is confidential. Group may only use Confidential Information for purposes of implementing this Agreement and will restrict disclosure of Confidential Information to those persons who have a "need to know" for purposes of performing under this Agreement. Group agrees to take appropriate and necessary precautions to maintain and hold such Confidential Information confidential and to not use, disclose or release to any person or entity Confidential Information, except as authorized in this Agreement or in writing by the Plan. Should an unauthorized disclosure of Confidential Information occur, Group must notify The Plan within five (5) days of such discovery.

9.0.4 This obligation of confidentiality shall not preclude disclosure of information by Group or The Plan if disclosure is required to fulfill obligations imposed by federal or state law or ethical guidelines; provided, however, that if Group becomes legally compelled by law, process, or order of any court or governmental agency to disclose any Confidential Information, Group will give The Plan maximum practical advance written notice to permit The Plan to seek a protective order or to take any other appropriate action to protect the Confidential Information.

9.1 Non-Disparagement: The Group, on behalf of itself, Group Participating Providers, and its Representatives, agree not to make, or intentionally cause or allow any other person to make, any public statement that is factually false or disparages or casts a negative light on The Plan, HCSC or any of its affiliates, or any of their respective officers, employees or directors. This section shall not be construed to prohibit any person from making truthful public statements in response to incorrect public statements or when required by law, subpoena, court order, or the like.

9.2 Public Disclosures: Notwithstanding anything else in this Article IX to the contrary, during the negotiation of a Proposed Transaction each party's public disclosures regarding the Proposed Transaction shall be limited to statements i) regarding the expiration date of the existing provider agreement between the parties, if any, and extensions of time proposed by either party; ii) generally identifying the nature of the issues being negotiated and the party's position on those issues (including net percentage and/or dollar impact of proposed overall increase/decrease in reimbursement rates); and iii) issues remaining for resolution, so long as the public statements do not disclose specific Confidential Information, make public written documentation or correspondence exchanged between the parties related to the Proposed Transaction, or violate the Non-Disparagement section. Neither party will make, or cause or allow any Consultant, Representative, or other person or entity to make, any public statement regarding the Proposed Transaction, regardless of content, using advertising or paid media, including but not limited to online, digital, outdoor, print, radio, TV, video and social media.

9.3 Remedies of The Plan: Violation of this Article IX may result in immediate termination of this Agreement in accordance with *Immediate Termination by The Plan* in Article XI. Further, Group agrees that any breach

(or anticipatory breach) of the obligations set forth in this Article will result in irreparable damage to The Plan for which it will have no adequate remedy at law. Therefore, it is agreed (and as an exception to any dispute resolution provisions in this Agreement) that The Plan may seek equitable relief to prevent unauthorized use or disclosure by Group, including, but not limited to, an injunction enjoining any such breach or anticipatory breach, and Group will pay all attorneys' fees and court costs incurred by The Plan to secure such equitable relief. Such equitable relief will be without prejudice to any other right or remedy to which The Plan may be entitled.

9.4 Survival: The covenants and obligations set forth in this Article IX shall survive termination of this Agreement.

ARTICLE X
AMENDMENTS

10.0 Amendments: The Plan may amend this Agreement by providing Group written notice via mail or secure electronic format of such amendment at least ninety (90) days in advance of the effective date of the amendment. If Group does not notify The Plan, in writing, of nonacceptance at least forty-five (45) days prior to the effective date of the amendment, the amendment will be deemed to have been accepted by Group. Nonacceptance of proposed amendments will result in representatives of Group and The Plan meeting to resolve problems occurring as a result of the amendment(s). Notwithstanding the above, if an amendment to the Agreement is necessary to comply with requirements of an accreditation body or to comply with state or federal law or regulation, Group agrees to accept such an amendment. If an agreement has not been reached regarding the subject of the amendment prior to its effective date, this Agreement will terminate on the date designated by The Plan, or on the date agreed to by the parties.

ARTICLE XI
TERM AND TERMINATION

11.0 Contract Term: This Agreement shall be effective as stated on the cover page of this Agreement and shall continue for twelve (12) months. This Agreement shall automatically renew for successive twelve (12) month terms and continue in effect unless terminated in accordance with other provisions of this Agreement.

11.1 Immediate Termination by The Plan: The Plan may terminate this Agreement or remove one or more Group Participating Provider(s) from this Agreement, upon any of the occurrences identified in the sub-sections below by providing written notice to Group. A termination made under this section shall be effective upon the later of the date of receipt of written notice, or the date identified by The Plan in the written notice.

11.1.0 Failure to meet or maintain credentialing requirements, or failure to notify The Plan of actions against a Group Participating Provider that would impact credentialing status; or

11.1.1 Engaging in fraud, waste or abuse or filing false claims, or filing inappropriate claims after notification by The Plan, which may include but is not limited to the following:

(a) Billing for costs of Noncovered or non-chargeable services, supplies, or equipment disguised as covered items;

(b) Billing for services, supplies or equipment not furnished, or not furnished at the level claimed;

(c) Billing the claim for an M.D. or D.O. when a P.A., N.P., therapist, surgical assistant or other person delivered the services;

(d) Billing more than once for the same service, billing The Plan and the beneficiary for the same services, submitting claims to both The Plan and other third parties without making full disclosure of relevant facts to, or immediate full refunds in the case of overpayment by, The Plan;

(e) Misrepresentations of location, dates, frequency, duration, description of services rendered, or the identity of the recipient of the service or who provided the service;

(f) Billing or claiming services furnished by another provider or furnished by the billing provider in a capacity other than billed or claimed (e.g., under-billing or Pass-Through Billing);

(g) Unbundling, fragmenting or manipulating the CPT® codes as a means of increasing reimbursement and/or misrepresenting the services rendered in a claim and/or medical record submitted to The Plan, or;

(h) Demonstrating a pattern of claims for services not Medically Necessary.

11.1.2 An arrest, plea of guilty or nolo contendere or a conviction for any criminal offense, or placement in a diversion program for any crime related to the payment or provision of health care;

11.1.3 The forfeiture or suspension of a required license, Drug Enforcement Administration (DEA) certificate, or Bureau of Narcotics and Dangerous Drugs (BNDD) certificate;

11.1.4 Censure, reprimand, restriction, suspension, revocation or reduction to probationary status of license to practice or any hospital related privileges;

11.1.5 Suspension or debarment from participation in a government program, including but not limited to Medicare or Medicaid, or censure, restriction, termination of deeming or participation status in Medicare or Medicaid;

11.1.6 Engaging in conduct that threatens the health or well-being of Members;

11.1.7 Disability or infirmity which prevents or reduces Group Participating Provider's ability to meet accepted practice standards at the level of skill and care that any health care practitioner would be expected to observe in caring for patients as set forth in Article II, *Scope of Services*, or the failure to successfully complete a program related to substance abuse.

11.1.8 Intentional or negligent disclosure of Confidential Information.

11.2 Termination by Either Party: Either party may terminate this Agreement by providing the other party with at least ninety (90) days prior written notice. Termination pursuant to this section shall not entitle Group to the Appeals and Grievance Procedures set forth in Article VII of this Agreement.

11.3 Termination for Breach by Group: Upon The Plan's default of any material obligation under this Agreement, including the attachments, Group may provide to The Plan written notice of such breach. The Plan has thirty (30) days to cure the breach. If the default is incapable of cure or which, being capable of cure, has not been cured in the thirty (30) days following receipt of written notice of such default (or such additional cure period as mutually agreed by the parties), Group may terminate this Agreement upon ten (10) business days prior written notice to The Plan.

11.4 Termination for Breach by The Plan: The Plan may terminate this Agreement, or remove one or more Group Participating Providers from this Agreement, upon ten (10) business days' prior written notice to the Group and Group Participating Provider(s), upon any of the following:

11.4.0 Upon the default of any material obligation, under this Agreement, including the attachments, by Group or Group Participating Provider, which default is incapable of cure or which, being capable of cure, has not been cured in the thirty (30) days following receipt of written notice from The Plan of such default (or such additional cure period as The Plan may authorize).

11.4.1 Upon the filing of claims by Group or Group Participating Provider which do not comply with the Agreement or The Plan's policies or guidelines, including but not limited to policies related to payment and coding, following receipt of prior written notice by The Plan of filing requirements and failure to cure within thirty (30) days following receipt of notice of such non-compliance (or such additional cure period as the non-defaulting Party may authorize).

11.4.2 Group or Group Participating Provider's failure to comply with quality improvement, peer review or utilization review procedures, following prior written notice by The Plan and failure to cure within thirty (30) days following receipt of written notice of such non-compliance (or such additional cure period as The Plan may authorize).

11.4.3 Failure to eliminate or remediate conflicts of interests between the Group and The Plan, or Group Participating Provider and The Plan, following prior written notice by The Plan and failure to cure within thirty (30) days following receipt of notice of the conflict of interest (or such additional cure period as The Plan may authorize).

11.4.4 Engaging in unprofessional conduct with a Member or The Plan by Group or Group Participating Provider following prior written notice by The Plan and failure to cure within thirty (30) days following receipt of written notice of such non-compliance.

11.4.5 Engaging in any of the below identified behaviors, following prior written notice by The Plan and failing to cure within thirty (30) days following receipt of written notice (or such additional cure period as The Plan may authorize):

(a) demonstrating a pattern of billing patients for amounts in excess of deductibles and copayments;

(b) demonstrating a pattern of waiving or rebating any portion of deductibles, copayments and coinsurance amounts owed by the Member, without regard for the financial need of the patient;

(c) identified as prescribing/dispensing controlled substances for other than therapeutic reasons;

(d) demonstrating a pattern of billing for services that are not Medically Necessary; or

(e) refusing access to records which are deemed essential by The Plan to determine The Plan's liability.

11.5 Transition Period: If this Agreement terminates under this Article XI, or if the contract period, including any mutually agreed extensions thereof, expires without the execution of a new provider agreement between the parties, The Plan may in its sole discretion elect to implement a Transition Period in order to provide for an orderly winding down of the parties' relationship. This section (Transition Period) shall survive termination or expiration of this Agreement. The intent of the Transition Period is to allow time for both parties to communicate with their respective stakeholders, to allow time for the transition of care, and to allow for the application of continuity of care benefits, after termination or expiration of this Agreement. If the Parties desire additional time to continue negotiations for a new agreement after the date upon which the contract period expires, the Parties must mutually agree in writing to extend the contract period prior to the expiration date.

11.5.0 The Transition Period begins at 12:01 a.m. on the day following the termination effective date and shall extend for a period of one hundred twenty (120) days.

11.5.1 During the Transition Period, Group and Group Participating Providers shall provide services to Members in accordance with the terms of the Agreement, as if the Agreement were still in place, with all provisions surviving termination through 11:59 p.m. of the last day of the Transition Period,

with the exception of *Audit/Review* and *Quality Improvement* in Article II, which survive termination for a period of two years commencing on the first day of the Transition Period, and *Notification of Incorrect Payments* (Article II), *Third Party Premium Assistance* (Article VIII), and *Confidentiality and Non-Disparagement* (Article IX) which shall survive such termination indefinitely.

11.5.2 Members who received services from Group and Group Participating Providers during the Transition Period will have their claims for Benefits processed as if they were in network. The Plan agrees to issue payment directly to Group for services rendered by Group and Group Participating Providers during the Transition Period and payment shall be at the rates negotiated in the Agreement as of the date of termination.

11.5.3 Group agrees to accept payment at the rates negotiated in the Agreement as of the date of termination and to hold the Member harmless from any sums in excess of the Maximum Reimbursement Allowance.

11.5.4 During the Transition Period, The Plan shall give notices to Members and Participating Providers of the termination of the Agreement and the change in Group's network status. Group shall cooperate to transition the care of Members to Participating Providers, if requested to do so by Members and their treating physicians.

Refer to cover page for effective date, contact information and signatures.