

**HEALTH CARE SERVICE CORPORATION  
ANCILLARY PROVIDER AGREEMENT**

This ancillary facility agreement (the "Agreement") by and between Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation ("HCSC"), a Mutual Legal Reserve Company and an Independent Licensee of the Blue Cross and Blue Shield Association, (referred to herein as "BCBS") and HIDALGO COUNTY (referred to herein as "Ancillary Provider") (Ancillary Provider and BCBS are referred to herein individually as a "Party" and collectively as the "Parties"), is made as of the Effective Date (as set forth on the signature page).

**WHEREAS**, Ancillary Provider is an entity that provides Health Care Services, which is licensed and in good standing under Texas Law to provide such Health Care Services; and

**WHEREAS**, BCBS arranges for access to Covered Services for Covered Persons pursuant to the terms of Coverage Agreements; and

**WHEREAS**, this Agreement is intended to memorialize the arrangement whereby Ancillary Provider will provide Covered Services to Covered Persons as a Participating Provider.

**NOW THEREFORE**, in consideration of the mutual covenants and agreements herein contained, the receipt and sufficiency of which the Parties hereby attest, and for their mutual reliance, the Parties mutually agree as set forth in this Agreement.

**Incorporation.** The following documents ("Attachments") are attached hereto, incorporated herein by reference, and together are part of the Agreement as of the Effective Date:

- **ATTACHMENT A: PROVIDER NETWORKS**
- **ATTACHMENT B: BILLING AND CLAIMS PROCESSING STANDARDS**
- **ATTACHMENT C: LISTING**
- **ATTACHMENT D: COMPENSATION RATES**
  - SUBATTACHMENT D-1: BLUE CHOICE PPO<sup>SM</sup> NETWORK COMPENSATION RATES
  - SUBATTACHMENT D-2: BLUE ESSENTIALS<sup>SM</sup> HMO NETWORK COMPENSATION RATES
  - SUBATTACHMENT D-3: BLUE ADVANTAGE HMO<sup>SM</sup> NETWORK COMPENSATION RATES
  - SUBATTACHMENT D-4: BLUE PREMIER<sup>SM</sup> HMO NETWORK COMPENSATION RATES
  - SUBATTACHMENT D-5: BLUE HIGH PERFORMANCE NETWORK COMPENSATION RATES
  - SUBATTACHMENT D-6: MYBLUE HEALTH HMO NETWORK COMPENSATION RATES
- **ATTACHMENT E: MEDICAID: MANDATORY TEXAS MEDICAID PROVIDER CONTRACT ATTACHMENT**
- **ATTACHMENT F: MEDICARE ADVANTAGE ATTACHMENT**

Base [TEXAS]

- SUBATTACHMENT F-1: ATTESTATION
- SUBATTACHMENT F-2: MEDICARE ADVANTAGE PPO COMPENSATION
- SUBATTACHMENT F-3: MEDICARE ADVANTAGE HMO COMPENSATION

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**Written Notice to BCBS.** Any Written Notice required or allowed to be given pursuant to the terms and provisions of this Agreement must be sent to BCBS at:

Blue Cross and Blue Shield of Texas  
Attention: Vice President, Network Management - TX  
1001 E. Lookout Drive  
Richardson, TX 75082

Copy to: Blue Cross and Blue Shield of Texas

Attention: Legal Division  
1001 E. Lookout Drive  
Richardson, TX 75082

**Notices.** Other Notices required or allowed to be given:

- **by email** pursuant to the terms and provisions of this Agreement must be sent to BCBS at: [TX\\_Written\\_Notices@bcbstx.com](mailto:TX_Written_Notices@bcbstx.com)
- **by U.S. Mail** pursuant to the terms and provisions of this Agreement must be sent to BCBS at the address specified above for Written Notices.

**Written Notice to Ancillary Provider.** Any Written Notice required or allowed to be given pursuant to the terms and provisions of this Agreement must be sent to Ancillary Provider at:

HIDALGO COUNTY  
1304 S 25TH AVE  
EDINBURG, TX 78542

**Notices.** Other Notices required or allowed to be given:

- (i) **by email** pursuant to the terms and provisions of this Agreement must be sent to Ancillary Provider at: [veronica.cuate@hchd.org](mailto:veronica.cuate@hchd.org);
- (ii) **by U.S. Mail** pursuant to the terms and provisions of this Agreement must be sent to Ancillary Provider at the address specified above for Written Notices.

Base [TEXAS]

**Counterparts.** This Agreement may be executed in one or more counterparts, each of which will be deemed an original, but all of which together will constitute one and the same instrument.

Base [TEXAS]

**IN WITNESS WHEREOF**, the undersigned have executed this Agreement to be effective as of the Effective Date set forth below.

**Each Party may sign this Agreement electronically. A scanned, imaged, electronic, photocopy or stamp of the signatures hereunder will have the same force and effect for purposes of validity, enforceability, and admissibility as an originally executed signature.**

**BLUE CROSS AND BLUE SHIELD OF TEXAS A DIVISION OF  
HEALTH CARE SERVICE CORPORATION, A MUTUAL LEGAL  
RESERVE COMPANY**

**HIDALGO COUNTY**

Authorized Signature:

Authorized Signature:

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Printed Name: Brad Tucker

Printed Name: DAIREN RANGEL

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Title: VP TX Health Care Delivery

Title:

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Date:

Date:

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Tax ID: 746000717

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PFIN: H0CL710601

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**Effective Date of Agreement:**  
*(BCBSTX Authorized Effective Date)*

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**ARTICLE I  
DEFINITIONS**

- 1.0 **Affiliate** means any corporation, firm, limited liability company, partnership or other legal entity that directly or indirectly controls, or is controlled by, or is under common control with, a Party, which may include subsidiaries, parent entities and sister companies. As used in this definition, "control" means (i) ownership of fifty percent (50%) or more of the shares of stock entitled to vote for the election of directors, in the case of a corporation; or (ii) any ownership of fifty percent (50%) or more of the equity interests in the case of any other type of legal entity; or (iii) status as a general partner in any partnership; or (iv) any other arrangement whereby a Party legally controls, or has the right to legally control, the governing body of a corporation or other legal entity.
- 1.1 **AMA** refers to the American Medical Association.
- 1.2 **Administrative Services Only ("ASO") Group** means an employer, union trust fund, or other legal entity with which BCBS has contracted to provide such entity only with administrative services that are, in whole or in part, related to a benefit Plan that is not underwritten by BCBS, or associated with the employer or entity's self-funded or otherwise funded (other than by BCBS), Product(s).
- 1.3 **Ancillary Provider** means any appropriately licensed or where applicable and appropriate, certified, provider of Health Care Services.
- 1.4 **Blue Cross and Blue Shield Association or BCBSA** means the association of independent Blue Cross and Blue Shield Plans.
- 1.5 **BlueCard Program** means an agreement among participating BCBSA-related Plans pursuant to which Covered Persons participating in a Product of any one such Plan may access the Provider Network and financial terms of other such Plans for Covered Services, when such Covered Persons are away from their primary home Plan state.
- 1.6 **Claim** means an itemized statement of Ancillary Provider's charges for Health Care Services provided by Ancillary Provider to a particular Covered Person.
- 1.7 **Clean Claim** has the meaning set forth by applicable Law for Covered Services performed at a Ancillary Provider location included in this Agreement.
- 1.8 **CMS** refers to the Centers for Medicare & Medicaid Services.
- 1.9 **COB** means coordination of health care benefits in accordance with Section 2.9.
- 1.10 **Codes** means the types of codes typically and commonly used in Claims and Clean Claims, which codes change from time to time, including, but not limited to, Diagnosis Related Group ("DRG"), Current Procedural Terminology ("CPT"), revenue codes, and International Classification of Disease ("ICD") codes which are published, authored, created or assigned by various third-parties, including, but not limited to, CMS, the AMA, or other agencies and their successors.
- 1.11 **Cost Share** means that portion of Facility's payment for a Covered Service for which a Covered Person is responsible, including, but not limited to, co-payments, co-insurance, deductibles, reduction of benefits, and any other applicable financial responsibility of the Covered Person, pursuant to his or her Coverage Agreement.

- 1.12 **Coverage Agreement** means any policy, contract, Plan document, or certificate entered into or issued by a Plan, which entitles Covered Persons to receive benefits for Covered Services, and which identifies the Covered Services that the Plan, or the Plan or the ASO Group's designee, has agreed to adjudicate, and, to the extent appropriate, pay for, on behalf of Covered Persons. A Coverage Agreement can be pursuant to an insurance arrangement, an administrative services arrangement, or an arrangement whereby a Plan contracts with BCBS to utilize Participating Providers. The Coverage Agreement explains the benefits, limitations, exclusions, terms, and conditions of a Covered Person's health coverage.
- 1.13 **Covered Person** means any person entitled to receive Covered Services pursuant to: (i) the terms of a Coverage Agreement, and (ii) the Provider Networks covered under the terms of this Agreement, at the time Health Care Service(s) are furnished.
- 1.14 **Covered Services** means Health Care Services that are specified as benefits covered under a Coverage Agreement and are provided by Ancillary Provider to Covered Persons pursuant to the terms of this Agreement.
- 1.15 **Credentialing and Recredentialing** means a process to validate the credentials of and approve Ancillary Provider and its Providers for participation in a BCBS Provider Network.
- 1.16 **Debarment** means the prohibition of a Provider from receiving compensation for services provided under any federal health benefit plan or program, including, without limiting the foregoing, Medicare, Medicaid, and the FEP, as reported by the federal OPM, OIG, CMS, OFAC, or any other applicable governmental agency.
- 1.17 **Designees** means a Party's vendors and independent contractors that assist a Party in the performance of its obligations under this Agreement, but excluding a Party's employees.
- 1.18 **Emergency Care** means Health Care Services provided in a hospital emergency facility, freestanding emergency medical care facility, or comparable facility to evaluate and stabilize Emergency Medical Conditions.
- 1.19 **Emergency Medical Condition** means of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that such person's condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; (4) serious disfigurement; or (5) in the case of a pregnant woman, serious jeopardy to the health of the fetus.
- 1.20 **Erroneous Payments** means any overpayment, underpayment, or any other improper payment of a Claim.
- 1.21 **Exclusive Provider Organization (EPO)** means a Plan excluding benefits to a Covered Person for some or all services, other than emergency care services, provided by a physician or health care provider who is not a preferred provider. For purposes of this Agreement, EPO as a line of business shall refer to EPO plans and Provider's express consent to participate in a panel of preferred providers to support such plans.
- 1.22 **FEP** refers to the Federal Employees Health Benefits Plan.
- 1.23 **Financial Records** has the meaning set forth in Section 2.5.1.
- 1.24 **Health Care Service(s)** means health care related services, items, treatments, testing, drugs, supplies, procedures, investigation or observation, including, but not limited to, services for the

- purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms.
- 1.25 **HHS** refers to the United States Department of Health and Human Services.
- 1.26 **HIPAA** means the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996, the Health Information Technology for Economic and Clinical Health Act ("HITECH"), and their implementing regulations, as amended from time to time.
- 1.27 **HMO** means an entity licensed as a Health Maintenance Organization under State Law.
- 1.28 **Hospital Acquired Conditions** or **HACs** means one of several specific medical conditions identified by CMS and based on ICD-10 diagnosis Codes.
- 1.29 **In-Network Services** means Covered Services provided to Covered Persons in accordance with the Coverage Agreements' requirements for in-network benefits as set forth in the applicable Coverage Agreement.
- 1.30 **Law(s)** means all applicable State and federal laws, rules, regulations, guidance, licensing requirements, common and case law, local ordinances and any other applicable authority of a tribunal or governmental entity (including, but not limited to, State Departments of Insurance), and including, but not limited to, court orders.
- 1.31 **Medical Director** means a physician designated by BCBS, or such physician's designee who, where required by Law, will also be a physician.
- 1.32 **Medically Necessary** or **Medical Necessity** means health care services that a Physician, exercising prudent clinical judgment, would provide to a Covered Person for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the Covered Person's illness, injury or disease; and (c) not primarily for the convenience of the Covered Person, 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 Covered Person'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. This definition shall be applicable to the terms "medically necessary" and "medical necessity" as used in this Agreement, including any amendments and attachments hereto, whether or not such terms are capitalized.
- 1.33 **Non-Covered Services** means those Health Care Services that are not Covered Services.
- 1.34 **Non-Patient** means a Covered Person that is neither an inpatient nor an outpatient of the Hospital, but has a specimen, scan, screening, image, or any other result (collectively and generally, "Test") that is submitted for analysis or billing by Hospital and the Covered Person is not physically present at the Hospital at the time of the test. Non-Patient specifically does not include Covered Person's specimens collected or received by Hospital that are subsequently transferred to another Hospital or Provider for testing and/or analysis, which Hospital agrees is also not a billable charge to the Covered Person or BCBS.
- 1.35 **Notice** means a notification required by this Agreement or Law, that is not a required Written Notice, but is a notification to one Party by the other Party: (i) by U.S. mail or email, or, (ii) from

BCBS to Ancillary Provider only, provider newsletter or website, and (iii) will be considered received as of: (a) the date on which the recipient receives the notification, or the date upon which the recipient refuses or otherwise fails to accept delivery, or (b) for U.S. mail, on the third business day following its deposit in the U.S. mail, or (c) in the case of BCBS, for Provider newsletter or website, the date that the newsletter or website notification is posted by BCBS.

- 1.36 **OFAC** refers to the Office of Foreign Assets Control.
- 1.37 **OIG** refers to the Office of the Inspector General.
- 1.38 **OPM** refers to the federal Office of Personnel Management.
- 1.39 **Participating Provider** means those licensed and credentialed Providers and practitioners that have an agreement with BCBS to provide In-Network Services to Covered Persons according to the terms of their Coverage Agreements, Plan direction and this Agreement.
- 1.40 **Penalty** means a fee or other monetary charge to Ancillary Provider.
- 1.41 **Plan** means BCBS, ASO Group, or any other HCSC Plan, Blue Cross and/or Blue Shield Plan licensed by BCBSA and a subsidiary of such plan, or any other BCBS Affiliate, or employer, with respect to which BCBS has contracted to provide access to Participating Providers.
- 1.42 **Point of Service (POS)** means a Plan that generally utilizes a PCP to coordinate referrals within an HMO or PPO determined by the Plan that also allows Covered Persons to obtain care from non-Participating Providers at a reduced benefit level compared to In-Network Services.
- 1.43 **Policies and Procedures** means the Provider Manual and any other policies, programs, rules, guidelines, protocols, and administrative procedures adopted by BCBS that relate to, without limitation, Credentialing and Recredentialing processes, medical policies, Utilization Management and Care Management processes, quality improvement, peer review, Covered Person grievance, concurrent review, or any other BCBS programs. For purposes of this definition, "Care Management" means a collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates the options and services required to meet a Covered Person's health needs, using communication and available resources to promote quality, cost-effective outcomes, and ongoing individual needs, as developed and approved by the Covered Person's physician.
- 1.44 **PPO** means a Preferred Provider Organization.
- 1.45 **Preauthorization** means BCBS's or its UM Agent's qualified prior approval of the Medical Necessity of certain Health Care Services provided to Covered Persons under the terms of their Coverage Agreement.
- 1.46 **Primary Care Physician or PCP** means a Participating physician, Physician Assistant or Advanced Practice Nurse who has agreed to be responsible for providing basic health services, coordinating the care of individual Members, and referring those Covered Persons to other Participating Providers for Covered Services. A PCP may be a family practitioner, internist, pediatrician, Physician Assistant or Advanced Practice Registered Nurse and/or Obstetrician/Gynecologist.
- 1.47 **Products** means those products, services, items, programs, arrangements, or Plans offered to Covered Persons pursuant to a Coverage Agreement.
- 1.48 **Proper Referral** means a referral issued by a Covered Person's Primary Care Physician pursuant to the applicable Utilization Management program, for a Covered Person to receive a particular In-Network Service within a specified time frame. Proper Referrals are required for all

In-Network Services provided to Covered Persons whose Coverage Agreement requires the selection of a Primary Care Physician that are not provided by the Covered Person's Primary Care Physician, except for (1) Emergency Care; (2) In-Network Services, including behavioral health services, obtained by a Covered Person by self-referral to a Participating Provider, as expressly permitted by his Coverage Agreement or as required by applicable Law; (3) obstetrical and gynecological care; (4) Coverage Agreements that do not always require Proper Referrals; and (5) urgent care services if they are Covered Services under Covered Person's Coverage Agreement. When applicable, a Proper Referral from the Covered Person's Primary Care Physician will identify the particular Participating Provider (or non-Participating Provider, if approved by BCBS or the applicable UM Agent) who is to provide the service. Where the Coverage Agreement requires a particular In-Network Service to be Preauthorized in order to be a Covered Service, a Proper Referral will include such Preauthorization.

- 1.49 **Provider Manual** means the BCBS document(s) located in a manual or on a BCBS website that describe(s) requirements applicable to Ancillary Provider for the provision of Covered Services to Covered Persons.
- 1.50 **Provider Network** means a network of Participating Providers which has contracted with BCBS to provide Health Care Services to Covered Persons on certain terms and conditions related to the applicable network(s) and Products covered under this Agreement.
- 1.51 **Serious Reportable Event** means, as defined by the National Quality Forum, adverse events that are serious, but largely preventable, and of concern to both the public and Providers and as may be more fully described in the Policies and Procedures.
- 1.52 **Service Area** means the area served by BCBS with respect to the Product in which the Covered Person is enrolled.
- 1.53 **State** means the state of Texas.
- 1.54 **UM Agent** means an entity that is a licensed Utilization Review agent under Law and is designated to perform Utilization Management in connection with the care of Covered Persons, which is usually indicated on the Covered Person's identification card. The administrator of the applicable Plan may designate Plan, BCBS or another licensed Utilization Review agent to act as UM Agent for purposes of this Agreement and may designate one or more UM Agents to perform various Utilization Management activities. To the extent that BCBS has been designated as the UM Agent, BCBS may delegate any of BCBS's obligations to perform Utilization Management to any other entity licensed or otherwise permitted, in accordance with Law, to perform Utilization Management.
- 1.55 **Utilization Management or Utilization Review** means the evaluation by BCBS, or its authorized agent, vendor or subcontractor, or an ASO Group, or its UM Agent, as applicable, of the Medical Necessity, appropriateness and efficiency of the use of Health Care Services, in accordance with the provisions of the applicable Covered Person's Coverage Agreement, this Agreement, and Policies and Procedures, including, but not limited to, for purposes of Preauthorization or pre-certification for benefits, concurrent review, and retrospective review.
- 1.56 **Written Notice** means a type of written notification required by this Agreement (other than Notice) which from either Party is sent by U.S. certified mail, postage pre-paid, return receipt requested, and will be deemed received: (i) on the same date as proof of delivery as evidenced by the certified mail green card, or (ii) on the date upon which the recipient refuses or otherwise fails to accept delivery.

## ARTICLE II OBLIGATIONS OF ANCILLARY PROVIDER

2.0 **Provision of Covered Services.** Ancillary Provider will (i) provide, or arrange for the provision of, Covered Services to Covered Persons in the same manner and of the same quality that Ancillary Provider customarily and usually provides to other patients in a similar situation and in accordance with generally accepted standards of medical practice and the scope of its license, certifications, registrations, or other appropriate legal authorization under Law, applicable Coverage Agreements, accreditation organization(s), the terms and conditions of this Agreement, the Provider Manual, and Policies and Procedures, (ii) require all Providers to comply with the terms and conditions of this Agreement and Policies and Procedures, (iii) participate in Utilization Review activities in accordance with Section 2.13 and the Utilization Management Policies and Procedures, and (iv) provide Covered Services to Covered Persons only at Ancillary Provider locations set forth in this Agreement, as it may be amended from time to time.

2.0.0 **Responsibility for Medical Treatment.** Ancillary Provider acknowledges and agrees that Ancillary Provider, not BCBS, is solely responsible for arranging or providing Covered Services to Covered Persons under this Agreement. All decisions regarding the treatment and care of Covered Persons are the sole responsibility of Ancillary Provider, and such decisions are neither directed nor controlled in any way by BCBS. Ancillary Provider will continually monitor and evaluate the quality and appropriateness of patient care and/or services, including the performance of Ancillary Provider employees and all other individuals and entities who furnish services under arrangements with Ancillary Provider, including, but not limited to identifying and implementing:

2.0.0.0 Required quality improvement activities;

2.0.0.1 Methods to identify incidents or patterns;

2.0.0.2 Mechanisms for taking follow-up action; and

2.0.0.3 Methods for implementing the monitoring and evaluation activities, for reporting the results, and for monitoring corrective action.

2.0.1 **Credentialing.** Ancillary Provider acknowledges and agrees that Ancillary Provider will cooperate with and participate in BCBS's Credentialing and Recredentialing programs as described in the Policies and Procedures and will provide in a timely manner to BCBS all Credentialing and Recredentialing information requested by BCBS, including evidence of licensure and accreditation. Ancillary Provider will obtain all necessary releases from Providers, as applicable, to release Credentialing and Recredentialing files to BCBS, and BCBS is entitled to presume that such releases have been obtained by Ancillary Provider. Acceptance of this Agreement by BCBS is conditioned upon approval by BCBS's Credentialing committee. Ancillary Provider's failure to meet Credentialing and Recredentialing criteria is considered to be a breach of this Agreement and may result in immediate termination of this Agreement by BCBS.

2.0.2 **Subcontractors and Designees.**

2.0.2.0 **Subcontract Agreements.** Ancillary Provider may not enter into a subcontract agreement with any third-party pursuant to which such third-party assumes responsibility for the delivery of any Health Care Services that are the responsibility of Ancillary Provider under this Agreement.

2.0.2.1 **Designees.** BCBS has the right to disapprove, at any time, any and all Designees. Upon request, Ancillary Provider agrees to provide BCBS with a list of Designees, if any, as of the Effective Date and will provide BCBS at least thirty (30) calendar days' prior Notice of any Designees engaged after the Effective Date. In the event that BCBS disapproves of a particular Designee,

BCBS will provide Notice to Ancillary Provider of such disapproval, and Ancillary Provider will remove such entity or individual as a Designee within ten (10) business days after Ancillary Provider's receipt of Notice from BCBS that such Designee is to be removed. In the event that there is a reasonable possibility, pursuant to BCBS's sole determination, that a Designee is likely to cause imminent harm to any Covered Persons, Ancillary Provider will immediately terminate or otherwise remove from service such Designee to the extent necessary to prevent such imminent harm from occurring. Moreover, Ancillary Provider will immediately terminate or otherwise remove from service any Designee that is terminated, suspended (other than a temporary short-term suspension for non-medical reasons), restricted, or otherwise loses medical staff membership privileges or affiliated or allied health professional staff membership or privileges at any hospital.

- 2.0.3 **Exchange Downstream Entity.** Provider agrees the following terms shall be applicable to the ANCILLARY PROVIDER's participation in those networks and/or benefit plans offered by BCBS on an Exchange, as defined in 45 C.F.R. §155.20:
- 2.0.3.0 In the course of performing the duties and obligations of the Agreement, ANCILLARY PROVIDER may constitute a "delegated entity," and may contract with other entities who constitute "downstream entities," as such terms are defined in 45 C.F.R. § 156.20.
  - 2.0.3.1 ANCILLARY PROVIDER shall comply with all applicable laws and regulations, including but not limited to the provisions of 45 C.F. R. Parts 155 and 156, to the extent relevant, in performing its duties and obligations set forth in the Agreement.
  - 2.0.3.2 ANCILLARY PROVIDER shall grant access to its books, contracts, computers, or other electronic systems (including medical records and documentation), relating to ANCILLARY PROVIDER's compliance with applicable provisions under 45 C.F.R. Parts 155 and 156 to the U.S. Department of Health and Human Services (or its designee), its Office of Inspector General (or its designee), and any other state or federal governmental authority that has jurisdiction over the applicable Exchange. Such access shall be granted for the duration of the period in which this Amendment is effective, and for a minimum of ten (10) years from the date this Amendment terminates.
  - 2.0.3.3 ANCILLARY PROVIDER shall include in its contract with any downstream entities and require such downstream entities to include in their contracts with other downstream entities, language that is the same or substantially similar to that contained in Sections (b), (c), and (d) of this Amendment.
  - 2.0.3.4 Upon request from BCBS, ANCILLARY PROVIDER shall furnish BCBS with a copy of the pertinent contract language (including amendments thereto) between ANCILLARY PROVIDER and any downstream entities, and among two or more downstream entities, as applicable, to demonstrate compliance with subsection (d).
  - 2.0.3.5 In the event that BCBS, HHS, or any other state or federal governmental authority that has jurisdiction over the applicable Exchange determines that ANCILLARY PROVIDER, or any downstream entity with whom ANCILLARY PROVIDER contracts, has not performed satisfactorily the duties and obligations set forth in the Agreement, BCBS shall have the right to revoke such duties and obligations and terminate ANCILLARY PROVIDER's

participation in those networks and/or benefit plans offered by BCBS on the applicable Exchange.

- 2.0.3.6 The provisions of this Section shall in no way be interpreted as an assumption by BCBS of legal liability for the actions of ANCILLARY PROVIDER or any downstream entities, including but not limited to malpractice liability.
- 2.0.4 **Nondiscrimination.** In providing or arranging for Covered Services pursuant to this Agreement, Ancillary Provider will not discriminate against any Covered Persons on the basis of membership in a Product, source of payment, sex, age, race, color, religion, health status, disability, gender, ethnicity, sexual orientation, or any other basis forbidden by Law. Ancillary Provider will provide Covered Services to a Covered Person without regard to such Covered Person's enrollment in a particular Product, as a private purchaser or as a participant in any financed or otherwise insured program of Health Care Services, unless Ancillary Provider should not render a Health Care Service because of its lack of training, experience, or skill or because of restrictions on Ancillary Provider's licensure.
- 2.0.5 **Accessibility.** Ancillary Provider will assure that its Covered Services are readily available and accessible in a prompt and efficient manner that is at all times in accordance with Ancillary Provider's scope of practice, applicable community standards, and as set forth in the Provider Manual. Ancillary Provider will provide such Covered Services in the same manner, in accordance with the same standards, and within the same time availability as such services are provided to other patients without regard to the degree or frequency of utilization of such Covered Services by Covered Persons or the Product in which such individual is enrolled.
- 2.0.6 **Culturally Competent.** Ancillary Provider will ensure that it provides information regarding treatment options in a culturally competent manner, including, without limitation, the option of no treatment and ensure that each Covered Person with disabilities or who speaks or understands only languages other than English has an effective means of communication with Providers in making decisions regarding treatment options.
- 2.0.7 **Facilities, Equipment and Staff.** Ancillary Provider will provide and maintain facilities and/or equipment that are of adequate capacity, clean, and safe, are readily accessible to Covered Persons and, where appropriate, properly licensed, certified, or registered. Ancillary Provider will assure the appropriate supervision of, licensure of, certification of, and insurance coverage in accordance with Section 2.11 for all Ancillary Provider employees and Designees. Ancillary Provider's supervision of physicians will be conducted by a Ancillary Provider medical Director who is an appropriately licensed physician designated by Ancillary Provider. If any employee or Designee violates any of the provisions of Law or the Policies and Procedures or commits any act or engages in any conduct for which Ancillary Provider's license and/or certification may be revoked or suspended (whether or not such license and/or certification is revoked or suspended) or is otherwise disciplined by such licensing authority or any professional organization having authority over such Ancillary Provider employee or Designee, BCBS may immediately require Ancillary Provider to direct such Ancillary Provider employee or Designee to cease providing Covered Services to Covered Persons under this Agreement and/or may immediately terminate this Agreement upon Written Notice of such termination.
- 2.0.8 **Covered Persons.** Ancillary Provider agrees that BCBS has no obligation to guarantee that any minimum number of Covered Persons will be provided any Covered Services by Ancillary Provider. Ancillary Provider will accept all patients who are Covered Persons. In the event that Ancillary Provider believes that a Covered Person poses a threat of

imminent harm to other individuals at Ancillary Provider, Ancillary Provider shall contact the appropriate authorities (e.g. local police) and not BCBS.

2.0.9 **Administrative Services.** Ancillary Provider will perform or contract with permitted Designees for all administrative and support services necessary for Ancillary Provider to perform its obligations under this Agreement.

2.0.10 **Eligibility Validation.** Ancillary Provider is responsible for validating in advance the identity, eligibility and coverage for each Covered Person for which Ancillary Provider submits a Claim to BCBS for coverage of Health Care Services. BCBS may adjust amounts paid to Ancillary Provider under this Agreement based on updated enrollment information received by BCBS after Health Care Services are provided by Ancillary Provider. BCBS and ASO Groups have no obligation under this Agreement to pay for Health Care Services provided by Ancillary Provider to individuals who were not Covered Persons at the time such Health Care Services were provided. Ancillary Provider understands and agrees that Claims may be denied by BCBS, or, if BCBS pays for Health Care Services in error, BCBS may recoup such payment pursuant to its right to recovery under this Agreement.

## 2.1 **Billing and Payment.**

2.1.0 **Payment.** For Covered Services provided to Covered Persons that meet the standards for payment under this Agreement, Ancillary Provider will accept, through: (i) Cost Share and (ii) payment from BCBS, the amounts set forth in this Agreement as full reimbursement for arranging and providing Covered Services to Covered Persons, in accordance with the terms of this Agreement and its applicable Attachments, Policies and Procedures, and the Coverage Agreement. To qualify for payment of a Claim under this Agreement, Ancillary Provider will submit such Claims in the format, time frame, and manner set forth in this Agreement and Policies and Procedures. Ancillary Provider agrees BCBS may make adjustments to amounts previously paid to Ancillary Provider in accordance with the terms of this Agreement. Ancillary Provider agrees and understands that BCBS will not pay for Non-Covered Services. Ancillary Provider agrees that only Claims for Covered Services that are performed at a location included in this Agreement are eligible for reimbursement under this agreement.

2.1.1 **Pass Through Billing Prohibited.** Subject to exceptions in the Policies and Procedures, Ancillary Provider may bill BCBS only for Covered Services performed directly by Ancillary Provider or its employees, and Ancillary Provider may not bill, charge, seek payment for or submit any Claims to BCBS, nor may Ancillary Provider cause such Claims to be submitted to BCBS, nor will Ancillary Provider have any recourse against BCBS or any Covered Person for amounts related to Claims related to such pass-through billing.

2.2 **Provider Networks.** Ancillary Provider agrees to be a Participating Provider in the Provider Networks as set forth in this Agreement and such other Provider Networks added pursuant to the terms of this Agreement. Ancillary Provider will not be a Participating Provider in any other Provider Network.

2.2.0 **Network Additions.** Ancillary Provider agrees that Provider Networks may be added to this Agreement at BCBS's discretion at any time after the Effective Date of this Agreement in accordance with the terms below. For purposes of this provision, Retail means a Coverage Agreement that is offered on the Health Insurance Exchange, the Small Business Health Options Program (SHOP) or other public offering as established pursuant to the Affordable Care Act or Laws whether federally facilitated or not, Medicare means any Coverage Agreement offered pursuant to a program or demonstration through CMS or related to CMS such as Medicare Advantage or a Medicare Medicaid

Plan(MMP), Medicaid Managed Care is not included and is separate from Medicare as defined herein, Medicaid Managed Care means the Medicaid, Childrens Health Insurance Plans, or other joint state and federal authorized under Title XIX of the Social Security Act, and Commercial means a Coverage Agreement offered by BCBS that is not Retail, Medicare, or Medicaid Managed Care.

2.2.0.0 **Provider Networks Added by Mutual Agreement.** Provider Network(s), which may or may not include new compensation or rates by BCBS, may be added to Attachment A of this Agreement pursuant to a mutually agreed-upon written amendment to this Agreement or as otherwise permitted in this Agreement.

2.2.0.1 **Provider Networks Added by Notice.** Ancillary Provider agrees that BCBS may by thirty (30) days prior Written Notice add Ancillary Provider to any Provider Network(s) under the following parameters:

2.2.0.1.0 **HMO.** Ancillary Provider may be added to any HMO Provider Networks under the same terms and conditions of this Agreement, including, but not limited to, compensation, applicable to a HMO Provider Network that includes Ancillary Provider as a Participating Provider (“Existing HMO Provider Network”), provided the HMO Provider Network added and the Existing HMO Provider Network are either both Retail, both Medicare, both Medicaid Managed Care, or both Commercial. Notwithstanding the foregoing, Ancillary Provider may be added to any HMO Provider Network under the terms and conditions of a Commercial HMO Provider Network agreement.

2.2.0.1.1 **PPO.** Ancillary Provider may be added to any PPO Provider Networks under the same terms and conditions of this Agreement, including, but not limited to, compensation, applicable to a PPO Provider Network that includes Ancillary Provider as a Participating Provider (“Existing PPO Provider Network”), provided the PPO Provider Network added and the Existing PPO Provider Network are either both Retail, both Medicare, both Medicaid Managed Care, or both Commercial. Notwithstanding the foregoing, Ancillary Provider may be added to any PPO Provider Network under the terms and conditions of a Commercial PPO Provider Network agreement.

2.2.0.1.2 **EPO.** Ancillary Provider may be added to any EPO Provider Networks under the same terms and conditions of this Agreement, including, but not limited to, compensation, applicable to the Blue High Performance Provider Network.

2.2.0.1.3 **Termination of Provider Networks Added by Notice.** Ancillary Provider may terminate its participation in any Provider Network(s) that are added by Written Notice as allowed above within thirty (30) days of receiving the Written Notice from BCBS. After such thirty (30) days, Ancillary Provider may terminate any Provider Networks added by Written Notice under the terms and conditions of this Agreement.

2.3 **BCBS Policies and Procedures.** Ancillary Provider will comply with all Policies and Procedures which are hereby incorporated, and made a part of, this Agreement. Electronic access to the Policies and Procedures will be provided to Ancillary Provider. The Policies and Procedures are subject to change at any time, including, but not limited to, all BCBS medical policies. In the event of a conflict between the terms of this Agreement and the terms of the Policies and Procedures, the terms of this Agreement will govern.

- 2.3.0 **Material Modifications to BCBS Policies and Procedures.** BCBS will notify Ancillary Provider of proposed changes to the Policies and Procedures that would materially affect Ancillary Provider. Ancillary Provider is materially affected by a proposed change to the Policies and Procedures if the adoption makes Ancillary Provider's performance of its obligations under this Agreement substantially more burdensome, affects compensation or affects Health Care Service delivery. Such Notice will be given at least ninety (90) calendar days before the effective date of the material change. Ancillary Provider may terminate the Agreement for those Provider Networks affected by the material change by Notice within thirty (30) days of the notification, with such termination to be effective on the implementation date of the material change. After thirty (30) days from the notification, Ancillary Provider will be bound by the changed Policies and Procedures after the effective date of those changes or may terminate this Agreement as allowed herein. Ancillary Provider agrees that changes to the Policies and Procedures do not constitute modification of this Agreement. Copies of the Policies and Procedures, and any other pertinent documents that are necessary for the performance of this Agreement shall be provided to and be available for examination by Ancillary Provider upon reasonable request. In the event BCBS utilizes third party software, BCBS shall supply name, edition, and model version of the software. For purposes of this paragraph, Policies and Procedures that would materially affect Ancillary Provider are Policies and Procedures that affect the payment of specific Claims submitted by or on behalf of Ancillary Provider, including recoupment. Ancillary Provider may consult the BCBS web site for further information and instructions concerning information available to Ancillary Provider.
- 2.4 **Cooperation.** Ancillary Provider will cooperate with BCBS in facilitating cost-effective, quality-driven Covered Services for Covered Persons, including, but not limited to, cooperation and participation in programs such as pre-admission testing, pre-service review, and generic drug substitution. Ancillary Provider will make commercially reasonable efforts to do business with BCBS electronically when such electronic business opportunity is made available by BCBS, or its Designee, including electronically checking eligibility status and Claims status, receiving Electronic Remittance Advices, Provider Remittance Advice or Provider Claims Summary documents (or their equivalent), and submitting requests for Claims adjustments for Covered Persons. Ancillary Provider will use commercially reasonable efforts to use BCBS's website, as applicable, for additional functionalities (such as notification of admission) after BCBS notifies Ancillary Provider that such functionalities are available for the applicable Covered Person.
- 2.5 **Medical and Financial Records.**
- 2.5.0 **Medical Records.** Ancillary Provider will establish and maintain an accurate electronic medical record for each Covered Person with whom Ancillary Provider has had an encounter that, at a minimum, will (i) include such information about the Covered Person and a description of all services rendered to the Covered Person as dictated by generally accepted practices and standards, (ii) be maintained for the period of time required by Laws, and (iii) be established and maintained in all instances as required by the Policies and Procedures ("Medical Records"). Ancillary Provider and each Provider will ensure that a Covered Person's Medical Records are legible, complete, dated, timed, and authenticated.
- 2.5.1 **Financial Records.** Ancillary Provider will maintain accurate financial books and records, including electronic records, concerning Covered Services provided to each Covered Person, including any charges to, and payments received from, the Covered Person by Ancillary Provider ("Financial Records").
- 2.6 **Use of Participating Providers.** Facility acknowledges and agrees that it is in the best interest of Covered Persons to utilize Facilities where all billing Providers contract with BCBS. With respect to any facility-based Provider who provides Covered Services to Covered Persons at Facility,

Facility shall use best efforts to require that the facility-based Providers obtain and/or maintain status as a Participating Provider with BCBS. Facility-based Providers include, but are not limited to, radiologists, pathologists, emergency room physicians, anesthesiologists, and neonatologists. Additionally, Facility will, except in instances of Emergency Care:

- 2.6.0 Notify Covered Person of the possibility that some Covered Services may be provided by out-of-network Providers, and that the Covered Person may contact BCBS for more information; and
- 2.6.1 Notify BCBS in advance of the procedures scheduled.
- 2.7 **BCBS Insurance Cards.** Ancillary Provider will use reasonable efforts to cross-reference the applicable Covered Person's BCBS insurance card with his or her driver's license, passport or State identification card, or other acceptable form of identification, and, if necessary, contact BCBS to confirm that the person presenting the BCBS insurance card is the Covered Person listed on the insurance card. Ancillary Provider will verify the identity, eligibility and coverage of each Covered Person prior to furnishing Covered Services to such Covered Person and from time to time throughout the course of such Covered Person's treatment. If Ancillary Provider does not verify the identity, eligibility and coverage of the Covered Person, Ancillary Provider agrees that the Claim may be denied by BCBS. If BCBS makes an Erroneous Payment under this Section, Ancillary Provider agrees that BCBS is entitled to recovery of such Erroneous Payment.
- 2.8 **Collection of Cost Share.** Ancillary Provider agrees to diligently pursue and collect from Covered Persons all applicable Cost Share amounts at the time and in the manner described in the applicable Coverage Agreement and in accordance with the Policies and Procedures. In no event will Ancillary Provider offer, advertise or otherwise publicize any waiver or other reduction of any Cost Share amount.
- 2.9 **Coordination of Benefits ("COB").** Ancillary Provider agrees to cooperate with BCBS in the coordination of benefits, to make inquiries regarding, and provide relevant information to BCBS relating to, any other coverage held by the Covered Person, and to abide by the COB, subrogation, and duplicate coverage policies, procedures, and rules of BCBS as set forth in the Policies and Procedures, Coverage Agreement, and this Agreement. Ancillary Provider will report to BCBS any fact of which it or its agents have knowledge which indicates that the condition requiring Health Care Services from Ancillary Provider 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 Covered Person has other insurance in effect which may provide health care benefits. Primary and non-primary responsibility will be determined based on the Coverage Agreement and the other coverage held by the Covered Person.
  - 2.9.0 **Primary Responsibility.** Payment for Covered Services for which a Coverage Agreement has primary coverage responsibility under COB will be limited to that amount due Ancillary Provider, if any, which, when added to Cost Share and COB amounts, equal one hundred percent (100%) of the amounts to be paid to Ancillary Provider pursuant to this Agreement in the absence of COB.
  - 2.9.1 **Non-Primary Responsibility.** Payment for Covered Services for which a Coverage Agreement has other than primary liability under coordination of benefit provisions will be determined by the Coverage Agreement's requirements and Law.
- 2.10 **Covered Person Hold Harmless.**

- 2.10.0 **Covered Person Hold Harmless.** Ancillary Provider agrees that in no event, including but not limited to nonpayment by BCBS, insolvency of BCBS, or breach of this Agreement, shall Ancillary Provider bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse against a Covered Person to whom Health Care Services have been provided, or person acting on behalf of the Covered Person for Health Care Services provided pursuant to this Agreement. This provision shall not prohibit collection by Ancillary Provider of any outstanding Cost Share which are inclusive of applicable gross receipts taxes in accordance with the terms of the applicable Covered Agreement or collection of payment for Non-Covered Services from the Covered Person. Remaining balances shall be treated as contractual adjustments by Ancillary Provider and shall not be billed to the Covered Person.

Ancillary Provider and any sub-contractors of the Ancillary Provider further agree that (1) this provision shall be applicable to all dates of service prior to termination of this Agreement, (2) this provision supersedes any oral or written agreement now existing or hereafter entered into between Ancillary Provider and any Covered Person or person acting on his behalf, and (3) the above shall survive the termination of the Agreement regardless of the reason for the termination, including the insolvency of BCBS.

- 2.10.1 **Charges for Non-Covered Services.** The provisions of this Section do not prohibit Ancillary Provider from collecting charges from a Covered Person for Non-Covered Services, so long as Ancillary Provider obtains written consent from such Covered Person or such Covered Person's legal representative or designee, in advance of providing the Health Care Services, on a Non-Covered Service waiver form containing an acknowledgment from the Covered Person that (1) the Health Care Services are Non-Covered Services, (2) BCBS will not be responsible for payment of such Non-Covered Services, and (3) the Covered Person will be financially responsible to the Ancillary Provider for such Non-Covered Services. Notwithstanding the foregoing, (i) Health Care Services which are not separately reimbursable by BCBS due to bundling or other Claim edits may not be billed to or collected from Covered Persons, even if the Covered Person has agreed in writing to be responsible for paying any of the charges for such Health Care Services as such Health Care Services are Covered Services, but are not separately payable by BCBS; and (ii) Health Care Services which require Preauthorization, but for which the Ancillary Provider or Covered Person did not obtain such required Preauthorization, as further described in Section 2.13.1, may not be billed to or collected from Covered Persons, even if the Covered Person has agreed in writing to be responsible for paying any of the charges for such Health Care Services. Such Health Care Services are Covered Services, but are not separately payable by BCBS.

- 2.10.2 **Amounts in Excess of Cost-Sharing.** Ancillary Provider may not charge Covered Persons any amounts in excess of the applicable Cost Sharing for Covered Services, including any access fees for "concierge" services or any other additional charges as a condition of accessing Ancillary Provider's services.

- 2.10.3 **Survival.** This Section 2.10 shall survive termination of this Agreement for any and all Health Care Services rendered prior to such termination, regardless of the cause of such termination.

- 2.11 **Insurance.** At all times during the Term of this Agreement and for at least two (2) years after termination of this Agreement, Ancillary Provider will obtain and maintain the following insurance coverages for itself, its Providers, Designees, agents, and employees:

2.11.0 **Coverages.**

- 2.11.0.0 **Medical Malpractice Insurance.** Ancillary Provider, at its sole expense, agrees to maintain insurance coverage for professional liability risk in minimum

amounts as required by BCBS Policies and Procedures at all times while this Agreement is in effect. In the event Ancillary Provider's liability coverage is through a self-funded arrangement, Ancillary Provider must provide coverage certificates and attestations requested by BCBS for such self-funding arrangement to be accepted by BCBS's credentialing committee.

2.11.0.1 **Commercial General Liability.** Ancillary Provider, at its sole expense, agrees to maintain insurance coverage for commercial general liability risk with limits of not less than one million dollars (\$1,000,000.00) per occurrence for bodily injury, personal injury and property damage. General liability insurance will be on Insurance Services Office ("ISO") form or equivalent and include operations, contractual liability and personal injury. The limits of such insurance may be satisfied with umbrella policies. Policy will name HCSC and its shareholders, directors, officers, employees, representatives and agents as additional insureds. The policy will be primary and non-contributing to any insurance carried by HCSC and will contain a waiver of subrogation and rights of recovery in favor of HCSC.

2.11.0.2 **Government Agency or Political Subdivision.** If Ancillary Provider is an agency or political subdivision of the federal or state government (as defined under a state Governmental Tort Claims Act or the Federal Tort Claims Act) and provided evidence of that fact satisfactorily to BCBS, Ancillary Provider will not have to provide the required liability insurance coverage. However, Facility must demonstrate that it carries professional liability and comprehensive general insurance sufficient to cover any claims for which it can be liable under Law. Should Ancillary Provider's status as an agency or political subdivision of the federal or state government change during the Term of this Agreement, Ancillary Provider must provide Notice to BCBS in writing and provide, within thirty (30) days of such change, evidence that Ancillary Provider has obtained the required liability insurance coverage.

2.11.1 **Termination for Loss of Insurance Coverage.** Failure to maintain any of the insurance coverages required in accordance with this Section will be grounds for termination of this Agreement. Ancillary Provider will indemnify BCBS for any loss incurred as a result of Ancillary Provider's failure to maintain such coverage, which obligation to indemnify will survive the termination of this Agreement.

2.11.2 **Survival.** This Section 2.11 shall survive termination of this Agreement for a period of two (2) years from the date of termination.

2.12 **Insurance Specifications and Requirements.** The following specifications and requirements will be conditions for all insurance identified in Section 2.11:

2.12.0 **Responsibility for Deductibles and Self-Insurance.** Ancillary Provider will be responsible for its own deductibles and self-insurance retentions, and such costs will not be the responsibility or liability of BCBS.

2.12.1 **Certificates of Insurance and Cancellation.** Ancillary Provider will furnish, or cause to be furnished, certificates of insurance, Association for Cooperative Operations Research and Development form or equivalent, evidencing the required coverages. Ancillary Provider will also furnish renewal certificates to BCBS within fifteen (15) calendar days prior to each renewal period and upon reasonable request of BCBS. Further, Ancillary Provider will provide BCBS with Written Notice at least fifteen (15) calendar days in advance of any cancellation, in whole or in part, non-renewal, or any material change in the terms of any such policy. Receipt of each certificate of insurance or other documentation of insurance by BCBS or by any of its representatives which indicate less

coverage than required will not constitute a waiver of Ancillary Provider's obligations to fulfill the insurance requirements. Ancillary Provider is solely responsible for obtaining and paying for any additional insurance or any increase of limits of liability not described above which are required by Law.

2.12.2 **No Limitation of Liability, Surplus and Reserves.** Nothing contained in Section 2.11 or this Section as it relates to Ancillary Provider will be construed in any way to limit the extent of Ancillary Provider's responsibility, liability or payment of monies or damages under any other provision in this Agreement. Ancillary Provider waives rights of subrogation and rights of recovery and will not seek contribution from BCBS under any circumstance. Ancillary Provider will maintain monetary resources to ensure Ancillary Provider's ability to meet its obligations under this Agreement and to comply with Law.

2.12.3 **Survival.** This Section 2.12 shall survive termination of this Agreement.

## 2.13 **Utilization Management and Quality Improvement.**

2.13.0 **Utilization Management.** Ancillary Provider will cooperate, participate and comply with all required Utilization Management, medical management, and quality improvement activities of BCBS, or ASO Groups, related to Covered Services, including, but not limited to, Utilization Management processes required by BCBS or its designee, ASO Groups, Blue Cross and/or Blue Shield Plans, BCBSA, BCBS's related managed care programs, or Law. The BCBS Utilization Management program may consist of various review methodologies, including but not limited to, case management, review of referrals, internal peer review, and prospective, concurrent, and retrospective review. Ancillary Provider acknowledges and agrees that BCBS's Utilization Management and quality improvement activities may change from time to time in the sole discretion of BCBS upon prior Notice to Ancillary Provider. Ancillary Provider acknowledges and agrees that Claims may not be reimbursed by BCBS if Utilization Management requirements are not followed by Ancillary Provider, and Ancillary Provider may not balance bill the Covered Person if such Claims are not reimbursed by BCBS. Ancillary Provider also agrees to provide all Medical Records required for Utilization Management, medical management, and quality improvement activities of BCBS, or ASO Groups, or their Designees, at no charge.

2.13.1 **Preauthorization.** Except for Emergency Services or where not required by the Policies and Procedures, Ancillary Provider must obtain Preauthorization for Covered Services in accordance with the Policies and Procedures before providing Covered Services to Covered Persons. Except where not permitted by Laws, BCBS may apply a Penalty or deny payment for Covered Services where the Ancillary Provider fails to meet BCBS's requirements for Preauthorization. Ancillary Provider may not bill or collect payment from a Covered Person for any Penalty applied by BCBS or any amounts denied or not paid under this Agreement due to Ancillary Provider's failure to comply with BCBS's Preauthorization requirements. (See also, "Hold Harmless" under Article II). This obligation to refrain from billing a Covered Person applies even in those instances in which Ancillary Provider believes that BCBS has made an incorrect determination. Preauthorization of Covered Services does not constitute a guarantee of payment to Ancillary Provider. BCBS may not use retrospective review to deny, reduce or delay payment on the basis that the Health Care Service was not Medically Necessary for Health Care Services that were preauthorized as Covered Services unless such retrospective review causes BCBS to conclude that such Preauthorization was based upon: (i) clinical findings in the medical record that vary materially from the clinical findings communicated to BCBS by Ancillary Provider, (ii) a proposed course of treatment that varied materially from the actual Health Care Services rendered by Ancillary Provider, (iii) a material misrepresentation or omission by Ancillary Provider, or (iv)

otherwise erroneous information obtained from Facility that informed or impacted the Preauthorization.

2.13.2 **Proper Referral and Preauthorization.** For POS, HMO or other Coverage Agreements requiring the selection of a PCP, Covered Services must generally be provided by Covered Persons' PCPs or obtained through a network of Participating Providers with a Proper Referral and with a Preauthorization where required. For PPO, EPO or other Coverage Agreements not requiring the selection of a PCP, Covered Persons must follow the requirements set forth in their Coverage Agreement; generally, in-network benefits are available when Covered Persons use network Participating Providers with proper Preauthorizations as applicable.

2.13.2.0 **Proper Referral Procedures.** Ancillary Provider will comply with all Proper Referral procedures set forth in this Agreement and the Policies and Procedures. Ancillary Provider will provide Covered Services to Covered Persons whose Coverage Agreement requires the selection of a Primary Care Physician only upon a Proper Referral, as applicable, except in cases requiring Emergency Care, Ancillary Provider will discuss with and seek approval from the referring Participating Provider prior to rendering or arranging any continuing treatment which is beyond the specific treatment described in the Proper Referral. In addition, Ancillary Provider will not refer a Covered Person to another physician or Provider without the prior concurrence of the Covered Person's Primary Care Physician except in cases of Emergency Care or when, with the concurrence of the Medical Director, no such Participating Providers are available.

2.13.2.1 **Preauthorization.** Ancillary Provider will comply with all Preauthorization requirements set forth in this Agreement and the Policies and Procedures. Ancillary Provider will provide Covered Services to Covered Persons only upon a proper Preauthorization, as applicable, except in cases requiring Emergency Care.

2.13.2.2 **Ancillary Provider Responsibility.** Costs of Health Care Services rendered without a Proper Referral or Preauthorization where required will be the financial responsibility of Ancillary Provider. The involvement of BCBS or other administrator of any Product and/or the applicable UM Agent in decisions relating to the coverage of Health Care Services rendered to Covered Persons under these managed care Plans will not diminish the ultimate and sole responsibility of Ancillary Provider for and professional authority over Ancillary Provider's professional practice with respect to the care of such Covered Persons.

2.13.2.3 **No Guarantee of Payment.** Subject to the procedures contained in the Policies and Procedures, Preauthorization is not an assurance or guarantee of payment; however, BCBS will not deny a Claim for Preauthorized services on the basis that they were not Medically Necessary, unless Ancillary Provider has materially misrepresented the proposed services or the Covered Person's condition. BCBS may deny a Claim for a Preauthorized service when Ancillary Provider has substantially failed to perform the proposed Health Care Services.

2.14 **Third-Party Payment Assistance.** BCBS allows premium payments or Cost Share assistance for Covered Persons only from (1) Covered Persons and their families; (2) required third-party entities identified in 45 C.F.R. § 156.1250, as it may be amended from time to time, and (3) not-for-profit foundations whose payment assistance programs (i) meet certain nondiscrimination and full coverage period commitment, and other related criteria, as outlined under federal regulatory guidance and determined by BCBS in its sole discretion, and (ii) make premium or Cost-Share

assistance available to a Covered Person (a) regardless of the Covered Person's health status, and (b) for the entire coverage period of the Covered Person's Coverage Agreement. BCBS does not accept payments from other third-party entities, including, but not limited to, Ancillary Provider or other Providers.

2.14.0 **Violations.** Payments for premiums made by a third-party in violation of this Section may not be credited by BCBS to a Covered Person's BCBS account, and, in the event Ancillary Provider makes, requires, or cooperates in the making of requests, or instructs the making of payments to cover a Covered Person's premium or Cost Share in violation of Section 2.14, BCBS may terminate this Agreement immediately upon providing Written Notice. In the case that Ancillary Provider makes unauthorized premium payments, BCBS may non-renew, cancel or terminate the Covered Person's Coverage Agreement where permitted under the terms of such Coverage Agreement.

2.14.1 **Offsets.** If BCBS discovers that any premium payments were provided directly by, or at the request of, or instruction from, Ancillary Provider or by a Provider with the knowledge of Ancillary Provider, on behalf of any Covered Person in violation of this Section, BCBS may also apply a Penalty under this Agreement equal to the amount of such premium assistance.

2.14.2 **Survival.** This Section 2.14 shall survive termination of this Agreement.

## 2.15 **Third-Party Responsibility and Waiver of Benefits Under Coverage Agreement.**

2.15.0 **Payment in Full.** Ancillary Provider will submit to BCBS all Claims for Covered Services rendered to Covered Persons, whether or not the costs for such Claims may be the responsibility of a third-party, such as an auto carrier or workers' compensation insurer or where there is a third-party lien and other liability. When Ancillary Provider submits a Claim to BCBS seeking payment under the terms of this Agreement, all terms are applicable, and Ancillary Provider will accept BCBS reimbursement as full and final payment for Health Care Services rendered, excluding any applicable Cost Share. If it is later determined that another person or entity is liable to the Covered Persons, Ancillary Provider may not refund the payment to BCBS and seek reimbursement from the liable person or entity. Notwithstanding the above, Ancillary Provider will cooperate with BCBS in the collection on BCBS's behalf of third-party payments including workers' compensation, third-party liens and other third-party liability according to the procedures set forth in the Policies and Procedures.

2.15.1 **Third-Party Billing and Covered Person Waivers.** Notwithstanding the foregoing, as the sole exception to the terms of this Section, if a Covered Person requests that Ancillary Provider seek payment from the Covered Persons, or one or more third-parties (collectively, "Third-Party") only and not from BCBS, Ancillary Provider may honor the Covered Person's request and bill the Third-Party for the Covered Services. For any Claim where Ancillary Provider honors a Covered Person's request for Ancillary Provider to bill a Third-Party for Covered Services, Ancillary Provider agrees that it waives any right to seek any payment for such Covered Services from BCBS or the Covered Person.

2.15.2 **No Impact on Claims Related Policies or COB.** Nothing in this Section changes, waives or amends any BCBS policies or procedures relating to Claims, Claim submission to BCBS (including, but not limited to, format and timely filing requirements) or subrogation, and all Policies and Procedures remain in force and effect. These third-party billing and waiver requirements do not affect in any way COB where the Covered Person has health benefit coverage under more than one policy or Plan.

2.15.3 **Survival.** This Section 2.15 shall survive termination of this Agreement.

- 2.16 **Communication of Treatment Options.** The Parties agree that BCBS does not provide medical treatment or Health Care Services to Covered Persons. Ancillary Provider agrees that BCBS does not dictate or direct Ancillary Provider in the practice of medicine, nor the exercise of medical judgment, nor making Health Care Service treatment decisions. Ancillary Provider acknowledges and agrees that BCBS decisions, policies, and procedures regarding the provision of Covered Services to Covered Persons apply solely to Ancillary Provider's right to payment, and will not be construed as interference with, direction of, or substitution for the professional judgment of Providers, staff and employees in the provision of Health Care Services. Nothing contained in this Agreement is intended to prohibit or discourage Ancillary Provider from discussing with or communicating in good faith to a current, prospective, or former patient, or patient's legal representative or designee, information or opinions regarding (1) the patient's health care, including but not limited to the patient's medical condition or treatment options, including alternative medications or medication treatment options, regardless of BCBS coverage limitations, or (2) the Policies and Procedures.
- 2.17 **Representations and Warranties.** Ancillary Provider hereby represents and warrants to BCBS that at all times during the Term of this Agreement the statements set forth below in this Section are true. Ancillary Provider will provide BCBS with immediate Notice via email and Written Notice upon any occurrence that contravenes any of its representations and warranties under this Section, and agrees that any such change is grounds for immediate termination of this Agreement with Written Notice to Ancillary Provider by BCBS. Ancillary Provider further acknowledges and agrees that any misrepresentation of Ancillary Provider's status or any change in Ancillary Provider's status at any time during the Term of this Agreement may be grounds for immediate termination of this Agreement by BCBS at the sole discretion of BCBS:
- 2.17.0 Ancillary Provider is in compliance with Laws;
  - 2.17.1 Ancillary Provider will maintain all requisite licenses, certifications, registrations, credentials and/or accreditations required by Laws or this Agreement;
  - 2.17.2 Within the three (3) year period preceding the Effective Date of this Agreement, Ancillary Provider has not had any public transactions (federal, state, or local) terminated for cause or default;
  - 2.17.3 Within the three (3) year period preceding the Effective Date of this Agreement, Ancillary Provider has not been charged with a criminal offense in connection with obtaining, or attempting to obtain, or performing of a public (federal, state, or local) contract or subcontract;
  - 2.17.4 Ancillary Provider meets, at a minimum, or exceeds all current BCBS participation and Credentialing and Recredentialing criteria as set forth in the applicable Policies and Procedures;
  - 2.17.5 Ancillary Provider has the authority to, and will, bind all Ancillary Provider employees and Designees to the terms and conditions of this Agreement;
  - 2.17.6 Ancillary Provider has given no commissions, payments, rebates, kickbacks, or other unauthorized inducements to any employee or agent of BCBS in connection with this Agreement;
  - 2.17.7 Ancillary Provider has not given any commissions, payments, rebates, kickbacks, or other unauthorized inducements to any Provider in connection with Covered Services performed or rendered at Ancillary Provider;

- 2.17.8 Neither Ancillary Provider, nor any Ancillary Provider employees or Designees, are knowingly involved in any illegal activities, or any activity that would reasonably create the appearance that it is illegal;
- 2.17.9 Ancillary Provider will only submit Claims for Covered Services provided to Covered Persons by Ancillary Provider;
- 2.17.10 Neither Ancillary Provider, nor its employees, or Designees have been (i) charged with a criminal offense involving any State or Federal government programs, including, but not limited to, Medicare and Medicaid, or (ii) proposed for Debarment or suspended from State or Federal government programs, including, but not limited to, Medicare or Medicaid; and
- 2.17.11 Neither Ancillary Provider, nor its employees or Designees, have been convicted of or had a civil judgment rendered against it regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property.

2.18 **Notices.**

- 2.18.0 **Change in Information.** Ancillary Provider will provide Notice to BCBS at least thirty (30) calendar days in advance of a change in Ancillary Provider's business address, telephone numbers, hours of operations, tax identification number, billing information, or the scope of services provided by Ancillary Provider.
- 2.18.1 **Notification Regarding Covered Persons.** Ancillary Provider will promptly provide BCBS with Written Notice if it becomes aware that a Covered Person:
  - 2.18.1.0 has any insurance coverage which differs from health coverage information provided by BCBS to Ancillary Provider;
  - 2.18.1.1 has committed acts of physical or verbal abuse that pose a threat to Ancillary Provider's staff or another Covered Person; or,
  - 2.18.1.2 has allowed another individual to use the Covered Person's insurance identification card to obtain Health Care Services.
- 2.18.2 **Hospital-Based Physician Group.** Ancillary Provider will notify BCBS as soon as reasonably practicable, but not later than the fifth (5th) business day following the termination of a contract between Ancillary Provider and a Ancillary Provider-Based Physician Group that is a Participating Provider. For purposes of this Section, a Ancillary Provider-Based Physician Group is a physician group consisting in whole or part of anesthesiologists, pathologists, radiologists, an emergency department physician, or neonatologists to whom a Ancillary Provider has granted clinical privileges and whose physicians provide Health Care Services to patients of the Ancillary Provider under those clinical privileges.
- 2.18.3 **Placement of Staff in Offsite Locations.** Placement of staff in offsite Locations. Ancillary Provider will provide thirty (30) days Written Notice to BCBS prior to placement of individuals in physician or other provider locations, whether as direct employees or under another arrangement, that will be responsible for direction of specimens, images, or tests of any type that may be sent to Ancillary Provider. For avoidance of doubt, staff responsibility for the direction of specimens includes any act in directing the specimen

even if Ancillary Provider has an agreement with the physician or other provider that the physician is responsible. Placement includes not only direct employment arrangements but also agreements whereby Ancillary Provider contributes in any way to the staffing for the physician or other provider.

**2.18.4 Change in Ancillary Provider's Status.** Ancillary Provider will give Written Notice to BCBS within five (5) business days after Ancillary Provider learns of any of the following:

2.18.4.0 Ancillary Provider's or any Ancillary Provider employees' or Designees' applicable license or certification or registration to provide Health Care Services or Drug Enforcement Agency registration or accreditation is suspended, revoked, terminated or subject to terms of probation or other restriction (whether or not such action is stayed);

2.18.4.1 Ancillary Provider or any Ancillary Provider employee or Designee, becomes the subject of any disciplinary proceeding, Debarment or action before an applicable governmental supervisory board or agency in any state, or the inclusion of Ancillary Provider or any Ancillary Provider employee or Designee in the OFAC/OIG/GSA/OPM list;

2.18.4.2 Ancillary Provider or any Ancillary Provider employee or Designee, is charged with or indicted for, or convicted of, fraud or a felony, such as regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property;

2.18.4.3 An act of nature or any event occurs which substantially interrupts all or a portion of Ancillary Provider's business or practice or which has a materially adverse effect on Ancillary Provider's ability to perform Ancillary Provider's obligations under this Agreement;

2.18.4.4 Ancillary Provider learns of any malpractice action or other lawsuit, arbitration, or other legal action brought against Ancillary Provider or any Ancillary Provider employee or Designee, or becomes aware of a malpractice judgment or settlement against Ancillary Provider or any Ancillary Provider employee or Designee; and/or;

2.18.4.5 Any other occurrence or situation that could reasonably be expected to materially affect the ability of Ancillary Provider to carry out Ancillary Provider's obligations under this Agreement or, if true, could subject Covered Persons to potential harm.

**2.18.5 Change in Operations.** Ancillary Provider will give one hundred and eighty (180) days Written Notice to BCBS prior to a Substantial Change in Operations. For purposes of this provision, a "Substantial Change in Operations" shall mean any change in Ancillary Provider's operations that could be anticipated to result in a shift in Ancillary Provider's volume of Covered Services of more than ten percent (10%) or where a primary service accounts for less than fifteen percent (15%) of Ancillary Provider's billing volume (e.g., a hospital having less than 10% of billings attributable to inpatient services or a long term care facility operating with a minimal number of beds).

**2.19 Appeals and Grievances.**

2.19.0 **Appeals and Grievance Procedures.** Ancillary Provider will cooperate with BCBS's Policies and Procedures related to the appeals and grievance process, including, but not limited to, furnishing all relevant information to BCBS, in resolving any grievance or appeal related to the provision of Health Care Services furnished to Covered Persons under this Agreement. Ancillary Provider will forward to BCBS any Medical Records related to any grievance or appeal at Ancillary Provider's expense within ten (10) days of BCBS's request unless a grievance or appeal is expedited, in which case Ancillary Provider will immediately provide the Medical Records to BCBS. Ancillary Provider will comply and cooperate with BCBS's adjudication process for any grievance or appeal. Any Covered Person complaints or grievances received by Ancillary Provider related to BCBS will be forwarded to BCBS within ten (10) days of Ancillary Provider's receipt of such complaint(s) or grievance(s). Prior to initiating any dispute under Article VI related to either whether a Health Care Service provided by Ancillary Provider is a Covered Service or the amount of compensation due Ancillary Provider under this Agreement for providing a Covered Service, Ancillary Provider must exhaust any applicable BCBS internal appeal process as set forth in Policies and Procedures or as otherwise communicated by BCBS to Ancillary Provider.

2.20 **Audit/Access to Records.**

2.20.0 **Access to Records.** Subject to compliance with Law regarding the confidentiality of Medical Records, and at no charge to BCBS, Ancillary Provider will:

2.20.0.0 Provide BCBS, its designee, or any applicable regulatory agency responsible for oversight of BCBS or Ancillary Provider, upon request, copies of records related to Health Care Services provided to Covered Persons that are in the custody of Ancillary Provider; and,

2.20.0.1 Upon three (3) business days' advance Notice or such shorter Notice as may be required by the circumstances or by Law, allow BCBS, its designee, or any applicable regulatory agency responsible for oversight of BCBS or Ancillary Provider to inspect and copy Medical Records on Ancillary Provider's premises during regular business hours; and

2.20.0.2 Allow BCBS to conduct any coding or Claim audit during reasonable business hours; and

2.20.0.3 Transmit information from Covered Persons' Medical Records, including by telephone, to BCBS, its designee, or any applicable regulatory agency responsible for oversight of BCBS or Ancillary Provider for purposes of Preauthorization or other Utilization Management or quality improvement activities; and

2.20.0.4 Provide copies of a Covered Person's Medical Records, upon reasonable request, to any other Provider treating such Covered Person.

2.20.1 **Access to Records.** BCBS's review of records under this Section may be undertaken to, among other things, verify BCBS's reimbursement was made in accordance with the provisions of this Agreement, comply with Medical Loss Ratio ("MLR") reporting requirements, verify that Health Care Services provided by Ancillary Provider were Medically Necessary, and identify cases for potential COB, workers' compensation, and other third-party liability.

2.20.2 **Regulatory Compliance.** Ancillary Provider will maintain and provide access to such Medical and Financial Records to BCBS or any applicable regulatory agency with

oversight of BCBS or Ancillary Provider, as may be necessary for compliance by BCBS with Law during the Term of this Agreement and for a period of at least ten (10) years after termination of this Agreement. All records, books and papers of Ancillary Provider pertaining to Covered Services provided to Covered Persons will be open to inspection during regular business hours by BCBS and by state and federal authorities at no charge to BCBS.

2.20.3 **Survival.** This Section 2.20 shall survive termination of this Agreement.

2.21 **Serious Reportable Events and Hospital Acquired Conditions.** Ancillary Provider agrees that BCBS may apply the CMS standards for Serious Reportable Events and Hospital Acquired Conditions (“HAC”) to Ancillary Provider. BCBS will not be liable to pay any amount to Ancillary Provider for a Claim for Health Care Services arising from or related to HACs or Serious Reportable Events.

2.21.0 **Violations.** If Ancillary Provider bills BCBS on a Claim for Health Care Services arising out of, or relating to, Serious Reportable Events or HACs, BCBS reserves the right to adjust the Claims to disallow charges arising from or relating to the Serious Reportable Event or HAC. Ancillary Provider agrees never to bill, or balance bill a Covered Person for costs associated with Health Care Services arising out of, or relating to, Serious Reportable Event or HACs. In the event BCBS incurs Claims costs for Covered Services provided by other Providers that are related to HACs or Serious Reportable Events for which Ancillary Provider is responsible, then Ancillary Provider must reimburse BCBS for such costs and BCBS may deduct such Claims costs from amounts otherwise due Facility under this Agreement.

2.21.1 **Present on Admission.** Ancillary Provider will populate the Present on Admission (“POA”) indicator on all Claims, including Clean Claims, where a Covered Person presented to Ancillary Provider with a condition or circumstance appearing to arise from or be related to a Serious Reportable Event or HAC. Failure to populate the POA indicator may result in Claim adjustments by BCBS to disallow charges for Serious Reportable Events or HACs.

### **ARTICLE III OBLIGATIONS OF BCBS**

3.0 **Compensation.** For Covered Services provided to Covered Persons that meet the standards for payment under this Agreement, BCBS will make payment to Ancillary Provider in the amounts set forth in this Agreement, minus any applicable Cost Share and COB, as full reimbursement for Ancillary Provider arranging and providing Covered Services to Covered Persons. BCBS may make adjustments to amounts previously paid to Provider consistent with the terms of this Agreement. BCBS will not pay for Non-Covered Services.

3.1 **Applicability of Agreement.**

3.1.0 **ASO Groups.** With respect to Covered Services provided by Ancillary Provider to an ASO Group’s Covered Persons, Ancillary Provider acknowledges and agrees that payment for Covered Services will be made solely from funds received by BCBS from the ASO Group, and Ancillary Provider acknowledges and agrees that BCBS has no liability for the financial capacity of such ASO Group to satisfy Ancillary Provider’s Claims. Ancillary Provider acknowledges that BCBS’s sole function relative to such a Coverage Agreement and Product will be to provide administrative services as agreed upon by BCBS and the applicable ASO Group. The ASO Groups, and not BCBS, have sole financial responsibility for all Covered Services provided to ASO Groups’ Covered Persons.

- 3.1.1 **BlueCard.** Ancillary Provider acknowledges and agrees that, pursuant to BCBS's BlueCard Program, Ancillary Provider will provide Covered Services to Covered Persons under the BlueCard Program while such Covered Persons are in the BCBS Service Area subject to the same terms and conditions of this Agreement as are applicable to the provision of Covered Services to other Covered Persons and subject to the BlueCard Program requirements set forth in the Provider Manual.
- 3.2 **Covered Person Identification.** BCBS or the Covered Person's ASO Group, as applicable, will provide appropriate insurance card identification to Covered Persons identifying them as Covered Persons under Coverage Agreements. BCBS will make available to Ancillary Provider electronic eligibility information regarding Covered Persons.
- 3.3 **Credentialing.** With Ancillary Provider's cooperation in accordance with Ancillary Provider's responsibility under Section 2.0.1, BCBS or its delegate will maintain Credentialing and Recredentialing and peer review processes for determining the eligibility of Ancillary Provider to participate in BCBS's network. BCBS will Credential and Recredential and review the qualifications of Ancillary Provider at least every three (3) years. BCBS may amend its Credentialing and Recredentialing Policies and Procedures at any time, at its discretion and upon Notice to Ancillary Provider. BCBS retains the right to approve, deny, suspend or terminate any Provider's participation with BCBS based on its Credentialing and Recredentialing review.
- 3.4 **Complaints.** BCBS will maintain a complaint procedure as required by Law and the Policies and Procedures.
- 3.4.0 **Retaliation.** BCBS acknowledges and agrees not to engage in any retaliatory action against Ancillary Provider, including termination of this Agreement, because Ancillary Provider has, on behalf of a Covered Person, reasonably filed a complaint against BCBS or has appealed a decision of BCBS.
- 3.4.1 **BCBS Complaint Procedures for HMO Products.** Ancillary Provider will cooperate with BCBS in identifying, processing and in supporting BCBS's resolution of all Covered Person complaints and grievances pursuant to the Covered Person complaint procedures set forth in an HMO Coverage Agreement. Ancillary Provider also will use the Provider complaint procedure described in the Policies and Procedures, in the event Ancillary Provider has a complaint. Ancillary Provider will post in Ancillary Provider's office(s) a notice to Covered Persons regarding the process for resolving complaints with BCBS substantially in the form recommended by the Texas Department of Insurance ("TDI"). The notice will include TDI's toll-free telephone number for filing complaints. Ancillary Provider will forward to BCBS all written and oral complaints from Covered Persons within three (3) business days of receipt, unless a shorter period is required by Law or applicable accreditation standards. Ancillary Provider will respond in an accurate, appropriate, and complete manner to BCBS inquiries and document requests within two (2) business days when the inquiries relate to TDI complaints, and within ten (10) business days when related to Covered Person and Provider inquiries and complaints, and maintain a log containing all Covered Person and Provider complaints setting forth the date and nature of each complaint, where the complaint originated, and whether the complaint was made orally or in writing. The logs will be available for review by BCBS during Ancillary Provider's normal business hours and copies will be provided by Ancillary Provider to BCBS upon request.
- 3.5 **Provider Status.** For those Provider Networks in which Ancillary Provider has agreed to be a Participating Provider pursuant to an Attachment to this Agreement consistent with Plan terms and Coverage Agreements accessing those Provider Networks. BCBS may identify Ancillary Provider as a BCBS participating Ancillary Provider to BCBS employees and independent contractors, as well as certain third-parties, including, but not limited to, ASO Groups and Covered Persons. Ancillary Provider acknowledges and agrees that Ancillary Provider will be a

non-Participating Provider in all other Provider Networks, unless otherwise provided for under the terms of this Agreement.

- 3.6 **Advisory Panels.** BCBS may establish one or more health services delivery advisory review panels to advise BCBS on a variety of issues. Ancillary Provider may be requested from time to time by BCBS to serve as a member on such panels.

#### **ARTICLE IV CONFIDENTIALITY**

#### **4.0 Confidential Information Definitions.**

4.0.0 **“Representatives”** of a Party, for purposes of this Article only, means the respective officers, directors, trustees, employees, agents, consultants and Designees of a Party, and its Affiliates.

4.0.1 **“Confidential Information”** means this Agreement, and the related discussions and negotiations, as well as information of either Party, whether oral, written, electronic, or in any other form or format, provided or made available by one Party to the other Party, including but not limited to the following: information pertaining to business operations, employees, staff, financial information, fee schedules, technology, suppliers, customers, Product administration and management, business practices, trade secrets, Policies and Procedures, compliance with standards from accreditation and certifying boards, or other information, documents, agreements, project work product, data, any oral discussions or negotiations of the Parties, analyses, compilations, studies or other documents or information prepared by the other Party or its Representatives (as defined in Section 4.0.0) containing or based in whole or in part on any information furnished by another Party or its Affiliates. The Parties acknowledge and agree that Claims and Clean Claims submitted to BCBS are owned by BCBS. Confidential Information does not include Protected Health Information (“PHI”), which is subject to the protections in Section 4.6. Nothing in this Agreement shall be construed to limit the parties’ compliance with applicable law, including section 2799A-9 of the Public Health Service Act.

4.0.2 **“Unauthorized Access or Disclosure”** means the access or disclosure, by or to, any unauthorized individual(s) or entity(ies), of any (i) Confidential Information received by the Recipient Party (as defined in Section 4.2.0) or (ii) PHI. The access or disclosure will be considered unauthorized without respect to whether the access or disclosure is the result of any criminal, intentional or negligent act or omission by any individual(s) or entity(s), including, but not limited to, the Parties to this Agreement.

#### **4.1 Information Excluded from Definition of Confidential Information.** Confidential Information will not include information that:

4.1.0 is or becomes generally available to the public other than as a result of a voluntary disclosure or release by a Recipient Party or its Representatives;

4.1.1 was available to a Recipient Party on a non-confidential basis prior to the disclosure in connection with this Agreement;

4.1.2 is lawfully obtained by the Recipient Party from a third-party under no duty of confidentiality to the Disclosing Party; or

4.1.3 is independently developed by the Recipient Party.

#### **4.2 Confidentiality Requirements.**

- 4.2.0 **Receipt and Disclosure of Confidential Information.** Each Party agrees that the Confidential Information of the other Party disclosed under this Agreement is confidential and that any use, disclosure or release of the Confidential Information that is not permitted under this Agreement would injure the other Party. To the fullest extent permitted by Laws, the Party receiving Confidential Information under this Agreement (the "Recipient Party") and its Affiliates will, and will cause its Representatives, to maintain and hold such Confidential Information confidential, and not use, disclose or release to any person or entity, any Confidential Information disclosed by the other Party (the "Disclosing Party") or its Affiliates in connection with this Agreement, except as permitted under Sections 4.2.2, 4.3, 4.4 and 4.8. Both Parties agree to comply with any and all Laws related to obtaining, maintaining, analyzing, securing, safeguarding, storing or transmitting Confidential Information, or reporting of unauthorized disclosures of Confidential Information.
- 4.2.1 **Care and Ownership of Confidential Information.** Recipient Party and its Representatives and Affiliates will use at least the same degree of care to use, maintain, store, and protect the Confidential Information as it employs in using, maintaining, storing, and protecting its own Confidential Information, but always with at least a reasonable degree of care. The Disclosing Party will be and remain the sole and exclusive owner of any and all Confidential Information it provides to the Recipient Party.
- 4.2.2 **Restricted Disclosures.** Recipient Party and its Representatives and Affiliates may only use Confidential Information solely for purposes of implementing this Agreement and will restrict disclosure of Confidential Information to those of its Representatives that have a "need to know" the Confidential Information for purposes of performing under this Agreement. Recipient Party and its Affiliates will take all necessary steps to inform each of its Representatives of, and to cause each of its Representatives to comply with, these obligations, including restrictions on use, protection, safeguarding, and disclosure of Confidential Information, as set forth herein. For purposes of clarity, Ancillary Provider and its Representatives may not use Confidential Information to coordinate, collaborate, or in any way act in concert with another to either avoid or utilize this Agreement in a manner inconsistent with the intent of this Agreement to provide Covered Services solely to Covered Persons at Ancillary Provider unless otherwise permissible by this Agreement.
- 4.3 **Required Disclosures by Law(s).** If Recipient Party or its Affiliates or Representatives becomes legally compelled by Laws, process or order of any court or governmental agency to disclose any Confidential Information of the other Party, except when disclosed pursuant to Section 4.4, such Party will give the Disclosing Party maximum practical advance Written Notice thereof to permit the Disclosing Party, or as appropriate, the Recipient Party, to seek a protective order or to take any other appropriate action to protect the Confidential Information. In addition, the Recipient Party will provide reasonable cooperation to the Disclosing Party to protect the Confidential Information to the greatest extent possible under Laws, and the Disclosing Party will request maximum protection and confidential treatment of such disclosure as may be afforded by Laws, including pursuant to any available protective legal mechanism, such as a confidentiality agreement. So long as the aforementioned terms and requirements of this Section have been met, a Party will be relieved of its confidentiality obligations under this Article to the extent that it becomes legally compelled by a court of competent jurisdiction or governmental agency to disclose Confidential Information, subject to protective orders or other restrictions imposed on or granted by the court or governmental agency.
- 4.4 **Disclosures to Regulators.** Each Party agrees to keep all terms of this Agreement confidential in accordance with this Article, except that a Party will be relieved of its confidentiality obligations under this Article for purposes of disclosure of the terms of this Agreement in response to a lawful request from any regulator or governmental agency with valid jurisdiction over BCBS or Ancillary Provider or that regulator's or agency's official designee(s), such as an auditor.

- 4.5 **Breach of Confidentiality.** The Parties agree that any breach (or anticipatory breach) of the confidentiality obligations set forth in this Article will result in irreparable damage to the Disclosing Party for which it will have no adequate remedy at Law. Therefore, it is agreed (and as the sole exception to the dispute resolution provisions described in Article VI of this Agreement) that a Disclosing Party may seek equitable relief to prevent unauthorized use or disclosure by the Recipient Party, including, but not limited to, an injunction enjoining any such breach or anticipatory breach, and Recipient Party will pay all attorneys' fees and court costs incurred by the Disclosing Party to secure such equitable relief. Such equitable relief will be without prejudice to any other right or remedy to which the Disclosing Party may be entitled, including but not limited to any damages resulting from a Party's breach of the confidentiality obligations under this Article. Any failure or delay in exercising any right, power or privilege hereunder will not operate as a waiver thereof, nor will any single or partial exercise thereof preclude any other or further exercise thereof or the exercise of any right, power or privilege hereunder.
- 4.6 **HIPAA/HITECH Compliance.** All PHI used or disclosed by either Party under this Agreement is subject to various state and federal statutory privacy standards and Laws, including HIPAA and HITECH. The Parties will use, maintain, store, safeguard, and protect all PHI at all times in accordance with HIPAA, HITECH and other Laws.
- 4.7 **Cybersecurity and Data Breach Cooperation.** Ancillary Provider will notify BCBS within forty-eight (48) hours of its knowledge of any event, act or omission that has resulted, or may have resulted, in the Unauthorized Access or Disclosure, regardless of the source of such event, act or omission.
- 4.8 **Release of Information.** Notwithstanding anything else in this Agreement, Ancillary Provider authorizes BCBS to publicly release general cost, utilization and other performance information and data concerning Ancillary Provider or Ancillary Provider's provision of Covered Services, or data in Claims or Clean Claims, as BCBS deems appropriate, consistent with BCBS's existing or future consumer transparency programs, tools and initiatives, as permissible by Law.
- 4.9 **Return or Destruction of Confidential Information.** Ancillary Provider will use best efforts to return or destroy all Confidential Information provided to it by BCBS in accordance with Policies and Procedures, together with all copies thereof, whether in electronic or tangible form, within fifteen (15) calendar days following a request from BCBS or termination of this Agreement. At such time, Ancillary Provider agrees to certify by a signed declaration provided to BCBS that all BCBS Confidential Information has been returned or destroyed.
- 4.10 **Survival.** The covenants and obligations of the Parties and their Affiliates and Representatives set forth in this Article IV shall survive termination of this Agreement.

## ARTICLE V TERM AND TERMINATION

- 5.0 **Term.** This Agreement will commence on the Effective Date and continue in effect until terminated in accordance with this Agreement. The initial term is the first one (1) year this Agreement is in effect (the "Initial Term"). Notwithstanding anything else in this Agreement, Ancillary Provider may not terminate this Agreement without cause during the Initial Term.
- 5.1 **Termination Without Cause.** After the Initial Term, either Party may terminate a Provider Network in this Agreement at any time without cause by giving the other Party at least one hundred eighty (180) calendar days prior Written Notice of its intent to terminate. Such Written Notice shall list all Provider Networks and will be insufficient to terminate a Provider Network, whether originally or subsequently added through amendment, that is not listed in the Written Notice,

- 5.2 **Termination for Material Breach.** A Party may terminate any or all Provider Networks for a material breach by the other Party, regardless if the breach was related to all Provider Networks being terminated, by providing at least ninety (90) calendar days' advance Written Notice, provided that such material breach is not cured within sixty (60) calendar days following such Written Notice of termination for breach.
- 5.3 **Immediate Termination by BCBS.** Upon Written Notice to Ancillary Provider, the following will constitute cause for immediate termination by BCBS of this Agreement or any applicable Attachment with respect to Ancillary Provider or one or more Ancillary Provider Location(s), without any opportunity for Ancillary Provider to cure:
- 5.3.0 **Solvency.** Ancillary Provider files a petition for insolvency, bankruptcy or is adjudicated bankrupt, ceases to operate as a going concern, or takes advantage of any insolvency acts or assignment for the benefit of creditors. At no time, nor for any reason, may this Agreement, or any of the compensation contemplated hereunder, be considered an asset of Ancillary Provider if it becomes insolvent.
- 5.3.1 **Standard of Care.** Ancillary Provider materially fails to provide or arrange for the provision of Covered Services to Covered Persons in accordance with the standards set forth in this Agreement (including, without limitation, BCBS's quality management program and medical management program) and does not correct such failure as required by and to the satisfaction of BCBS within the time frame required by BCBS's Written Notice to Ancillary Provider. In addition to the foregoing, BCBS reserves the right to immediately terminate the provision of Covered Services by Ancillary Provider to any Covered Persons in the event the health or safety of Covered Persons is endangered by the actions of Ancillary Provider or one or more Ancillary Provider Location(s).
- 5.3.2 **Patient Safety.** Ancillary Provider, or Ancillary Provider employee or Designee causes, or in BCBS's reasonable determination, is likely to cause: (i) material harm to the safety and well-being of BCBS's Covered Persons, (ii) material harm to the reputation of BCBS, or (iii) material disruption to the provision of services to Covered Persons by Participating Providers. For purposes of clarification, BCBS's termination right under this Section will only be triggered with respect to the felony charge against or other violation of a Ancillary Provider employee or Designee if Ancillary Provider fails to immediately remove such Ancillary Provider employee or Designee who is charged or who causes, or is likely to cause, the material harm described herein.
- 5.3.3 **False Data Transmissions.** Ancillary Provider knowingly submits false or misleading billing information or encounter data to BCBS.
- 5.3.4 **Loss of Status.** Ancillary Provider loses Medicare certification, is added to the Medicare sanctions list, or is included on the OIG's List of Excluded Individuals/Entities, the General Services Administration Excluded Party List System, a listing of debarred Providers published by the OPM, or any successor to, or substantial equivalent of, the foregoing sanctions, exclusions, and Debarment sources.
- 5.3.5 **Licensure.** Ancillary Provider or one or more Ancillary Provider Location(s) fails to maintain licensure or accreditation status necessary to provide Covered Services under this Agreement or Ancillary Provider or one or more Ancillary Provider Location(s) is sanctioned or reprimanded by any licensing authority or review organization, including, but not limited to, any Blue Cross and/or Blue Shield Plan or any state licensing board.
- 5.3.6 **Breach of Warranty.** Ancillary Provider provides Notice to BCBS regarding any occurrence that contravenes the representations and warranties in Section 2.17 that involve the potential for imminent harm, licensing that could affect the Provider's ability to operate as a Provider, fraud, or malfeasance.

5.4 **Severability.** In accordance with Section 7.18, either Party may terminate this Agreement by providing at least sixty (60) calendar days' prior Written Notice to the other Party if the Parties are unable to negotiate an amendment or modification of a provision of this Agreement that an arbitrator has deemed unenforceable.

5.5 **Termination Notices Under this Article.** Written Notices concerning termination under this Article shall identify the specific Provider Network(s) included in the Written Notice of termination if it does not by its terms apply to the entire Agreement. Written Notices of termination shall be deemed insufficient to terminate any Provider Network(s) or Ancillary Provider Location(s) not included in such Written Notice if it does not by its terms apply to the entire Agreement. Written Notice of termination or expiration of the Agreement without an extension may result in suppression of Ancillary Provider as a Participating Provider or other actions to inform Covered Persons for the Provider Networks terminating.

5.6 **Rights Upon Termination.**

5.6.0 As of the date of termination, this Agreement will be considered of no further force or effect and each of the Parties will be relieved and discharged from this Agreement, except that:

5.6.0.0 Termination will not affect any rights or obligations hereunder which have previously accrued or will hereafter arise, with respect to any occurrence prior to termination and such rights and obligations will continue to be governed by the terms of this Agreement, including the dispute resolution provisions described in Article VI.

5.6.0.1 In the event of termination of this Agreement, Ancillary Provider will make available and provide to a Medical Director, to the extent authorized by Covered Persons and directly to Covered Persons, at no cost, copies of such information and records as BCBS and Covered Persons may request concerning such Covered Persons. Upon termination of this Agreement, Ancillary Provider will provide a Covered Person a copy of his or her Medical Records for a period of up to one (1) year after termination at no cost to the Covered Person.

5.6.0.2 Ancillary Provider's appeal rights, if any, in the event BCBS terminates this Agreement are set forth in more detail in the Policies and Procedures. In the event of termination of Ancillary Provider by BCBS, if Ancillary Provider is terminated for reasons other than at Ancillary Provider's request, BCBS will provide a written explanation to Ancillary Provider of the reason(s) for termination. Except in a case of termination under Section 5.3, Immediate Termination by BCBS, Ancillary Provider may, within thirty (30) calendar days following the Notice of termination, request in writing that a review be conducted by BCBS's advisory review panel and BCBS will conduct such a review consistent with Laws. Within sixty (60) calendar days following receipt of Ancillary Provider's written request for review, BCBS will notify Ancillary Provider of BCBS's review decision. At Ancillary Provider's request, Ancillary Provider will be entitled to an expedited review of such termination by BCBS's advisory review panel. At Ancillary Provider's request, BCBS will provide Ancillary Provider with a copy of the recommendation of the advisory review panel. The decision of the advisory review panel will be considered by, but is not binding upon, BCBS.

5.6.1 **Survival.** This Section 5.6 shall survive termination of this Agreement.

5.7 **Continuity of Care and Transition of Services.**

5.7.0 Termination of this Agreement does not release Ancillary Provider from the obligation to continue ongoing treatment under the terms of this Agreement and subject to the dictates of medical prudence, of a Covered Person of “special circumstance,” as defined by Laws, including but not limited to, Covered Persons with a disability, acute condition or life-threatening illness, or Covered Persons past the thirteenth (13th) week of pregnancy, or BCBS from the obligation to compensate Ancillary Provider for such Covered Services at the rate set forth in this Agreement. Special circumstance will be identified by Ancillary Provider, who will request that the Covered Person be permitted to continue under Ancillary Provider’s care and who will agree not to seek payment from Covered Person for any amounts for which Covered Person would not be responsible if the Agreement had not terminated. Disputes regarding continuity of care will be resolved according to the dispute resolution procedures set forth in this Agreement and the Policies and Procedures. Ancillary Provider’s and BCBS’s obligations hereunder will continue until the earlier of the appropriate transfer of Covered Person’s care to another Participating Provider or the expiration of ninety (90) calendar days from the effective date of termination of the Agreement. Additionally, Ancillary Provider’s and BCBS’s obligations hereunder will continue up to nine (9) months in the case of a Covered Person who at the time of the termination has been diagnosed with a terminal illness and will extend through delivery of a child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery for a Covered Person who, at the time of the termination, is past the thirteenth (13th) week of pregnancy. Ancillary Provider will cooperate in the referral of Covered Persons to other Participating Providers in order to assure continuation of care. In the event that BCBS has not used due diligence to make alternative care arrangements available to Covered Person within ninety (90) calendar days after receipt by BCBS of Notice from Ancillary Provider or Covered Person, and such arrangements are not available to Covered Person within such ninety (90) day period, BCBS will thereafter compensate Ancillary Provider for continued care at the BCBS compensation for comparable services provided by a comparable Provider that is not a Participating Provider. Nothing herein will be construed as requiring BCBS to agree to cover continued care rendered by Ancillary Provider that BCBS deems unfit to care for Covered Persons by reason of incompetence or unprofessional behavior or otherwise.

In the event of termination of the Agreement, BCBS acknowledges and agrees that BCBS will provide at least thirty (30) calendar days advance Notice to Covered Persons receiving care from Ancillary Provider of the impending termination, except that if Ancillary Provider is terminated for a reason other than at the request of Ancillary Provider and has made a timely request for review by an advisory review panel, BCBS will not notify Covered Persons of Ancillary Provider’s termination prior to the time the advisory review panel makes a formal recommendation. If Ancillary Provider is terminated or suspended immediately pursuant to Section 5.3, BCBS may notify Covered Persons immediately. Ancillary Provider will cooperate with BCBS and upon request to provide reasonable assistance to effect such Notice.

5.7.1 In the event that a Covered Person is enrolled in a Qualified Health Plan, as defined by the Patient Protection and Affordable Care Act and its implementing regulations, BCBS and Ancillary Provider shall comply with any applicable requirements relating to continuity of care under 45 C.F.R. § 156.230, as it may be amended from time to time, including the requirement to provide continued treatment to the Covered Person in an active course of treatment for ninety (90) days after Ancillary Provider is terminated without cause or until treatment is complete, whichever is shorter. A “Qualified Health Plan,” for purposes of this Section, is a Product that has in effect a certification that it meets the standards to be sold through an American Health Benefit Exchange established under 42 U.S.C. § 18031, as it may be amended from time to time.

5.7.2 **Survival.** This Section 5.7 shall survive termination of this Agreement.

**ARTICLE VI  
DISPUTE RESOLUTION**

6.0 **Dispute Resolution.** In order to avoid the cost and time consuming nature of litigation, any dispute between BCBS and Ancillary Provider arising out of, relating to, involving the interpretation of, or in any other way pertaining to this Agreement or any prior Agreement between BCBS and Ancillary Provider that relates to Ancillary Provider's role as a Participating Provider for the Provider Networks indicated in this Agreement for Covered Persons, or any Laws relating thereto, shall be resolved using alternative dispute resolution mechanisms instead of litigation. BCBS and Ancillary Provider agree and acknowledge that it is their mutual intention that this provision be construed broadly so as to provide for mediation and/or arbitration of all disputes arising out of their relationship, including claims not yet filed that predate this Agreement, as third-party payer and Ancillary Provider. The Parties further agree that resolution of any dispute pursuant to this Agreement shall be in accordance with the procedures detailed below.

6.0.0 **Initial Resolution by Meeting or Mediation of Dispute.** BCBS or Ancillary Provider, as the case may be, shall give Written Notice to the other of the existence of a dispute (the "Initial Notice"). BCBS and Ancillary Provider shall schedule a meeting not later than thirty (30) calendar days after delivery of the Initial Notice in order to attempt to resolve the dispute unless both Parties agree in writing to proceed directly to mediation. If the dispute is not resolved at any meetings held, the Parties shall submit the dispute to a mutually agreed upon mediator. The mediation process shall be subject to the following conditions:

6.0.0.0 The Parties agree to participate in the mediation confidentially and in good faith;

6.0.0.1 The Parties agree to have present at the mediation one or more individuals in the Parties' employ with decision-making authority regarding the matters in dispute. Either Party may, at that Party's option, be represented by counsel;

6.0.0.2 The mediation will be held within sixty (60) days of the mediator's acceptance of the matter unless the Parties agree on a later date. The mediation will be held in Richardson, TX. BCBS may agree to other locations or to mediate virtually at its sole discretion;

6.0.0.3 The Parties shall each bear their own costs and shall each pay one-half of the mediator's fees and costs, unless the mediator determines that one Party did not participate in the mediation in good faith, in which case that Party shall pay all of the mediator's fees and costs; and

6.0.0.4 The Parties agree that the obligation to mediate (but not the obligation to arbitrate) is not applicable to any dispute that was pending in any court on the Effective Date of this Agreement, or that had been submitted to binding arbitration on or before the Effective Date of this Agreement.

6.1 **Binding Arbitration.** In the event mediation is not successful in resolving the dispute, either BCBS or Ancillary Provider may submit the dispute to confidential, final, and binding arbitration under the commercial rules and regulations of the American Arbitration Association, subject to the following:

6.1.0 The arbitration shall be conducted by a single arbitrator selected by the Parties from a list furnished by the American Arbitration Association. If the Parties are unable to agree on

an arbitrator from the list, the arbitrator shall be appointed by the American Arbitration Association;

- 6.1.1 The arbitrator shall be required to render a written decision resolving all disputes, and designating one Party as the “prevailing Party”;
  - 6.1.2 Except in the case of fraud, no arbitration decision may require any adjustment in compensation or payments respecting any dispute involving services rendered more than twenty-four (24) months prior to receipt of the Initial Notice;
  - 6.1.3 Neither Party shall be entitled to an award of lawyers’, consultants’, or witness fees, it being the intention of the Parties that each side shall bear its own lawyers’, consultants’ and witness fees. The costs of arbitration, including the arbitrator’s fee and any reporting or other costs, but excluding lawyers’, consultants’ and witness fees, shall be borne by the non-prevailing Party unless the arbitrator determines as part of the award that such allocation is inequitable under the totality of the circumstances. In the event that the dispute in arbitration concerns the appropriateness of BCBS’s adjudications of Claims, the Party challenging the adjudications shall have the initial burden of proving that there is a reasonable probability that the disputed Claims adjudications were incorrect adversely to that Party. When the other Party reasonably determines that it is required in its defense, or is required by the discovery process or otherwise by Law, to research the basis for the adjudications of challenged Claims for which such reasonable probability has not been proven, the other Party shall be awarded the administrative cost for such research for each such Claim that is found in the arbitration proceeding, after such research, not to have been adjudicated incorrectly adversely to the challenging Party;
  - 6.1.4 The arbitration hearing will be held in Richardson, TX. BCBS may agree to other locations or to mediate virtually at its sole discretion;
  - 6.1.5 The arbitrator may award declaratory or injunctive relief only in favor of the Party seeking relief and only to the extent necessary to provide relief warranted by that Party’s individual claim. Ancillary Provider and BCBS 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 Ancillary Provider and BCBS agree otherwise, the arbitrator may not consolidate Ancillary Provider ’s claims with the claims of any other hospital, and may not otherwise preside over any form of a representative or class proceeding; and
  - 6.1.6 Ancillary Provider acknowledges that this arbitration provision precludes Ancillary Provider from filing an action at Law or in equity and from having any dispute covered by this Agreement resolved by a judge or a jury. Ancillary Provider further acknowledges that this arbitration provision precludes Ancillary Provider from participating in a class action filed by any other Ancillary Provider or any other plaintiff claiming to represent Ancillary Provider or Ancillary Provider’s interest. Ancillary Provider agrees to opt-out of any class action filed against BCBS that raises claims covered by this Agreement to arbitrate, including, but not limited to, class actions that are currently pending.
- 6.2 **Exceptions.** The provisions of this Article shall not be applicable to the following:
- 6.2.0 Any legal proceeding brought by a third-party against BCBS or Ancillary Provider (a “Defendant”), as well as any cross-claim or third-party claim by such Defendant against BCBS or Ancillary Provider.
  - 6.2.1 Termination of this Agreement pursuant to a termination without cause.

6.2.2 Immediate termination of this Agreement if based on external data relating to loss of licensure, status, certification, maintenance of insurance, breach of warranty, inducement, or BCBS's judgment relating to cases involving standard of care or patient safety. However, a wrongful termination claim may be brought to recover the contractual rates under this Agreement.

6.3 **Survival.** This Article VI shall survive termination of this Agreement.

## **ARTICLE VII GENERAL PROVISIONS**

7.0 **Recitals.** All recitals contained in the beginning of this Agreement are hereby restated and incorporated into the Agreement as if fully set forth herein.

7.1 **Headings.** The headings or captions of sections of this Agreement are for reference only and do not affect the meaning or interpretation of this Agreement.

7.2 **No Third-Party Beneficiaries.** Except as otherwise specifically set forth herein, BCBS and Ancillary Provider are the only entities with rights and remedies under this Agreement.

7.3 **Relationship.**

7.3.0 **Independent Entities.** Neither Party is the agent or representative of the other. Neither Party will have any express or implied right or authority to assume or create any obligation or responsibility on behalf of or in the name of the other Party. Each Party is and will continue to be an independent entity. Neither Party is the agent or representative of the other. BCBS does not practice medicine and does not provide professional and/or medical services, including, but not limited to, Covered Services.

7.3.1 **Taxes, Insurance and Other Benefits.** Ancillary Provider will be solely responsible for paying all taxes assessed on Ancillary Provider, including but not limited to payroll taxes, withholdings, workers' compensation insurance and other insurance or benefits of any kind for itself and Ancillary Provider's employees providing services under this Agreement, and shall have no recourse against BCBS. Ancillary Provider will indemnify and hold BCBS harmless from all damages, defense costs, or liability incurred by BCBS as a result of claims against BCBS for such tax payments brought by Ancillary Provider's employees or the government against BCBS.

7.4 **Entire Agreement; Amendments.**

7.4.0 **Entire Understanding.** This Agreement, together with any exhibits, Attachments and amendments hereto contains the entire understanding between the Parties pertaining to the subject matter contained herein and supersedes all prior agreements, either oral or in writing, with respect to the subject matter herein.

7.4.1 **Amendments.** This Agreement may be amended by mutual written agreement of the Parties. Notwithstanding the foregoing, however, BCBS may amend this Agreement upon thirty (30) days prior Notice to Ancillary Provider or such longer time period as may be required by the Laws. Ancillary Provider may terminate this Agreement by giving Notice of such termination to BCBS within thirty (30) days of receipt of the Notice of amendment, effective no earlier than thirty (30) days after such termination Notice is given. Ancillary Provider's failure to give Notice of termination to BCBS within thirty (30) days of Ancillary Provider's receipt of the Notice of amendment shall constitute agreement to and acceptance of such amendment by Ancillary Provider. The amendment shall be effective on the effective date provided in BCBS's Notice of

amendment, provided that amendments or modifications required by the Laws shall be effective no later than the date required by such Law or regulation and may be implemented beginning on that date by BCBS.

**7.5 Assignment and Merger.**

**7.5.0 Assignment.** Neither Party may assign (including, without limitation, by operation of law, as a result of a merger, consolidation, amalgamation, or other transaction or series of transactions or any change of control) this Agreement or any of its rights or obligations hereunder to any other person, entity or Affiliate, without the prior written consent of the other Party. Ancillary Provider shall also obtain BCBS's written consent in connection with any transaction, or series of transactions, resulting in a change of control of Ancillary Provider. As an exception to the foregoing, any of the rights and obligations of BCBS under this Agreement may be assumed by, or assigned to, an Affiliate of HCSC or BCBS, including, but not limited to, subsidiaries, of HCSC (including any successor corporation, whether by merger, consolidation or reorganization) without the prior written consent by Ancillary Provider. Any reference in this Agreement to HCSC or BCBS will include its directors, officers and employees, as well as the directors, officers and employees of any of its subsidiaries or Affiliate companies (including any successor corporations, whether by merger, consolidation or reorganization) and HCSC or its successor corporation will be responsible and liable for all rights and obligations in connection with this Agreement. This Agreement will be binding upon and inure to the benefit of the respective Parties hereto and permitted assigns. BCBS'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. BCBS does not recognize affiliates of Participating Providers which are not considered Affiliates, as defined in Section 1.0, for purposes of contracting, negotiations and legal relationships.

**7.5.1 Consolidation of Locations.** Ancillary Provider shall also obtain BCBS's written consent prior to consolidating locations, whether listed in this Agreement or not. The Provider Number and Physical Address listed herein shall be the only permissible billing provider for that location, and for that location alone, unless otherwise agreed to by BCBS.

**7.5.2 New Locations.** Ancillary Provider acknowledges and agrees that this Agreement applies to Covered Services provided at Ancillary Provider's locations as set forth in this Agreement. In the event Ancillary Provider desires to provide Health Care Services at new Affiliate locations, such new Affiliate locations will become subject to this Agreement only upon the written agreement of the Parties.

**7.6 Compliance with Laws.** Each Party will comply with all Laws, including the Laws of the State and any other state in which: (a) Health Care Services are provided to Covered Persons or (b) benefits are provided pursuant to a Coverage Agreement. Ancillary Provider will promptly, upon request by BCBS, provide to BCBS such information and documentation as is reasonably necessary for BCBS's compliance with Laws and accreditation standards. In addition, Ancillary Provider will cooperate with and provide reasonable assistance to BCBS regarding regulatory compliance efforts as they relate to Ancillary Provider's and BCBS's activities under this Agreement.

**7.7 Cooperation of Parties.** The Parties agree to meet and confer in good faith on common problems or issues including, but not limited to, matters concerning utilization of Covered Services, Claims, Clean Claims, or reporting procedures, and information and forms provided to Ancillary Provider for use in connection with the provision of Covered Services to Covered Persons.

**7.8 Force Majeure.** No Party will be held liable by the other Party for any failure to timely perform its obligations under this Agreement if prevented from doing so by a cause or causes beyond its

commercially reasonable control including, but not limited to, acts of God or nature, fires, floods, storms, earthquakes, riots, strikes, wars or restraints of government. Each Party will resume its obligations under this Agreement as soon as practicable after a force majeure event.

- 7.9 **Disaster Recovery/Business Continuity.** During the Term of this Agreement, Ancillary Provider will maintain and, upon request by BCBS, provide a summary of a comprehensive disaster recovery and/or business continuity plan which is consistent with industry standards and Laws, and at a minimum, allows resumption of performance under this Agreement within a reasonable time following an interruption of operations due to a disaster. If a state or federal agency or regulator requires a copy of Ancillary Provider's comprehensive disaster recovery and/or business continuity plan, Ancillary Provider will provide such information in an acceptable format to the state entity or regulator.
- 7.10 **Data Accuracy/Integrity.** During the Term of this Agreement, Ancillary Provider will use reasonable best efforts to provide accurate data and information, including data and information regarding Claims and/or Clean Claims, as required by this Agreement, in a format requested by BCBS, including, but not limited to, all data received or supplied from any person or entity that is necessary to perform under this Agreement. Ancillary Provider will comply with all applicable data privacy and security Laws concerning data accuracy, integrity, maintenance, receipt and transmission.
- 7.11 **Use of Name, Trademarks.** Each Party reserves the right to, and control of, its names, symbols, trademarks and service marks presently existing or later established. All names, symbols, trademarks and service marks of, or related to, BCBS and its Products are owned and/or controlled by BCBS, and Ancillary Provider has no rights in or to such names, symbols, trademarks and service marks. BCBS has the right to use such marks under its licensing agreement with the BCBSA. All names, symbols, trademarks and service marks of Ancillary Provider are owned and/or controlled by Ancillary Provider and/or its Affiliates, and BCBS has no rights in or to such names, symbols, trademarks and service marks. Neither Party will use the other Party's name, symbols, trademarks or service marks in advertising, promotional or informational materials, describe the business or services of the Party, or otherwise, without the prior written consent of that Party. This Section will in no way limit the Parties from preparing materials for regulatory filing purposes, or other non-marketing materials that will not be disseminated to the public or externally, as associated with the normal operation of its business. As an exception to the foregoing, Ancillary Provider agrees that BCBS may list such information as Ancillary Provider's name, address and telephone number and relevant information, including information relating to Ancillary Provider's services and performance and any other information required by Law, in BCBS publications provided to Covered Persons, including BCBS's Provider directories.
- 7.12 **No Solicitation.** During the Term of this Agreement and for a period of one (1) year thereafter, Ancillary Provider will not solicit, influence or induce or attempt to solicit, influence, or induce any Covered Person to disenroll from any Product or enroll in any other health care plan that would require such Covered Person to disenroll from a Product, and Ancillary Provider will not solicit, influence or induce employers, including, but not limited to, ASO Groups, or other entities with which BCBS has entered into agreements to provide health care benefits to cease doing business with BCBS or diminish or otherwise affect their business relationship with BCBS.
- 7.13 **Governing Law.** This Agreement will be interpreted and construed in accordance with the Laws of the State, which Laws will prevail in the event of any conflict of laws.
- 7.14 **Non-Exclusivity.** This Agreement is non-exclusive and both Parties may enter into similar agreements with other entities.
- 7.15 **Products and Coverage Agreements.** Nothing in this Agreement will be construed to prohibit BCBS from introducing new Products, programs, Plans or networks into the marketplace, nor

from revising or amending any Coverage Agreement, or implementing new Product benefit designs or Provider Network strategies.

- 7.16 **No Default.** Each Party warrants that the execution and delivery of this Agreement and compliance with the provisions hereof will not in any material respect conflict with or constitute a default on the part of either Party under any instrument or agreement or under any Laws to which it is subject.
- 7.17 **Partial Invalidity and Severability.** In the event that an arbitrator (in accordance with the provisions of Article VI) determines that a provision, or any portion thereof, contained in this Agreement is unenforceable, then such provision will be deemed stricken and the remaining portions or provisions will continue in full force and effect. In the event that a provision of this Agreement is rendered unenforceable, and its removal has the effect of materially altering the obligations of either Party in such manner as will cause serious financial or administrative hardship to such Party, the Party so affected will have the right, within thirty (30) calendar days of the arbitrator's decision, to request that the Parties enter into good faith negotiations for the purpose of establishing such amendments or modifications to this Agreement as may be appropriate in order to preserve the original intent of the Agreement. If, after thirty (30) calendar days of such negotiations, the Parties are unable to reach an agreement on an appropriate amendment or modification, the affected Party may terminate this Agreement upon sixty (60) calendar days' advance Notice to the other Party. If the affected Party does not request good faith negotiations within thirty (30) calendar day time frame after the arbitrator's decision, the Agreement will continue in force and effect as modified by the arbitrator's decision, and such affected Party thereby waives its right to such good faith negotiations and to termination under this Section.
- 7.18 **Responsibility for Acts.** Each Party will be responsible for its own acts or omissions and any and all claims, liabilities, injuries, suits, demands and expenses of all kinds which may result in or arise out of any alleged malfeasance or neglect caused or alleged to have been caused by that Party, its employees or non-physician agents, in the performance or omission of any act or responsibility of that Party under this Agreement.
- 7.19 **Waiver.** The failure of either Party to exercise any right or strictly enforce any provisions of this Agreement will not be construed as a waiver or relinquishment of such provision or right. No waiver by any Party of any Term of this Agreement will be effective unless it is in writing signed by the Party waiving its rights.
- 7.20 **BCBSA.** Ancillary Provider hereby expressly acknowledges that this Agreement constitutes a contract solely between Ancillary Provider and BCBS, which is an independent corporation operating under a license from the BCBSA, permitting BCBS to use the Blue Cross and Blue Shield Service Marks in the State, and that BCBS is not contracting as the agent of BCBSA. Ancillary Provider further acknowledges and agrees that Facility has not entered into this Agreement based upon representations by any person other than BCBS and that no person, entity, or organization other than BCBS will be held accountable or liable to Ancillary Provider for any of BCBS's obligations to Ancillary Provider created under this Agreement. This paragraph does not create any additional obligations whatsoever on the part of BCBS other than those obligations created under other provisions of this Agreement.
- 7.21 **Attachments.** One or more Attachment(s) may be attached to this Agreement, setting forth additional provisions included in this Agreement in order to satisfy requirements under State Law, set forth Claims processing requirements and compensation arrangements, for Medicare Advantage Products or Medicaid Products, or for other purposes. By executing the cover page to this Agreement, the Parties acknowledge that these Attachments, and any Attachments to them, are expressly incorporated into this Agreement and are binding on the Parties. In the event of any inconsistent or contrary language between an Attachment or any other part of this Agreement, the Attachments will control, to the extent applicable. Each Attachment(s) shall be

effective until the effective date of termination of this Agreement unless such Attachment(s) expires by its terms or is separately terminated by either Party pursuant to the terms of this Agreement and/or such Attachment(s).

- 7.22 **Administrative Functions.** BCBS and Ancillary Provider acknowledge that BCBS may delegate certain responsibilities or activities that are provided for in this Agreement without notice to or approval by Ancillary Provider.
- 7.23 **Terminology.** Use of the masculine, feminine or neuter gender and the singular or plural numbers will be deemed to include the others whenever the context so indicates or requires.
- 7.24 **Survival.** In addition to the Sections and Articles already surviving pursuant to the terms of this Agreement, Articles I and VII will also survive termination of this Agreement.

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**ATTACHMENT A TEXAS**

**PROVIDER NETWORKS**

This Attachment A is made a part of this Agreement. All capitalized terms not defined in this Attachment have the meanings ascribed to them in Article I of the Agreement and in Article I of Attachment D.

By its signature below, Ancillary Provider provides its express authority to be a Participating Provider in the Ancillary Provider(s) indicated at the compensation schedule(s) set out herein and pursuant to the terms of the Agreement. Ancillary Provider acknowledges that each Provider Network may support multiple Products.

**Ancillary Provider may sign this Agreement electronically. A scanned, imaged, electronic, photocopy or stamp of the signatures hereunder will have the same force and effect for purposes of validity, enforceability, and admissibility as an originally executed signature.**

<p><b>Blue Choice PPO<sup>SM</sup> Provider Network</b></p> <p><b>(Inclusive of Blue Precision/Blue Options)</b></p>	<p>Authorized Signature:</p> <p>_____</p> <p>Date: _____</p>
<p><b>Blue Essentials<sup>SM</sup> HMO Provider Network</b></p>	<p>Authorized Signature:</p> <p>_____</p> <p>Date: _____</p>
<p><b>Blue Advantage HMO<sup>SM</sup> Provider Network</b></p>	<p>Authorized Signature:</p> <p>_____</p> <p>Date: _____</p>
<p><b>Blue Premier<sup>SM</sup> HMO Provider Network</b></p>	<p>Authorized Signature:</p> <p>_____</p> <p>Date: _____</p>
<p><b>Blue High Performance Network Provider Network</b></p>	<p>Authorized Signature:</p> <p>_____</p> <p>Date: _____</p>
<p><b>MyBlue Health HMO Provider Network</b></p>	<p>Authorized Signature:</p> <p>_____</p> <p>Date: _____</p>

<p><b>*STAR Medicaid Provider Network</b></p>	<p>Authorized Signature: _____</p> <p>Date: _____</p>
<p><b>*STAR Plus Provider Network</b></p>	<p>Authorized Signature: _____</p> <p>Date: _____</p>
<p><b>*STAR Kids Provider Network</b></p>	<p>Authorized Signature: _____</p> <p>Date: _____</p>
<p><b>*CHIP Provider Network</b></p>	<p>Authorized Signature: _____</p> <p>Date: _____</p>
<p><b>Blue Cross Medicare Advantage (PPO)<sup>SM</sup> Provider Network</b></p>	<p>Authorized Signature: _____</p> <p>Date: _____</p>
<p><b>Blue Cross Medicare Advantage (HMO)<sup>SM</sup> Provider Network</b></p>	<p>Authorized Signature: _____</p> <p>Date: _____</p>

\*Each of these Provider Networks are included as a part of the Medicaid Managed Care Plan in this Agreement.

## ATTACHMENT B TEXAS

### BILLING AND CLAIMS PROCESSING STANDARDS

This Attachment B is made a part of this Agreement. All capitalized terms not defined in this Attachment have the meanings ascribed to them in Article I of the Agreement and in Article I of Attachment D.

#### ARTICLE I CLAIMS PAYMENT/PROCESSING

- 1.0 **Compensation.** BCBS will pay Ancillary Provider for Covered Services rendered to Covered Persons less any applicable Cost Share amounts: (a) as described in Attachment D and the applicable Provider Network fee schedule, or (b) as described in Section 1.2 below, Items Compensated on a Percentage of Eligible Charge Basis. Ancillary Provider will accept such compensation as its only compensation for Covered Services. Any dispute arising from such payment will be resolved in accordance with the terms of this Agreement.
- 1.1 **Services Covered by Payment.** Compensation allowed by BCBS for Covered Services by Ancillary Provider within the scope of its practice or its license is inclusive of:
- 1.1.0 **Incidental Services.** The cost of incidental services in support of such Covered Services, including without limiting the foregoing technical charges for equipment and its purchase, rental and maintenance. Compensation for such incidental services may not be billed separately by Ancillary Provider or another Provider or other entity; provided that professional services necessary for the treatment of the Covered Person that require the use of equipment that is supplied or arranged for by Ancillary Provider may be billed separately by the person providing those professional services.
- 1.1.1 **Technical and Ancillary Provider Services.** Any and all technical and facility related services provided to Covered Persons at Ancillary Provider's facility, notwithstanding any permitted arrangements that Ancillary Provider may have entered into with any third parties regarding use of Ancillary Provider's facility. Only Ancillary Provider may bill BCBS for all services provided to Covered Person at Ancillary Provider's facility, and compensation for such incidental technical and facility related services may not be billed separately by Ancillary Provider or another Provider or other entity.
- 1.2 **Items Compensated on a Percentage of Eligible Charge Basis.** See Attachment D.
- 1.3 **Claims Submission.**
- 1.3.0 **Complete Claims.** Ancillary Provider will submit complete and properly executed Claims information to BCBS within the required filing period, as described herein.
- 1.3.1 **Claims Submission.** Claims for compensation for Covered Services will be submitted in accordance with the following:
- 1.3.1.0 **Timing of Claims Submission.** Ancillary Provider will promptly submit a Claim for Covered Services to BCBS, but in no event later than one (1) year after the date Ancillary Provider provides the Covered Services for which the Claim is made. For a Claim for which COB applies, the filing period does not begin for submission of the Claim to the secondary payer until Ancillary Provider receives Notice of the payment or denial from the primary payer. If Ancillary Provider is an institutional Provider, the filing period does not begin until the date of discharge. If Ancillary Provider fails to submit a Claim in compliance with this paragraph, Ancillary Provider forfeits the right to payment unless Ancillary

Provider has certified that the failure to timely submit the Claim is a result of a catastrophic event. Ancillary Provider will include a discharge diagnosis when submitting Claims to BCBS.

- 1.3.1.1 **Claim Format.** Claims may be submitted (1) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format or (2) on a completed current version of the applicable CMS Claim form. When submitting charges, Ancillary Provider will bill BCBS its standard retail price (i.e., the highest price Ancillary Provider bills any other carrier) for the Health Care Services rendered.
- 1.3.1.2 **Duplicate Claim.** Ancillary Provider may not submit a Duplicate Claim prior to the 46th day (for non-electronically filed Claims) or the 31st day (for Claims filed electronically) after the date the original Claim is presumed to be received by BCBS. As used herein, "Duplicate Claim" means any Claim submitted by Ancillary Provider for the same Health Care Service provided to a particular individual on a particular date of service that was included in a previously submitted Claim. The term does not include corrected Claims.
- 1.3.1.3 **Batch Submission.** BCBS and BCBS's clearinghouse may not refuse to process or pay an electronically submitted Clean Claim because the Claim is submitted together with or in a Batch Submission with a Claim that is deficient. As used herein, the term "Batch Submission" means a group of electronic Claims submitted for processing at the same time within a HIPAA standard Facility X12N837 Transaction Set and identified by a batch control number.
- 1.3.1.4 **Claims in Error.** If Ancillary Provider submits a Claim to BCBS and latter determines that the Claim contained an error (e.g. the wrong diagnosis, date of admission, etc.), then Ancillary Provider will send a corrected Claim to BCBS. The documentation necessary to substantiate a corrected Claim is forwarded to BCBS upon request.
- 1.3.1.5 **Representation and Warranty.** Each submission of a Claim by Ancillary Provider pursuant to this Agreement will be deemed to constitute the representation and warranty by Ancillary Provider to BCBS that: (i) the representations and warranties of Ancillary Provider set forth in this Agreement are true and correct as of the date the Claim is submitted; (ii) Ancillary Provider has complied with the requirements of this Agreement with respect to the Covered Services involved and the submission of such Claim; (iii) the charge amount set forth on the Claim does not exceed the fee that Ancillary Provider would ordinarily charge if the patient were not a Covered Person; and (iv) the Claim is a valid Claim.
- 1.3.2 **Claims Information.** Ancillary Provider is entitled, upon written request, and in accordance with Law and confidentiality requirements, to all information reasonably necessary to determine that Ancillary Provider is being compensated in accordance with the terms of this Agreement. Ancillary Provider may consult the Blue Cross and Blue Shield of Texas website for further information and instructions concerning information available to Ancillary Provider.

## ARTICLE II CLAIMS PAYMENT

### 2.0 Recovery of Overpayments.

- 2.0.0 **Overpayment Recovery.** In the event that BCBS determines an overpayment, including a duplicate payment, has been made, Ancillary Provider will promptly make repayment to BCBS when requested. If Ancillary Provider fails to promptly make such repayment when requested, Ancillary Provider will allow overpayments to be deducted from future payments, for the same or different Covered Persons, with an explanation of the action taken. Likewise, any underpayments will be added to future payments by BCBS to Ancillary Provider. Any dispute arising from such deduction or payment will be resolved in accordance with the terms of the dispute resolution procedures as outlined in this Agreement.
- 2.0.1 **Return of Overpayments.** Overpayments determined by Ancillary Provider on a Claim(s), including duplicate payments, will be refunded to BCBS, but in any event no later than thirty (30) days following such determination.
- 2.0.2 **Refund of Covered Person Overpayments.** Ancillary Provider will refund any Covered Person overpayment to Covered Person not later than the thirtieth (30<sup>th</sup>) day after the date an overpayment has been identified.
- 2.0.3 **Under/Overpayments.** Barring any systematic practice to underpay Ancillary Provider by BCBS, BCBS and Ancillary Provider agree that under-payments and/or over-payments amounting to less than \$50.00 on an individual entire Claim will be considered to have been paid in accordance with the terms of this Agreement and will not be appealed by Ancillary Provider or BCBS. Rather, Ancillary Provider or BCBS will write-off such under and/or over-payment difference unless BCBS's agreement with the applicable ASO Group requires otherwise.
- 2.0.4 **Deadline for Reconsideration.** Requests for reconsideration of Claims payment determinations will be in writing, include all pertinent information, and sent as directed and within the deadline as specified in the Policies and Procedures.

**ATTACHMENT C**  
**PROVIDER LISTING**

**(ALL LOCATIONS FOR INPATIENT AND OUTPATIENT SERVICES)**

This Attachment C is made a part of this Agreement. All capitalized terms not defined in this Attachment have the meanings ascribed to them in Article I of the Agreement and in Article I of Attachment D.

<b>Provider Number (PFIN)</b>	<b>Provider Name</b>	<b>Tax ID</b>	<b>NPI Number</b>	<b>Medicaid Provider Number</b>	<b>Medicare Number</b>	<b>City</b>
H0CL710601	HIDALGO COUNTY	746000717	1043194731			EDINBURG

## ATTACHMENT D

### COMPENSATION RATES

This Attachment D, including any sub-attachments to this Attachment D (e.g., Attachment D-1, Attachment D-2, etc.) (collectively, this "Attachment"), is made a part of this Agreement. All capitalized terms not defined in this Attachment have the meanings ascribed to them in Article I of the Agreement.

#### ARTICLE I DEFINITIONS

All capitalized terms not defined in this Attachment and its Sub-Attachments will have the meanings ascribed to them in the Agreement. The definitions in this Attachment and its Sub-Attachments apply only to the terms of this Attachment and its Sub-Attachments unless expressly noted otherwise.

- 1.0 **Admission Type** means the identification by standard code set (e.g. assigned DRG code National Uniform Billing Committee (NUBC) Revenue Code) of the reason for the Inpatient or Outpatient Service.
- 1.1 **Admission Type Hierarchy** means the method used to determine the applicable method of compensation when the Claim meets the definition of more than one Admission Type. Refer to the BCBS website for the Admission Type Hierarchy.
- 1.2 **Allowable Amount** means the Contract Rate and any applicable compensation provision set forth herein.
- 1.3 **Ancillary Service** is the description of the Covered Service(s) that Facility for a particular Contract Rate(s) as agreed to in this Attachment and its Sub attachments as further described on the BCBS website.
  - 1.3.0 The following definitions supplement the Ancillary Services on the BCBS website. In the event of a conflict between the following definitions and the BCBS website, whether the name of the Ancillary Service or a parameter in the definition of an Ancillary Service, the definitions in this Attachment shall prevail for purposes of establishing Contract Rates for this Agreement.
- 1.4 **Base Compensation Schedule** means a schedule of Contract Base Rate amounts used to calculate the Contract Rate for Health Care Services billed. Ranges of services and/or procedures are broken down into the separate Base Compensation Schedules referred to in this Attachment and its Sub-Attachments. Refer to the BCBS website for the Base Compensation Schedules.
- 1.5 **Case Rate Day Limit** means the number of days covered by the applicable Case Rate.
- 1.6 **Case Rate Per Diem** means the Per Diem rate allowed for each covered Inpatient day exceeding the Case Rate Day Limit.
- 1.7 **Contract Base Rate** means the rate agreed upon by Ancillary Provider and BCBS set forth in this Agreement to be used in the calculation of the Contract Rate.
- 1.8 **Contract Rate** means the calculation using the Contract Base Rate and applying the algorithm for the method of compensation.
- 1.9 **Contract Rate Cap** means the amount not to be exceeded by the calculated Contract Rate.

- 1.10 **Eligible Charge** means a charge for Covered Services.
- 1.11 **Implants/Prosthetics Devices Threshold** means the amount of total Eligible Charges which determines when Implant / Prosthetic Devices compensation is considered.
- 1.12 **Incidental Services** means the specific Health Care Services for which the allowed compensation by BCBS for Covered Services is included in the compensation paid by BCBS for the primary procedure to which the Incidental Services relate.
- 1.13 **Inpatient Services** means Covered Person is admitted by a physician to Ancillary Provider as a registered bed patient and requires the acute bed patient overnight setting and includes room and board services.
- 1.14 **Method of Compensation** describes the calculation of the Contract Rate. For Ancillary Provider the possible values include the following:
- 1.14.0 **Nonsurgical Case Rate** means a method of compensation which is an all-inclusive flat fee amount allowed for services rendered for an outpatient service
- 1.14.0.0 Incidental surgical procedures as identified on the BCBS website are incidental to the related surgical or cardiac Cath lab procedure.
- 1.14.0.1 For Inpatient Services for which the length of stay exceeds the applicable Case Rate Day Limit, Ancillary Provider is paid the Case Rate plus the Case Rate Per Diem multiplied by the number of Medically Necessary days in excess of the applicable Case Rate Day Limit.
- 1.14.0.2 The Case Rate includes compensation for (1) pre-admission testing provided by Ancillary Provider within three (3) days of the Inpatient or Outpatient Service and (2) all other Covered Services provided during Covered Person's admission.
- 1.14.1 **Per Unit** means a method of compensation which is a flat fee amount allowed for a given Health Care Service. The Per Unit amount is multiplied by the number of units billed for the given Health Care Service. The Per Unit amount is calculated as follows:
- 1.14.1.0 Per Unit Contract Base Rates are multiplied by the units billed for the specific Health Care Service.
- 1.14.1.1 Units are based on the CPT/HCPCS Code description if billed or NUBC revenue code description if the CPT/HCPCS Code is not billed.
- 1.14.1.2 Incidental Services as identified on the BCBS website are incidental to the related surgical, cardiac Cath/PTCA, or other primary procedure indicated on the Claim.
- 1.14.2 **Percent of Base Compensation Schedule** means the percentage applied to the Base Compensation Schedule which determines the Contract Rate. The specified percentage shall be determined by BCBSTX for each ancillary specialty fee schedule(s). The Ancillary Provider will receive notice of the multiplier and/or applicable percentage payable for each schedule(s) prior to or in addition to receiving this Agreement. The Percent of Base Compensation Schedule is determined as follows:
- 1.14.2.0 The Contract Rate for each of the Health Care Services found on the Base Compensation Schedule is determined by multiplying the percentage to the

Base Compensation Schedule Rate. The Base Compensation Schedule is only payable when applying a percentage multiplier. If Ancillary Provider did not receive notice containing the multiplier and/or percentage payable, it shall be the responsibility of the Ancillary Provider to contact their Network Management Consultant to verify the multiplier.

- 1.14.2.1 Percent of Base Compensation Schedule is calculated prior to the application of the multiple surgical procedure percentages.
- 1.14.3 **Percent of Eligible Charge when the Threshold is Exceeded** is a method of compensation where the Percent of Eligible Charges listed in the compensation table is applied to the line level Eligible Charges if the Eligible Charges exceed the specified threshold as further described below:
  - 1.14.3.0 The contracted threshold is compared to the line level Eligible Charge.
  - 1.14.3.1 If the line level Eligible Charge is less than or equal to the threshold, the Health Care Service is considered incidental to the Claim level Contract Rate.
  - 1.14.3.2 If the line level Eligible Charge is greater than the threshold, the contracted Percent of Eligible Charge is applied to the total line level Eligible Charge and allowed in addition to the Claim level Contract Rate.
  - 1.14.3.3 Eligible Charges across multiple lines of a Claim are not accumulated when comparing Eligible Charges to the threshold.
- 1.14.4 **Per Diem** is a method of compensation which is an all-inclusive flat fee amount allowed for all Inpatient and Outpatient Services rendered to Covered Person for a given day.
  - 1.14.4.0 The formula for calculating a Per Diem Contract Rate is the Per Diem Rate multiplied by the number of Medically Necessary days.
    - 1.14.4.1 Per Diem Rates based on the DRG code apply to all Medically Necessary days of the admission.
    - 1.14.4.2 Per Diem Rates based on the NUBC room and board revenue Code apply to the Medically Necessary days applicable to the revenue Code.
    - 1.14.4.3 The Per Diem includes compensation for (1) pre-admission testing provided by Ancillary Provider within three (3) days of the Inpatient or Outpatient Service and (2) all other Covered Services provided during Covered Person's admission.
- 1.14.5 **Surgical Case Rate** means a method of compensation which is an all-inclusive flat fee amount allowed for Health Care Services rendered for an Outpatient Service. When multiple procedures are billed for the same operative session on an outpatient surgical Claim, a Case Rate is calculated based on the application of the multiple procedure percentages as listed in the Multiple Surgery Percentage Table in the applicable Sub attachment(s).
  - 1.14.5.0 The primary and secondary procedures are identified by the highest and second highest Contract Rates. All other procedures are considered subsequent.

- 1.14.5.1 Incidental surgical procedures as identified on the BCBS website are incidental to the related surgical or cardiac Cath lab procedure.
- 1.14.5.2 For Inpatient Services for which the length of stay exceeds the applicable Case Rate Day Limit, Ancillary Provider is paid the Case Rate plus the Case Rate Per Diem multiplied by the number of Medically Necessary days in excess of the applicable Case Rate Day Limit.
- 1.14.5.3 The Case Rate includes compensation for (1) pre-admission testing provided by Ancillary Provider within three (3) days of the Inpatient or Outpatient Service and (2) all other Covered Services provided during Covered Person's admission.

1.15 **Transferring Ancillary Provider** means an Ancillary Provider which initially admits and subsequently transfers Covered Person to a Receiving Ancillary Provider other than itself.

## **ARTICLE II ALLOWABLE AMOUNT TO ANCILLARY PROVIDER**

2.0 **Allowable Amount.** The Allowable Amount to Ancillary Provider as described in this Attachment applies to Covered Services provided to Covered Persons beginning on or after the Effective Date, except in the following situations:

2.0.0 Health Care Services determined not to be Medically Necessary by BCBS under the terms of Covered Person's Coverage Agreement;

2.0.1 Covered Person receiving services for which Covered Person has coverage under Medicare and Medicare is primary until such time as Covered Person has exhausted the Medicare benefits.

2.1 **Compensation Schedules.** Notwithstanding other terms and conditions in this Agreement, the Compensation Schedules table, entries, and headings in this Attachment are relevant to the interpretation of this Attachment.

2.2 **Contract Rate.** The Contract Rate in effect on the date of service for Covered Person's inpatient or outpatient admission is used to determine BCBS's Allowable Amount payable for the inpatient or outpatient admission. When submitting Claims under this Attachment, Ancillary Provider will bill BCBS Ancillary Provider's price that they bill to all other payers, including CMS (billed charge) for the Health Care Services rendered during the outpatient admission involved.

2.2.0 The Contract Rate in effect on (1) the date of Covered Person's Inpatient admission is used to determine BCBS's Allowable Amount payable for the entire admission, or (2) the date of service for Covered Person's Outpatient admission is used to determine Covered Person's Allowable Amount payable for the Outpatient admission.

## **ARTICLE III CODE UPDATES**

3.0 **Code Updates.** BCBS quarterly reviews HCPCS Codes and bi-annually reviews AMA CPT Codes. Ancillary Provider and BCBS agree that new Codes will be added or deleted periodically by CMS and AMA, and a rate will be established for such Codes by BCBS. BCBS will establish rates for such new Codes that are based on the prevailing CMS rates that are established for the Codes, for the year that the Codes were created. If no CMS rates are available, rates will be established by BCBS until such time CMS establishes a rate. HCPCS and CPT Codes determined to be no longer valid by AMA are end dated effective on date announced by AMA.

New Codes and rates are added to the Base Compensation Schedules found on the BCBS website. Any contracted percent of Base Compensation Schedule applies to these rates.

- 3.1 **Notification to Facility.** BCBS will notify Ancillary Provider at least ninety (90) days prior to the effective date of changes to established rates on the Facility Base Compensation Schedules or any other changes to established Facility Contract Rates.

#### **ARTICLE IV BCBS WEBSITE**

- 4.0 **Website.** All Base Compensation Schedules and reference material is posted on the BCBS website (<http://www.bcbstx.com>).

4.0.0 The following reference material is posted to the BCBS website: NUBC revenue Codes, HCPCS / CPT Codes, Admission Type definitions, BCBS DRG Weights, and other information aiding in the interpretation of this Agreement.

#### **ARTICLE V ANCILLARY PROVIDER ADMINISTRATIVE BILLING/CODING**

- 5.0 Ancillary Provider will notify BCBS ninety (90) days in advance of implementing a systematic administrative coding or billing change that increases Ancillary Provider revenue for Covered Services without increasing the volume or acuity of Health Care Services. If BCBS becomes aware of such coding or billing change from Ancillary Provider or other sources, then BCBS will evaluate the annual financial impact of such administrative coding or billing change. If such administrative coding or billing change results in an increase in expected compensation to Ancillary Provider greater than or equal to (i) of one hundred thousand dollars (\$100,000) or (ii) five percent (5%) of the total allowed amount for any Admission Type, (i.e., ER, Outpatient, etc.), then BCBS may submit to Ancillary Provider an amended Attachment D which adjusts compensation rates for the affected service to neutralize the financial impact of such a change as though the administrative coding or billing change did not occur. Ancillary Provider may object, in writing, to such amended Attachment D within thirty (30) days of receipt, and BCBS and Ancillary Provider will negotiate a mutually agreeable adjustment to Attachment D. If Ancillary Provider does not object to such amended Attachment D within such thirty (30) day period, then BCBS will implement amended Attachment D.

#### **ARTICLE VI CHARGE MASTER**

- 6.0 **Items Compensated on a Percent of Eligible Charge Basis.** For Covered Services compensated on Percent of Eligible Charge basis ("POC"), Facility agrees it will not increase its charges for those items ("Charge Master") more than ZERO (0%) in any contract year ("Allowable Increase"). Facility agrees it will provide BCBSTX with sixty (60) days' advance Written Notice of any and all increases to its Charge Master, identifying the overall aggregate increase, increase for Inpatient Services, increase for Outpatient Services and any changes to Facility's mark-up algorithm on Implants in the aggregate for the contract year. If BCBSTX determines that the actual Chargemaster increase, including mark-up algorithm on Implants, is in excess of the Allowable Increase, then BCBSTX may elect to adjust the POC to adjust for any increase in excess of the then applicable Allowable Increase per contract year going forward. In addition, if Facility is contracted with BCBSTX for Stop Loss and Carve Outs, BCBSTX may elect to adjust all Stop Loss and/or Carve Out thresholds and any discounts applicable to Stop Loss and/or Carve Outs, for the prospective contract year to keep such values within the Allowable Increase. Adjustments will be rounded to the nearest whole dollar or tenth of a percent, respectively. BCBSTX may also recover total dollars overpaid by BCBSTX to Facility pursuant to Article VI based on the Charge Master increase in excess of the Allowable Increases as well as overpayments related to Facility's failure to provide adequate notice. For claims adjudication

Attachment D [TEXAS]

purposes, BCBSTX will adjust the POC and thresholds in a manner consistent with the following examples:

Adjusted Payment Rate Example:	
Baseline Charge	\$100
Percent of Eligible Charges Reimbursement Rate	59.8%
Allowable Amount	\$59.80
Allowed Charge Master Increase	3%
Adjusted Allowable Amount (Allowable Amount x 1.03)	\$61.59
Actual Charge Master Increase	6%
Revised Baseline Charge	\$106
Adjusted Percent of Eligible Charge Payment Rate (59.8% x (1.03/1.06) - Rounded to the nearest tenth of a percent	58.1% (which yields the Adjusted Allowable Amount of \$61.59)
If applicable:	
Existing Stop Loss Threshold	\$200,000
Adjusted Stop Loss Threshold (1.06/1.03 x \$200,000) – Rounded to the nearest whole dollar	\$205,825
Existing Stop Loss Percent of Eligible Billed Charge	55.1%
Revised Stop Loss Percent of Eligible Billed Charge (55.1% x 1.03 / 1.06) – Rounded to the nearest tenth of a percent	53.5%
Existing Carve-out Threshold	\$5,000
Revised Carve-out Threshold (1.06 / 1.03 x \$5,000) – Rounded to the nearest whole dollar	= \$5,146
Existing Carve-out Percent of Eligible Billed Charge	=35.7%
Revised Carve-out Percent of Eligible Billed Charge (35.7% x 1.03 / 1.06) – Rounded to the nearest tenth of a percent	= 34.7%

**SUBATTACHMENT D-1**

**BLUE CHOICE PPO<sup>SM</sup> NETWORK**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Notwithstanding anything to the contrary in Attachment D, Ancillary Provider agrees to accept as compensation for Covered Services the lesser of (1) eligible billed charges or (2) compensation pursuant to the then current Blue Cross and Blue Shield of Texas fee schedule(s) for the ancillary specialty for such service, as posted on the BCBSTX Web site, calculated under the terms of this Agreement; less any applicable Copayments, Coinsurance or Deductibles offset by any payments to Ancillary Provider from other sources, including but not limited to coordination of benefits and subrogation.

**SUBATTACHMENT D-2**

**BLUE ESSENTIALS<sup>SM</sup> HMO NETWORK**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Notwithstanding anything to the contrary in Attachment D, Ancillary Provider agrees to accept as compensation for Covered Services the lesser of (1) eligible billed charges or (2) compensation pursuant to the then current Blue Cross and Blue Shield of Texas fee schedule(s) for the ancillary specialty for such service, as posted on the BCBSTX Web site, calculated under the terms of this Agreement; less any applicable Copayments, Coinsurance or Deductibles offset by any payments to Ancillary Provider from other sources, including but not limited to coordination of benefits and subrogation.
- 1.1 **Health Select Compensation.** Notwithstanding anything to the contrary in Attachment D, Ancillary Provider agrees to accept as compensation for Covered Services the lesser of (1) eligible billed charges or (2) compensation pursuant to the then current Blue Cross and Blue Shield of Texas fee schedule(s) for the ancillary specialty for such service, as posted on the BCBSTX Web site, calculated under the terms of this Agreement; less any applicable Copayments, Coinsurance or Deductibles offset by any payments to Ancillary Provider from other sources, including but not limited to coordination of benefits and subrogation.

**SUBATTACHMENT D-3**

**BLUE ADVANTAGE HMO<sup>SM</sup> NETWORK**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Notwithstanding anything to the contrary in Attachment D, Ancillary Provider agrees to accept as compensation for Covered Services the lesser of (1) eligible billed charges or (2) compensation pursuant to the then current Blue Cross and Blue Shield of Texas fee schedule(s) for the ancillary specialty for such service, as posted on the BCBSTX Web site, calculated under the terms of this Agreement; less any applicable Copayments, Coinsurance or Deductibles offset by any payments to Ancillary Provider from other sources, including but not limited to coordination of benefits and subrogation.

**SUBATTACHMENT D-4**

**BLUE PREMIER<sup>SM</sup> HMO NETWORK**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Notwithstanding anything to the contrary in Attachment D, Ancillary Provider agrees to accept as compensation for Covered Services the lesser of (1) eligible billed charges or (2) compensation pursuant to the then current Blue Cross and Blue Shield of Texas fee schedule(s) for the ancillary specialty for such service, as posted on the BCBSTX Web site, calculated under the terms of this Agreement; less any applicable Copayments, Coinsurance or Deductibles offset by any payments to Ancillary Provider from other sources, including but not limited to coordination of benefits and subrogation.

**SUBATTACHMENT D-5**

**BLUE HIGH PERFORMANCE NETWORK**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Notwithstanding anything to the contrary in Attachment D, Ancillary Provider agrees to accept as compensation for Covered Services the lesser of (1) eligible billed charges or (2) compensation pursuant to the then current Blue Cross and Blue Shield of Texas fee schedule(s) for the ancillary specialty for such service, as posted on the BCBSTX Web site, calculated under the terms of this Agreement; less any applicable Copayments, Coinsurance or Deductibles offset by any payments to Ancillary Provider from other sources, including but not limited to coordination of benefits and subrogation.

**SUBATTACHMENT D-6**

**MYBLUE HEALTH HMO NETWORK**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Notwithstanding anything to the contrary in Attachment D, Ancillary Provider agrees to accept as compensation for Covered Services the lesser of (1) eligible billed charges or (2) compensation pursuant to the then current Blue Cross and Blue Shield of Texas fee schedule(s) for the ancillary specialty for such service, as posted on the BCBSTX Web site, calculated under the terms of this Agreement; less any applicable Copayments, Coinsurance or Deductibles offset by any payments to Ancillary Provider from other sources, including but not limited to coordination of benefits and subrogation.

**ATTACHMENT E TEXAS  
MEDICAID: MANDATORY TEXAS MEDICAID PROVIDER CONTRACT ATTACHMENT  
PURSUANT TO HHSC UNIFORM MANAGED CARE MANUAL (UMCM) CHAPTER 8.1**

**ARTICLE I  
MANDATORY TERMS**

- 1.0 **Compliance with Terms.** Ancillary Provider will comply with the applicable terms and conditions set forth in this Attachment. The Texas Health and Human Services Commission (HHSC) Medicaid and CHIP Managed Care Contract(s) with BCBS mandates that the provisions contained below be included as part of BCBS's agreement with all Participating Providers. The provisions set forth in the HHSC Uniform Managed Care Manual (UMCM) Chapter 8.1, which is incorporated into the Uniform Managed Care Contract and STAR Kids Contract, are included herein as applicable to the Medicaid or CHIP Program in which BCBS participates.
- 1.1 **Term and Termination.** Ancillary Provider acknowledges and agrees that this Attachment will remain in effect for the duration of the term of the Agreement. Furthermore, Ancillary Provider acknowledges and agrees that this Attachment is conditioned upon continuation of the Texas Medicaid Contract(s) and will terminate automatically upon termination of same. Except in the event of such automatic termination, this Attachment will terminate upon termination of the Agreement.
- 1.2 **Network Provider(s).** In this Attachment, Network Provider(s) means, as applicable, Ancillary Provider and is interchangeable with those terms as defined in the Agreement.
- 1.3 **Terminology.** The following terms are referenced in the chart as set forth in this Section:
- 1.3.0 Uniform Managed Care Contract: UMCC.
  - 1.3.1 CHIP Rural Service Area Contract: RSA.
  - 1.3.2 STAR+PLUS Expansion Contract: S+P Exp.
  - 1.3.3 STAR+PLUS Medicaid Rural Service Area (MRSA) Contract: S+P MRSA.
  - 1.3.4 Uniform Managed Care Manual: UMCM.
  - 1.3.5 In this Agreement, Medicaid HMO Provider Network means the Provider Network for BCBS in its capacity as a Medicaid Managed Care Organization under Chapter 533 of the Texas Government Code.
- 1.4 **Applicable UMCM Revisions included in this version are as follows:** UMCM Revision Version 2.5, effective November 1, 2015: "STAR Kids" column and contract citations are added. Item 11 Behavioral Health is clarified. Item 12 Behavioral Health is clarified. Item 13 Coordination between Behavioral Health Services Provider and PCP is clarified. Item 39 Health Passport is removed. Item 54 "Member Communications" is modified to update the contract citations. Item 54.1 "Member Protections" is added. Item 55 "Payment for Services" is modified to remove "or CHIP" and to correct the contract citations. Item 65 "Termination" is clarified.

**ARTICLE II  
COMPENSATION**

- 2.0 **Compensation.** Notwithstanding anything else in this Agreement, Ancillary Provider will accept as payment in full for the provision of a Covered Service to a Covered Person having a Coverage Agreement accessing a Medicaid HMO Provider Network (also referred to as a Medicaid

Managed Care Network or “MMCN”) the lesser of (i) billed charges, or (ii) 100% of Medicaid fee schedule of the state of Texas Medicaid Fee Schedule in effect at the time such Health Care Services are rendered to the Covered Person, including, but not limited to, Claim edits, processes, bundling logic etc., in effect at the time the Covered Service is provided, less any applicable Cost Share amount that is the responsibility of the Covered Person pursuant to the terms of such Covered Person’s Coverage Agreement. Covered Persons enrolled in a CHIP Product shall access the MMCN and payment shall be subject to this Article.

- 2.1 **Modifications to MMCN Rates.** Within ninety (90) days after official written notification by the state of Texas or its contracted claims processor of any modifications to the state of Texas Medicaid Fee Schedule, BCBS shall complete necessary coding or other adjustments to incorporate the modifications into its Compensation Schedule. Payments to Ancillary Provider under this Agreement will be adjusted retroactive to the effective date of the state’s Fee Schedule changes.
- 2.2 **Administrative Billing/Coding.** Ancillary Provider shall notify BCBS ninety (90) days in advance of implementing a systematic administrative coding or billing change that increases Ancillary Provider revenue for Covered Services without increasing the volume or acuity of services. If BCBS becomes aware of such coding or billing change from Ancillary Provider or other sources, then BCBS shall evaluate the annual financial impact of such administrative coding or billing change. If such administrative coding or billing change results in an increase in expected compensation to Ancillary Provider greater than or equal to (i) of one hundred thousand dollars (\$100,000) or (ii) five percent (5%) of the total Allowed Amount for any Admission Type, (i.e., ER, Outpatient, etc.), then BCBS may submit to Ancillary Provider an amended Attachment E which adjusts compensation rates for the affected service to neutralize the financial impact of such a change as though the administrative coding or billing change did not occur. Ancillary Provider may object, in writing, to such amended Attachment E within thirty (30) days of receipt and BCBS and Ancillary Provider shall negotiate a mutually agreeable adjustment to Attachment E. If Ancillary Provider does not object to such amended Attachment E within such thirty (30) day period, then BCBS shall implement amended Attachment E.
- 2.3 **BCBS Website.** Some compensation reference material is posted on the BCBS website: <https://www.bcbstx.com/content/dam/hcsc/docs/provider/tx/provider-medicaid/education/2067877-758408-1124-TX-Medicaid-STAR-CHIP-STARKids-Provider-Manual-Handbook.pdf>.

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## ATTACHMENT F MEDICARE ADVANTAGE

### MEDICARE ADVANTAGE ATTACHMENT

This Medicare Advantage (“MA”) Attachment, including any sub-attachments to this Attachment F (e.g., Attachment F-1, Attachment F-2, etc.) (collectively, the “MA Attachment”), supplements the Agreement with respect to Covered Persons enrolled in a BCBS Medicare Plan (“Medicare Covered Persons”).

**WHEREAS**, BCBS and CMS have entered into one or more agreements (as defined below, “CMS Contracts”) for the provision of BCBS’s Medicare Plan, pursuant to the MA program;

**WHEREAS**, Provider would like to join BCBS’s network of Participating Providers to provide Health Care Services to Medicare Covered Persons; and

**WHEREAS**, BCBS and Provider will comply with the statutory and regulatory requirements for the MA program.

**NOW, THEREFORE**, the Parties agree as follows:

#### ARTICLE I DEFINITIONS

All capitalized terms not defined in this MA Attachment will have the meanings ascribed to them in Article I of the Agreement. The definitions in this MA Attachment apply only to the terms of this MA Attachment unless expressly noted otherwise.

- 1.0 **BCBS** for purposes of this Attachment shall mean Health Care Service Corporation, a Mutual Legal Reserve Company (as defined in this Agreement) and certain of its Affiliates (“BCBS Affiliates”) that have entered into one or more agreements with CMS (as defined below, “CMS Contracts”) for the provision of BCBS’s Medicare Plans, pursuant to the MA and Part D programs.
- 1.1 **BCBS Affiliate** means any current or future subsidiaries or affiliates of Health Care Service Corporation, a Mutual Legal Reserve Company, that offer or sponsor Medicare plans in certain service areas, either now or at a future date, including but not limited to: HCSC Insurance Services Company (“HISC”); GHS Health Maintenance Organization, Inc. d/b/a BlueLincs HMO (“BlueLincsHMO”), GHS Insurance Company (f/k/a GHS Property and Casualty Insurance Company) (“GHSIC”); and BCBSTX Government Programs Insurance Company (“BCBSTX GPIC”) (by whatever name each may be known in the future if different from the name stated herein), and any successor corporation, whether by merger, consolidation or reorganization. Any reference to BCBS in this Attachment shall mean the BCBS Affiliate in those instances where a BCBS Affiliate holds the CMS Contract.
- 1.2 **BCBS Medicare Plan(s)** means MA Plan(s) and Part D Plan(s) sponsored by BCBS or its Affiliate pursuant to a CMS Contract.
- 1.3 **BCBS Provider Network** means the network of Participating Providers maintained by BCBS to provide Covered Services to Medicare Covered Persons pursuant to the terms of their BCBS Medicare Plan.
- 1.4 **CMS Contract** means all the contracts between CMS and BCBS or BCBS Affiliate pursuant to which BCBS or BCBS Affiliate sponsors MA and Part D Plans.
- 1.5 **Downstream Entity** has the same definition that in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this Agreement, means any person or entity that enters into a written

arrangement with persons or entities involved in the MA and/or Medicare Part D Programs, below the level of the arrangement between BCBS and a First-Tier Entity, such as Provider.

- 1.6 **First Tier Entity** has the same definition as in 42 C.F.R. §§ 422.2 and 423.4, which, at the time of execution of this Agreement, means any person or entity that enters into a written arrangement with BCBS to provide administrative and/or Health Care Services, including Covered Services, to Medicare Covered Persons.
- 1.7 **HHS** means the U.S. Department of Health and Human Services.
- 1.8 **Medicare Advantage Plan or MA Plan** means a Medicare Advantage Plan sponsored by a Medicare Advantage Organization, as the term is defined in Laws, pursuant to the Medicare Advantage Program.
- 1.9 **Medicare Advantage Program or MA Program** means the Medicare managed care program established and maintained under Laws.
- 1.10 **Medicare Prescription Drug Plan or Part D Plan** means a Medicare prescription drug Product sponsored by a Part D Plan Sponsor, as the term is defined in Laws, pursuant to the Part D Program.
- 1.11 **Medicare Prescription Drug Program or Part D Program** means the Medicare prescription drug benefit program established and maintained under Laws.
- 1.12 **Medicare Covered Persons** means Covered Persons who are enrolled in a BCBS Medicare Plan.
- 1.13 **Participating Provider** means a person or entity who or which directly or indirectly contracts with, BCBS to deliver Health Care Services, including Covered Services, to Medicare Covered Persons.

## ARTICLE II BCBS OVERSIGHT AND ACCOUNTABILITY

- 2.0 **BCBS Oversight.** The Parties acknowledge and agree that BCBS will oversee, and ultimately remain responsible and accountable to CMS for, those functions and responsibilities required of BCBS pursuant to Laws and its CMS Contract. BCBS will provide ongoing monitoring and oversight of all aspects of Ancillary Provider's performance of its obligations under the Agreement and this MA Attachment.
- 2.1 **Cooperation with CMS.** The Parties acknowledge and agree that either Party's failure to cooperate with CMS or its designees may result in a referral of BCBS and/or Ancillary Provider to law enforcement and/or implementation of other remedial action by CMS, including, without limitation, imposition of intermediate sanctions.

## ARTICLE III COVERED SERVICES

- 3.0 **Provision of Covered Services.** Ancillary Provider will furnish Covered Services to Medicare Covered Persons and otherwise perform under the Agreement, including this MA Attachment in a manner consistent and in compliance with the requirements of all Laws; the CMS Contract; all applicable BCBS Policies and Procedures and guidelines, including, but not limited to, BCBS's compliance plan and such policies, procedures and initiatives for combating fraud, waste and abuse; and professionally recognized standards of health care. Ancillary Provider will ensure that Covered Services are provided to Medicare Covered Persons in a culturally competent manner,

including for those Medicare Covered Persons with limited English proficiency and/or reading skills, diverse cultural and ethnic backgrounds, physical disabilities, and mental disabilities. Ancillary Provider will discuss all treatment options with Medicare Covered Persons, including the option of no treatment, as well as related risks, benefits and consequences of such options. As applicable, Provider will provide to Medicare Covered Persons instructions regarding follow-up care and training regarding self-care.

- 3.1 **Direct Access to Certain Benefits.** Ancillary Provider will comply with all referral and Preauthorization procedures set forth in the Provider Manual, provided that no referral or prior authorization will be required for or imposed upon a Medicare Covered Person to obtain (i) a screening mammography from a Participating Provider, (ii) influenza vaccine from a Participating Provider, or (iii) routine and preventive Covered Services from an in-network women's health services specialist. Further, no cost-sharing obligation will be imposed on the Medicare Covered Person to obtain influenza and pneumococcal vaccines.
- 3.2 **Availability.** Ancillary Provider will make necessary and appropriate arrangements with other Participating Providers to ensure that Medically Necessary Covered Services are readily available to Medicare Covered Persons twenty-four (24) hours a day, seven (7) days a week.
- 3.3 **Non-Discrimination.** Ancillary Provider will not deny, limit, or condition coverage or the furnishing of Health Care Services or benefits, including Covered Services, to Medicare Covered Persons based on any factor related to health status, including, but not limited to, medical condition (including mental and/or physical illness or disability), Claims experience, receipt of health care, medical history, genetic information, or evidence of insurability (including conditions arising out of acts of domestic violence).
- 3.4 **Advance Directives.** Ancillary Provider will comply with advance directive requirements in accordance with Laws and will document in a prominent part of each Medicare Covered Person's current medical record whether or not such individual has executed an advance directive as required by Laws. Ancillary Provider will not condition the provision of Health Care Services or benefits, including Covered Services, or otherwise discriminate against any Medicare Covered Person based on whether or not the individual has executed an advance directive.

#### **ARTICLE IV RECORDS AND FACILITIES**

- 4.0 **Maintenance of Records.** Ancillary Provider will maintain adequate operational, financial, and administrative records, medical and prescription records, contracts, books, files and other documentation involving transactions related to the CMS Contract and/or the administration or delivery of Covered Services to Medicare Covered Persons under this Agreement, including this MA Attachment ("Records"). At minimum, such Records will be sufficient to enable BCBS to (i) evaluate Ancillary Provider's performance, including accuracy of data submitted to BCBS, and (ii) enforce BCBS's rights under the Agreement, including this MA Attachment, and in accordance with Laws.
- 4.1 **Inspection of Records.** Ancillary Provider, at Provider's sole cost and expense, will provide BCBS, HHS, the Comptroller General or their authorized designees with direct access to audit, evaluate, collect, and inspect all Records, personnel, physical premises, computers and other electronic systems, facilities and equipment relating to Ancillary Provider's performance under the Agreement, including this MA Attachment, including the provision of Covered Services to Medicare Covered Persons. Such direct access will be provided through 10 years from the date of the final contract period of the applicable CMS Contract, 10 years from the date of completion of any audit, or 10 years from the submission of data to CMS to verify for Medical Loss Ratio requirements, whichever is later, or such other time frame that may be required by Laws. Ancillary Provider, at Ancillary Provider's sole cost and expense, will provide all reasonable facilities and assistance for the safety and convenience of the personnel conducting any such

auditing, evaluation, collection, and inspection. Ancillary Provider, at Ancillary Provider's sole cost and expense, will provide BCBS with copies of any and all Records audited, evaluated, collected, or inspected by HHS, the Comptroller General and/or their authorized designees, within the timeframe necessary to allow for HCSC review before production, unless otherwise instructed by the HHS or Comptroller General. Ancillary Provider will notify BCBS immediately by telephone, to be followed with Written Notice within three (3) business days, if it receives any request directly from HHS, the Comptroller General or their authorized designees for any Records or information or to inspect Ancillary Provider's premises, physical facilities or equipment, or to confer with Ancillary Provider's personnel, and Provider will permit BCBS to participate in any such inspection or conference.

## **ARTICLE V PRIVACY, SECURITY AND CONFIDENTIALITY**

Ancillary Provider will obtain, analyze, store, transmit and report Protected Health Information, as defined under Laws, in accordance with all Laws. As applicable, Ancillary Provider will abide by all Laws and BCBS procedures regarding privacy, confidentiality, and accuracy of Medicare Covered Persons' medical and prescription records and other health and enrollment information.

## **ARTICLE VI PAYMENT**

- 6.0 **Claims Payment.** BCBS will pay Ancillary Provider for Covered Services rendered to Medicare Covered Persons pursuant to this Agreement, including this MA Attachment.
- 6.1 **Claims to Federal Government Prohibited.** Ancillary Provider will not request payment for Covered Services provided under this Agreement in any form from CMS, HHS, or any other agency of the United States of America or their designees for items and services furnished in accordance with this MA Attachment, except as may be approved in advance by BCBS and CMS.
- 6.2 **Overpayment.**
  - 6.2.0 **Timing of Notice and Refund.** Ancillary Provider will provide Notice to BCBS of any overpayment(s) identified by Ancillary Provider, including duplicate payments, within fifteen (15) days of identifying such overpayment, and, unless otherwise instructed by BCBS in writing, Ancillary Provider will refund any amounts due to BCBS within thirty (30) days of identifying such overpayment.
  - 6.2.1 **Recovery of Overpayments.** Notwithstanding the provisions in Section 6.2.0, above, in the event of any overpayment, duplicate payment, or other payment in excess of that to which Ancillary Provider is entitled for Covered Services furnished to a Medicare Covered Person under the Agreement and/or this MA Attachment, BCBS may recover the amounts owed by way of offset or recoupment from current or future amounts due from BCBS to Ancillary Provider.

## **ARTICLE VII HOLD HARMLESS**

- 7.0 **Medicare Covered Person Hold Harmless.**
  - 7.0.0 **Hold Harmless.** Ancillary Provider hereby agrees that in no event, including, but not limited to, non-payment by BCBS, insolvency of BCBS, or breach of the Agreement or this MA Attachment by BCBS, will Ancillary Provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against Medicare Covered Persons or persons other than BCBS acting on such Medicare

Covered Person's behalf for fees that are the legal obligation of BCBS, including Covered Services. This provision will not prohibit Ancillary Provider from collecting charges for Non-Covered Services or cost-sharing obligations for Covered Services imposed on Medicare Covered Person pursuant to the terms of such Medicare Covered Person's BCBS Medicare Plan.

- 7.0.1 **Survival.** Ancillary Provider further agrees that: (a) this provision will survive the termination of this MA Attachment regardless of the cause giving rise to termination and will be construed to be for the benefit of the Medicare Covered Person; and (b) this provision supersedes any oral or written contrary agreement now existing or hereafter entered into between Ancillary Provider and the Medicare Covered Person or persons other than BCBS acting on such Medicare Covered Person's behalf.
- 7.1 **Dual-Eligible Cost-Sharing.** Ancillary Provider agrees that, to the extent Ancillary Provider provide Covered Services to Medicare Covered Persons who are eligible for benefits under both the Medicare and Medicaid Programs ("Dual-Eligible Covered Persons"), and unless otherwise instructed by BCBS in writing:
- 7.1.0 **Cost-Sharing.** Ancillary Provider will not bill, charge, collect a deposit from or seek compensation, remuneration or reimbursement from or have any recourse against any Dual-Eligible Covered Person for payment of Medicare Part A and/or Part B cost-sharing when the state Medicaid program is responsible for payment of such amounts;
- 7.1.1 **Payment in Full.** Ancillary Provider will accept payment under the Agreement and this MA Attachment as payment in full for the Covered Service provided to a Dual-Eligible Covered Person or submit a Claim to the State Medicaid source for payment of any cost-sharing amount that is the obligation of the State Medicaid program.
- 7.2 **Dual-Eligible Benefits.** Ancillary Provider will coordinate with BCBS to ensure that Ancillary Provider is informed of Medicare and Medicaid benefits available to Dual-Eligible Covered Persons, including cost-sharing obligations of such Dual Eligible Covered Persons as well as any applicable eligibility requirements.
- 7.3 **Preclusion List.** Ancillary Provider agrees, for all services on or after January 1, 2020:
- a. Medicare Covered Persons do not have any financial liability for services, items, or drugs furnished, ordered, or prescribed to the Medicare Covered Person by an MA contracted individual or entity on the Preclusion List, as defined in 42 C.F.R. § 422.2 and as described in 42 C.F.R. § 422.222.
  - b. After the expiration of the 60-day period specified in §422.222, a provider will no longer be eligible for payment from the plan and will be prohibited from pursuing payment from the Medicare Covered Person as stipulated by the terms of the contract between CMS and the plan per 42 C.F.R. § 422.504(g)(1)(iv); and
  - c. Such provider will hold financial liability for services, items, and drugs that are furnished, ordered, or prescribed after this 60-day period, at which point the provider and the Medicare Covered Person will have already received notification of the preclusion.

**ARTICLE VIII  
COMPLIANCE WITH QUALITY IMPROVEMENT, GRIEVANCE, AND APPEAL REQUIREMENTS**

- 8.0 **Quality Improvement.** Ancillary Provider will cooperate and comply with all applicable BCBS Policies and Procedures, including, but not limited to, procedures and programs for quality improvement, performance improvement and medical management, including, as applicable,

drug Utilization Management, medication therapy management, and e-prescribing programs. Such cooperation and compliance will include, but not be limited to, making all information regarding medical policy, medical management and quality improvement available to BCBS and CMS upon request, and providing to BCBS such data as may be necessary for BCBS to implement and operate any and all quality improvement and medical management programs and Credentialing and Recredentialing requirements.

- 8.1 **Grievances, Coverage Determinations and Appeals.** Ancillary Provider will cooperate and comply with all requirements of BCBS regarding the processing of Medicare Covered Person grievances, coverage determinations and appeals relating to such Medicare Covered Persons' BCBS Medicare Plans, including the obligation to provide to BCBS any and all information within the time frame reasonably requested by BCBS to ensure BCBS's compliance with Laws.

#### **ARTICLE IX DATA COLLECTION**

- 9.0 **Data Reporting.** Ancillary Provider acknowledges that BCBS collects, analyzes and integrates data relating to the provision of Covered Services to Medicare Covered Persons in order for BCBS to meet its obligations under Laws, including, without limitation, 42 C.F.R. §§ 422.310, 422.516, 423,329, and 423.514, the CMS Contract and BCBS Policies and Procedures, and Ancillary Provider will provide to BCBS any and all data, including encounter data and medical and prescription records, relating to the provision of Health Care Services and benefits, including Covered Services, by Ancillary Provider to Medicare Covered Persons pursuant to the Agreement and this MA Attachment as BCBS so requests, and to submit such data to BCBS, or such other party designated by BCBS, in the format and within such time frames as may be prescribed by BCBS. Such data will include, without limitation, medical records used to determine Medicare Covered Persons' health status for purposes of submitting risk adjustment data, and any other data that may be used to determine the amount of payment to BCBS. Ancillary Provider agrees that all data Ancillary Provider submits to BCBS under this MA Attachment will conform to all relevant national standards and to the requirements for equivalent data for Medicare fee-for-service, as applicable.

- 9.1 **Acknowledgement of Data Used to Obtain Payment Under Federal Program.** Ancillary Provider acknowledges and agrees that data furnished by Ancillary Provider to BCBS in connection with the provision of Covered Services under the Agreement and this MA Attachment will be used by BCBS to obtain payment from CMS under the CMS Contract and to support BCBS's participation in the MA Program and Part D Program, including submission of bids for renewal of the CMS Contract in future years. Furthermore, Ancillary Provider acknowledges and agrees that BCBS and CMS will rely on the accuracy, completeness and truthfulness of any data Ancillary Provider submits to BCBS under the Agreement and this MA Attachment.

- 9.2 **Certification of Data Accuracy.** Ancillary Provider will, upon request by BCBS, have its CEO or CFO or an individual delegated the authority to sign on behalf of one of these officers and who reports directly to such officer, certify to the accuracy, completeness and truthfulness of all data submitted under the Agreement or this MA Attachment in the form and format set out in Attachment F-1.

- 9.3 **Potential Financial Penalties.** BCBS reserves the right to adopt, upon Notice to Ancillary Provider, a schedule of financial penalties to be imposed on Ancillary Provider, in BCBS's sole discretion, for Ancillary Provider's failure to comply with the terms and conditions of this Article.

#### **ARTICLE X DELEGATION AND SUBCONTRACTING**

10.0 **Delegation of Activities.** The Parties agree that to the extent that BCBS delegates to Ancillary Provider performance of any function, duty, obligation, or responsibility imposed on BCBS under the CMS Contract (“Delegated Activity”):

10.0.0 The Delegated Activity will be set out in writing and in the case of partial delegation such writing will specify the delegated components as well as those components retained by BCBS. If such Delegated Activity includes credentialing of Participating Providers and/or selection of Participating Providers, such written arrangement will address BCBS’s right to review, approve, and audit Ancillary Provider’s credentialing process and/or right to review, approve, suspend, and terminate such Providers, as applicable;

10.0.1 BCBS will conduct on-going monitoring and review of Ancillary Provider’s performance of the Delegated Activity;

10.0.2 Ancillary Provider’s performance of the Delegated Activity will comply with Laws, the Agreement, and this MA Attachment; and

10.0.3 Such delegation will be subject to the requirements of Laws.

10.1 **Revocation of Delegated Activities.** The Parties agree that, with respect to any Delegated Activity, BCBS may suspend or revoke the delegation in whole or in part or take such other remedial action as BCBS, in its reasonable discretion, deems appropriate, where CMS, in its sole discretion, or BCBS, in its reasonable discretion, determine that Ancillary Provider is not performing such Delegated Activity satisfactorily.

10.2 **Subcontracting.**

10.2.0 **Subcontract.** Ancillary Provider agrees that BCBS may, at its option and in its sole discretion, outsource various functions of its CMS Contract, including, but not limited to, marketing, Claims processing and membership.

10.2.1 **First Tier and Downstream Entities.** The Parties acknowledge that all vendors and Participating Providers involved in the provision of a Delegated Activity under this MA Attachment are considered First Tier or Downstream Entities and that all First Tier and Downstream Entities will comply with all provisions contained in this MA Attachment. Accordingly, Ancillary Provider, as a First-Tier Entity, agrees that it will not contract with any entity (“Subcontractor”) to administer or deliver Covered Services to Medicare Covered Persons unless (i) such arrangement is approved by BCBS in writing in advance, (ii) such Subcontractor is specifically obligated, through a written agreement between Subcontractor and BCBS or Subcontractor and Ancillary Provider, to comply with all of the provisions contained in this MA Attachment, and (iii) such written arrangement specifically permits BCBS to suspend or terminate the subcontractor or take such other remedial action as BCBS, in its reasonable discretion, deems appropriate, upon determination by CMS, in its sole discretion, or BCBS, in its reasonable discretion, that such Subcontractor is not performing the services satisfactorily.

## **ARTICLE XI COMPLIANCE, FRAUD, WASTE AND ABUSE PROGRAM AND REPORTING**

11.0 **Compliance Program.** Ancillary Provider will implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in Laws, including, without limitation, the Federal Sentencing Guidelines, and that addresses the scope of services under the Agreement and this MA Attachment. Such compliance program will require cooperation with BCBS’s compliance plan and BCBS Policies and Procedures and will include, without limitation, the following:

- 11.0.0 **Code of Conduct.** A code of conduct particular to Ancillary Provider that reflects a commitment to preventing, detecting and correcting fraud, waste, and abuse in the administration or delivery of Covered Services to Medicare Covered Persons.
  - 11.0.1 **Policies and Procedures.** Policies and Procedures that promote communication and disclosure of potential incidents of non-compliance or other questions or comments relating to compliance with Laws and Ancillary Provider's compliance and anti-fraud, anti-waste, and anti-abuse initiatives. Such program will include implementation and publication to Ancillary Provider's directors, officers, employees, agents and contractors of a compliance hotline and/or other method(s) of communication, which provides for anonymous reporting of issues of non-compliance with Laws or other questions or comments relating to compliance with Laws and Ancillary Provider's anti-fraud, anti-waste, and anti-abuse initiatives;
  - 11.0.2 **Risk Assessments.** Annual compliance risk assessments, performed at Ancillary Provider's sole expense. Ancillary Provider will, upon request, share the results of such assessments with BCBS to the extent any part of the assessment directly or indirectly relates to the Agreement and/or this MA Attachment.
  - 11.0.3 **Monitoring and Auditing.** Routine monitoring and auditing of Ancillary Provider's responsibilities and activities with respect to the administration or delivery of Covered Services to Medicare Covered Persons and the Agreement and this MA Attachment. Ancillary Provider hereby represents and warrants to BCBS that Ancillary Provider has an adequate work plan in place to perform such monitoring and audit activities. Provider will take corrective action to remedy any deficiencies found as appropriate.
  - 11.0.4 **Report to BCBS.** Upon request, provision of a report to BCBS of the activities of Ancillary Provider's compliance program required by this Agreement, including, without limitation, reports and investigations, if any, of alleged failures to comply with Laws, regulations, the terms and conditions of the CMS Contract, or the Agreement or this MA Attachment so that BCBS can fulfill its reporting obligations under Laws. Upon request, Ancillary Provider will provide to BCBS the results of any audits related to the administration or delivery of Covered Services to Medicare Covered Persons. Ancillary Provider will make appropriate personnel available for interviews related to any audit or monitoring activity.
- 11.1 **Incidents of Suspected Non-Compliance, Fraud, Waste or Abuse.**
- 11.1.0 **Non-Compliance.** Ancillary Provider will promptly investigate any potential and/or suspected incidents of non-compliance with Laws, fraud, waste, or abuse in connection with the Agreement, this MA Attachment, and/or the administration or delivery of Covered Services to Medicare Covered Persons ("Incident") and report any such Incident to BCBS as soon as reasonably possible, but in no instance later than thirty (30) days after Ancillary Provider becomes aware of such Incident. Such Notice to BCBS will include a statement regarding Provider's efforts to conduct a timely, reasonable inquiry into the Incident, proposed or implemented corrective actions in response to the Incident, and any other information that may be relevant to BCBS in making its decision regarding self-reporting of such Incident.
  - 11.1.1 **Ancillary Provider Cooperation.** Ancillary Provider will cooperate with any investigation by BCBS, HHS or its authorized designees relating to such Incident, and Ancillary Provider acknowledges that its failure to cooperate with any such investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under Laws.

- 11.1.2 **Reporting.** Ancillary Provider will cause its Downstream Entities to promptly report to Ancillary Provider, who will report to BCBS, any Incidents in accordance with this Section.
- 11.1.3 **Compliance Reviews.** In addition to any other audits or reviews agreed to pursuant to the Agreement or this MA Attachment, Ancillary Provider will provide BCBS with access to Ancillary Provider's records, physical premises and facilities, equipment and personnel in order for BCBS, in its sole discretion and at its sole cost and expense, to conduct compliance reviews in connection with the terms of the Agreement and this MA Attachment.
- 11.2 **Conflicts of Interest.** Ancillary Provider will require any manager, officer, director or employee associated with the administration or delivery of Covered Services to Medicare Covered Persons to sign a conflict of interest statement, attestation or certification at the time of hire and annually thereafter certifying that such individual is free from any conflict of interest in administering or delivering Covered Services to Medicare Covered Persons. Ancillary Provider will supply the form of such statement, attestation or certification to BCBS upon request.
- 11.3 **Exclusion of Certain Individuals.**
- 11.3.0 **Certification.** Ancillary Provider certifies that neither Ancillary Provider, Ancillary Provider employees, any Subcontractor, any Affiliate or any Downstream Entity involved in the provision of a Delegated Activity under this MA Attachment has been (i) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, State or local) contract or subcontract, (ii) listed by a federal governmental agency as debarred, (iii) proposed for Debarment or suspension or otherwise excluded from federal program participation or listed on the CMS preclusion list described in 42 C.F.R. § 422.222 ("CMS Preclusion List"), (iv) been convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of Federal or State antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property, or (v) within a three (3) year period preceding the date of this Agreement, had one or more public transactions (Federal, State or local) terminated for cause or default.
- 11.3.1 **Database Checks.** Ancillary Provider will check appropriate databases at least monthly to determine whether any Ancillary Provider employees, Subcontractors Affiliates or Downstream Entities involved in the provision of a Delegated Activity under this MA Attachment have been suspended or excluded from participation in the Medicare Program, any other Federal health care program, State contracts or State medical assistance programs. Databases include the CMS Preclusion List, the OIG List of Excluded Individuals/Entities ("LEIE"), the System for Award Management ("SAM") exclusion lists, and any other federal or State governmental agency exclusion list of persons who are sanctioned, debarred or voluntarily withdrawn as a result of a settlement agreement. Ancillary Provider shall provide to BCBS upon request within the timeframe requested, but no later than within 48 hours, documentation showing such databases/exclusion lists were reviewed for all individuals involved in the provision of a Delegated Activity under this MA Attachment.
- 11.3.2 **Notification.** Ancillary Provider acknowledges and agrees that it has a continuing obligation to notify BCBS in writing within seven (7) business days if any of the above-referenced representations change. Ancillary Provider further acknowledges and agrees that any misrepresentation of its status or any change in its status at any time during the term of this Agreement may be grounds for immediate termination of this Agreement, at the sole discretion of BCBS.

**ARTICLE XII  
OFFSHORE OPERATIONS**

Ancillary Provider will not itself nor directly or indirectly through another person or entity, undertake any functions, activities, or services in connection with the Agreement or this MA Attachment, including without limitation, storage of Medicare Covered Persons information, outside of the United States of America without the prior written consent of BCBS. Ancillary Provider will provide any and all information and attestations requested by BCBS to facilitate BCBS's process of identifying and evaluating privacy and security risks to Medicare Covered Persons data in any contemplated offshore function, activity or service. Ancillary Provider acknowledges that such information and attestations are necessary to enable BCBS to make the required attestations to CMS related to such offshore function, activity or service within the required timeframes established by CMS.

**ARTICLE XIII  
TERM AND TERMINATION**

- 13.0 **Term.** The Parties agree that this MA Attachment will commence on Provider Network Effective Date as listed in this Agreement or applicable amendment ("MA Attachment Effective Date") and continue in effect for one (1) year (the "Initial MA Attachment Term"). Thereafter, the MA Attachment will automatically renew for successive one (1) year terms (each, a "MA Attachment Renewal Term" and together with the "Initial MA Attachment Term," the "MA Attachment Term") unless:
- 13.0.0 a Party sends a Written Notice of termination of this MA Attachment to the other Party by June 30th prior to any MA Attachment Renewal Term, with such termination to be effective upon the expiration of the then-current Initial MA Attachment Term or MA Attachment Renewal Term, as applicable, or,
- 13.0.1 the MA Attachment is earlier terminated as set forth in Article V in accordance with any of the bases for which the entire Agreement may be terminated under Article V of the Agreement.
- 13.1 **Termination upon Termination of CMS Contract.** The Parties agree that this MA Attachment is conditioned upon the CMS Contract and will terminate automatically upon termination of the CMS Contract. BCBS will, to the extent practical and feasible, undertake commercially reasonable efforts to advise Ancillary Provider in advance of the termination of the CMS Contract.
- 13.2 **Termination upon CMS Request.** The Parties agree that this MA Attachment will terminate immediately upon the request of CMS.
- 13.3 **Termination of Agreement.** This Attachment shall terminate upon termination of the Agreement.
- 13.4 **Notice of Termination to Medicare Covered Persons.** Upon termination of this MA Attachment for any reason, BCBS, and not Ancillary Provider, will, as required by Laws, notify Medicare Covered Persons treated by Ancillary Provider in the six (6) months prior to the effective date of the termination of this MA Attachment and Ancillary Provider's participation in the BCBS Provider Network. Ancillary Provider will cooperate with and assist BCBS in identifying such Medicare Covered Persons.
- 13.5 **Continuation of Benefits.** Ancillary Provider will continue to provide Covered Services to Medicare Covered Persons for the duration of the contract period for which BCBS receives payment from CMS. Upon termination of this MA Attachment for any reason or the insolvency of BCBS, Ancillary Provider will continue to provide Covered Services to Medicare Covered Persons who are hospitalized as of the date of termination of this MA Attachment or BCBS's insolvency

through the date of such Medicare Covered Person's discharge or when medically appropriate alternative care is arranged for the Medicare Covered Person ("Continuation Services"). Such Continuation Services will be provided in accordance with the terms and conditions of the Agreement and this MA Attachment, including, but not limited to, the compensation rates and terms set forth in Attachment F-2 and Attachment F-3, unless the Parties otherwise agree in writing.

- 13.6 **Transition of Medicare Covered Persons.** Upon either Party's provision of Notice of termination of this MA Attachment to the other Party, Ancillary Provider will cooperate fully with BCBS and BCBS protocols, if any, in the transfer of Medicare Covered Persons to other Participating Providers.
- 13.7 **Survival of Term and Termination.** The terms of this Article XIII will survive the termination of this MA Attachment.

#### **ARTICLE XIV CONFLICT AND PREEMPTION**

- 14.0 **Conflict.** To the extent any provision of this MA Attachment conflicts with any provision in the Agreement, this MA Attachment will control with respect to the provision of Covered Services or Ancillary Provider's obligation or duty under the Agreement or this MA Attachment as the same relates to Medicare Covered Persons, BCBS Medicare Plans, or the CMS Contract.
- 14.1 **Preemption.** The Parties acknowledge and agree that the standards established by the Medicare Advantage Program and Medicare Part D Program supersede any State Law or regulation, other than State licensing Laws or State Laws relating to the solvency of sponsors of such Medicare Plans.

#### **ARTICLE XV AMENDMENT DUE TO LEGAL OR REGULATORY CHANGES**

The Parties acknowledge and agree that this MA Attachment will supersede any previous amendment, addendum, or attachment to the Agreement regarding the subject matter herein. Further, the Parties agree that this MA Attachment will automatically be amended as necessary to conform to Laws and to include any additional terms and conditions as CMS or BCBS may find necessary and appropriate in order to implement and comply with the requirements of Laws and any such additional or conforming terms and conditions will be considered incorporated herein as if fully stated, pending formal amendment.

#### **ARTICLE XVI COMPENSATION**

Ancillary Provider will accept as payment in full for the provision of a Covered Service to a Medicare Covered Person compensation outlined in the applicable Subattachment to this Agreement. If the arrangement between the Parties involves physician incentive or risk arrangement, both Parties agree to comply with the Physician Incentive Plan (PIP) regulations set forth in 42 CFR § 422.208 and 42 CFR § 422.210.

#### **ARTICLE XVII CLAIMS SUBMISSION**

- 17.0 **Claims Submission.** Ancillary Provider will submit complete and properly executed Claims for a Covered Service to BCBS or its designee within one hundred eighty (180) days of the date the Covered Service is rendered. If Ancillary Provider fails to submit a Claim in compliance with this paragraph, Ancillary Provider forfeits the right to payment from BCBS or the Covered Person.

- 17.1 **Format.** Claims may be submitted (i) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format, or (ii) on a completed version of the applicable CMS Claim form.

**ARTICLE XVIII  
CLAIMS PAYMENT**

BCBS will make payment on a Clean Claim, as defined in Laws, to Ancillary Provider within thirty (30) days of BCBS's receipt of such Claim at such address designated by BCBS.

**ARTICLE XIX  
INDEMNITY**

- 19.0 Ancillary Provider agrees to indemnify and hold BCBS harmless for any losses suffered by BCBS as described in this Article. Notwithstanding any limitation of liability in the Agreement, and in addition to any other indemnification provided for in the Agreement, Ancillary Provider shall pay BCBS for:
- 19.0.0 any loss associated with a finding of non-compliance by CMS or other governmental agency against BCBS or BCBS Affiliate; and
  - 19.0.1 for the amount of any fine, penalty or liquidated damage assessed by CMS or other governmental agency against and payable by BCBS or BCBS Affiliate to any agency of government or under law;
- 19.1 If the loss described in Section 19.0 was caused by Ancillary Provider or Ancillary Provider's officers, directors, employees, agents, or Downstream Entity(ies) in the performance of or failure to perform any function, duty, responsibility, or performance standard under the Agreement or this MA Attachment or as required to comply with Laws, the CMS Contract, the Agreement, and/or this MA Attachment.
- 19.2 If the loss described in Section 19.0 is caused in part by Ancillary Provider (including its officers, directors, employees, agents, or Downstream Entity(ies)) and in part by BCBS, Ancillary Provider will pay BCBS for Ancillary Provider's proportionate share of such loss based on a percentage of responsibility for the performance or failure at issue, as determined by BCBS. The aggregate amount Ancillary Provider is liable for under this section is not limited or in any way subject to limitation of liability under the Agreement.
- 19.3 For the avoidance of doubt, the Parties agree that all other claims, losses, liabilities or expenses arising from any action, suit or proceeding that is incurred because of the failure of Ancillary Provider to comply with any other contractual, statutory, or regulatory requirement, relating to any function, duty, responsibility, or delegation that is Ancillary Provider's responsibility under the Agreement are subject to indemnification as set forth separately in the Agreement.
- 19.4 This Article shall survive termination of the Agreement and this MA Attachment, regardless of the cause giving rise to termination.

**ATTACHMENT F-1 MEDICARE ADVANTAGE  
ATTESTATION MEDICARE DATA SUBMISSION  
ATTESTATION**

**(SAMPLE - TO BE SUBMITTED WITH ANY DATA COLLECTION REQUEST BY BCBS)**

<Enter Name of Provider Type > acknowledges that the information described below directly affects the calculation of payments to BCBS in connection with its sponsorship of BCBS Medicare Plans pursuant to the CMS Contract and/or additional benefit obligations of BCBS. <Enter Name of Provider Type > acknowledges that misrepresentations to BCBS and/or CMS about the accuracy of such information may result in federal civil action and/or criminal prosecution.

<Enter Name of Provider Type> has reported to BCBS, for transmission to CMS, and for the period of \_\_\_\_\_(INDICATE DATES), all \_\_\_\_\_(INDICATE TYPE OF DATA) data requested by BCBS available to <Enter Name of Provider Type > with respect to the BCBS Medicare Plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to BCBS and/or CMS via this report is accurate, complete, and truthful.

Authorized Signature:

\_\_\_\_\_  
\_\_\_\_\_

(INDICATE TITLE [CEO, CFO, or delegate])

on behalf of

\_\_\_\_\_

<Enter Name of Provider Type >

\_\_\_\_\_

Date

**ATTACHMENT F-2 MEDICARE ADVANTAGE  
MEDICARE ADVANTAGE PPO COMPENSATION**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Ancillary Provider will accept as payment in full for the provision of a Covered Service to a Covered Person enrolled in a BCBS PPO Medicare Advantage Product the lesser of (i) 100% of Covered Charges or (ii) 100% of the Medicare allowed amount taking into account all Medicare Claims processing rules, including, but not limited to, Claim edits, processes, bundling logic, etc., in effect at the time the Covered Service is provided, less any applicable Cost Share. The definition of Medicare allowed amount includes the Hospital base payment plus capital and disproportionate share (DSH).
- 1.1 **Cost-Sharing.** Ancillary Provider may bill BCBS Medicare Advantage Covered Persons directly for any Cost Share amounts due under the applicable Medicare Advantage Plan, and for amounts for Non-Covered Services.
- 1.2 **Sequestration.** Both Parties acknowledge and agree that certain reductions to Medicare Provider payments are mandated pursuant to the Budget Control Act of 2011 and its implementing rules, regulations, and guidance as amended from time to time (“Sequestration”). Both Parties further acknowledge and agree that additional reductions to Medicare Provider payments may be implemented pursuant to similar regulatory authority enacted on or after the effective date of this Agreement. Accordingly, both Parties agree that the rates payable under this Agreement will be adjusted by the amount proportionally equal to any reductions under Sequestration and such other regulatory authority.
- 1.3 **Medicare Advantage Considerations.** The Parties further agree that there will be no “bad debt” settlement payments made to Ancillary Provider by BCBS at any time. “Bad debt” settlement payments are those bad debt reimbursements to providers that meet the minimum Medicare requirements under applicable laws, rules, regulations and Medicare guidance. The Parties further agree that participation in the BCBS Medicare Advantage HMO and PPO Products will be at fixed rates which rates will include current Federal sequestration reductions. Except, that if one Party is unsatisfied with the current applicable Federal sequestration reductions, then such Party may terminate the MA Attachment with ninety (90) days’ prior written notice to BCBS in accordance with the Written Notice requirements set forth in this Agreement.

**ATTACHMENT F-3 MEDICARE ADVANTAGE  
MEDICARE ADVANTAGE HMO COMPENSATION**

**ARTICLE I  
COMPENSATION**

- 1.0 **Compensation.** Ancillary Provider will accept as payment in full for the provision of a Covered Service to a Covered Person enrolled in a BCBS HMO Medicare Advantage Product the lesser of (i) 100% of Covered Charges or (ii) 100% of the Medicare allowed amount taking into account all Medicare Claims processing rules, including, but not limited to, Claim edits, processes, bundling logic, etc., in effect at the time the Covered Service is provided, less any applicable Cost Share. The definition of Medicare allowed amount includes the Hospital base payment plus capital and disproportionate share (DSH).
- 1.1 **Cost-Sharing.** Ancillary Provider may bill BCBS Medicare Advantage Covered Persons directly for any Cost Share amounts due under the applicable Medicare Advantage Plan, and for amounts for Non-Covered Services.
- 1.2 **Sequestration.** Both Parties acknowledge and agree that certain reductions to Medicare Provider payments are mandated pursuant to the Budget Control Act of 2011 and its implementing rules, regulations, and guidance as amended from time to time (“Sequestration”). Both Parties further acknowledge and agree that additional reductions to Medicare Provider payments may be implemented pursuant to similar regulatory authority enacted on or after the effective date of this Agreement. Accordingly, both Parties agree that the rates payable under this Agreement will be adjusted by the amount proportionally equal to any reductions under Sequestration and such other regulatory authority.
- 1.3 **Medicare Advantage Considerations.** The Parties further agree that there will be no “bad debt” settlement payments made to Ancillary Provider by BCBS at any time. “Bad debt” settlement payments are those bad debt reimbursements to providers that meet the minimum Medicare requirements under applicable laws, rules, regulations and Medicare guidance. The Parties further agree that participation in the BCBS Medicare Advantage HMO and PPO Products will be at fixed rates which rates will include current Federal sequestration reductions. Except, that if one Party is unsatisfied with the current applicable Federal sequestration reductions, then such Party may terminate the MA Attachment with ninety (90) days’ prior written notice to BCBS in accordance with the Written Notice requirements set forth in this Agreement.

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