HIGHMARK PROFESSIONAL PROVIDER AGREEMENT REGULATIONS

Effective Date: January 1, 2024

1. RELATIONSHIP TO THIS AGREEMENT

These Regulations are a part of the Highmark Professional Agreement and binding on Professional Providers as if set forth fully therein. The Regulations contain operational provisions applicable to all Professional Providers across all Networks, Lines of Business, and Products covered by this Agreement. The Regulations will be provided to Professional Providers upon issuance of this Agreement. The Regulations also will be made available in electronic format on the Provider Resource Center or its successor, the Participating Professional Provider Online Provider Portal, or other internet website posting available to Professional Providers. The Regulations can be updated unilaterally by Highmark to maintain uniformity of operations. Highmark may amend and update the Regulations or any provision hereof by sending a paper copy of the replacement Regulations or sending information on where to access an electronic copy of the replacement Regulations to Professional Provider at least sixty (60) days but no less than thirty (30) days prior to the Effective Date of such replacement Regulations which shall be binding upon Professional Provider.

2. SHARED PROVISIONS

The Regulations apply to you as a Professional Provider after execution of this Agreement, regardless of the Participation Attachment(s) you hold or what Products you have been designated to participate in. Highmark, in its discretion, requires underlying contracts, amendments, or attachments to be executed to be eligible to participate in certain Products, Networks, or Lines of Business. Networks or sub-networks may support various Products and Professional Provider's participation in a Product shall be subject to Highmark's discretion as set forth in this Agreement. The inclusion of terms applicable to any Network, Line of Business, or Product in this comprehensive set of Regulations does not act as an offer or an agreement for Professional Provider to participate in any Network, Line of Business, or Product.

3. DEFINITIONS

Unless defined elsewhere in this Agreement, capitalized terms shall have the meanings assigned to them below and shall apply whether the defined term is used in the singular or the plural. No definition shall conflict with the definitions set forth in the applicable Plan Document or any applicable Laws. In the event of a conflict, the definitions contained in the Plan Document or any applicable Laws shall control:

3.1 "Administrative Requirements" shall mean, individually and collectively, Highmark's and/or, where applicable, Health Plan's guidelines, policies, procedures, provider manual, other manuals, instructions, bulletins, directives, and/or other documents.

3.2 "Agreement" shall mean the Highmark Professional Provider Agreement executed by the parties and all attachments, exhibits, and Regulations hereto.

3.3 "ASO Account" shall mean an entity that sponsors a self-insured Group Health Plan for which Highmark or Health Plan, as the case may be, agrees to provide a network of Professional Providers and is responsible for all or part of the administration of the Group Health Plan.

3.4 "Auxiliary Personnel" shall mean non-physician, licensed health care personnel who assist in rendering Provider Services to Members under the supervision of a physician in accordance with applicable Laws and the Administrative Requirements.

3.5 "Clean Claim" shall have the same meaning as required by applicable Laws governing a claim for Provider Services.

3.6 "Compliance Requirements" shall mean those requirements applicable to Highmark, Health Plan, or Providers that are necessary for compliance with the terms or conditions of applicable Laws or accreditation standards related to Products (including government sponsored or regulated Products), Member benefits, or operations of Highmark or Health Plan**.**

3.7 "Cost Sharing" shall mean any amounts payable by a Member in connection with Covered Services as required by the Member's Plan Document including deductible(s), copayment(s), and coinsurance.

3.8 "Covered Services" shall mean those Provider Services rendered to eligible Members which qualify for reimbursement pursuant to the terms of this Agreement, applicable Plan Documents and/or Administrative Requirements.

3.9 "Effective Date" shall mean the day and year as assigned by Highmark and set forth on the execution page of this Agreement.

3.10 "Group Health Plan" shall mean a plan, fund, or program that is established or maintained by an employer or employee organization for the purpose of providing medical, surgical, hospital care, or similar welfare benefits to Members.

3.11 "Health Plan" shall mean, individually and collectively, as applicable, (a) Highmark; (b) a Highmark Affiliate, except where Members are covered under a separate agreement with the Highmark Affiliate; (c) a Group Health Plan established or maintained by an ASO Account; and/or (d) any other Blue Cross and/or Blue Shield plan licensed by the Blue Cross Blue Shield Association where claims are processed pursuant to the requirements of a Blue Cross Blue Shield Association network access/sharing program including but not limited to Blue Card or its successor program and/or (e) a Network Access Partner.

3.12 "Highmark Affiliate" shall mean an entity or entities that directly controls, is controlled by, or is under common control with Highmark including HMOs.

3.13 "HMO" shall mean a Health Maintenance Organization organized under the Laws of the State in which the HMO operates.

3.14 "Laws" shall mean any applicable foreign, domestic, federal, state, and/or local constitution, treaty, statute, regulation, rule, code, ordinance, order, policy, directive, injunction, writ, decree, award, or the like of any Official Body applicable to or issued in a matter having jurisdiction over Highmark and/or Health Plan. Without in any way limiting the generality of the foregoing, any reference to any specific Law herein or any specific sections or provisions thereof shall include existing provisions and all amendments, modifications, or replacements of such Law which are adopted, issued, enacted, or promulgated after this Agreement's execution.

3.15 "Lines of Business" shall mean a type of Product sold by Highmark or a Highmark Affiliate including but not limited to those known as HMOs, PPOs, or Affordable Care Act "ACA." Such Lines of Business may require the issuance of an Attachment to this Agreement for participation. Lines of Business do not include those that require the execution of a separate Professional Provider agreement as determined by Highmark

3.16 "Member" shall mean any person enrolled and eligible for coverage under a Plan Document of a Product.

3.17 "Network" shall mean a group of Professional Providers designated by Highmark as participating providers, who have agreed under the terms of this Agreement to service Members covered under one or more Products or Lines of Business. Networks can be broad, meaning that there are fewer Participation Criteria. Networks can also be high performing, meaning that there are a greater number of Participation Criteria. Selection to participate in a broad network does not mean that a Professional Provider will be selected to participate in high performing networks or all networks or Products.

3.18 "Official Body" shall mean any government or political subdivision or any agency, department, or instrumentality of either, or any court, tribunal, grand jury, or arbitrator, in each case, whether foreign or domestic, applicable to a matter involving Highmark and/or Health Plan and having jurisdiction over Highmark and/or Health Plan.

3.19 "Online Provider Portal" shall mean the provider web based portal, or its successor portal, used by Highmark and/or Health Plan to provide information, interface, and communications to providers.

3.20 "Overpayment" shall mean any payments greater in amount than actually due Professional Provider under this Agreement or to which Professional Provider was not entitled regardless of the reason and no matter how Highmark, Health Plan, or Professional Provider learns of such error. Overpayments shall also include, but are not limited to, any payments to Professional Provider for Provider Services provided during any period in which Professional Provider failed to satisfy any Participation Criteria.

3.21 "Participating Provider" shall mean generally a provider who has entered into or is covered by one or more provider agreements with Highmark and/or Health Plan to provide Provider Services to Members. Such term shall include Professional Provider and its recognized

Practitioners upon Professional Provider's execution of this Agreement. A Participating Provider may be designated for participation in some or all Products, Networks, and Lines of Business in accordance with the terms of this Agreement.

3.22 "Participation Criteria" shall mean the general participation criteria, credentialing criteria, contracting criteria, network criteria, quality criteria, and insurance criteria as described in this Agreement and/or Administrative Requirements which govern Professional Provider's participation in a Product, any Network supporting a Product, or a Line of Business, as applicable.

3.23 "Plan Document" shall mean any document that governs the rights and responsibilities of a Member with respect to Covered Services under a Product.

3.24 "PPO" shall mean a Preferred Professional Provider Organization organized under the Laws of the State in which the insurer offering the PPO operates.

3.25 "Practitioner" shall mean, in accordance with this Agreement, all individual providers covered under and bound by an agreement between Highmark and a Professional Provider.

3.26 "Provider Resource Center" shall mean the website maintained by Highmark which provides resources, Administrative Requirements, other content and notices to Participating Providers.

3.27 "Provider Services" shall mean those services, goods, and/or supplies which are customarily furnished by Professional Provider to patients and described in this Agreement.

3.28 "Product" shall mean indemnity, managed care, and other products and benefit programs, including but not limited to any insured or self-insured Group Health Plans, offered or administered by Highmark or Health Plan and for which Highmark or Health Plan has the authority to approve, designate, or select Participating Providers. The term "Product" shall not include any Products or Lines of Business that require the execution of a separate Professional Provider agreement as determined by Highmark.

3.29 "Regulations" shall mean those binding general terms and conditions applicable to all Professional Providers issued by Highmark in the form of regulations and as provided for in this Agreement.

3.30 "Service Area" shall mean the service area of issuer or administrator of the Member's Product as prescribed by Blue Cross and Blue Shield Association rules and guidance.

3.31 "Term" shall mean, collectively, the initial term and any and all renewal terms of this Agreement.

3.32 "Usual Charges" shall mean the amount that Professional Provider bills other payors and/or patients for the same services.

3.33 "Value Based Reimbursement Programs" or "VBR Programs" are those programs administered by Highmark or Health Plan which incentivize or reimburse providers for services based on measurable quality, cost effectiveness, and/or other standards.

4. GENERAL REQUIREMENTS

4.1 Insurance Requirements. Professional Provider shall procure and maintain at all times during the Term such policies of general liability and professional liability (malpractice and other) insurance in such minimum amounts as appropriate and as required by applicable state Laws or Highmark.

4.2 Government Funds. Professional Provider acknowledges that payments Professional Provider receives for Covered Services rendered to Members in accordance with this Agreement are, in whole or in part, derived from government funds and that any false or fraudulent claim or statement in any document, or any concealment of a material fact, or any other form of fraudulent activity relating to Professional Provider's involvement with any government program covered by this Agreement as a Product, as the case may be, may be a cause for prosecution under applicable Laws. In the event of a successful prosecution of Professional Provider, Highmark and/or Health Plan may, at their discretion, suspend or terminate Professional Provider's participation in any government program covered by this Agreement as a Product.

4.3 Communication with Members. Notwithstanding anything to the contrary in this Agreement, nothing herein shall be construed to prohibit any Professional Provider from communicating with any Member regarding any treatment option available to Member that is within such Professional Provider's scope of practice, regardless of the Member's Product benefit coverage limitations.

4.4 Equal Access and Non-Discrimination. Professional Provider shall not deny, limit, fail to admit a Member, discriminate, or otherwise condition the furnishing of Provider Services on the basis of the Member's race, color, national origin, ancestry, religion, sex, including sex stereotypes and gender identity, marital status, sexual preference, disability, age, (or known or believed relationship or association by the Member with an individual or individuals of a particular race, color, national origin, sex, age, or disability) or the Member's source of payment, cost, anticipated cost, membership in a Product of Highmark or Health Plan or health status (to include, but not be limited to, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability). Professional Provider agrees that under no circumstance will Professional Provider refuse to render Provider Services based on the assumption that the anticipated cost that will be incurred by Professional Provider will be in excess of Highmark's payment for Covered Services. Further, Professional Provider shall provide Members with equal access at all times to those Provider Services that are made available to individuals who are not Members.

4.5 Administrative Requirements. Highmark or Health Plan shall make available to Professional Provider the Administrative Requirements with which Professional Provider must comply in the form of a manual, policies, procedures, and/or other written material, and Highmark or Health Plan shall provide notice of any changes thereto. The Administrative Requirements may be in an electronic format and available on the Provider Resource Center, the Participating Provider Online Provider Portal, or other internet website posting available to Professional Provider. Notice of any changes or updates to the Administrative Requirements will be given to Professional Provider via a bulletin or other provider communication which may also be available in electronic format. Highmark and Professional Provider shall each be bound by the Administrative Requirements. Highmark and Professional Provider shall each further agree to comply with and abide by any final determination made in accordance with all applicable Administrative Requirements, including, but not limited to, (a) utilization management; (b) care management and quality improvement; (c) management and assurance programs; (d) procedures and activities; (e) special studies; (f) credentialing and re-credentialing; (g) sanctioning; (h) external audits; (i) cost management programs, (j) account programs; (k) charge audit programs; (l) integrity programs; (m) coordination of benefits programs; (n) other carrier liability programs and (o) administrative appeals, complaints and grievance procedures for Members and Participating Providers, as in effect from time to time, and the terms of any and all applicable Plan Documents. If Professional Provider fails to comply with any applicable Administrative Requirements, Highmark shall have the right to pursue remedial actions as appropriate, including, without limitation, rejection of claims, retrospective review of claims, collection of any Overpayments, and/or termination of this Agreement. In such event, Professional Provider will hold Highmark, Health Plan, and/or the Member harmless with respect to fees and/or charges for Provider Services, except for the collection of applicable Cost Sharing.

5. PROVISION AND PAYMENT FOR COVERED SERVICES

5.1 Provision of Services. Professional Provider agrees to and agrees to cause its Practitioners to provide Members all Provider Services in the most efficient manner and in the most appropriate setting for the appropriate treatment of the Member. Professional Provider and each Practitioner shall make sure that Provider Services are available consistent with Administrative Requirements to include covering arrangements, where applicable. All Provider Services provided for Members by Professional Provider shall be performed by Professional Provider and/or Practitioners either personally or under his, her, or its supervision as defined in the Administrative Requirements. In rendering Provider Services, Professional Provider and its Practitioners can freely communicate with Members regarding the appropriate treatment options and alternatives available to them, including medication treatment options, regardless of benefit coverage limitations. Professional Provider further agrees that all duties performed hereunder shall be (a) consistent with relevant Administrative Requirements and (b) performed in accordance with the customary rules of ethics and conduct of applicable state and professional licensure boards and agencies.

5.2 Use of Participating Providers. Professional Provider agrees that, except in the event of an emergency, a Member's specific request or the unavailability of a Participating Provider, Professional Provider shall use best efforts, and shall cause each Practitioner to use best

efforts to, direct Members as needed for additional health care service to Professional Providers participating in the Member's Product. When ordering drugs and medical items or supplies for Members, Professional Provider and each Practitioner shall use Participating Providers participating in the Member's Product. Professional Provider and each Practitioner shall document in the Member's records any and all reasons why a Member was directed to a non-Participating Professional Provider, and shall inform the Member that there may be additional costs to the Member resulting from the use of a non- Participating Professional Provider. Professional Provider shall notify Highmark of any referral to a non-Participating Professional Provider.

5.3 Member Eligibility and Payment Determinations. Highmark and/or Health Plan shall provide each Member with an identification card or its equivalent and give Professional Provider access to relevant Member benefit information. Highmark shall, and/or shall cause any applicable Health Plan to, also provide determinations as to eligibility and authorization for Provider Services in accordance with applicable Administrative Requirements and any time frames and procedures set forth in applicable Laws. Professional Provider shall verify a Member's eligibility as a Member, as well as coverage of a Provider Service, as required by and in accordance with applicable Administrative Requirements.

5.4 Value Based Reimbursement Programs. Highmark may, from time to time, offer one or more supplemental or integrated VBR Program(s) involving Professional Providers. A supplemental VBR Program is separate from Highmark or Health Plan's traditional fee-for-service reimbursement allowances and may result in additional or reduced reimbursement to the Professional Provider if the Professional Provider meets or fails to meet certain metrics that will be set by Highmark in Highmark's sole discretion ("VBR Metrics"). An integrated VBR Program replaces, in whole or in part, Highmark or Health Plan's traditional fee-for-service reimbursement allowances upon the Professional Provider meeting VBR Metrics. Highmark may require Provider to participate in any such VBR Program. A supplemental or integrated VBR Program may apply to one or more Networks, Lines of Business, or Products. Professional Provider shall ensure that its Practitioners, as applicable, participate in Highmark's VBR Program(s) as requested or required by Highmark. Details regarding VBR participation criteria for, and the terms and conditions of, any Highmark VBR Program shall be communicated to Professional Provider in a manual, newsletter, or other appropriate means of communication. Professional Provider agrees that Highmark may prohibit or restrict participation in any VBR Programs for any Professional Provider based on the program's requirements, such as minimum Member attribution, location, or other reason. Professional Provider's participation in any VBR Programs shall be at Highmark's sole discretion.

Professional Provider shall cooperate and take such further actions, including the execution of instruments and documents, as may be necessary or appropriate to fully consummate any VBR Program as reasonably requested by Highmark in order to carry out the provisions and purposes of this Agreement as it pertains to any VBR Program.

5.5 Prompt Payment. Highmark agrees to comply with all applicable Laws governing Clean Claims submitted for Covered Services including the payment of required interest.

5.6 Payment Data/Billing. Professional Provider will submit encounter, claim and/or certain clinical data to Highmark including data related to HEDIS measures or other data needed to comply with governmental, Blue Cross and Blue Shield Association, or NCQA or other accreditation agency initiatives and/or, as applicable, Health Plan, or, as appropriate, to other Professional Providers, using such forms, media, format and coding structures, including the use of modifiers, as may from time to time be acceptable to and required by Highmark and/or, as applicable, Health Plan. Billings shall include all patient identification information and itemization of Provider Services in a standardized format acceptable to Highmark and/or, as applicable, Health Plan. Information identifying Provider Services rendered to Members shall include standard references as required by applicable Laws and/or such other more specific references as may be established and required by Highmark and/or, as applicable, Health Plan. When requested by Highmark and/or, as applicable, Health Plan, or as required by Administrative Requirements or correct coding standards, Professional Provider shall also provide a description of a Provider Service, a copy of the Member's records, or other appropriate documentation. During the Term, Professional Provider billing instructions will be issued periodically and made available to Professional Provider to update and clarify the billing requirements of Highmark and/or, as applicable, Health Plan. Such instructions shall be binding upon Professional Provider and its Practitioners. Professional Provider may not bill for Provider Services rendered by a Practitioner if such Provider Services are subject to billing independently by Practitioner, by another Professional Provider, and/or another entity subject to another agreement or arrangement with Highmark and/or, as applicable, Health Plan. Under no circumstances may Professional Provider engage in duplicative billing.

5.7 Timely Filing and Cooperation. Professional Provider agrees to submit claims, including the initial claim, as well as edits to and re-submissions of the initial claim, within six (6) months of the Member's date of discharge or service. Where claims are subject to coordination of benefits, non-duplication of benefits, or subrogation, Professional Provider agrees to submit such claims, including the initial claim, as well as edits to and re-submissions of the initial claim, within six (6) months of the process date of the primary carrier. Highmark or Health Plan will deny payment of claims not submitted within these time frames and Professional Provider may appeal such denial in accordance with the terms of the Administrative Requirements. Additionally, Professional Provider agrees to timely cooperate with Highmark or Health Plan's requests for information needed to process and adjudicate a timely filed claim. Highmark will deny claims which are submitted within these timeframes but which are incomplete (not Clean Claims) when Professional Provider does not provide all information necessary to adjudicate the claim within six (6) months of the original submission. Denials related to incomplete claims may also be appealed in accordance with the terms of the Administrative Requirements. Professional Provider shall hold Highmark, Health Plan, and Members harmless for all such denied claims.

5.8 Prohibition of Fees for Directing Members. Professional Provider and its Practitioners are prohibited from paying or receiving a fee, rebate or any other consideration in return for (a) directing a Member to another Professional Provider or (b) furnishing services to a Member as directed to Professional Provider or a Practitioner by another Professional Provider.

5.9 No Double Billing by Practitioners. Professional Provider agrees that it shall ensure that each Practitioner does not bill Highmark, Health Plan, or a Member independently for Provider Services rendered to Members on behalf of Professional Provider. Professional Provider further agrees, and shall ensure that each Practitioner agrees, that in no event shall Highmark or a Member be liable to such Practitioner for any payments made with respect to the Provider Services rendered by such Practitioner on Professional Provider's behalf. Professional Provider agrees to return promptly to Highmark and/or, when requested by Highmark, to the applicable Member, any payment received by Professional Provider or, where applicable, any Practitioner, in violation of the terms and conditions of this Agreement.

5.10 Billing for Non-Covered Services. Except as otherwise stated herein, Professional Provider may, at all times, bill a Member for services which are not Covered Services. Billing for non-covered services may occur only if Professional Provider has given the Member advance written notice that the service may not be eligible for coverage and an estimate of the cost thereof. Thereafter, the Member must agree in writing to assume financial responsibility for the service in advance of receiving such service. The signed agreement shall be kept in Professional Provider's records. Non-covered services include those ineligible under the Member's Plan Documents, deemed experimental or investigational, or deemed not medically necessary by Highmark and/or, as applicable, Health Plan.

5.11 Preauthorization. Preauthorization, the pretreatment review by Highmark or Health Plan of a treatment plan, service, and/or treatment site, is a contractual obligation under the terms of the Member Plan Documents. Preauthorization must be requested prior to the initiation of certain services in accordance with the Member's Plan Document. Highmark or Health Plan may require certain clinical records and diagnostic aids relating to a Member to be included with requests for preauthorization and Professional Provider agrees to provide such information in a timely manner. Charges for services denied because Professional Provider failed to initiate or receive preauthorization may not be collected from the Member. Appeal processes applicable to the Member may be Professional Provider's only recourse.

5.12 Coordination of Benefits and Subrogation. Professional Provider agrees to and shall cause Practitioners to cooperate with Highmark's coordination of benefits efforts consistent with a Member's Plan Document and the Administrative Requirements. Professional Provider shall make efforts to collect and provide to Highmark other payor information as requested under established Highmark billing requirements. Professional Provider further agrees to and shall cause Practitioners to cooperate with Highmark or Health Plan in efforts to pursue subrogation claims against others where a person or entity other than Highmark or Health Plan has primary responsibility for payment.

5.13 Restrictions on Billing. Professional Provider may not charge Members or Highmark more than Professional Provider charges its other insured and uninsured patients. When requested, Professional Provider must substantiate his, her, or its Usual Charges to Highmark. Professional Provider may enter into agreements with a HMO, PPO, insurer, third party administrator or similar entity to accept allowances or reimbursement different than Professional Provider routinely receives from Highmark or its Usual Charges. Additionally, a Professional

Provider may waive any and all applicable Member Cost Sharing to benefit a financially disadvantaged patient, provided that documentation supporting such is noted in the Professional Provider's records and is appropriate under the circumstances.

5.14 Restrictions on Additional Fees and Charges. Highmark's allowances for Provider Services that are Covered Services include reimbursement for supplies, overhead, and other expenses. Therefore, Professional Provider shall not bill or collect from a Member, Highmark or Health Plan any fees or charges itemized and distinguished from Provider Services provided and submitted to Highmark for payment unless such fees or charges are expressly permitted under applicable Plan Documents or Administrative Requirements. Nothing in this section is intended to prohibit collection of missed appointment or late appointment penalties so long as the Member is provided with notice and agrees in writing to accept responsibility for such penalties.

5.15 Electronic Submissions Requirement. In an effort to reduce paper waste, if Highmark has an electronic tool that supports a process that Professional Provider is bound by in the Administrative Requirements, Professional Provider must use the electronic tool for such process. The electronic tool(s) include, but are not limited to the Online Provider Portal. In addition, Professional Provider agrees to submit to Highmark and Health Plan claims through an electronic media system acceptable to Highmark. Professional Provider agrees to ensure access to electronic connectivity access capabilities and will maintain such access throughout the Term as set forth in the Administrative Requirements.

6. RELATIONSHIP BETWEEN THE PARTIES

6.1 Independence of Practitioners. Neither of the parties hereto, nor any of their respective employees shall be construed to be the agent, employer, employee or representative of the other, nor will either party have an expressed or implied right of authority to assume or create any obligation or responsibility on behalf of or in the name of the other party. Neither Professional Provider nor Highmark shall be liable to the other party for any act, or any failure to act, of the other party to this Agreement. In performing services for Members, Professional Provider and its Practitioners are not employees of Highmark, and Highmark shall do nothing to interfere with the customary Professional Provider-patient relationship in such cases. Furthermore, Professional Provider should not withhold care from Members if Highmark does not consider the service to be a Covered Service. Highmark shall not be liable or responsible to anyone or any person as a result of any negligence, misfeasance, malfeasance or malpractice on the part of Professional Provider or any Practitioner, as applicable, performing services for Members.

6.2 Indemnification. Each party hereby agrees that it shall indemnify and hold harmless the other party and/or such party's subsidiaries, affiliates, owners, subcontractors, vendors, or agents or the respective successors, assigns, employees, officers, or directors of any of the foregoing (individually, "Indemnified Party," and collectively, "Indemnified Parties") against any and all claims, actions, demands, losses, costs, or penalties incurred because the Indemnified Party or Parties becomes a party to any lawsuit, settlement, hearing, or other judicial or administrative proceeding arising in connection with (either directly or indirectly) the Indemnified

Party's or Parties' performance under this Agreement and due to any act or omission of the other party hereto and/or such party's subsidiaries, affiliates, owners, subcontractors, vendors, or agents or the respective successors, assigns, employees, officers, or directors thereof. The foregoing indemnity shall include judgments, settlements, penalties, losses, liabilities, fees, damages, reasonable costs, reasonable expenses, and reasonable accountant's, appraiser's, and attorney's fees as incurred by the Indemnified Party or Parties.

Notwithstanding the foregoing, the indemnity obligations of Highmark shall in no event apply to any professional malpractice or general liability claims brought by any person, entity, or organization arising out of any negligent or wrongful act or omission by any physician or health care Professional Provider, nor arising out of any negligent or wrongful act or omission by or on behalf of Professional Provider, its agents, contractors or employees, except such act or omission done by the sole and specific direction of Highmark. This indemnification provision is not intended to make Professional Providers responsible for any negligence or wrongful acts of Highmark or Health Plan.

6.3 Blue Cross and Blue Shield Association Liability Disclaimer. Professional Provider hereby expressly acknowledges that this Agreement constitutes a contract between Professional Provider and Highmark, that Highmark is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies permitting Highmark to use the Blue Shield Service Mark in the Commonwealth of Pennsylvania and the Blue Cross Service Mark in a portion of the Commonwealth of Pennsylvania, and that Highmark is not contracting as the agent of the Blue Cross and Blue Shield Association. Professional Provider further acknowledges and agrees that it has not entered into this Agreement based upon representations by any person other than Highmark and that no person, entity, or organization other than Highmark shall be held accountable or liable to Professional Provider for any of Highmark's obligations to Professional Provider created under this Agreement. This paragraph shall not create any additional obligations whatsoever on the part of Highmark other than those obligations created under other provisions of this Agreement.

7. DISPUTE RESOLUTION

7.1 Procedure for Resolving Disputes. Except those disputes that must be resolved by a process required by 40 Pa.C.S.A. § 6324(c), this section is intended to apply to all disputes between Highmark and Professional Provider arising under this Agreement or otherwise (regardless of the type or manner), including, without limitation, billing and payment disputes, medical policy disputes, audit issues, torts, contract issues, unfair trade practices, antitrust allegations, and all other disputes between the parties which could otherwise be brought in a state or federal court action. This section does not apply to disputes involving a Member grievance or complaint, which shall be handled in accordance with other applicable procedures as set forth in the Administrative Requirements.

7.1.1 Coding Audit Disputes. To resolve Coding Audit Disputes, Professional Provider shall follow the process set forth in the Administrative Requirements. For purposes hereof, the term "Coding Audit Dispute" shall mean a dispute that arises as a result of one or more

claims coding audits as conducted by Highmark and/or its designated agent and that: (a) result in a disagreement as to the appropriate code(s) assigned to a particular diagnosis and/or service rendered or supplied by Professional Provider to a Member; and (b) has not been resolved by the parties through informal means.

7.2 Process for All Other Disputes. All other disputes which would not be determined by the Coding Audit Dispute Process or which must be heard by a process required by 40 Pa.C.S.A. § 6324(c) shall be submitted to negotiation, mediation, and/or arbitration pursuant to the following standards:

7.2.1 Informal Meeting. Should Professional Provider seek an interpretation of a specific provision of this Agreement or question an administrative decision made by Highmark, a Professional Provider representative will first discuss the matter with a member of the Highmark Provider Relations department. If the matter is not resolved, Professional Provider's representative will request that a Highmark representative arrange an informal meeting of representatives of Professional Provider and Highmark. Such meeting will be held within forty-five (45) days of the date the request is received by the appropriate Highmark representative. Prior to such meeting, the requesting party shall present a written explanation of its position with regard to the matter.

7.2.2 Mediation. If, after the completion of this process, a dispute should continue related to this Agreement or an administrative decision made by Highmark, any party may make a request for non-binding mediation by making a written request in writing with the other parties, and such mediation shall be conducted by a single mediator acceptable to the parties. If a mutually acceptable mediator cannot be agreed to within ten (10) days of the request for mediation, the parties shall utilize a mediator appointed by the American Arbitration Association ("AAA") or such other similar body having rules governing alternative dispute resolution as mutually agreed to by the parties (hereinafter "an Association") and the Association mediation rules (except as modified herein) shall apply. The mediation shall occur in one of the following locations: Pittsburgh, Pennsylvania, Harrisburg, Pennsylvania, or Wilkes-Barre, Pennsylvania and shall be conducted within thirty (30) days of the mediator's appointment. The cost of the mediator shall be split equally by the parties. It is expressly understood that the mediation (including any letters or other documents sent or filed with the AAA or mediator shall remain confidential, including communications at the mediation or between the parties and/or the mediator.

7.2.3 Arbitration. Only if the parties fail to resolve a dispute in accordance with the informal meeting and mediation process, then any or all of the parties may submit the dispute to binding arbitration, such arbitration to be conducted under the auspices and rules (except as modified herein) of the AAA, or such other Association as agreed to by the parties before a mutually agreed-upon panel of three (3) arbitrators, such arbitrators to be chosen in accordance with the rules of an Association. The arbitrators shall convene a hearing on the dispute in one of the following locations: Pittsburgh, Pennsylvania, Harrisburg, Pennsylvania, or Wilkes-Barre, Pennsylvania within ninety (90) days of the arbitration request unless the parties agree to an extension. It is expressly understood that the arbitration (including any letters or other documents sent or filed with the Association or mediator shall remain confidential, including communications at the arbitration or between the parties and/or the arbitrators. The award of the arbitrators shall

be final and binding and shall contain no right of appeal by the parties. Judgment upon the award rendered by the arbitrators may be entered in any court having jurisdiction thereof, and any such judgment so entered shall be entered as a confidential judgment under seal. The costs and expenses of arbitration, including the fees of the arbitrators, but excluding attorney's fees and expenses, shall be paid in such proportion as is determined by the arbitrators as part of the award or, if no such determination, equally by the parties. Except as otherwise provided herein, the arbitrators shall have broad discretion with respect to any dispute governed by this section to award any and all types of compensation or damages as well as to render any and all legal and equitable relief which a court of competent jurisdiction could have ordered if the dispute had not been arbitrated hereunder and had been determined by such court.

7.2.4 Individual Disputes. The parties hereto intend and agree that the provisions of this section shall apply to individual disputes between the parties and that the arbitrator(s) shall have no power or authority to certify or otherwise determine a class action or otherwise combine any individual dispute with other disputes between the parties or between a party hereto and one or more third parties without the prior written consent of all affected parties hereto.

7.2.5 Limitations Period. All disputes not resolved by negotiation must be submitted to arbitration within the time period provided by the applicable statute of limitations found in applicable Laws and in no instance more than two (2) years after the occurrence of the event giving rise to the action.

7.2.6 Survival. Any and all disputes of the parties which relate to matters (including the termination of this Agreement) occurring during the Term of this Agreement, even if the dispute is alleged after the termination of this Agreement, shall be subject to and governed by this section regardless of the termination of this Agreement.

8. NETWORK ACCESS

Professional Provider agrees that Highmark allows persons covered by other Health Plans to access its Networks of Participating Professional Providers under the terms and conditions of this Agreement including the Participation Attachments. All Highmark Affiliates are subject to this Agreement unless Professional Provider has a separate agreement with the Highmark Affiliate governing payment for Provider Services rendered to a person who would otherwise be covered as a Member herein.

Professional Provider acknowledges and agrees that Highmark or a Highmark Affiliate may also allow persons insured by other health insurers or administered by other third party administrators to directly or indirectly (through Highmark or a Highmark Affiliate) access its Networks of Participating Professional Providers under the terms and conditions of this Agreement (such other health insurers hereinafter called "Network Access Partners") so long as the payment rates applicable to such Network Access Partners are the same as the then current payment rates for the same category of Product as agreed to in this Agreement. Professional Provider agrees to treat any such person covered as a Member regardless of where the person resides or receives coverage and

agrees to render Provider Services to such persons and accept payments by Highmark for Covered Services under the terms and conditions of this Agreement unless Highmark informs Professional Provider of any different terms and conditions applicable to such persons. Highmark agrees that such Network Access Partners will comply with the terms of this Agreement unless Highmark informs Professional Provider of any different terms and conditions applicable to such Network Access Partners. Professional Provider further agrees to cooperate with administrative procedures involving network access and shall comply with any reporting or data collection requirements with respect to Provider Services rendered to such persons given access under the terms of this section. In the event of a conflict between the requirements of the applicable Plan Document in which such person is enrolled and the terms and conditions of this Agreement, the requirements of the applicable Plan Document will govern. Notwithstanding the foregoing, any dispute or complaint involving Professional Provider shall be handled in accordance with this Agreement and the Administrative Requirements of Highmark or, if none, by applicable Laws.

9. RECORDS, INFORMATION MANAGEMENT AND RELEASE, AUDITS, AND REVIEWS

9.1 Records Maintenance and Access. Professional Provider will maintain an accurate system for maintenance and distribution of administrative, medical, claims, and financial records of all services rendered by Professional Provider and will maintain records, documents, and any other information relating to Members and this Agreement for ten (10) years or such longer period as required by Law. With respect to medical records, Professional Provider will maintain appropriate medical records for each Member receiving services. Professional Provider shall keep all Member information or data confidential and shall comply with all applicable Laws governing confidentiality, privacy, breach notification, and disclosure for medical records and patient information including, but not limited to, the Health Insurance Portability and Accountability Act of 1996, as amended. Professional Provider will ensure timely access by Members to their records and information and agrees to the timely transfer of copies of a Member's medical records at Highmark's written request. Professional Provider shall also ensure that Highmark, accrediting bodies and Official Bodies, and/or each of their designated agent(s) have access at all reasonable times to the books, medical records and other records and papers of Professional Provider relating to this Agreement.

9.2 Information Management and Release.

9.2.1 Professional Provider Information. Professional Provider agrees that now and hereafter Highmark may utilize, publish, disclose, and display information relating to Professional Provider to entities and individuals, including, but not limited to, current and potential group customers and their agents or designees, the Blue Cross and Blue Shield Association and its related companies, Participating Providers, third party vendors, and current and potential Members, using those formats and media (including, without limitation, marketing materials, other publications, directories, and internet) that are most appropriate under the specific circumstances. Such information to include, but not be limited to, information related to Professional Provider's services such as quality, utilization, and other data relating to Professional Provider's delivery of

health care and findings and assessments generated in connection with a Highmark designed program, report, and/or study regarding Professional Provider and/or other Participating Providers.

9.2.2 Cost Information. Information relating to Professional Provider's charges, payment rates, patient pay amounts (including Cost Sharing amounts), and/or other fees, costs, or payment amounts related to Provider Services under the terms of this Agreement may be confidentially disclosed by Highmark to current and potential Group Health Plan customers (and their agents and designees) the Blue Cross and Blue Shield Association (and its related companies), Members, participants in risk sharing or care management programs, Participating Providers, and third party vendors under Highmark's normal course of business and consistent with the Administrative Requirements. Such information may also be used to inform tools and resources to estimate care costs provided such cost information is used in a manner consistent with the use of such cost information from all similarly situated Professional Providers.

9.2.3 Member Information. Professional Provider agrees that information regarding Members and this Agreement is a highly confidential trade secret of Highmark and is entitled to protection as such. Except as necessary during the normal provision of services to Members in accordance with applicable Laws, Professional Provider agrees not to reveal any information or data regarding Members (individually or collectively) to any other person or entity during the Term of, and after the termination of, this Agreement without the prior written consent of Highmark. Professional Provider further agrees, except as required by Laws or to the extent information is publicly otherwise available, not to utilize or disclose any information gathered or provided regarding the cost and utilization of health care services by Members (whether Member specific, account specific, or aggregate) or software data that is owned or licensed by Highmark or Health Plan. Professional Provider may not use information including identification of Members or other Highmark beneficiaries to directly or indirectly solicit, target, influence, or attempt to influence any Member to: (i) disenroll from coverage or (ii) participate in or subscribe to another health plan. Professional Provider should not utilize or disclose any of the foregoing without prior consent from Highmark or Health Plan. Notwithstanding the foregoing, during the Term of this Agreement, Professional Provider may use aggregate data regarding Members which is not Member specific or account specific if included in the aggregate with similar data from other parties in a form which will not allow the party to whom disclosure is made to identify the information as Member information.

9.2.4 Other Confidential, Proprietary, and Trade Secret Information. The parties agree that the terms of this Agreement and information exchanged related to this Agreement or any potential amendments thereto (including, but not limited to, rates, utilization, and revenues), and other proprietary information related to Highmark's operations disclosed to Professional Provider are highly confidential trade secrets of Highmark and are entitled to protection as such, and Professional Provider agrees not to reveal such proprietary information to any other person or entity during the Term of, and after the termination of this Agreement without the prior written consent of Highmark.

Professional Provider may identify, at the time of its submission to Highmark, any such information that it believes to be proprietary or a trade secret. Such proprietary information

identified by Professional Provider shall not include information generated by Highmark, a third party, or an Official Body and shall not include information discussed in the Provider Information, Cost Information and Member Information sections above. Information received by Highmark, and agreed by Highmark to be proprietary, will not be released without the prior consent of Professional Provider.

For the purposes of this Section, proprietary information or methods of operation shall not include: (i) those which are contained in printed publications available to the general public; or (ii) those which are or become publicly known through no wrongful act or omission of Professional Provider. Notwithstanding the foregoing, proprietary information may be revealed if required by Laws.

9.3 Health Information Exchange. Professional Provider agrees to participate in any Highmark, Highmark sponsored, and/or Highmark-designated community sponsored health information exchange program, which supports and/or facilitates the availability and exchange of claims-based information and clinical information for the treatment and ongoing management of Highmark members and/or other patients of Professional Provider. Any requirements relating to participation in such health information exchange program shall be provided through Highmark communications and/or Administrative Requirements in advance of such participation requirement and shall be binding on Professional Provider and Highmark.

10. FRAUD, WASTE, AND ABUSE

10.1 Reviews, Inspections, and Audits. Highmark, Health Plan, and/or each of their designated agent(s), appropriate Official Bodies, and appropriate accrediting bodies may perform any and all reviews (on-site, off-site, or otherwise), inspections, and audits of Professional Provider that are deemed necessary as specified further in the Administrative Requirements. Such reviews include, but are not limited to, credentialing activities, medical necessity reviews, data validation reviews, billing and claims payment audits, coding audits, cost effectiveness reviews, quality of care reviews, and quality improvement audits. Professional Provider agrees to reasonably cooperate in arranging or allowing such activities and by making available Professional Provider's premises, physical facilities and equipment, medical and other records, and information relating to Members at no cost to Highmark. Professional Provider will provide electronic copies of medical records and other information at no cost to Highmark. Based on such reviews, inspections, and audits, Professional Provider agrees to participate in any reasonable corrective action plan required by Highmark.

Professional Provider agrees that Highmark may, in compliance with applicable Laws, deny payment, reject claims, and/or review claims on a retrospective basis and/or collect any Overpayments using the process set forth in the Administrative Requirements. In such event, Professional Provider will hold Highmark, Health Plan, and the Member harmless with respect to payment for applicable Provider Services, except for the collection of applicable Cost Sharing.

Highmark may also disclose the terms of this Agreement or provide a third party with a copy of this Agreement (including all Exhibits) where a disclosure of terms is required for an audit.

10.2 Professional Provider Statements. Professional Provider shall be fully and completely responsible for all statements and representations made on any claim form submitted to Highmark and/or, as applicable, Health Plan, with respect to Provider Services, regardless of the mode of execution or verification of such form that may be accepted by Highmark and/or, as applicable, Health Plan. If Professional Provider misreports or misreports services to Highmark and/or Health Plan, or engages in duplicative billing, Professional Provider shall immediately notify Highmark and/or, as applicable, Health Plan in writing of such misreporting. Professional Provider shall be responsible for reimbursing Highmark and/or, as applicable, Health Plan, for all Overpayments caused by such misreporting or duplicative billing.

11. PRIVACY REQUIREMENTS

Professional Provider shall comply with HIPAA, HITECH and all applicable Laws, as amended, and the regulations thereunder.

11.1 General Privacy Standards. All Protected Member Information is subject to various statutory privacy standards, including, without limitation, the regulations of the PID implementing the provisions of Title V of the Gramm-Leach-Bliley Act (31 Pa. Code Chapters 146a and 146b), HIPAA and HITECH. Professional Provider shall, and shall ensure that all Practitioners, treat all such information in accordance with those standards, and shall use or disclose Protected Member Information only for the purposes stated in this Agreement or to comply with judicial process or any applicable Law.

11.2 General HIPAA and HITECH Compliance. Professional Provider agrees that Professional Provider will adopt such policies and procedures, will execute or has executed such written agreements, and will provide or has provided such further assurances as required to make Professional Provider's activities under this Agreement and all attachments compliant with HIPAA and HITECH, including, without limitation, the following:

Business Associate Agreements	45 C.F.R. §164.504(e);
Information Safeguards	45 C.F.R. §164.530(c);
Standard Transactions	45 C.F.R. Part 162;
Data Security	45 C.F.R. Part 164; and
HITECH Requirements	45 C.F.R. Parts 160 and 164.

If the regulations adopted pursuant to HIPAA and HITECH are modified in any way that affects the terms of this Agreement or any attachments or Professional Provider's obligations under such documents, Professional Provider agrees to adopt such policies and procedures, execute such written agreements and provide such further assurances as may be required to make Professional Provider's activities under this Agreement and the attachments compliant on or before the final compliance date of any such modifications.

11.3 Electronic Transactions. The parties agree that all communications between Professional Provider and Highmark that are required to meet the Standards for Electronic

Transactions, as defined and set forth at 45 C.F.R. Part 162, shall do so. For any other communications between Professional Provider and Highmark, Professional Provider shall use such forms, tape formats or electronic formats as Highmark may approve.

11.4 Provision of Protected Member Information for Treatment, Payment and Health Care Operations. The parties acknowledge and agree that HIPAA permits Professional Provider to provide Protected Member Information to Highmark or Health Plan, as applicable, for purposes of Treatment, Payment and Health Care Operations (each as defined by HIPAA) without a consent or authorization, except for psychotherapy notes. The definition of Health Care Operations includes, but is not limited to, quality assessment and improvement activities, activities related to improving health or reducing health care costs, case management and care coordination, credentialing of Professional Providers, and evaluating Professional Provider performance. Upon request by Highmark or Health Plan, as applicable, Professional Provider agrees to provide information, including Protected Member Information, to the requesting entity for purposes of Treatment, Payment and Health Care Operations activities without the authorization or consent of Members who are the subject of the Protected Member Information, unless such consent is otherwise required by applicable Law. In those instances where the Member's consent is required by Law, Professional Provider will use its best efforts to obtain such consent.

12. ACT 146 PRODUCT(S) COMPLIANCE REQUIREMENTS

The following provisions will apply in all instances where Professional Provider is providing services to a Member enrolled in a Managed Care Plan in accordance with the terms of this Agreement including all applicable Participation Attachments:

12.1 Definitions.

12.1.1 "Act 68" shall mean the Pennsylvania Quality Health Care Accountability and Protection Act (40 P.S. §§991.2101, et seq., as amended) and its implementing regulations as promulgated by the DOH and the PID.

12.1.2 "Act 146" shall mean the 2022 Amendments to Article XXI of the Insurance Company Law of 1921 (40 P.S. §§991.2101, *et seq., as amended*) and its implementing regulations as promulgated by the DOH and the PID.

12.1.3 "Act 146 Product(s)" shall mean any Product that is a "health insurance policy" or a "Children's Health Insurance Program managed care plan" as such terms are defined in Act 146.

12.1.4 "DOH" shall mean the Department of Health of the Commonwealth of Pennsylvania.

12.1.5 "PCP" shall mean a health care Professional Provider who, within the scope of the Professional Provider's practice, supervises, coordinates, prescribes or otherwise

provides or proposes to provide health care services to a Member, initiates Member referral for specialist care and maintains continuity of Member care.

12.1.6 "PID" shall mean the Pennsylvania Insurance Department of the Commonwealth of Pennsylvania.

12.2 Hold Harmless. Professional Provider acknowledges and reaffirms the hold harmless provision in this Agreement and agrees that such provision shall survive the termination of this Agreement and is to be construed for the benefit of the Members.

12.3 Act 68 and Act 146 Member Records. All Member records shall be kept confidential by Highmark and Professional Provider in accordance with section 2131 of Act 68 and Act 146 and other applicable Laws, including, without limitation, HIPAA, the Gramm-Leach-Bliley Act of 1999, and HITECH, as the same may be amended and the regulations thereunder.

12.4 Primary Care Professional Provider. PCP shall serve as the Member's initial and most important point of contact regarding health care needs (except in emergencies or for direct access benefits). Consequently, in addition to all other requirements hereunder, Professional Providers who are PCPs shall meet the following minimum responsibilities:

12.4.1 Providing primary and preventive care, and acting as the Member's advocate, providing, recommending, and arranging for care;

12.4.2 Maintaining continuity of each Member's health care;

12.4.3 Where required, making referrals for specialty and other medically necessary services, both in and out-of-network;

12.5 Maintaining a current medical record for the Member, including documentation of all Provider Services rendered to the Member by the PCP, as well as any specialty or referral services (including procedures that are coded using the most current ICD coding classification system);

12.6 Providing office hours accessible to Members for a minimum of twenty (20) hours per week and being available directly or through on-call arrangements with other qualified Professional Providers who are PCPs twenty-four (24) hours per day, seven (7) days per week for urgent and emergency care; and

12.7 Any additional standards imposed by Title 28, Section 9.678 of the Department of Health regulations (28 Pa. Code §9.678) implementing Article XXI of Act 68, as amended (including any successor standards or Laws) or any additional standards imposed by regulations implementing Act 146 (including any successor standards or Laws).

12.8 Act 68 and Act 146 Member Records and Access to Records. Professional Provider will maintain medical records in accordance with all requirements set by Highmark and

applicable Laws, and shall permit Highmark and Official Bodies, access to records for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Act 68 and Act 146, the regulations of the DOH adopted thereunder, and other Pennsylvania Laws, provided, however, that records shall only be accessible to Highmark and Official Bodies' employees or agents with direct responsibilities for the functions enumerated above.

12.9 Quality Programs. Professional Provider will participate in and abide by the decisions of all quality assurance and improvement, utilization review, or management, and Member complaint, grievance and external appeal systems applicable to Act 146 Product(s).

12.10 Compliance with Laws. Professional Provider will adhere to all Laws applicable to the provision of professional health care services under this Agreement.

12.11 Prompt Payment. Highmark will pay all Clean Claims as required by Section 2166 of Act 68 and Act 146 and 31 Pa. Code §154.18.

12.12 Notice. Where required by Act 68 and Act 146, Highmark will notify Professional Provider in writing at least thirty (30) days before it implements any changes to its contracts, policies or procedures affecting Professional Provider or the provision or payment of health care services to Members unless the change is required by Law. No such notice shall be required if the change is required by Law. Such changes shall be binding upon Professional Provider upon the effective date thereof.

12.13 No-Gag Clause. Nothing in these Regulations shall be construed to limit or prohibit Professional Provider's right to discuss, and Professional Provider may freely discuss, with any Member, or, where applicable, on behalf of such Member with such Member's representative: (a) the process that Highmark or Health Plan uses or proposes to use to deny payment for a health care service; (b) medically necessary and appropriate care available to such Member that is within Professional Provider's scope of practice, including information regarding the nature of treatment, risks of treatment, alternative treatments, or the availability of alternate therapies, consultation or tests, regardless of benefit coverage limitations under the terms of the Member's Act 146 Product; and (c) the decision of Highmark or Health Plan to deny payment for a health care service.

12.14 Termination. As required by Act 68 and Act 146, Highmark or Health Plan will not sanction, fail to renew or terminate Professional Provider's or Practitioner's participation in an Act 146 Product for any of the following reasons:

12.14.1 Advocating for medically necessary and appropriate health care for a Member, where such care is consistent with the degree of learning and skill ordinarily possessed by a reputable health care professional provider practicing according to the applicable legal standard of care;

12.14.2 Filing of a complaint, grievance or external review in accordance with the terms of Act 68 and Act 146, or assisting Members in filing their own grievances;

12.14.3 Protesting a decision, policy or practice that Professional Provider or Practitioner reasonably believes, consistent with the degree of learning and skill ordinarily possessed by a reputable health care professional provider practicing according to the applicable legal standard of care, interferes with the ability to provide medically necessary and appropriate health care;

12.14.4 Professional Provider's having a practice that includes a substantial number of patients with expensive medical conditions;

12.14.5 Professional Provider's objecting to the provision of, or refusing to provide, perform, participate in or refer a Member for health care services when the refusal of Professional Provider is based on moral or religious grounds and Professional Provider makes adequate information available to Members or, if applicable, prospective Members;

12.14.6 Professional Provider's communicating with a Member or a Member's representative in accordance with the terms of these Regulations; or

12.14.7 Professional Provider's taking any other action specifically permitted under Sections 2113, 2121 and 2171 of Act 68 and Act 146 (40 P.S. §§991.2113, 991.2121 and 991.2171, *as amended*).

12.15 Obligation Upon Termination. In the event of the termination of this Agreement by Highmark or Professional Provider, Professional Provider agrees upon request to cooperate with Highmark or Health Plan in obtaining information from Professional Provider or its Practitioners regarding those Members enrolled in an Act 146 Product that may be affected by such termination such as they are undergoing an ongoing course of treatment or are otherwise active patients of Professional Provider or Practitioner. Such information includes, but is not limited to, the name, address, and identification number of affected Members of an Act 146 Product.

13. SURVIVAL

Any terms or other covenants contained in these Regulations that require action or inaction by a party after the termination of the Regulations shall survive said termination.